

Implementation Working Group Meeting
December 21, 2006

Attending: Bill Hayes, Bill Mitchin, Kate Cauley, Philip Powers, Stephanie Jursek, Ayeshia Ellington, and Rick Moore.
By phone: Margie White, Megan Smith, Kim Keiser, Jeffrey Kapp, and Tricia Bohlander.

Kate called the meeting to order, completed introductions and asked the telephone group to please reference the wiki for today's handouts, specifically the RTI Implementation Report specifications. These include identifying actionable steps for each, the responsible entity, resources required, projected timelines and incremental steps. Kate started the group on page 18 of the Interim Solutions report and started with categories A and B,

A. Solutions affecting variations in organization business practices and policies (but not affecting state laws); and

B. Solutions affecting state laws/regulations;

The other categories will be addressed later at the next several meetings.

1 b. At the state level, there should be a monitoring body that routinely reviews interpretation, compliance and practice related to the national standards. Planned compliance timelines are needed for smaller institutions and practices.

For the monitoring body, the group discussed how the existing HISPC Steering committee might either provide the oversight described, be reconfigured to do so, or serve as an interim step to the establishment of a new/modified structure. Whatever group is finally configured must have broad stakeholder representation and geographic equity. The work of the group could be as specific as running a state level RHIO, or as general as serving as a clearing house for information. Its responsibilities might include acting as a monitoring body for compliance with state agreed upon standards and business practices, and it might be responsible for guiding consistent interpretation/implementation of national standards. At a state level, there was consensus around requiring the Continuity of Care Record as the starting point for what is included in the clinical record in order to facilitate health information exchange (HIE). The group also acknowledged that given the major changes underway with State Medicaid any state level policy setting, coordination/monitoring body would have to be closely integrated with Medicaid and other state level agencies including Department of Development and Broadband Ohio. Timelines for implementation would have to take into account the transitional issues inherent in the upcoming changes to Medicaid and the fact that we have a new administration coming on board. Discussion also identified the need for developing bylaws and clear definitions of authority for such an oversight group, and that this would be coordinated through the office of the Secretary of State in Ohio. There was also discussion about a sub-committee of the state level oversight group with a focus on legislative issues, and that the membership might include legislators who understand the need for health information exchange and funding at the state level to support it. The idea of an HIE Czar at the state level as a potential part of implementation for this solution was raised, but the group concluded that this was a task for the oversight group to review.

- Kim Keiser agreed to contact Bridget Gardner to look into who in the state legislature is already championing HIE and propose some other members who might be part of an implementation step around the state umbrella group.

- Margie agreed to map the necessary state departments to Steering Committee membership to insure that all state departments are appropriately represented.

4 a. *States should take responsibility for developing the basic infrastructure to support health information exchange.*

The PUCO, ODOD, the Board of Regents, Broadband Ohio and the Department of Insurance, Department of Homeland Security, Department of Development through the Third Frontier, the Secretary of State office, and the LMC are all entities currently working in this area. The first step in the implementation is to be able to describe what exists now and what is in the planning stages through these efforts already underway. For example, Department of Development holds has a great deal of money, Broadband Ohio is working to change tariffs, and develop an atmosphere conducive to implementing HIE. The steps that have already been completed and the metrics that will be used to measure progress and completion must be developed. The goal is to have equitable and ubiquitous connectivity as the foundation for insuring HIE across the state. ARIC would be a good network of providers to use as a barometer to determine when we have been successful in getting the infrastructure sufficiently developed to facilitate statewide HIE. In terms of funding this solution, we need to clearly define what is the state's responsibility vs. what is the feds' responsibility. It would be good to know what kinds of expenditures are routinely being supported at the state vs. federal level in other states.

