

**MEETING MINUTES**  
**OFFICE OF THE STATE COORDINATOR FOR HIT STEERING COMMITTEE**  
**(HITSC)**

**DATE:**        **DECEMBER 16, 2013**  
**TIME:**        **10:00 TO 12:00**  
**LOCATION:**   **CROSS BUILDING, ROOM 300**  
**CHAIR:**       Dawn Gallagher

**ATTENDEES:** Shaun Alfreds, Dev Culver, Patti Chubbuck, Jonathan Ives, Joanie Klayman, David Maxwell, Chris Muffit, Hazel Stevenson, Rodney Redstone, Phil Lindley, Julie Shackley, Lorie Smith, Lina Earls, James Murphy-Dean, Poppy Arford, Danielle Hall, Stephen Sears, Susan Corbett, Holly Miller, Perry Ciszewski, Steven Cyrs, Kristan Drzewiecki, Sandeep Kapoor, April Smith, Gary Ozanich and Debra Hertz Nestadt

**Meeting Objectives**

Forum to provide status updates regarding statewide project initiatives to the Office of the State Coordinator for HIT. Maine’s statewide HIT strategy encompasses the following ideal:

*“Preserving and improving the health of Maine people requires a transformed patient centered health system that uses highly secure, integrated electronic health information systems to advance access, safety, quality, and cost efficiency in the care of individual patients and populations.”*

**Introductions**

Health Tech Solutions (HTS) members introduced: Sandeep Kapoor, April Smith, Gary Ozanich and Debra Hertz Nestadt.

**Opening Remarks** – Dawn R. Gallagher (chair)

In 2009 HealthInfoNet (HIN) entered into a cooperative agreement with the State of Maine to provide HIE for the Office of State Coordinator (OSC). HTS has been selected via an RFP to provide an evaluation on two components of the OSC/HIE efforts in Maine.

- 1.) The cooperative agreement between the ONC and OSC, which includes the exchange of Health Information in Maine.
- 2.) The future of HIE in Maine. We want to also look into ongoing provision of HIE in the winter and spring 2014, i.e. what HIE will look like? How will the OSC help inform the emerging initiatives in Maine? What sources of funding are available to help build on the important work of HIE in Maine?

The HTS members will help us develop the next path, i.e. what does it look like, what do we want from the HIE? Next steps, will also involve a request for funding which is typically: CMS 90 percent federal and 10 percent state allocation under the Meaningful Use Program.

**Background Information:** The ONC requires us to collect specific data on the HIE. CMS through the Office of National Coordinator (ONC) funded a four year agreement for OSC to have a HIE. Clinical data, claims data and care-coordination information are some of the specific data which is required to be collected. Other data is IHOC data to improve the health of children in Maine. Funding was spent on a baseline Survey Project of the HIE, some survey questions where i.e.

- How many Maine providers' have an E HR,
- Are they connected to exchange,
- Who is there broadband service provided? Etc.

HIN also conducted a survey of usage on the HIE as well.

### **2014 OSC Project Pursuance**

Several stakeholders on the conference phone for this meeting today are interested in the **FCC Healthcare Connect Fund (HFC)** Grant opportunity with application deadlines in early 2014 for the purpose of broadband service connections for rural, Maine Healthcare Providers (HCPs) and possibly additional connections to the HIE.

FCC are also proposing to have a **Pilot Project for Skilled Nursing Facilities (SNF)** that will provide E HR connections at least (point-to-point i.e. hospital to SNF) and the OSC's goal would be for SNFs to then be able to connect into the HIE. The goal will be to have SNF produce patient care documents in their E HR and then, share this data in the HIE once they are connected; resulting in improved continuity of care and quality of care for SNF patients and their providers.

The **Health Home (HH) Project** for patients with two or more chronic conditions or risk of two and chronic conditions are hoping to connect HH project participants to the exchange and the SIM Grant.

All of these projects (and others) are coming together and our goal and plan is for these new adventures to be included and integrated into the HIE.

