

Utah Digital Health Service Commission Meeting

Thursday March 3, 2016, 10:00 a.m. – 12:00 p.m.

Utah Department of Health, 288 North 1460 West, Rm 129, Salt Lake City, Utah

Pending Minutes

Members Present: Sarah Woolsey (Chair), Henry Gardner, Craig Herzog (online), Mark Hiatt, Teresa Rivera (online), Randall Rupper, Tamara Richards (online), Patricia Carroll

Members Absent: Andrew Croshaw, Mark Dalley, Preston Marx

Staff Members: Humaira Shah (UDOH)

Guests: Robert Rolfs (UDOH), Christopher Katis (UHIN), Candace Czerny (UHIN), Deepthi Rajeev (HealthInsight), Heather Borski (UDOH), Karen Coats (UDOH), Nancy McConnell (UDOH), Theron Jeppson (UDOH), Angela Dunn (UDOH), Stephanie McVicar (UDOH), Krysta Badger (UDOH), Peter Taillac (UDOH), Nancy Ortiz (UDOH), Mike Newman (UOU), Cynthia Alexander (UDOH), Emily Varner (UDOH), Amanda Hovermale (UDOH), Courtney Dinkins (AUCH) (online), Mark Fotheringham (UMA) and Jyl Bosone (UDOH)

Welcome and Introduction:

Sarah Woolsey started the meeting with introductions. Everyone introduced themselves and Mark Hiatt and Randall Rupper were the highlighted commissioners who gave self introductions. Mark has been a commissioner for about 2 years and is the Executive Medical Director for Utah for health insurance planning. Randall's research mostly focuses on care for rural and frontier populations including a lot of Native American communities and Telehealth. He has been on the commission for about a year.

January meeting minutes were **motioned** for approval by Patricia Carroll and seconded by Henry Garner and unanimously passed.

There was a follow up to the January discussion on improving interoperability. The next topic is the state innovation model has provided support to talk more about HIT infrastructure. Iona's team is planning the Summit and topics from the November meeting will be reflected in the agenda for the summit. All the commissioners are invited to the Summit.

Teresa Rivera explained the Summit see attached agenda. Christopher Katis jumped in and took over for Teresa since her line dropped. He discussed three breakout sessions, diabetes and obesity, behavioral health, and ePolst. The meeting will also highlight Privacy and Security. All DHSC are specially invited to attend.

FOCUSED DISCUSSION: Public Health Information Exchange

The Goal for Today's Discussion

Sarah highlighted Public Health and said her interest in better health outcomes and looking at where we have advanced in our interoperability and potential opportunities. She stated appreciation for Wu's hard

work and the clinical folks. This topic has not been reviewed by the Commission for a few years and we are interested in advancements.

Public Health Meaningful Use Highlights:

Immunization/USIIS:

Nancy McConnell is the USIIS coordinator and she discussed Meaningful Use Public Health Measure, which is submitting electronic immunization data to USIIS by establishing an ENH-USIIS HL7 interface. She discussed stages of Meaningful Use compliance. The intent of Meaningful Use Measure for state IIS is that the state IIS data is used for patient care and to improve public health and immunization forecast. She discussed USIIS Meaningful Use activities and the cumulative growth of the two stages. Over the years Stage 1 has declined and Stage 2 has taken over. See slides.

Nancy completed the presentation while the phone line was disconnected. Commissioners asked questions. Henry Gardner asked if there are equivalents of her in other states and she said yes.

A question was asked- There is a coherent organization of information system operators and then there are vendors who hold both immunization systems and providers hostage to this. Has anyone looked at creating an organization of providers? They all suffer from the fact that vendors do this. Nancy said she has recommended it to the providers here.

How do you know that a record that comes from one provider may be for the same individual that had the record and it's from a different provider- Nancy answered that there is a matching algorithm and this is one of the biggest problems.

Syndromic Surveillance:

Theron Jeppson discussed Syndromic Surveillance and how Meaningful Use has contributed to that. He discussed the Syndromic Surveillance MU objectives. Eligible providers and hospitals have Stage 1 and Stage 2. Stage 1 has eligible providers and hospitals submit 1 test message to public health generate and demonstrate capability to submit electronic SS data to public health. Stage 2 requires they set an interface with public health agency to transmit ongoing SS data. They have to be in a valid structure. At the end of December 2015 there is no more MU Stage 1 and it goes to modified Stage 2.

For Stage 2 from 2013 to present there are approximately 475 eligible providers and hospitals registered intent with UDOH. He discussed secure interface options. Some MU outcomes are mentioned. UDOH has more than doubled the amount of SS data coming into the system and have received over 26 million SS messages. Gaps and opportunities are discussed. Biosense only accepts SS data from hospital, ER/ED, urgent care facilities, less than 50% follow complete SS MU Stage 2, and some providers send more than the minimum required SS data elements and some only send the minimum.

