THSA HIE Planning Engagement

EHR Adoption & Consumer Engagement Workgroup Meeting Minutes

Date: 06/09/2010
Time: 1:00–3:00 p.m. CDT
Location: University Health System, San Antonio
And webinar/conference call

In Attendance

Workgroup members:

Scott Albosta, Blue Cross Blue Shield of Texas		Susan Franscini, Greenway Medical Technologies		David Renfro, Availity	Y
Julia Alejandre, Texas HHSC	Y	Chris Guerrero, Texas DSHS		Sharon Robinson	
Timothy Barker, MD, Heart of TX Community Health Center	Y	Edie Hagens, Axolotl	Y	Carrie Thomas, Maximus	
Sue Biedermann, Texas State University	Y	David Hager, MD, Kerrville State Hospital	Y	Thomas Thrower, Ascension Health	Y
Philip Bradley, Harris County Hospital District		Lawrence Hanrahan, MD, Accenture		James Turley, PhD, RN, UT Health Science Center at Houston	
David Bradshaw, Memorial Hermann Healthcare System		Eric Hollander, DDS	Y	Gijs van Oort, PhD, Healthcare Access San Antonio	Y
Margaret Bruch, Texas DSHS		Zachery Jiwa, Microsoft	Y	David Vliet, Central TX Community Health Centers	
Christine Bryan, Clarity Child Guidance Center	Y	Jeanne Knapp, Healthcare Alliance of Montgomery Co.		Richard Voets, Tenet Health System	Y
Ryan Bush, McKesson		Sally Leighton, MD, PhD, Texas Children's Hospital	Y	Dave Wanser, MD, University of Texas	
Barbara Cambron, Texas Workforce Commission	Y	Robert Ligon, TMF Health Quality Institute		Debra Warner, Valley Baptist	
Ali Candas, MD, Coastal Children's Clinic		Julie Lindenberg, DNP, UT Health Science Center at Houston		Bob Warren, MD, PhD, Texas Children's Hospital	Y
Kathleen Costello, Texas HHSC		Ronald Lutz, Gensis Physician Group		Charles Webster, EncounterPRO Healthcare Resources	
Brian DeVore, Intel	Y	Ramdas Menon, Texas DSHS	Y	Audra Wells, Dell	
Darrell Dixon, MD, CHRISTUS Health		William Moran, MD	Y	Bryan White, Dallas County Medical Society	
Steven Eichner, Texas DSHS	Y	Sue Newhouse, North Texas Medical Center	Y	Michelle Zadrozny, Alliance Work Partners	Y
Joshua Escalante, Texas DSHS		Chuck Parker, Continua Health Alliance	Y	Jia Jie Zhang, PhD, UT Health Science Center at Houston	
John Forrest, ICW Inc.	Y	David Pearson, TX Organization of Rural & Community Hospitals			

Other participants:

Scott Bullock, CTG	Y	Tony Gilman, THSA	Y	Maria Nelson, Memorial Hermann Healthcare System	
Taylor Cook, Texas HHSC		James Honn, CTG	Y	Stephen Palmer, Texas HHSC	
Mirsa Douglass, Texas DSHS	Y	Radhika Iyer, CTG	Y	Liz Thelen, CTG	Y
Mary Ann Kostusiak, CTG	Y	Larry Flournoy, ATCIC	Y	Jim Campbell, CTG	Y

Joe Eberle, CTG	Y	Helen Haman, Accenture	Y	Shelley Lucas, DSHS	Y
Andrea Cobb, TMA	Y	Carole Tamayo, ICC	Y		

Agenda Items

#	Item Name	Item Owner	Time Allotment
1	**Overview and introductions**	**Scott Bullock**	**1:00–1:10 pm**
2	**Workgroup status updates**	**Jim Honn**	**1:10–1:20 pm**

Discussion points:

- Clarify the role/relationship of the HHSC to THSA: HHSC is the fiduciary organization for THSA—has submitted the grant application and held the funding for THSA