### **Program Updates**

**HIN Overview, Advances, Future Goals** (Dev Culver and/or Shaun Alfreds)

- 2 year, Demonstration Project of four, major healthcare systems' delivery stations in the State of Maine and Franklin Memorial
- Shaun Alfreds came on board as COO and began to re-tool the exchange
- 2011 focused on physicians and physician practices
- All hospitals in Maine are now contracted
- 380 physician practices are contracted
- A few specialty care practices, more difficult to engage these providers as some of them are not Eligible Providers under the MU program.
- 93-94% of Maine residents currently have at least one record in exchange
- The exchange has an opt-out model, about 15,000 Maine residents chose not to participate
- 13-15,000 uses of HIE system monthly, related to access to care management strategies i.e. Bangor Beacon for notifications to the exchange
- The HIE is a Centralized Repository System Model for the value of population health
  - HIE model was based on the All-Payers Claims -Data Base (APCD) model, many providers are comfortable with this
- Data in real time, aggregated around the patient and available to providers
- HIE does not collect all patient information; does collect Demographic, allergies, lab, encounters, diagnosis, documents, etc.
- Data collected has increased, when Meaningful Use (MU) came forward increased interest
- Advancing the business model, i.e. initially collecting primary diagnosis, now collect secondary diagnosis
- Clinical information initially, now providers want to know payer and formularies
- 4 million transactions per week, this is inbound only i.e. feeds coming to HIN
- Participants can now receive notifications from the exchange and this feature resulted in increased access
- Goal to integrated Behavioral Health with the Clinical Community, by end of first quarter 2014 will have 12 LTC facilities and SNF connected
- See HIN as becoming more 'middle-ware' i.e. when someone is admitted somewhere i.e. ER Dept. information will flow out to PCP, etc. We believe this is part of the HIN future
- Another future goal is a consumer access point to the exchange, i.e. pilot through a provider's E HR portal under SIM and a VA grant
- Payer access through Medicaid is another future goal

- Sandeep CEO of the company; will let others introduce themselves
- Debra background in healthcare, research
- Gary senior research on HIE since 2008, National Chair for HIE Committee, etc.; completes assessments for ONC
- April, Project Manager
- HIE work space since 2009, company based in Kentucky
  - HIE work in WY, GA and CN
  - Meaningful Use work in SC and WY
  - E HR audits for FL and SD
  - Technical Assistance to CMS, Stage II work on audits, Stage III brainstorming, etc.

### **Sustainability Opportunities**

- **Life after ARRA**
- **Adding Value to Exchange of HIE**
- **E HR and other systems**
- **Meaningful Use data usage**
- **HIE for Quality Measures and Reporting Purposes**
- **Other HIE Data Usages**
- **Projects for adding value to HIE**

We all agree the exchange is good, but how do we take what we have now and add more value. It was described that providers can enter the HIE with just three mouse clicks and it takes approximately 15 seconds to enter the HIE. These are improved access points and advantages that providers value, but also want to investigate adding additional values listed.

### **HIN** (Dev and/or Shaun)

Provider survey results on reasons why providers do not actively use the exchange:

- Lack of knowing the HIE existed
- Users didn't know what we were or where we were; didn't know what the HIE was or what it could do
- Lessons learned, HIE requires a champion, a single most significant result of survey
- Not all data was in the system, but it wasn't the intent of the design initially
- Some complained that there wasn't enough patient data
- Others complained that there was too much patient data to filter through

Positives:

- Medications available
- Discharge Summaries for transition of care
- Ease of Use, natural flow of data for providers

Suggestions:

- Received suggestions on data that was not present i.e. EKG strips versus just the written report on the EKG procedure
- Providers were interested in larger anatomical pathology reports
- Interest in the inclusion of images

Sandeep: Does your outreach strategy include boots-on-the-ground to assist providers?

HIN

- Yes, a train-the-trainer program has been set up
- Recently, hired a clinical coordinator to work with on-going education needs

Dawn: What is the process you would share to interested provider that wanted to know 'how' they would get connected i.e. major steps?

