MINUTES

eHealth Care Quality and Patient Safety Board
Information Exchange Workgroup
July 20, 2006

Location: 121 E. Wilson Street, Madison
Time: 10:00 a.m. – 4:00 p.m.

Attendees:

Members
- Debra Rislow (Teleconference)
- Susan Turney
- Denise Webb
- Hugh Zettel (Chair)

Resources
- Keith Haugrud
- Terry Hiltz
- Debbie Rickelman
- Vinny Taneja
- Lorna Will

Staff
- Alison Bergum
- Seth Foldy
- Stacia Jankowski
- Audrey Nohel
- Judith Nugent
- Susan Wood

Guest
- Susan Manning

Approval of meeting minutes
The minutes from June 29 were approved with the following minor changes: Added Vinny Taneja as attending as a resource and referenced Wisconsin Health Information Organization's (WHIO's) recruitment of an executive director.

Density of health information technology adoption
The workgroup members reviewed the draft document provided by Louis Wenzlow. Hugh Zettel stated that this paper will be useful to identify the gaps in health information technology adoption. Debra Rislow connected by teleconference and asked the Workgroup for a little more time to complete the density of health information technology adoption materials. She agreed to provide preliminary results at the next meeting.

Susan Wood reported that MetaStar has submitted a proposal to the Department of Health and Family Services to survey health information technology adoption in Wisconsin. The goal of this effort would be to create a better inventory of the extent of information exchange efforts that are taking place.

Discussion of architecture options and identification of research needed to understand and rank them.
Mr. Zettel reported on the following models:

1. Centralized – a model in which the health information of a community is centralized in one location.

Pros	Cons
▪ Easy access to all data ▪ One entity responsible and accountable for the information	▪ Privacy and security is a concern since all a person's health information is in one location

2. Federated – a model in which health information is stored where care is provided. With this model, an infrastructure is created that enables information about individual patients to be tapped from any location with proper authentication.

Pros	Cons
▪ Patient has more control over access to the information ▪ Information is assembled on the fly	▪ Expensive ▪ Many policy issues need to be worked through ▪ Not conducive to public health or population health uses

Outstanding question – is this information able to be downloaded across health care systems or only available in query format?

3. Hybrid – this is a model where certain elements of a health record are centralized and other information is stored at the location in which the care is provided. For example, a hosted centralized repository of a master person index or a mirror of the information in each health care setting.

Pros	Cons
▪ Allows greatest flexibility for each health care organization to choose the system they use	▪ Privacy and security could be a concern if all a person's health information is in one location

The workgroup discussed which model is the best, and decided that more discussion was needed on how the data will be used before deciding on an architectural model. Keith Haugrud cautioned the group that although technology often is seen as the barrier to adoption, he thinks that often this is because the policy issues are not adequately taken into consideration.

The workgroup did not directly discuss the issue of a personal health record model in which the patient is responsible for his or her care information, but did briefly discuss who would be the guardian of the personal health record.

Susan Turney asked if there is a resource to find out which model is the best fit in light of the continuing advances in technology. This led to a discussion of the need for the

workgroup to address the bigger issue of data maintenance and storage and the need to address the volume of data over time.

Key findings, unique opportunities, advantages, etc.
The workgroup went through an exercise in which they identified all the unique opportunities and advantages that Wisconsin has. These were then categorized. Listed below are the high-level topics and the specific information collected for each:

1. Opportunity - funding
   - Some unique funding sources to help support startup costs: 1) Blue Cross funds at two medical schools and 2) Patient Compensation Fund to minimize risk for physicians.
   - Environment for health quality research – incubator for pay-for-performance
2. Opportunity – patient education
   - Unique opportunity for major patient education regarding personal health record and electronic health information using focused, targeted message released through medical systems, hospitals, etc., to patients.
3. Opportunity – state infrastructure
   - State IT infrastructure program for cost-effective broadband access
   - Infrastructure (ESB, BadgerNet)
4. Opportunity – Existing resources for Master Person Index (MPI)
   - The existence of the Wisconsin Immunization Registry as a repository of Wisconsin residents. Could be used as the basis for piloting information exchange on a broader scale
   - Potential for State of Wisconsin to create/post a master person index.
   - State-hosted master provider index – tied to licensure oversight
   - State MPI infrastructure for immunization
5. Advantages – engagement of state government
   - Engagement, interest, and investment of state government
   - Leadership of government to pull a plan together and engage stakeholders and of private-sector leaders who have created Wisconsin Collaborative for Healthcare Quality (WCHCQ) and WHIO
6. Advantages – Health care environment in Wisconsin
   - Large practice affiliation for 60% of physicians
   - Wisconsin is unique due to the number of docs in large group practices and projects like WHIO, RHIO, WCHQ, this group. How can this best be leveraged?
   - It may be easier for smaller organizations to achieve the goal than larger ones, i.e., less complex if you remove cost as a barrier.
   - Majority of physicians are in a limited number of practices in Wisconsin.
   - High density of large physician practices (60% of physicians), and low number of solo MD practices
   - Collaboration around quality reporting (WCHQ)
   - Mature, widespread IDN's throughout most of the state

- Opportunity – the WHIO data collection of insurance claims information presents an opportunity to standardize certain data elements common to insurance data/health record data. Creating data standards is a major issue to accomplishing ehealth implementation success.
- Wisconsin Medicaid Data Warehouse (claims-based data) and ER-Tool
- Wisconsin Medicaid reporting infrastructure with emergency departments
- WHIO infrastructure of private and public payer data – opportunity to build "EMR-lite"
- WHIO
- RHIOs
- Existing exchanges, e.g., birth record collection system, immunization registries, and future WHIO
- Significant statewide infrastructure already exists to leverage several Master Client Index (MCIs), public health information network, Medicaid systems, and BadgerNet
- Early RHIO development in SE Wisconsin
- Unique opportunity – potential for state population-based master index, instead of "client-based" master index
- Wisconsin Immunization Registry (WIR)
- Public Health Information Network (PHIN) infrastructure at the UW
- Health care infrastructure for WIR – potential backbone for linking all public/private sector health facilities
- There are multiple efforts already underway in WI for collecting and reporting health care data that can be built on

7. Advantage – private corporation leadership in health information technology and exchange
   - Pharmacy near real-time data through POS systems (contribution: patient safety, manage costs, quality of care)
   - Two large EMR vendors (can they collaborate?)
   - Advantage –major technical supplies in state, i.e., EPIC, GE, etc.
   - Well developed system to learn from (e.g., Marshfield)
   - GE and EPIC leadership are in WI
8. Advantage - stakeholders
   - A lot of stakeholders are at the table in the workgroups and on the BOD.
9. Advantage – Timeliness related to other states' progress in health information technology and exchange
   - Key finding – Florida PIN for patient data confidentiality
   - We can learn from the successes and failures of other states
10. Health Information Technology Adoption
    - Soon we will have a reasonably good understanding of the penetration of Electronic Medical Records (EMRs).

More information needed, potential risks, gaps, challenges, etc.
The Workgroup went through an exercise in which they identified where more information is needed, potential risks, and challenges. These were then categorized. Listed below are the high-level topics and the specific information collected for each:

A. Public health/sector participation
   - Need more public health sector representation
   - Free-rider effect
   - Sustainable governance structures
   - Ownership/stewardship
B. Engagement of **all** stakeholders
   - Competitive environment between major providers (at least Southeast Wisconsin)
   - High health care costs absorbing $ needed to capitalize and sustain exchange (and lowering interest of non-providers to contribute)
   - Payers not at table
   - Need to know concerns of key stakeholder groups (i.e., providers, payers, consumers, and public health to be able to put forth HIE/HIT recommendations)
   - Obstacles – effort involved in multiple stakeholders developing policy in a short time
C. Data management
   - As part of our design we should have a thorough understanding of data uses/users
   - Risk - Patient population feels "threatened" by this whole "ehealth thing"
   - Failure to meet consumer needs
   - Consumer input and education
   - Participation/buy-in by providers
   - Acceptance at consumer level
   - Challenge – data management in the world of health information is a huge issue that needs to be addressed as part of the information exchange
D. What is the goal of this effort?
   - Need more info – what do we want to be able to do with the data/information? Need to spend more time identifying "what you want to do at the end of the day" (stakeholder involvement)
   - End goals?
E. Adoption
   - Existing IDN infrastructure readiness and willingness to support information exchange
   - Physician EMR adoption
   - Cross-border health care requirements – primary care and tertiary
   - Gap – need a complete inventory of current HIT/HIE in Wisconsin to be able to put forth HIE/HIT recommendations
F. Funding
   - Initial funding
   - Sustainable funding
   - Sustainable funding models for small hospitals and small clinics

