Executive Committee
Healthcare Reform Commission
January 23, 2012
Meeting Minutes

Attendees: Lt. Governor Elizabeth Roberts, Secretary of Health and Human Services Steven Costantino, Health Insurance Commissioner Chris Koller, Governor's Policy Director Brian Daniels, Director of Administration Richard Licht

I. Call to Order: Lt. Governor Roberts called the meeting to order at 2:00pm. She advised that the group would be hearing presentations on Health IT Initiatives in the state, and turned it over to today's presenters.

II. Health IT Initiatives in RI:
   a. Al Kurose, Coastal Medical President: Today, there is already some significant value added from current*care*, as seen by Coastal docs. Hospitals are signing on now as part of currentcare, so our docs receive notification when patients are admitted to hospitals, and when they leave. This aids in proper transitions of care. Coastal in the next few months will be moving up efforts to enroll patients in current*care*. There is little that is more important than having up-to-date patient evaluations, specialist evaluations, etc. when meeting with patients. In a small number of years, we believe a statewide health information exchange will come to us, and that we will use it so often, in many ways, and a discussion of its value will be gone. Certainly, the design of current*care* is highly functional. One of the things the healthcare system needs is to be more efficient – some of our current inefficiencies comes from a lack of information, and a system like this can cut down on that inefficiency.
      i. Lt. Governor Roberts: Is the notification regarding a patient in a hospital only for a notice for admittance or for discharge as well?
         1. Al Kurose: Yes, it is for both.
      ii. Commissioner Koller: As a clinician, do you believe there is a reason why there should be one large health info exchange, vs. one per area, hospital networks etc.
         1. Al Kurose: Smaller implementations are a way to get started, to edge up and show what is possible, but then expand from there.
      iii. Lt. Governor Roberts: If I am a current*care* member, but also have an e-clinical, like with Lifespan. Is that information shared?
         1. Al Kurose: Not at this time. E-clinical is going to have to write some software and build it in, so that if a clinician

sees a patient, and inputs a note, all the clinicians can see that note across the board for that patient.

b. Current*care* Demo and summary slides discussion: Charlie Hewitt, Charlie Danserou, Steve. Demonstration is from test environment, and in order to bring this data for preview. [Slides available here: http://www.healthcare.ri.gov/documents/01_23_12%20currentcare%20presentation%20To%20Health%20Care%20Reform%20Commission.pdf]

   i. Lt. Governor Roberts: I am a current*care* member, just had lab work done. At my physicians practice I can see my results. Do the results exist out in current*care* somewhere, or just at the lab and my physician practice; is it going two places or one?
      1. Response: It is going one place initially, for physicians, but then once it is accepted, it can be uploaded to the general current*care* feed.
   ii. Director Licht: Signed up for curren*tcare* last summer after a procedure; now go to a lab for tests, a current*care* lab – it will grab that data, so long as the feed has been established between entities?
      1. Response: Yes.
   iii. Secretary Costantino: Who owns the record?
      1. Response: The record is always owned by the patient. How physicians can and must make information available to patients and what they can charge. Hasn't been updated yet to deal with electronic care – required only to give paper records. Now beginning to look at the electronic aspect.
   iv. Secretary Costantino: Who owns current*care*?
      1. Laura Adams: It was established as a public-private partnership set in RIQI as established by the state. Governed by regulations, thus wouldn't say RIQI owns it. RIQI is a source, a steward of the data; the idea that one has an online record is not precise enough to think about how that works, and a document goes up to any info exchange, it is not a complete copy of the record.
      2. Al Kurose: In most respects your total medical record lives in a physician office, current*care* is going to get pieces.
   v. Director Licht: Are you saying there can be some subjective data that may not get to current*care*? How about a read of imaging? Does the MRI go in there, does the conclusion after the read go in there?