HIN

- Provider contacts HIN > on-boarding material i.e. what it is? > Legal framework of participation > basically, voluntarily give up their PHI and put it into HIE > this is a significant legal agreement:
  - 1.) data agreement
  - 2.) legal uses of data
  - 3) how to request additional information
  - 4) HIPAA business agreement
    - a. small practices i.e. 39 pages
    - b. larger practices 79 pages, which requires a legal review.
    - The legal review can take two weeks to two months.
- Once Participation Agreements are signed it can take 3-9 months to get connected to the HIE through HIN.
- Everyone pays something as far as Participation Agreement, some are subsidized agreements
- The payment section of Participation Agreement tends to be 3 year agreements
- Fees are based on schedule i.e. every hospital within a range pays the same amount, same thing is true with LTC i.e. number of prescribers or beds determines payment amount. This information is considered by company to not be not public information

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Sandeep: Is there anything payer committees are committing towards funding?

HIN: Not yet.

Martha: How is the subscription fee paid?

HIN: Subscription fees are either in-kind or paid to another party i.e. hospitals staff are committed to a HIN Project or if small practice it may differ.

Sandeep: So the HIE uses HL7 messaging. Does the HIE create CCDs with that information?

Shaun: Yes we use HL7. CCDS are cumbersome in some cases and not really the business model that we began with nor really use.

Dawn: What are future perspectives as they relate to HIE and the IHOC Program, CDC Programs, HIT Programs, etc. i.e. What would be the expansion of the exchange that some of these program leaders would want to see?

Joanie: IHOC, overview expression. We are trying to use the HIE for purposes beyond what it was designed for i.e. quality reporting for quality measures for children.

Jonathan: Some of the items discussed earlier i.e. data that comes into the exchange is based on the continuity of care document which is about transitions of care that is different than quality reporting and quality measures. What it was designed to do and what we are trying to do with it to support quality measurements is different. If there was one lesson learned from the IHOC perspective and for us utilizing HIE data, that would be it.

Sandeep: Are the IHOC measures related to Clinical Quality Measures in Stage II Rule or beyond? i.e. Related to the CHIP Grant.

Sandeep/Jonathan: Quality may be captured in certified E HRs, but it is not passed through to the HIE. Sandeep: The business of calculating those measures at least for the CQMs has been defined and standard transaction sets are to be sent to a source, based on the data you have. I think the better way to calculate these quality measures would be for the E HRs to calculate them because the HIE can never have all the quality measures. Jonathan: if there was a quality repository in an HIE provided by HIN or another HIE; it would be helpful.

## HIN

Quality at the provider level is not always dependable either because patients are not loyal to one PCP and go to multiple providers. Our goal was to look at where the HIE could support communities and population health.

Joanie: We keep trying to draw the links and there have been a lot of lessons learned from a quality aspect.

Dawn: I keep hearing a reoccurring theme. Data in HIE and the available quality measures and reports that are available to come out. The original, HIE model was the input of data on individual patients, but what is being asked is from various sources and what is predominantly available is on adults. IHOC addresses mostly children, MH data, LTC, HH Program data, etc. is not currently available. How do we accomplish calculating quality for these various solutions?

## Sandeep

- Whether the request is for quality data or other data requests the HIE would...
  - Look at payers needs i.e. MaineCare is a payer as well and has data needs
  - What are the key requirements for augmenting or moving to a payer-based model i.e. who is funding the program?
  - Under ARRA, 85% of finances should be spent in clinical care data requirements, not in the administration bucket, which should make the HIE fees more palatable to the providers

## HIN

- HIE currently has limited payer involvement
- Challenge is that Anthem, WellPoint, Blue Cross/Blue Shield are not a local Maine focus
- Our model was built to be clinically focused
- Our model doesn't really recognize that the payer as a participant
- The data remains the property of the source i.e. the providers
- The only source we have are providers
- We are managing data on behalf of the providers, but we need to create a new class of participant--'payers'
- We need to find the point of convergence and value between the providers and payers and patients
- Now that we are drifting into notifications and analytics interest in payers in info in the HIE is rising

## Sandeep:

- Yes, payers have been slower to come to the table.