- Phillip agreed to learn more about what Broadband Ohio is doing

4 b. *Any publicly funded projects must be standards based including compliance with the Continuity of Care Record (CCR) standard.*

As we begin to address implementation of this solution we have to keep in mind that there are multiple requirements from multiple sources which may have an impact on defining how we do HIE in the state. For-example, in Ohio the state does not license hospitals, and organizations like JCAHO will soon implement requirements that the hospitals submit specific clinical data, and CMS is starting a post acute demonstration project, and it is not clear that they will require the CCR. However, if the state establishes this standard, then we can better coordinate with all the other requirements. The state could most readily establish this standard through the practical authority of its purchasing power—when Medicaid, OPERS, prisons etc., make decisions about what to purchase, there is significant economic impact. If they all agreed to the CCR standard we would be well down the road of establishing a business practice that required the CCR. A current example of how the state's purchasing power could then be expanded into the private sector is that Medicaid and DAS are purchasing services through both public and private health plans. Loren Ranbom is working to get Medicaid and private insurers at the same table to discuss joint purchasing and quality issues. It will be important to coordinate the authority of the state as purchaser across the various state purchasing activities related to health information technology and HIE. It is more a process of change management to move to requiring the business practice of a state standard like use of the CCR. The definition of “publicly funded” will need to be further clarified, and the authority for stipulating this condition may need to be identified beyond the marketplace.

The real issue has to do with interoperability across HIT systems, and adopting a state standard like the CCR would facilitate this more readily and at a lower cost. Additionally, at the RHIO level it will be important to have a state standard for clinical data elements because at the RHIO

level, we can then coordinate multiple provider systems, and/or work with central systems. As was true above, it will be important to include other health focused groups with established jurisdictions when it comes to recognizing and monitoring RHIOs across the state—Homeland Security RMMS areas, health districts, and economic development areas are just a few that come to mind which involved health care data. Also as was true above, legislative involvement and “champions” from elected officials will be an important part of successful implementation.

At this point in the discussion there was some discussion about why we need standards and/or some state level coordinating/monitoring body, and the issues raised focused on the need to emphasize health information exchange as the reason to develop and coordinate RHIOs, to be interoperable and to facilitate getting the right information about patients at the point of care to improve the quality of care and health outcomes.

A decision about what types of information will be exchanged is critical to planned implementation. The discussion of how many regions and how much funding was tabled was begun but determined not germane to this particular solution/implementation point.

6 a. *Consumer education is needed to articulate the perceived value of health information exchange against the perceived risk of privacy and security breeches in an electronic system.* Since Hurricane Katrina public perception of the need for electronic health information exchange and storage has increased and to a large degree sensitivity to privacy issues has decreased. However, education of the public is still needed and this will require a marketing campaign that articulates the advantages of HIE rather than focusing on all the protections in place to decrease the risk. The primary concern still being raised in the public is related to health information getting into the hands of employers or insurers, and used to discriminate against people as they apply for jobs/promotion and/or insurance. There was little confidence noted in the group in the laws that are designed to protect people from this kind of information misuse. The group had many specific ideas about messages and potential design of the marketing campaign, but suggested that the state oversight body would be the responsible organization and that private philanthropic organizational participation for funding such a marketing campaign would be important. In addition to consumer education, provider education is also needed to assure effective implementation of health information exchange. It was also noted that an implementation plan could identify existing networks across the state through which health related information is currently disseminated—OSHIP and the Medicare education efforts were cited as examples--and could utilize volunteers through networks that are not typically health related but would be concerned about health issues. Additionally, consumer advocate groups including organizations like AARP could be a source of educational efforts.

For homework the group was asked

- (1) to read the current roadmap document, with an eye toward implementation, (2) to read the Interim Solutions Report,
- (3) to read the template for the Implementation Report, and
- (4) to be prepared to discuss the balance of the solutions:

6 b. *Increased human oversight, evaluation of data integrity and enforcement of security protections are all recommended.*

5 a. *Current laws and practices that govern the paper release of treatment related information, should be implemented electronically to allow transfer and exchange of data and to track specific patient permissions.*

5 b. *The Continuity of Care Record, the only current national standard identifying fields for clinical data in an electronic record, should be used as the standard for determining what kind of information is routinely exchanged with regard to mental health, substance abuse and other diseases such as HIV/AIDS.*

5 c. *A federal and state approved emergency release should be adopted that patients routinely provide at the outset of treatment for exchange of information related to mental health, substance abuse and other “sensitive diseases” in case of an emergency.*

Meeting adjourned at noon.