Utah Digital Health Service Commission Meeting

Thursday January 7, 2016, 10:00 a.m. – 12:00 p.m.
Utah Department of Health, 288 North 1460 West, Rm 129, Salt Lake City, Utah

Minutes

Members Present: Sarah Woolsey (Chair), Andrew Croshaw (online), Henry Gardner, Craig Herzog, Mark Hiatt, Preston Marx (online), Teresa Rivera, Randall Rupper, Tamara Richards, Mark Dalley, Patricia Carroll
Staff Members: Humaira Shah (UDOH), Wu Xu (UDOH)
Guests: Kailah Davis (UDOH), Navina Forsythe (UDOH), Wyatt Parker (HealthInsight), Emily Varner (UDOH), Brux Mcclellan (HealthInsight), Marc Bennett (HealthInsight), Dr. Joseph Miner (UDOH), Iona Thraen (UDOH), Ruben Rocha (SLCC), Mike Newman (UoU).

Welcome and Introduction:

Sarah Woolsey thanked everyone for being there and began introductions. Dr. Joseph Minor, the new executive director of UDOH introduced himself followed by the commissioners introducing themselves and the individuals on the phone. Every meeting there will be two commissioners that do extended introductions. Patricia Carol, Telehealth Development Manager at Utah Telehealth Network introduced herself and shared handouts. Henry Gardner introduced himself and has been in banking for the past 40 years and then got introduced to healthcare.

November meeting minutes were **motioned** for approval by Teresa Rivera and seconded by Craig Herzog and unanimously passed.

Sarah Woolsey discussed the summary document of things that are potentially actionable for the state to integrate behavior and physical health services. She asked if there were any additional comments or if the commission felt comfortable with it, then it can be approved to be a resource document and posted on the website. The recommendations are: 1) Utah citizens and its legislative leaders have an opportunity to address federal review of the confidentiality of alcohol and drug abuse patient records for CFR Part 2 Rule as it significantly impacts the ability to coordinate care between physical and behavioral health; 2)Advance understanding of the law through wider education and the ability to appropriately share through the QSOA arrangement; 3) Continue to innovate and advocate for colocation of physical and behavior health service locations; and 4) Continued interest in innovative models.

This document is **motioned** for approval with the change of adding the term payers overall by Craig Herzog and Henry Gardner seconded the motion with that suggested change and it was unanimously passed.

FOCUSED DISCUSSION: IMPROVING INTEROPERABILITY

Introduce Today's Topic:

Sarah Woolsey mentioned that she and Henry Gardner talked to commissioners to figure out key topics for the year and interoperability is a highlight. We want to kick off the new year with an interoperability discussion. ONC published their interoperability HIT road map and they also came out with some

standards guidance. The GAO report is mentioned. She talked about the Statewide Health Vision for Utah to be a place where all people can enjoy the best health possible, all can live, grow and prosper in healthy and safe communities. The Statewide Vision for Health IT is for Utah to be a place where the secure and efficient use and exchange of electronic health information will result in improved health status, better healthcare, lower costs and healthier communities. The health IT priority is to improve system interoperability and portability. The state proposed Goal 2 is to advance secure and interoperable health information. The slides are briefly discussed.

Definition of Interoperability in Our Discussion:

Henry Gardner read some responses he got back from his survey to the definition of interoperability. One is the ability to receive patient information in a readable and storable format regardless of the sources. Another is ability for information, genetics, and uses of family history and environmental drivers, etc. to determine health goals and commitment of people and provide what resources are available within a predefined format to assist people getting the maximum care needed. Interoperability- all EHR's can export and import data. Also, data can easily and reliably be shared and accessed. Qualitatively interoperability relates to health care data, and the ability of healthcare applications to exchange health care data refers to how quickly and securely applications are able to accomplish the exchange. The right healthcare data in the right hands at the right time is Henry's personal definition of interoperability.

The Office of the National Coordinator for Health IT defines interoperability as the ability of healthcare systems to exchange and use healthcare information without special effort by the users. Henry proposed that we use the ONC definition in our discussion.

Overview of Challenges and Opportunities in the Nation and Utah:

Marc Bennett said he looked at the GAO report and it's an interesting outline of the challenges faced in Utah. Marc describes his many roles and how they face the various challenges. The reason they invest in HIE and interoperability is because from their vantage point at *HealthInsight*, this is put in the context of transparency as defined as information available to the right person at the right time, where it is needed and to advance the goals of the system. This is where the patient, the provider, family members, payers, policy makers, decision makers and purchasers need it.

The lack of information flow transparency is a critical barrier to that transformation flow and the system properly functioning, it is worth every investment. He offered some national perspectives on the GAO report. Nationally, we are in a tug of war between the interest in policy makers around supporting transparent flow of information and the interest of industry and to some extent delivery systems to control the flow of information for their benefit. ONC took a bold step around data blocking in sending messages that they had to shame data blockers. There has been an unhealthy relationship between vendors of EHRs and policy makers at the federal level that reuse to allow sufficient movement towards commitment, encouragement, and demand, and water down the expectation of data being able to flow between departments in the community. This has been at the heart of the national challenge faced.