- Alerts for example, many payers are willing to pay based on a per transaction basis
- In a few states this has been finalized and explored in the payer market a little more
- MaineCare and the State of Maine is a big customer, so the Participation Agreement has to be balanced and it is a dance that has to be danced

Dawn: For instance MHDO (the all-claims database) if we had payers that wanted to be in the exchange, why would a provider who views its clinical information as somewhat “financial” information and proprietary, want to participate in a voluntary exchange system? If they don’t participate, then they get to keep their data “private.”

Sandeep:

- Many state licenses and their provider agreements, express providers must be a part of an exchange
- Some state licenses require that the holder must be a Meaningful User
- Financially, if it is a barrier to join the HIE, then getting ‘in the game’ kind of thing from the financial aspect has helped that cause of increasing payers in a HIE
- In Maine, you’ve got about 100% of your hospitals in the HIE
- Payer participations’ will help, since for obtaining MU funds, CMS doesn’t think of themselves as a provider, because Medicaid doesn’t provide “direct services.”

**CDC Lessons Learned, Future use of HIE (Stephen Sears, Danielle Hall)**

- We would like all our reportable conditions to be available to us electronically and to populate our databases, and that data would then, populate the federal databases electronically
- For example, Syndromic Surveillance for the purpose of overall use, the more we can automate this data the better off we’ll be
- The Maine Immunization Program, ImmPact2 would benefit from the above scenario
- For the Future: easy to transfer information from all healthcare partners
  - Anyone doing labs i.e. notifiable diseases, all in an electronic format
  - So we have it timely and we can react to it
  - Do better surveillance for public health purposes
  - Another area is Refugee Health, to better capture this type of PH information
  - All these from an infectious disease stand-point too
  - We appreciate the work that has been completed with HIN and value having a connection with our clinical partners

Dawn: What are other states doing with Cancer Registries?

Sandeep:

- Unlike other registries, the Cancer registry is fairly new
- It has significant higher amounts of data points
- On the flip side, when other registries came aboard this was before much technology was utilized
- I think the ramp up and out come for Cancer Registers will be much faster because the technology is already in place
- I would strongly suggest looking into the HIE for connections between the E HRs and the Cancer Registry, not a point-to-point, but a connection to the HIE

Dawn: If there was a provider that's not a regular HIE participation how would they do that?

Sandeep:

- Back office systems that delivers it to HIE
- Think of it as only a Data Deliverer to HIE, not a consumer of the data
- Immunization at the state level are just a transaction user, not someone that is a consumer of the HIE data
- The HIE would develop a role that only 'delivers' data

Sandeep: The Maine HIE has done a great job of getting hospitals connected, but if other like payers, registries and MaineCare would benefit from advancing engagements of the HIE for sustainability. CMS is changing and there seems to be a change in where the money is going to come from.

Dawn: Would like to hear from OIT Department i.e. Wizard system, ability and reports available? (Hazel and Rod)

- The MaineCare Wizard is a mechanism for collecting data to ultimately make MU payments to providers; this was the original purpose
- It has evolved and now we can pass information onto the CDC
- We can ensure we are ready for Stage II MU
- We also have reporting capabilities, but would refer to Bob Kelley for details on reporting

Dawn: Some data taken from the Wizard i.e. we know all providers who have done AIU, MU Stage I, all demographics, what type of E HR system being used and could cross-refer this data with HH Practices with at least two chronic conditions. It is mostly aggregate information by provider. So this provides:

- Various sources of data
- Some aggregate, some data points in real time

Dawn: What use do we make of this data? If you wanted to integrate claims, clinical, quality, data, etc. why kind of a business model do we want to use to aggregate data?

