

Adoption

Which are most viable?

- Must integrate a system that people will use and use properly; we cannot force it.
- Electronic system must integrate well with the clinical workflow.
- Input and develop end-users.
- User acceptance; validation of user acceptance.
- 2.6: incentive for those to adoption.
- 2.6: support idea of additional \$ for use of technology. 2.2?
- 2.1: lower priority; transition into cultural shift; starting place to build systems working together; much is already being done
- 2.1: lower priority can be a starting place by admin. Payment has to interface clinical; much is already being done—CORE, private initiatives.

Barrier:

- Funds needed to maintain EHR and workforce training; lack of standards.
- 2.1: public and non-profits—may not have desktop/admin. Technology for some sectors it is still a need.
- 2.2 and 2.3: What do you do about the people who have already stuck their financial necks out?
- 2.3: one time subsidy could be used to reinvent in an upgraded system of provider already adopted system; or to upgrade to necessary interoperability; Those already using it could be a barrier; unwillingness to change.
- 2.2: token payment not workable; time limited; a mandate looming; needs to include decision; implementation scribes
- 2.4 with additional recommendation:
 - “Geeks don’t understand healthcare and healthcare does not understand Geeks” Rhios could solve this barrier.
 - RHIOs could offer implementation help; need technical people who understand healthcare.
 - Recruit trouble shooting IT workers.
 - This is a package of services necessary for long-term viability and implementation successful.
- Support is a key piece.
- 2.7: ODH: disease reports electronically (see flip chart)
- 2.5: saving the cost of an illness; financial support; there may not be ROI for the individual provider; the overall ROI is to the system.
- How do we get the people who benefit to pay for it?
 - Taxes? Coverage premiums?
- ROI discussion? (see flip chart)
 - How do we communicate this?
- Government; government bring in private sector; move from competitive type environment to holistic type environment.
- Various consistencies; use existing partnered organizations to disseminate the word.

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Break-Out Session 2 Discussion Notes
October 23, 2006

- Structure: state by-in required; game plan needed; federal preparedness; inventory of health resources; real-time monitoring by health status

Next steps:

- Demonstration product; let's how that it could be done; does not require 6 figures to do demonstration.
- HR issue: health informatics; colleges and universities teaching health/IT informatics.
- Regional: ODH database, Medicaid; geographic research; organize what makes sense
- Public vs. private organization:
- Who are all the stakeholders? Who is going to role demonstration project out first?
- Need incremental plan to build success.
- What services will be provided? What services are needed?
- Who wants to pay for it? Sure is the way the world turns.
- Those who benefit, pay for it.
- Don't lose sight of long-term vision—what is your nirvana?
- Who is our cheerleader?
 - (Are feds doing enough?)
- Squad of champions needed.
- Start at state level and have others contribute;
 - i.e. Medicare/Medicaid, associations, patients, etc.
- Information on public health should flow 2 ways; docs could get valuable info on their state and community levels.

Health Information Exchange

Recorder – Bonnie Hollopeter – Ohio KePRO
Dennis Swartzlander - Facilitator

Payer-based health records

- Concern in less confidence/accuracy
- Provider is closer to the data
- Personal health records should not be entered by just anybody/reliability
- Data integration perspective
 - source of truth/different conclusions/clearinghouse
 - needs to stay at the clinical level
- Do not equate claims base to payer base
 - Uninsured / where get that data?
 - Somehow tied back to patient/wherever it comes from
- Is there a repository?
 - Distributed model/query response/identify themselves/respond
- Where will oversight come from to release data?
- BCBS across the nation want to share data/initiated this
- Identification of requestor/how to identify person requesting?
 - Medicaid number
 - Valid information to prevent exchanging the wrong health information
 - Payer ID(through the payer) accurate
 - Universal Identifier
 - Needed to perfectly identify the correct patient
 - If we can't get our credit report right

Personal health record information exchange

- Physician Office may be the one to be maintain
- EHR being the source of the information
 - \$\$\$
 - Time
- Electronic clipboard
 - Updated – Medicaid – Patient Self Management
- Define that this information
 - Came from patient – source of truth
 - Caregivers have the most accurate account of information
 - Enhance IT literacy level
 - Who decides what goes into EHR that would be accessible to others?
 - Who's responsible for updating the information?
- **Regulatory Boards/State Licensing Boards**
 - IT Training?