Emergency Medical Services Connection to CHIE:

Peter Taillac introduced himself and his topic. The lay of the land for EMS and Health Information Exchanges are discussed. EMS has zero access to any patient's medical records. EPCR's are single use exempt related things and they don't allow them to be connected to EMS. They have been working on a

grant with ONC and UHIN and working with California's DOH to take steps towards fixing this. There are several features involved in this all based on the HL7 architecture. Step 1 is to be able to have EMS access, at least a limited database of patient information. As this has been developing, EMS getting data from medical records, it made sense that the HIE would be a suppository that EMS could get information back about the patient. EMS information going into the permanent medical record is third step. The EMS folks getting information back from the hospital for patient outcomes is the last step.

It was asked what portion of the EMS responses is transported to the hospital? He answered that about 50% surprisingly resulted across the board. Also asked was no health providers participate in the cHIE? All of the major health systems do participate. Teresa mentioned we have the 4 largest hospital systems and our goal is to get 100% of them before the end of the year.

Clinical Data Needs for Population Health Collaboratives:

Karen Coats started the discussion. She is representing healthy living through environment policy and improved clinical care. The improved clinical care piece is related to improving hypertension and diabetes control. Hypertension is identified, as the leading risk for mortality in the world and diabetes is the number one cost driver of health care in Utah and the U.S. We are in the third year and CDC's charge is to increase the number of health system that are using clinical quality measures to improve quality and to implement evidence based programs.

Basic first steps to these starts with the basic grant we have gotten. She goes on to discuss how Data is Information and public health does statewide surveillance and hypertension is a burdensome measure to get. Basically you have to get it by measurements and clinicians and health care providers are doing those measurements. States don't have good data for hypertension in general. The surveillance will help to understand the data. Also, in our charge we facilitate health systems to use data for quality improvement to provide actionable information back to health systems. We do have a gap-we have access to payer data but little access to clinical data. Along with that we lack understanding of health systems current use and burden of sharing clinical data. Our opportunity right now is that we have got EHR's and now is the time to understand how can clinical health data guide population health improvement and how primary care and public health cannot improve outcomes alone.

We need to increase our understanding of clinical data in EHR's and find least burdensome methods to share EHR data. We also want to identify the best role for public health. The plan is within the next two years to work with at least two health systems to develop a process to share EHR data and understand needs. Furthermore we want to work with UHIN to understand data sharing through their system. We also want to share the findings with additional partners and stakeholders and work towards scaling up. Lastly the longer-term goal is to expand statewide. She then discussed few challenges like knowing where to start, understanding health system needs, technical challenges, and competition. Some resources we have are informatics data analysts, infrastructure, and strategic planning for collective approach.

Karen asked for suggestions and feedback.

Commission asked what the partners are hoping to get from this project.

Karen answered that we need to think about what we can offer back instead of just walking in to a health system and asking for data. We talked about it and thought that we could offer them some public health data. A lot of our providers think of public health as providing care courses or classes. That is something we are really going to have to look at.

Newborn Hearing Screening Results & Diagnostics Reports Exchange:

Stephanie McVicar said their project here is the result of a short one-year grant received from the Office of National Coordination back in September. It's a community interoperability project. The purpose of the project is to expand the use of the cHIE to improve the care coordination for newborn hearing screening process. She discussed the various partners for the project, with Intermountain Healthcare being the big one. To give you some background, before children are one month of age they should receive a screen for hearing loss and before they are three months of age they should receive a diagnose of hearing loss. Also, a child with hearing loss needs to be enrolled in early. Utah has an additional milestone on top this which is a CMV test which must occur before the child is 21months of age. We actually have two Use Cases that we are concentrating on this year.

We want to have Intermountain's EHR be able to send diagnostic audiology reports and CMV lab test results through the cHIE's direct mailbox. This is just the start of the process and ideally for the future we would like to have it so there's an electronic interface between cHIE and our database. That was part of Use Case One. The second part is to send hearing screening results from the EHDI's systems through the UDOH CHARM system and interoperability Gateway to the cHIE to Intermountain providers. Some project metrics are first of all making our connections between all partners involved. We are going to also keep track of how many we receive. One challenge we found was finding a common code to transfer data. Overall we've done really well. We are ahead of schedule on Use Case one; we are just about ready to start receiving items into our mailboxes. We are just a few months into it but we are making good progress.

Question asked was what do you do with the data once you get it?

Stephanie answered that we are the ones that are in charge of making sure that the children are meeting these milestones so we have to report to the state but also nationally that these children are making their milestones. Our data coordinator gets all of the data into the database and hospitals have an automatic upload.

Discussion of Challenges and Opportunities:

Sarah Woolsey asked for any comments: Henry Gardner said I'd recommend that next year at the same time we perhaps can discuss advancements and improvements in the projects

Teresa Rivera agreed. No other comments.

Takeaways from the meeting include Commission support for policies that encourage data sharing, use of IT tools to facilitate public health, such as exemptions from CDS training for docs demonstrating regular use of the database to improve care or incentives for USIIS use aside from Meaningful Use. Additionally there are clearly some unclear messages coming from Meaningful Use entities regarding IIS and Syndromic Surveillance and community-wide streamlining of messages may reduce duplicative applications or submissions.

Meeting adjourned.