***Participants**: Jim Honn, Gijs van Oort*

#	Item Name	Item Owner	Time Allotment
3	**Physician adoption** Key model components: ▪ Incentives ▪ Quality ▪ Communication strategy ▪ Governance ▪ Technology and infrastructure	**Scott Bullock**	**1:20–1:50 pm**

Discussion points:

Incentive for adoption: Reduced pricing model

- Create/identify a reduced pricing model
- Some states have done this by funding/making available EMR through ASP approach
- Others have arranged a type of preferred vendor agreement to leverage economies of scale (however Texas has been discussing a vendor-neutral environment so the preferred vendor approach might not be viable)
- The federal government is proposing 21-percent cuts in Medicare reimbursement; if this goes through, this incentive would be moot

Adoption among pediatric providers

- Pediatricians and children's hospitals will not qualify for Medicare incentive payments
- Although hospitals in general can apply for both, children's hospitals are excluded from applying for Medicare
- In terms of Medicaid, there is very little pressure to adopt rapidly through the meaningful use incentive payments—providers may start as late as 2016; there are no penalties as long as they are complete by 2020
- There are threshold (volume) issues for providers to be able to be eligible

Possible incentives to adoption for pediatric providers

- Getting the first year's money as hospital or eligible provider under Medicaid is easy as long as the provider

sees volume: the first payment year, pediatric providers simply have to show that they are adopting, updating, or implementing an EHR; none of the other stage 1 criteria apply

- The payment schedules for Medicaid (stage 1, etc.)... first payment year is 2011 so they have to get sooner...
- Total incentives are the same whether your first payment year is 2011, 2013, etc.
- Texas is considering incentive per e-prescription (similar to NY); this would probably not start until later on
- It has been suggested that adoption levels be measured after the first three months of the program, and then incentives could be offered; but that might be a negative incentive—people could purposely wait to sign on until incentives have been established
- Public pressure: websites may state "I'm a meaningful use hospital/practitioner," media may use it; this could be an incentive

Adoption considerations for the statewide HIE versus RECs

- Our mission is to create a HIE in Texas. HIE is only a small part of the meaningful use component. How much can we incent providers to adopt an EMR simply because we offer HIE? Is adoption more the territory of the RECs and providers than the HIE?
- This workgroup's charge is just the HIE part, so how much EMR adoption can the state support given limited resources?
- On the other hand, you can't have an HIE if you don't have good EMR adoption

Incentives for behavioral health providers

- Medicaid/meaningful use incentives currently do not apply to behavioral health providers (if 5040 goes forward, these providers will be added to the Medicare/Medicaid pots for incentive payments)

Workgroup scope

- Facilitated reporting ("stick approach") use of EHR tool can simplify state/federal reporting and support PQRI initiatives
- Meaningful use: this workgroup's role is to look at *overlap* between EMR/EHR adoption and HIE components, to create backbone that enables all EHRs to communicate effectively so patient records are able to be shared
- Important to make sure that meaningful use is sustainable: what will providers need/want to pay for to sustain whatever is put into place?
- This workgroup's focus on the HIE components of EHR, rather than simply EMR/EHR adoption in general

Non-primary physicians and white spaces

- RECs are focused on primary care, not any kind of specialist level; so statewide HIE might take on the role of leveraging information that's available through the RECs to support adoption among non-primary care practitioners
- Particularly important among non-primary providers in rural areas/white spaces
- Some states adopt a *hosting* model that limits the services provided by the state
- How do we support the providers who are not in any HIE and not on the REC's engagement list?
- Through education and outreach, describing the benefits and incentives are (rather than solving the problem at the state level); however this is expensive and will take a long time

Broadband access

- Larry Flournoy (Texas A&M) and Gene Crick helped procure $15 million FCC grant to provide broadband

access in rural areas (waiting for LOAs and matching funds to begin using the funds; CHRISTUS is the fiscal agent; have one year to procure matching funds then five years to use the money); this workgroup could partner with the group that has received the funding