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Break-Out Session 2 Discussion Notes
October 23, 2006

- Controlled substances
- **Health Plan participation with Ohio Based RHIOs**
 - Funding source?
 - Medicaid requirement
 - Culture change – data – vendors – competitive edge
 - Large number of national payors – Multiple states – how would connect ‘Aetna’ to all states?
 - Consider national mandates –
 - RHIO may become a monopoly that plan submits data
 - Providers electronically bill
 - Healthbridge
 - Did not see ROI – Pulled out
 - Make sure it is a value added service to participate – not necessarily mandated
 - Standard transmission standards
 - Extra points to those that participate
 - Consistency across all RHIOs

Providers must submit mandatory reporting through RHIOs

- Some entities already used to reporting
- Providers may be very happy to one system/one site
- Key is standardization across the board
- Prioritization as a ‘must list’ instead of doing all at once

Separate this statewide repository out of the policy issue

Not enough resources to handle both at once

Biggest bang for the buck

*****Priority – 4.3 Require regulatory boards to meet together and align their policies and rules to support HIT adoption and HIE**

Funding Issues

Service areas are unique

- Support local work
- Broader statewide work – state vs local issues

ROI to general public – show the benefit up front

- “My Health Record”
Competitive
- Already started by some plans
- Compared to England – all kinds of problems

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Break-Out Session 2 Discussion Notes
October 23, 2006

*******Patient Identifier** needs to be researched

- Without it information cannot be exchanged
- Birth certificate – Minnesota model
- Would also address public health?
- National guidance is necessary

Prioritization based on provider

- What data do we really need to submit to do quality of care work data?
- Recommendation - Continuity of Care Record - Timeline
 - Rolled Out – Not Big Bang
 - Medications
 - Allergies

Recommendation

Combine state and local exchange???

Modify Topic #1

- Patient Based Health Information Exchange
- More sharing / constructive discussion / ongoing communication with RHIO development

Funding

- Need more money
 - FCC money / 55 million year to connect rural health
 - Create new category development to get Third Frontier \$\$
 - Will take about a year – statewide
- CMS (Medicaid) 3 year matched RHIO \$\$\$
- Matched Communities – Intranet for non profits – can local efforts connect to
- Consider national network coming down the pike

Privacy and Security

- Major concern
 - If we make it easy enough to allow Low IT literacy people to use, will be much easier for hackers to access
 - Can't use HIPAA regulations to put people into jail? / recently passed – federal laws not where they should be
 - Authorization rights – needs defined and how granular do we go?
 - Different than paper world?
 - Easier to audit electronic
 - We have a lot more tools to track
- Balance between security and usability?
 - What does the public think?
 - Public understanding about hacking
 - Public expects that their information would not just be placed 'out on the internet'
- Rights to protect against lawyer access and/or life insurer access.

Interoperability

1. Based on the policy recommendations outlined in the Ohio HIT Strategic Roadmap for this focus area, which have the greatest viability from your perspective?
 2. What do you see as the barriers for implementation? Why?
 3. What do you see as next steps (tasks to be done), given these barriers?
- Adapters – how is that defined?
 - HL7, protocol?, XML, standard lexicon?, application?, vendors?
 - no silver bullet – nomenclature; standards different time development; Why do we want one standard or many standards?
 - Superset of standards – then variety can be had by different providers/vendors that feed in the superset – message formatting, etc.
 - MDS – federally required; every facility uses;
 - Flexible – to meet both local, state, and national needs;
 - Keeping the national goal in mind – HIPAA, for example; need to raise the national standards ... watch the feds in determining the standards
 - International standards – meet those needs as well such as ICD-10 –
 - How do we keep up Dynamics of national standards\
 - Standards constantly change – must keep up the dynamic of the changing world
 - ... the ATM example
 - What kind of core information do we really want? the CCR?
 - Basic information – demographics, etc.
 - Eligibility issues? Patient identifiers?
 - Agreed upon a data model
 - Patient Identifier - Who's who? Master Patient Index ... who is the owner?
 - Huge crosswalks between payers, providers, etc.
 - Master Patient Identifiers - HIPAA – Medicare D issues – industry-providers-payers - “turf wars” competition
 - Patient Advocacy – involved in the data; PHR - - health coaches –
 - Government role – worry of government prescriptive – worry of killing of the innovation
 - “What is the core set?” –
 - Administrative and clinical standards
 - Technical standards
 - Security and privacy
 - Data mapping
 - Different levels of information to be shared – patient consent
 - Example: Behavioral health – how much to share?
 - Different levels of how much to share
 - Ex: Drug interactions
 - Pay for performance issues
 - Advanced web crawler – like the web itself

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Break-Out Session 2 Discussion Notes
October 23, 2006

- Semantics is the issue to deal with this issue – a data model –
- CCR
- Standards are a compromise –
- IT is going from a centralization model versus going to a federated data repository method
- Futuristic – crystal-balling issues – need to think about the future
- ROI
- Education – academic centers related to the future
- Service Oriented Architecture
- BASIC bottom line – common definition/lexicon
- Clinical silos – so how do we get the clinician involvement in this issue
- Culture issues of each provider, practitioner, etc. involved
- Processes different within each facility even in an integrated system
- Six Sigma – process improvement – data flow – workflow issues – re-engineering
- Workforce development – roles changing –
- Reference architecture – how to get clinician involved ...show what's in it for me?
- Stakeholders – who are they?