The GAO report talks about privacy and the challenge. The real challenge is that information security environment we work in now has created fear. You are always reading about the next data breach and challenge, which creates a paralysis. Record matching issue is a problem to be able to appropriately use an algorithm to have enough confidence you are talking about the correct information which isn't going to be a problem significant enough, so absent this ability there is difficult policy conundrum. Cost; our

Clinical Health Information Exchange (cHIE) in Utah is not yet sustainable, we sustain it because we have grants but largely by the clearing house function that UHIN pays. I don't think it will be sustainable until the product is significantly robust and we can have strong enough business cases. We are way better off than 90% of HIE efforts in the country however. There is also an issue of trust, and it is much easier to lose it than to gain. We spend a lot of time trying to cultivate it and manage it. We don't have it fully figured out. Yesterday we had the UHIN committee meeting and we have strong opinions in that group and some assert that their motivation is more pure than somebody else's motivation, which is a reality of the environment we work in. From a trust standpoint this is the challenge we face because we want to read into people's motives behind their actions.

The UHIN Direction In The GAO's 5 Key Areas:

Teresa Rivera explained whom UHIN is working with; they belong to several national organizations, such as Strategic HIE Collaborative and ONC. The Strategic HIE Collaborative is trying to make some inroads. There are 31 HIE's across the country, 95 million patients within our databases. We are starting on a project which we call the patient data center home (PDCH) where patients data actually follow them, getting data to go beyond geographical boundaries that HIE created. The pilot starts with Arizona, Colorado and Utah.

The GAO got a comment about insufficiency in standards, but there are a ton of standards. For example UHIN participates in various standard groups, pilots new data formats, and provides a standard format when sending data out of the HIE. UHIN is also certified through the eHealth Exchange confirming that we are interoperable with nationally defined standards and are working with ONC standards to identify common standards that can be used nationally. She then talks about variations in state privacy rules. The cHIE is using the Opt Out consent model so UHIN has provided a process for patients to opt out of sharing through the cHIE. There is also a pilot project for patients to control their own records. Furthermore we are doing a pilot project to integrate physical and behavioral health services and developing a process to transfer specific consent. UHIN is also working with UDOH to educate the community on federal privacy laws at combined HIT Conference.

Next she talked about accurately matching patient's health records. The cHIE utilizes the initiate master data management software which is rated a as a top data management software. For this UHIN accesses additional databases for correct matching and actively works with the data sources to improve the quality of their patient. Furthermore UHIN is participating in the USIM project to work on a shared identity service. Teresa continued to talk about costs associated with interoperability. The cHIE does not charge providers for contributing data for secure sharing with the community but rather providers are charged for using services. cHIE services can also be bundled for to save more. She also talked about how UHIN provides connection grants to reduce the burden of cost place of EHR vendors and also allows for multiple connectivity methods. By connecting to the cHIE, the provider can reach multiple entities and improving security and reducing costs.

She continued to talk about the need for governance and trust, and how the cHIE is governed by the UHIN Board. The board includes a broad representation of stakeholders like providers, hospitals, payers and patient representatives. The ECA provides for indemnification and member requirements and we also provide for data sharing at the level providers are able and willing to share. Moreover, UHIN has also identified issues with ONC including EHR vendor resources lacking, value to the provider beyond Meaningful Use incentives, not all provider types are included in Meaningful Use incentives and better workflow design and integration of data including seamless access in needs.

Discussion:

Marc Dalley made a comment- when you talk about rural in Utah you're talking about different settings. There are rural hospitals affiliated with systems, there are a handful that aren't affiliated with systems and that try to deal with all of the challenges that have been identified on our own which is difficult. We don't have the resources of the system, financial or personal. One of the biggest challenges we have is mentioned in interoperability and being able to connect to various systems. It would be nice to have a single point and be able to set up the information. I don't have great solutions to solve the challenges in rural Utah because I deal with a small subset of rural hospitals.

Preston Marx echoes a lot of the sentiments shared and feels the commentary has been great. Sometimes we try to silo rural health into something different but the same challenges apply. I would add that over the last few years a lot of our efforts as an independent rural health have been to have interoperability in house within our own organization. The digitizing of our record needed to happen in house first and at large we have gotten there statewide and if not nationwide, for most people are now willing to look at how do we communicate with other nonaffiliated entities. The reality of a rural hospital is we are entirely dependent on our EMR vendors. Something that would really move the rural hospitals is the tertiary sites that we refer to jump first and be active.

Marc Dalley made a comment- when you talk about cost of care, one of the struggles that we have is when we refer patients to larger facilities they duplicate everything we have done, lab tests, MRI's, CT, even though we have the ability to send that information to them. I don't know if this is an issue we can have much impact on but it is a cost item.

Craig Herzog- A lot of talk about getting some of the big vendors to participate, writing interfaces, and such, it seems to me that most of those big vendors don't really listen to anybody except maybe push from the end users. Maybe we as end users need to be better, it is really important if we want to provide exceptional patient care and we need to worry about patient safety standpoint and push from the end user point to these vendors and lets write the interface of whatever is necessary so that information can go into the health information exchange and everyone can participate in that.

Sarah Woolsey brought up action items- Tamara said one that came up was the HIT roadmap at the global policy level and the 5 areas.

Preston Marx- I would love to know what the current landscape is for each of the health care entities in Utah as far as interoperability. What are they doing as far as interoperability now with the health exchange or other methods?

Sarah Woolsey said Wyatt Packer is interested in looking at each of the elements. All of the larger entities have connected with the HIE, the next step is just to get the rural ones connected.

Sarah Woolsey wrapped up the meeting and thanked everyone. For future discussion topics, data and quality reporting is something that a lot of folks are interested in. Patient engagement in HIT and digital health in general is a topic that I have not seen us tackle and I am not sure how we would. Telemedicine and how rural can plug in. Anybody wants to put a vote out for those topics to be talked about next

meeting? I wanted to start another topic I am interested in and is increasingly interesting to the health department is the public health connection in health data. Commissioners agreed.

Meeting adjourned.