



Department of Health

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**Health Information Exchange (HIE) Advisory Commission  
June 5, 2014  
Meeting Minutes**

**Attendance:**

*Commission Members:* Ted Almon, David Gorelick, MD (Chair), Paula Hemond, Nicole Lagace, Lisa Shea, MD

*State Staff:* Michael Fine, MD, Jane Morgan, Samara Viner-Brown, Amy Zimmerman

*Guests:* Laura Adams (Rhode Island Quality Institute), Elaine Fontaine (Rhode Island Quality Institute), Alicia Maltz (Rhode Island Quality Institute)

**1. Meeting called to order** at 3:33PM by Chair, Dr. David Gorelick.

a) Introductions

b) Minutes (April 3, 2014) approved

c) Recommendations: The Commission will make recommendations to Dr. Fine via an advisory letter and incorporate public comments. The Commission is also required to submit an Annual Report to the Department of Health and the Regional Health Information Organization (RIHO) that will include recommendations to Dr. Fine and meeting minutes. Staff will find out when the Annual Report is due.

**2. Public Comment: None**

**3. Use of HIE Confidential Health Information**

Amy Zimmerman noted that the role of the commission as stated in the law is to advise the Director of Health on HIE and making recommendations related to the *use of, and appropriate confidentiality protections for, the confidential health care information of the HIE*. To assist the commission with this charge, the current policies related to access to and uses of CurrentCare, RI's Health information exchange, was presented by Rhode Island Quality Institute's (RIQI) compliance officer (Alicia Maltz).

**a) Access to CurrentCare**

- Only healthcare providers, as defined by Rhode Island regulations, and limited RIQI staff (for operational purposes) have access to CurrentCare. Additionally RIQI's policy requires that the following three requirements be satisfied prior to an individual gaining access to CurrentCare: 1) a valid data use agreement has been signed (usually by the providers' health care organization); 2) CurrentCare trainings were completed; and 3) the user has been approved by the health care organization's delegated user administrator (who is identified and named by the signatory). Every 6 months a report goes to the administrator of who has access to review/refine as needed.
- CurrentCare is HIPAA compliant with role-based permissions.
- There are three levels of access: 1) licensed independent practitioners (can see all data and access data in an emergency (break the glass)); 2) licensed non-independent practitioners (can see all data but cannot access data in an emergency); and 3) clerical/administrative staff (access to demographic data not clinical data).

- Individuals when enrolling in CurrentCare can choose from three options for who can access their data: all treating providers (like HIPAA), only certain providers and in an emergency, or only in an emergency.
- 95% of all enrollees have chosen to allow access by all providers and not just limited to emergency care.
- All policies are available on the CurrentCare website and all data users must comply. Additionally, CurrentCare has numerous controls and detections procedures it undertakes in order to monitor the access and use of CurrentCare data for appropriate use. RIQI auditing includes daily access review, those after 9pm other than ER, long log-ins, same last name, coworkers, as well as a weekly audit of RIQI employees. A certified letter is sent to the site if anything unusual, they must reply within 10 days.

*Access Issues:*

- 1) *How can CurrentCare support “team-based healthcare” for healthcare providers working for entities that are not traditional “health care delivery organizations” or “care-based”* (e.g., payer-based nurse care managers, school nurses, etc.): While CurrentCare data would be extremely helpful to school nurses, EMTs employed by a municipality (city/town), and nurse care managers that are employed by health insurers, the data use agreement requires certain assurances that non health care entities may not be able to comply with, such as being a covered entity under HIPAA, etc. How can these types of legal barriers be addressed to support transformation of the health care system under new payment models which are more team based, etc?
- 2) *Policies that support the patient and their families/caretakers appropriate access to CurrentCare through the community/patient portal:* While the law requires individuals have the ability to access what is in their CurrentCare record, implementing a patient portal raises specific challenges to implementing policies around parental access to adolescent records that are compliant with federal and state privacy laws; and providers need to gain the trust of their adolescent patients, as well as issuing access to caregivers, etc.
- 3) Supplying data to payers to support value-based payments (as they partner with providers and take on care management roles).

*Discussion:*

- Dr. Shea suggested that the purpose of the data (e.g., for whom and how the data will be used) should be considered. Are the data being used to treat a patient or for the coordination of care? The patient needs to be aware—they may not expect a case manager from an insurer to have access. Insurers are different since they are not direct care providers. Ms. Lagace also mentioned that it is important to know what the information is being used for and that users have different purposes (e.g., school nurses vs EMS vs licensed healthcare professionals). RIQI mentioned that a nurse care manager works between the patient and hospitals. CurrentCare provides live data rather than having to wait for claims data, which take time. The nurse can intervene with emergency departments and help coordinate patient care, possibly reduce unnecessary readmissions if care coordination can keep care at the appropriate delivery level.
- Dr. Gorelick commented that emergency departments can look up the patient to see their history and primary care providers can use the information to identify trends. Nurse care managers representing insurers should be able check CurrentCare and get hospital alerts etc. as they may be assisting with clinical care coordination. The insurer may have data that the treating clinical team may not be aware of. CurrentCare access may help the case manager provide another level of care coordination that may benefit the patient and community.
- Ms. Lagace stated that it is in the interest of insurers’ care coordinators/nurse managers to make sure patients are getting the care they need, but insurers also want to make sure they are

saving money. It is important to respect consumer privacy. She felt that giving nurse managers access to CurrentCare falls into a different category compared with healthcare providers who are responsible for the health of their patients.