1. Response: Imaging reports are not being captured by *currentcare* today.
2. Lt. Governor Roberts: Somewhere there will be a relatively complete record, some abstract of whatever inpatient experience that I have had – will that exist? Yes, eventual goal.
    a. Al Kurose: This is a place we can go to get data to fill out the picture – as time goes by it gets more and more robust, always know there may be omissions, but if we have access to some data it continues to provide a better patient experience.

vi. Director Licht: Do you have a vision of what it will look like with images?
1. Response: Yes
2. Director Licht: Once you have images – what will go into it?
    a. Response: The report and a link to the actual image. When taking care of patients - could get a chart that demonstrates how results are trending over time, it is extremely helpful. This program allows for that.

vii. It is quite possible to subscribe to a patient, and have current*care* 'ping' you when something occurs to this patient. Lt. Governor: In that context, it is a daily list, or is it only when you look for a particular patient.
1. Response: It would be more of a daily list.

viii. Lt. Governor: If I am a patient, and know to go find it, can I extract the info and download it?
1. Response: From this service right now, we have no button to push that says send it to me in a summary and in paper form. We did a test of that feature last summer, and it is feasible, and the intention is to build it in.
2. Lt. Governor Roberts: If a primary care physician taking care of 2K patients, do we have any sense of a workflow issue? How many notifications one physician will get, and if 100 or 200 notifications will overwhelm an already full workflow.
    a. Response: That is a workflow issue – at Thundermist what they are doing is taking a secure message, and a summary is auto sent into its system.

ix. Lt. Governor Roberts: Does this format for the continuity of care document – is that RI specific? It is a national standard.
1. Laura Adams – consumer group has affected things like the consent, oversee some of the clinical, Those clinical advisory committees are continuing to give information

about that. Which governance committee addresses that particular question?

x. Enroll in each physicians office, also, patients can say, in terms of opting in, want it for emergency only, or want all informed on care, or can note which locations can see, or can block as necessary.
    1. Secretary Costantino: They can carve out certain providers?
        a. Response: They can, we find that about 90% of the people opt for everyone, but the rest, by and large, select emergency only. The other thing developing now is how to police being involved in patients care. One of the options is an auto notification if they select it – patient can receive notification if their record is reviewed. If you give permission to view the record, then have permission to view the whole record. Can change the viewing providers – but cannot select the data type revealed per provider.

xi. Director Licht: Is the intention to have pharmacies involved in here?
    1. Response: Yes over time.

c. Amy Zimmerman, OHHS, State Health Information Technology Coordinator presented on other health initiatives [presentation available here: http://www.healthcare.ri.gov/documents/01_23_12%20exec%20comm%20health%20it%20presentation.pdf]

i. Commissioner Koller: Medicare & RI Medicaid HER Incentives - Individual providers or institutions?
    1. Amy Zimmerman: Individual providers.
    2. Commissioner Koller: Do we know what percentage of physicians in Rhode Island are practicing with an EHR that meets meaningful use criteria.
    3. Amy Zimmerman: The Department of Health does a survey yearly on EHR use. There is a survey coming back soon, which will gather the data on. We do not have data on meaningful use at this time.

ii. Lt. Governor Roberts: When does the federal government expect RI to meet the RI REC HER Adoption Milestone?
    1. Amy Zimmerman: Two years.

iii. Lt. Governor Roberts: Wasn't one of the problems around funding was that the community mental health organizations were not qualified. If they do not have the platform, does it get you there, or is there an expectation of more funding?

1. Amy Zimmerman: Aggregating the two most prevalent platforms, the two that have the market share, also have money earmarked for behavioral health.

iv. Commissioner Koller: The quality reporting piece – although RI has legislation, it is pretty anemic compared to other states. Been able to use the money through ARRA and the ACA, and probably use some fed money to build the APCD, more for utilization than clinical quality. Learning how to do that there, at the same time as moving forward with these pieces. There are other states that have invested more heavily in this, and it ends up more important in the long run.

III. New Business: None

IV. Public Comment: None

V. Adjourn. Next meeting scheduled for February 6, 2:00pm.