- Some rural providers have been dissatisfied with existing programs which were seen as too prescriptive; the proposed program would be neutral and focus on moving medical data
- We could add the exploring of grant money to address some of the gaps for the rural providers and look into that section for the strategic plan
- Possible scenario: FCC would provide broadband connectivity, RECs would focus on providers and encourage adoption, and the state HIE could provide sort of a product/service that the RECs could deliver/cultivate through broadband access
- Consider whether this (access/support) is the HIE's role or the IDN that the rural providers are already currently working with
- Concentrate on educating and engaging consumers/providers/all stakeholders on the value of HIT/HIE
- Look at environmental scan to quantify outliers specifically in rural communities
- This workgroup's role: identify gap, review it with the board, look at ways to address it
- Determine what RECs envision in terms of tying into HIE
- The ability for providers to get records from/exchange with other providers would be a good carrot (better incentive than just "transfer your paper records to electronic")

Quality/liability

- Develop a patient-centered system in which data follows the patient contextually, so that the provider can have confidence that they're making decisions and providing treatment based on a complete record
- Physicians may be concerned that once they embark on HIE, they could be held liable if a piece of information is missing
- The state should reassure providers that if they use an HIE their exposure is not increased if there is a data point missing etc.
- The Privacy & Security Workgroup will be discussing this issue

Communication strategy

- Clarify what meaningful use means and requires for providers
- Providers may need assistance selecting and EMR product; this can be bewildering especially for those who aren't tech-savvy; consumer (provider)-friendly information should be available to help providers make their decisions
- It should be for providers to change their systems if they need to without doing an enormous amount of data migration at a tremendous expense
- For providers who don't have enough resources to enter all patient history, the value in having access to an HIE is that some of the patient history (maybe not all) is already there in the system

Interoperability:

- The Technical Infrastructure Workgroup has been discussing statewide interoperability standards, vendor-agnostic
- Physicians need to know what their pain point will be if they choose one system and change it later
- Providers should be able to switch between vendors and providers of EHRs, and even switch HIEs, without so much pain
- The purpose of interoperability standards is to avoid proprietary standards or products
- There is a happy medium between establishing broad interoperability standards and giving the provider

(who has a lot of technology choices) a specific answer

- The Technical Infrastructure Workgroup has asked vendors to provide an educational (non-sales/non-marketing) "state of the industry" presentation
- Additional help provided to providers: some RECs are vetting contracts from vendors to look at beneficial terms and pricing structures
- EMR adoption and incentives are not for an HIE implementation but for ARRA/EMR; the communication should be sure to point out the doctors' incentives for getting an EMR to hook up to the HIE –$44K/60K payouts for Medicaid)

Technology and infrastructure

- Providers will be at the table throughout the governance structure
- If products do not integrate into the workflow and become an obstacle to getting through the physician's day, that will become a hurdle to adoption
- It's important to address everyone on the adoption curve: e.g. a provider who's been in practice for 40 years and has tried-and-true workflows may never adopt but they should be supported (e.g. by faxing providers to get the information they need
- Can also set up portals where providers view lab results, pathology results, etc.; other states/regions have used this to get providers to come to the solution, get engaged, and further increase adoption
- Other states have been able to bring providers EMRs while keeping their workflows intact; this is an incentive
- Tell providers why it's good for them and how it will reduce their workload
- Make sure when recommendations are made to the board that it is also made clear that rural, inner-city, low-end, and underprivileged providers are being considered (tell people they'll still be able to use their faxes, phone calls, etc.)
- What are some best practices for getting those types of providers to adopt? Use cases are available from Jay Sanders, American Telemedicine Association (ATA), Jonathan Linkous, Doctors Without Borders, etc. for inside and outside the U.S.
- Make sure the HIE is communicating at all levels: it's not about one-way communication, it's about making the least common denominator feel like part of the process
- The end users of a system can make/break a technology implementation; finding a way to include them creatively and collaboratively is a very valuable key to success
- Will the state communicate directly to the providers, or provider materials to the RECs? RECs may be more in regular contact with the providers