Sandeep:

- Some states are using all-payers database and MU together to do the patient calculations to ensure that providers meet the 30% Medicaid encounter requirements. Strongly suggest to use the APCD for post payment audits, not pre-payment audits.
- Trend is away from just using the administrative claims “dollars” analysis to identify payment amounts to creating the Continuity of Care Document (CCD) for each member which actually pulls the clinical data out of the claims data to create this “claims” CCD.
- **An option may be to have the APCD create a claims CCD that flows to the exchange (HIE) that is used to create an integrated (claims and clinical) data file that can be used by both payers and providers.**
- Some providers will ask: Why should I let HIN know what I got paid for something?
  - Create a CCD out of this data, example: All-claims payer base CCD
  - Anything you can do that the payment is going to the right person and eliminate fraud there is some funding available until at least to 2021-22.
  - By making these ‘linkages’ you have to **define the process** on **how** this might happens and work for the purposes described

Dawn: Poppy, from an artificial boundary and perspective and as a consumer; what would you want to be able to see going forward?

Poppy:

- From the MHDO (all payers claim database) model
- Broadening stakeholder community i.e. patients or people that might be patients in the future
- Transparency of information. There are currently silos of information, claims data is very concrete and a direct line of accountability
- The non-profit model is not required to be transparent
- Non-profit models are only responsible to their boards
- How a consumer comes in is very confusing to understand. What they can really trust, what is really happening with their personal data?
- I think that the best thing possible is full transparency, to be able to access claims data or their own patient record in a way they can afford.

Sandeep: Closing Remarks

- Federal money through the ONC is running out
- Examples of what states are doing:
  - Initially the state of KY took the ownership to set up the KY HIE and the state owned it and it runs out of the state government--HIE answers to the tax payer
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  - Some States that started out with private non-profit want more public oversight; while other states that started out with public, now are looking at private.

Poppy:

- Boils down to who pays for HIE
- Creates intense competition because funding is limited, how will HIE survive?

Sandeep:

- Bottom line, regardless of whether a state chooses to have a private non-profit, the State Coordinator has to have an active role in the governance because there is a public good and public dollars invested and there needs data available to all providers and ultimately payers.

Dawn: We'd like to hear on the development of workforce for HIT in the State of Maine too.

Martha: HIT originated out of HITECH Funding and ARRA. Education was made available through grant funds to employees currently in IT or with clinical backgrounds or both. The KVVC Program taught them all the nuances and history and different HIT workforce roles.

- 3 year educational program; with a E HR Consultant Track and an Engineering Track
- 250 graduates
- 50% took examines and became certified, some have multiple certifications
- Small percentage of students actually go into HIT roles; many are resources where they are employed
- HIT is ultimate responsible to the patient, which is the source that should own their own healthcare information
- The KVVC and DHHS joint effort was to help major providers and some smaller practices
- To date: over 1,000 facilities/practices helped to date
- Early cited challenge was that providers are busy and want to do the best for their patients, but struggle with all the HIT and who is to understand it and take next steps for their practices. This requires education and hand holding through complex processes. The joint effort provided these HIT resources to provider practices
- Struggle with process of understanding massive amounts of information

- Breakdown happens without educated resources to explain the process and what it the next step for incentive payments, redirecting to who to contact to connect to the HIE, etc.

Struck by Shaun's comment that providers did not know that the HIE existed or the benefit of the HIE. Outreach is critical to its success and it would be beneficial to have increased outreach, such as what the consultants provide.

Next Step/Action Items:

1. ONC Core Report: HIN will provide background information to HTS by January 15, 2014. Target is to have final draft done no later than February 7, 2014.
2. This meeting today provided a lot of good background information which will be used to help inform not only the ONC core report but the next component of sustainability and future path of HIE, including integration with emerging health care models and initiatives. Over next 3-4 years many grant opportunities; strongly encourage to get additional funding such as 90/10 MU funding; increase HIE to payers, to supplement funding since it is an inevitable need once ONC funding runs out.

**Adjourned at 12:09**