- Engagement of private sector for investment in HIE services

G. Use of health information technology in non-hospital settings
   - We need more information on use and purpose of IT in non-hospital settings
   - Pharmacy IT needs – eRx as part of state plan

H. Receiving periodic updates
   - Gap – would be helpful to all workgroups if there could be a demo of information exchange at some point. Would help in making decisions about what is feasible in ehealth efforts.
   - We need periodic updates on other data aggregation projects occurring at state and national levels.
   - Updates from the other workgroups on regular basis will be helpful
   - Policy
   - Legislation that allows for electronic exchange of protected health information

I. Technology and security risks
   - More information needed on various exchange models in terms of strengths and benefits as well as limitations of each model
   - System design is not user-friendly so is not used
   - Data security
   - Risk – get ahead of developing standards

Workgroup Reports

Governance Workgroup

Mr. Zettel provided overview of the Connecting for Health Common Framework on governance. Discussion items that followed his presentation included:

- Allowing redisclosure of patient information between providers for care purposes without explicit patient consent. Currently, if one provider sends patient information to another, the provider receiving that information cannot redisclose that information without explicit patient consent.
- Legislative changes to allow for opt-out of an exchange system. Currently, Wisconsin law requires that patient information be exchanged for care purposes only (with certain exemptions) without direct patient consent. Ms. Bergum noted that the Consumer Interests Workgroup is already working to address the issue of opt-in/opt-out.

Patient Care Workgroup

Seth Foldy reported that the Patient Care Workgroup had undergone an exercise to rank different aspects of a patient record in terms of the information they desired most. This information was provided to the group. Ms. Bergum reported that the Consumer Interests Workgroup is also looking at these recommendations and will provide their feedback once they have had a chance to discuss these results.

Dr. Foldy said that the Patient Care Workgroup has begun working on use case scenarios, which are intended to be "real world" examples that will stimulate discussion about critical issues.

Consumer Interests Workgroup
Ms. Bergum reported on the activities of the Consumer Interests Workgroup. She identified the following as high priority HIE/HIT outcomes for the workgroup:

- Consumer/provider access
- Security
- Decision support

She said that the Consumer Interests Workgroup has been considering information that requires special protection and will be providing the Information Exchange Workgroup with this information once their analysis is complete so that the Information Exchange Workgroup can discuss how these protections will be implemented.

Ms. Bergum reported that the Workgroup plans to work collaboratively with the Patient Care Workgroup on the outcomes listed above, the priorities identified by the Patient Care Workgroup, and the use case scenarios being considered.

Segmentation Exercise
Hugh Zettel put a slide on the screen like the following:

High		
Low		
	Low	High

Mr. Zettel asked the group to consider how we could create a grid like this so that priorites could be plotted. He said such a diagram could address the cost to implement and the impact on state health care costs. The workgroup discussed making a grid like this to address the pieces of its charge related to safety, quality and cost. The decision was that staff would take a first cut at preparing a diagram for each of the following: safety, quality, and cost. Technical feasibility and the cost of health care would be on the x and y axis, respectively.

Report status for the eHealth Board meeting
Ms. Bergum provided an overview of how the document being used by all the workgroups for reporting to the Board was developed. Susan Wood said that she thought it was really important that all the workgroups state assumptions in this report. A draft of this report will be created prior to the next meeting for discussion.

Next Meeting
July 27, 2006, 11:00 a.m. – 12:00 p.m.