ECRCs: an earlier version of the RECs

- Michelle Zadrozny described work 10 years ago with the Electronic Commerce Resource Centers (ECRCs), basically RECs (same exact model) for electronic invoicing and billing; Texas had four of the 20+ ECRCs around the U.S.
- The ECRC provided education and training; marketing would take 3, 4, or 10 times before some of the non-technical users would begin using it
    - Example: a provider of a cleaning service, who now has to invoice electronically because it's been federally mandated, has to find out how to use the Internet etc.
    - The ECRC would help the user get set up but when he hooked up to the clearinghouse, there were problems with the connection and it wasn't seamless/transparent
    - Users became frustrated and angry, and annoyed by the technology
- Consider how that connection can move smoothly from the REC to the HIE—it should be totally transparent to the end users

- Consider that all four RECs may be very different (the four or five ECRCs in Texas were very different, in spite of the federal mandate they were all subject to)
- Suggestion: benchmark/survey the contractors who worked on the ECRCs in Texas to find out lessons learned, best practices, what they would do differently if they had to do it again

The technology has to work (what happens when it doesn't?)

- The Technical Infrastructure Workgroup has discussed a grandiose, perfect world, 'panacea' model, but bottom line: it has to work; if it's a pain in the neck or a problem, it won't be adopted
- Implementation plan has to roll out, in a reasonable and practical manner, a core set of functionality that works from the beginning; has to provide value, and then you can expand to the 'grandiose' type scheme (this is part of the implementation strategy)
- If the implementation plan doesn't bring value and pull people in, critical mass cannot be achieved and HIEs will fail
- With transparency and relationship-building from the beginning, when there are problems during implementation those relationships may prevent users from getting too frustrated
- Key stakeholders/end users should be involved from the beginning so when if the technology doesn't work perfectly, it's okay and they will get through it, rather than giving up when one thing goes wrong
- Communication is critical because technology will have problems; expectations and communication are as important as the technology
- Although the main part of the bell curve will probably be addressed first (with an incremental implementation) the people on other parts of the curve need to know they will be addressed as well

Regional versus statewide HIEs

- Will providers have a choice of whether to connect to the regional HIE or the statewide HIE?
- The Technology Infrastructure Workgroup has discussed the state level as a "thin layer" providing HIE services including interoperability standards
- The vast majority of the infrastructure would be a 'network of networks' at the regional or REC level
- There are huge 'white spaces' in Texas (refer to THIEC map showing HIEs concentrated in urban areas); should local HIEs start expanding to cover those white spaces, should that be addressed by the FCC grants for broadband access . . .
- The Governance and Finance Workgroup is considering the white space issue; is under discussion with the THSA Board

Regional Councils on Government (COGs)

- Several (usually 5–9) counties banding together for shared state-provided services (e.g., groundwater, emergency services, fire services, ambulances, epidemiology, hospital board, school board, etc.)
- Starting September 2009 the National Association of Regional Councils on Government they started paying attention to telecommunications
- Recommend contacting Texas Association of Counties (TAC) and Texas Association of Regional Councils (TARG) to discuss in-fill issues for HIEs that get formed in/around the COGs
- These groups cover white space and have access to a variety of funding sources at national and state levels, so as HIEs seek to fill up white spaces, these organizations could be valuable partners; COGs might support/incubate for HIEs, create 501(c)3s, etc.