- Mr. Almon asked whether employers can stipulate enrollment into CurrentCare or withhold benefits. The answer is no, since enrollment is voluntary.
- Dr. Gorelick suggested looking more closely at access to CurrentCare information by EMTs, school nurses, teens (access and enrollment) One idea was not to allow access by insurance company nurse managers as users, as they can contact other providers who have access to CurrentCare.
- Mr. Almon mentioned that the Health Department needs to assess the health status of the community, but that is hard to do while also protecting privacy. Data can be aggregated. The All Payer Claims Database will be an additional tool.
- This issue of user access will be a topic for which we determine recommendations. It was agreed that more information is necessary before recommendations are made. A subcommittee could work on this on topic. It was also suggested that some nurse care managers attend the next Advisory Commission meeting so that commission members can better understand their role within a health care insurance company.

## **b) Uses of Data**

### *Analytic Uses Presentation*

- CurrentCare data can be used for treatment and coordination of care, by RIQI for operations, and the data can be used for public health purposes • Some uses by RIQI include resolving duplicate enrollments; assessing enrollment trends; identifying minors to revoke eligibility when they turn 18; managing data sharing partners; evaluating impact of CurrentCare on return on investment (ROI).
- RIQI has policies and procedures for Analytics: requests for reports that contain protected health information (PHI) must be approved by the Chief Privacy Officer.
- Active Analyses is the analytic platform to assist in analyzing CurrentCare data: areas that have/are being analyzed such as readmission rate analysis.
- Future analyses could include: flu outbreaks; Lyme disease incidence; asthma incidence by geography and pollution indicators; duplicative imaging.
- Research: there have been no disclosures for research to date; RIQI is developing policies and procedures to address when researchers request data with PHI as well as for de-identified data. They will come to this commission with PHI requests so the commission can recommend to the director if the research/use would be considered a public health use .

### *Discussion:*

- Ms. Zimmerman mentioned three allowable uses of identifiable data per regulations: 1) treatment and care coordination; 2) RIQI-HIE operations; and 3) public health purposes (e.g., outbreaks—trace individuals to protect the community). The regulations are broad and can be interpreted in different ways. De-identified data can be used to see patterns in trends vs. individual level data. Research studies may need individual level data, but publications would include aggregate data only. Need to understand HIPAA guidelines regarding identifiable data.
- The Commission needs to develop a process for determining the release of identifiable (PHI) data. Although it is difficult to anticipate requests, a process needs to be in place. Mr. Almon suggested there will need to be a case by case review. Ms. Lagace asked about a Human Subjects Review Board. The Health Department does have an Institutional Review Board. Dr. Shea suggested that guiding principles should be developed even if requests are reviewed on a case by case basis. Dr. Gorelick mentioned a mechanism should be developed for the

submission of requests for both de-identified data and identifiable data. How data are handled after the project is completed will need to be included in requests. Ms. Zimmerman suggested that if an academic researcher requests data from RIQI, this commission must review the request. Data cannot be obtained just because they have IRB approval from their institution.

- The Commission will need to develop criteria to assure protection of data and information.

#### **4. Topics for Future Meetings**

##### *1) Access to HIE*

- Need more clarity on those entities that want access to HIE. More information on specific needs and roles (those associated with insurers, how use information, what are protections, etc.) is needed.
- Develop recommendations for Director Fine. Identify subcommittee to look at law and community process.
- Mr. Almon suggested looking at what other HIEs are doing and questioned whether there is a trade association of HIE's. Ms. Adams responded that Rhode Island is furthest along compared to other HIE's. We have opt-in with strong privacy and protection components. There is a listserv and can ask what other HIEs are doing regarding access.
- Dr. Gorelick also suggested we look at what RIQI is doing to assure privacy protection and appropriate data use, while still providing appropriate access to HIE data. We should also consider the role of this commission as an advisory body. We will make recommendations and may need to bring others (experts, etc.) in for discussions.

2) *Power of HIE and Barriers*: Dr. Shea suggested the commission consider issues related to the power of the HIE and identifying any barriers. She mentioned optimizing the HIE for issues such as MOLST (currently in process) and also questioned whether there are barriers to having certain information in the HIE due to laws? For example, how does CurrentCare deal with mental health (CFR42) data? There may be other barriers to care and coordination. It was mentioned that there is an opportunity for Public Comment at each of these meetings. Clients and agencies can attend and state what they want addressed.

3) *Single Sign On*: Once logged into CurrentCare, being able to launch into the Prescription Monitoring Program (controlled substances database) or one's own EHR vs having to log in and out of various it systems.

4) *Accountability and Privacy Issues*: Ms. Legace questioned whether there are touch points with patients to inform them of who has been given access? Patients should be able to log into one place rather than individual healthcare provider portals. Patients are being asked by specialists to access their portals and multiple portals and systems can be overwhelming. RIQI is building a patient portal which can be demonstrated at a future Commission meeting.

#### **5. Future Meetings**

*Next Meeting*: August 7, 2014, 3:30pm-5:00pm, Department of Health, Room 401

- Presentation on definition of roles (nurse managers, etc.); RIQI will return with suggestions and options.
- Recommendations can then be formulated. Ms. Adams noted that the HIE Commission can develop recommendations, but they are to be reviewed by both the Health Department and the RHIO (RIQI), and additional suggestions may be made.

*Frequency of Meetings*:

- Currently, meetings have been scheduled for every other month (regulations require a minimum of one meeting annually). We will discuss the 2015 schedule at next meeting (bring calendars). Meetings can be monthly, quarterly, etc.

**6. Meeting Adjourned** at 5:02pm