Boiled Down

- Mission – better outcomes, health care reform
- Patient Advocacy
- State-level organization/involvement – collect and communicate information/best practices – keeping areas from becoming silos – local/state/national issues
- Common data model – change from a niche industry/cottage industry to an open industry
- Set semantic standards – common lexicon/superset – minimum amount – ATM example
- Major Stakeholder sponsorship/endorsement
- Incentives – “What's in it for me?”
- Master patient index – who is it?
- Health Care Culture

Organizational Structure Breakout

Holt Anderson, Lorin Ranbom (assistant director Ohio Medicaid), Cathy Nelson (Pres/CEO of 16 hospitals association and Mercy Health Partners), Jodi (ODMH), Cindy (CIO Mount Carmel), Karen Smith (Bricker), Chris Robino (vendor IT background, consultant to providers), Amy Leopard (facilitator), Rick Sites (recorder). Brian, Socrates and Stephanie arrive late.

1. Which organizational structure?
 - Cindy and Loren support a state level organization because too many different meetings - e.g., meetings with mayor, local groups, local CEO meeting with business, etc., “it’s a mess”. All are ad hoc groups, none chartered.
 - Does anyone know how many local organizations are trying to do the same thing and would be dissolved by a statewide effort? They create political obstacles since they have momentum and feel threatened.
 - Money is coming from a hundred different places.
 - Who should be at the table? Holt cites NC’s experience with Medicaid, the only Blue in the state, Governor’s leadership, the hospital association, etc. that were statewide.
 - Cathy supports state level organization with statewide representation but has some concerns about funding and priority and funding affected by governor and state budget.
 - Consensus supports a state level organization.
 - Role of state government is to provide start-up funding but not funding over time, e.g., states issuing grants to get RHIOs started.
 - What is role of state entity over time?
 - Coordination
 - Providing seed funds
 - Seek federal and other grant money
 - Education
 - Setting standards (federal government? is taking lead)
 - Oversight, more than coordination and facilitation—keeping people accountable
 - Who decides who gets funding?
 - Holt refers to his handout
 - Discussion of standard-setting, local versus national
 - Cindy doesn’t want state level entity to rule on national technical standards, fearing inconsistencies that make difficult data exchange outside of Ohio
 - Holt: NCHICA adopts standards but doesn’t create them
 - Standards include legal and policy, not just interoperable
 - Convene board of pharmacy, medical board, and other entities that have conflicting policies and standards
 - May need legislation to solve inconsistencies (Socrates worries about legislature’s lack of expertise)
 - Address remote access (standards?)

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Break-Out Session 2 Discussion Notes
October 23, 2006

- Making decisions such as “how many regions” that will make funding and other tasks easier for Medicaid
- State entity should accommodate regional RHIOs
- Apparent consensus that there should be a CIO in governor’s office and he/she should sit on the statewide entity
 - Holt: important because of governor’s bully pulpit but how much power do you want to give that CIO?
 - CIO could address legal barriers such as HIPAA interpretation and pharmacy board rules or interpretation of rules
 - CIO is communication channel into governor’s office
 - CIO is a policy person to help coordinate state agencies
 - Concern with continuity if CIO changes when governor changes
- State entity could provide forum for contentious issues such as pharmacy board regulations, different HIPAA interpretation, etc.
- State entity would identify work plan and ask governor to address
- Apparent consensus that state entity is a 501(c)(3) with some government representation
 - However no discussion of 501(c)(3) versus (4) or (6) or other business model

2. Barriers

- Need endorsement and leadership by new governor
- Bringing regions together
- Funding
- Competition with regional RHIOs

3. Next Steps and Overcoming Barriers

- Current proponents (those in attendance and engaged in OHHIT) need to be champions, talk to legislators and educate decision-makers
- Might be funding by legislature, from Medicaid

4. Call the Questions

- Should be state level structure with public-private representation
- Should support regions
- Should be CIO or coordinator in governor’s office and sit on board of statewide entity

Privacy and Security

Comments from the facilitator: Authentication of requestor and verification of user asking for the information is one of the biggest presented to the map.

- Challenges to protecting information
 - Transmitting info between entities-keeping it secure during transmission
 - Infrastructure availability/what does it look like?
 - Pay to play-how we pay to participate-technology is expensive?
 - How then do we secure the data after we make it available?
- Greatest viability for the recommendations from your perspective:
 - HIPAA guidelines was the first step in convening a body to take a stance to begin thinking this is the minimum standards in which to protect PHI
 - Where do we go from here, what are the next steps for standards?
 - Who should be setting standards?
 - 51 some orgs who dev. Info standards, the federal government has encouraged these organizations to get together and come up with one standard everyone can use.
 - One option Governs office is the state appointed agency to develop standards
 - Enforcement at state level most logical
- Barriers for implementation
 - Lack of standards for transmission
 - No trusted gatekeeper
 - Concern with private vendors stepping in to be gatekeepers
 - Protecting the public by assuring that all entities are following standards
 - Opt out
- Next Steps
 - Determine who is to be the trusted source to be the gatekeeper of the information.
 - Define benefit to stake holders
 - Look at best practices from other industries
 - Ex: Cleveland Clinic: when a pt comes from another organization, Cleveland clinic allows that referral org. to become a member of their organization to share / access the patient PHI.