Participants: *Scott Bullock, David Hager, Bob Warren, Steve Eichner, Zachery Jiwa, Edie Hagens, Larry Flournoy, Gijs van Oort, Radhika Iyer, Joe Eberle, Michelle Zadrozny, Christine Bryan, Rich Voets*

4	Physician adoption and the RECs	Scott Bullock	1:50–2:10 pm
5	HIE rollout plan and milestones	Scott Bullock	2:10–2:20 pm

Discussion points:

Meaningful Use Requirements	Year
Lab Results Delivery	2011
e-Prescribing	2011
Claims Eligibility and Checking	2011
Registry reporting and reporting to public health entities	2013
Electronic ordering	2013
Health summaries for continuity of care	2013
Receiving public health alerts	2013
Home monitoring	2013
Populating PHRs	2013

Suggested changes to timeline

- 2011: Make available ADT information, radiology results, transcription, and reports (not the images themselves)
- Move "Health summaries for continuity of care" to 2011 or 2012
- Change "e-Prescribing" to "medication history and display" (use language consistent with HIE toolkit)
- Move "Electronic ordering" up to 2011 (same year as lab results delivery)

e-Prescribing

- Although eligibility and e-prescribing are not functions of an HIE, eligibility and e-prescribing information is available in the HIE through the exchange of data, so that providers can achieve meaningful use of their EHR/EMRs
- It has to be accomplished, but not necessarily as part of the strategy for the HIE—consider leveraging a prebuilt system/network (e.g. SureScripts-RxHub)
- The strategy from an HIE standpoint could be to achieve interoperability to meet these requirements
- SureScripts-RxHub dominates the market; consider how the HIE can interface with it:
    - Surescripts supplies the information to physicians who are prescribing from one of its tools
    - But there's a fee to just pull information into your system
    - For health information exchange, it would be important to have all the prescribing data and past medical history from that network
    - How would the statewide HIE be integrated with that source of data?
    - The data could go to eScripts, and the resulting repository (i.e., medication reconciliation) could be in the HIE, unless you use the HIE as a transport mechanism only
    - It should be in the HIE, but how will that happen? Do your e-prescribing through the EMR, get the result back, and then you send the medication to the HIE for others to see it
    - The details of how this will be handled may be explored more thoroughly by the Technology Infrastructure Workgroup
- e-prescribing capability must be available, whether through an EHR system or some other mechanism—the intent is that all providers have some ability to do that; we are accountable for making sure Texas' e-prescription numbers go up and that the providers have the ability to do that

Eligibility checking

- Eligibility checking is a fee for service (per transaction fee); physicians won't want to pay for that service and then share it out to other providers for free, and payers would not accept that (unless this is a service/toolset the HIE is offering for free)

Lab ordering

- In terms of sustainability, Quest, LabCorp, etc. pay physicians' interface fees
- If the HIE provided a single point of entry for those vendors it would make their job easier and they might pay for some of the infrastructure
- The HIE is used as a pass-through: it goes to LabCorp through the HIE, the results come back through the HIE, and it goes to those people who have a persistence with that patient—the lab orders will be stored but ordering itself shouldn't be a function or transaction of the HIE

Participants: *Scott Bullock, Edie Hagens, Gijs von Oort, Joe Eberle, Zachery Jiwa, Rich Voets, Larry Flournoy, Tony Gilman*

6	Consumer engagement strategy	Scott Bullock	2:20–2:35 pm

Discussion points:

Add to guiding principles

- Community engagement: several community groups (e.g. public health) are very engaged with consumers already, and know how to market to and engage them (this could also help engage with rural providers)

Communication

- PHR is the responsibility/property of the patient but adds potential value to the provider (at the point of care)
- A PHR portal should be available (subject to appropriate security and consent) but this isn't a core requirement—the Technology Infrastructure Workgroup has discussed supporting it but specifics of how and when that will be done have not been addressed
- Integration to the provider's data set has not been addressed yet
- Consumer engagement should go beyond just sharing information between provider and consumer (PHR); consider the value of a state HIE infrastructure to a patient:
  - Provide a universal scheduling mechanism
  - Engage with chronic disease management

Participants: *Scott Bullock, Michelle Zadrozny, Gijs van Oort, Joe Eberle, Zachery Jiwa*

~~7~~	~~Objectives for July 14 meeting~~	~~Scott Bullock~~	~~2:35–2:40 pm~~
~~8~~	~~Open discussion~~	~~All~~	~~2:40–3:00 pm~~