

# HIE Work Group Meeting Agenda 05-07-2014

***VT Health Care Innovation Project  
HIE Work Group Meeting Agenda***

**Wednesday, May 7, 2014; 9:00-11:30am  
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT  
Call-In Number: 1-877-273-4202; Passcode 2252454**

<b>Item #</b>	<b>Time Frame</b>	<b>Topic</b>	<b>Presenter</b>	<b>Relevant Attachments</b>
1	9:00-9:02	Welcome and Introductions	Brian Otley	
2	9:02-9:05	Review and Acceptance of April 9 <sup>th</sup> Meeting Minutes	Brian Otley	Attachment 2: HIE Work Group Minutes 4.09.2014
3	9:05-10:55	Telemedicine/Telehealth/Telemonitoring: Intro <ul style="list-style-type: none"> <li>• Overview (10 minutes)</li> <li>• VA Presentation (45 minutes)</li> <li>• VAHHA Presentation (45 minutes)</li> <li>• Participant discussion (10 minutes)</li> </ul>	Steve Maier Peter Cobb, VAHHA Judy Audette, VA	Attachment 3: VA Presentation (to be distributed later)  Link to State Telehealth Laws and Reimbursement Policies - A Comprehensive Scan of the 50 States and the District of Columbia <a href="http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/50_State_Scan_February_2014_Final.pdf">http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/50_State_Scan_February_2014_Final.pdf</a>
4	10:55-11:15	Grant Program 'referrals' discussion: <ul style="list-style-type: none"> <li>• Quick review of how the budget will work</li> <li>• Suggested for assigning/approving the different referrals</li> <li>• Suggested priorities</li> </ul>	Brian Otley	
5	11:15-11:25	Public Comment	Brian Otley	
6	11:25-11:30	Next Steps, Wrap-Up and Future Meeting Schedule	Brian Otley	

Attachment 2 - HIE Work  
Group Minutes 04-09-14



***VT Health Care Innovation Project  
Health Information Exchange Work Group Meeting Minutes***

**Date of meeting:** Wednesday, April 9, 2014; 9:00-11:30am DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

**Call in: 877-273-4202, Passcode: 2252454**

**Attendees:** Brian Otley, Simone Rueschemeyer, Co-Chairs; Georgia Maheras, AoA; Joel Benware, Northwestern Medical Center; Shelia Burnham, VT HC Assoc.; Steven Maier, Alicia Cooper, Jennifer Egelhof, Larry Sandage, DVHA; Nick Emlen, VT Council of Dev & MH Services; Leah Fullem, OneCare; Michael Gagnon, VITL; Joyce Gallimore, CHAC; Darin Prail, Mike Maslack, Julie Wasserman, AHS; Brendan Hogan, Bailit-Health Purchasing; David Martini, DFR; Lou McLaren, MVP; Kaili Kuiper, Legal Aid; Amy Putnam, NW Counseling & Support; Heather Skeels, Bi-State; Beth Rowley, DCF; Richard Slusky, GMCB, Tela Torrey, Jen Woodard, DAIL; Eileen Underwood, VDH; Jack Donnelly, Community Health Center of Burlington; Karl Finison, Onpoint; Chris Smith, MVP; Sean Uiterwyk, White River Family Practice; Jessica Mendizabal, George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
<b>1. Welcome, roll call and agenda review</b>	Simone Rueschemeyer called the meeting to order at 9:04 am.	
<b>2. Approval of Feb. 26 minutes</b>	Sean Uiterwyk noted that he was misattributed in the previous minutes as having spoken to people in Massachusetts. Georgia stated that it was Marybeth McCaffrey instead. There were no further comments. Michael Gagnon moved to approve the minutes as amended and Joyce Gallimore seconded. The motion passed unanimously.	<b>The minutes will be revised and posted to the website.</b>
<b>3. ACO and ACTT</b>	Georgia Maheras gave the following update: the ACO proposal was submitted to CMMI for approval on	<b>Georgia will email</b>

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<p><b>Proposal: Updates</b></p>	<p>April 2<sup>nd</sup>. They have 30 days to approve the proposal. The contract will be between DVHA and VITL- she thanked the staff at VITL for working on the scope of work quickly. The contract is for 15 months, with some flexibility if there are delays in federal approvals or other issues.</p> <p>At the February meeting the HIE work group voted to recommend approval of the ACTT proposal, which went to the Steering Committee for review in March. The Steering Committee asked for additional information before they would give a recommendation to the Core team. Members of the HIE work group met with VITL to clarify some of the management and funding issues as well as roles and responsibilities. At the February meeting Paul Harrington moved to approve the proposal with certain caveats which were then incorporated into the revised proposal including: researching the use of SIM funds verses Medicaid as the best way to maximize federal dollars; and making sure that ACTT work aligns with the all the other work being proposed for the ACOs. The analysis was presented to the Steering Committee but not yet shared with the work group.</p> <p>Eight Provider Grant awards were made by the Core Team. The team received 33 applications totaling \$17 million in requests with about \$3.4 million to award. The awards total \$2.6 million, and there will be a second round later this year. The HIE work group will receive six applications that were not awarded in the grant program. The applications will be reviewed at the next meeting (see agenda item 6).</p>	<p><b>the work group the additional information that was provided to the Steering committee regarding the ACTT proposal.</b></p>
<p><b>4. WG Charge: What we have done and what have left to do (Work plan review vs. approved projects)</b></p>	<p>Simone reviewed the current work plan (attachment 4a) and presented a tentative three month agenda for May, June and July (attachment 4b).</p> <p>The group will begin to review the HIT Plan and connect it to the group’s work plan. There will be a presentation in June on the current HIT plan which was last updated in 2010. The group will also review the Vermont Health Information Strategic Plan. During the early phase they will work closely with VITL to update the older narrow scope which will become part of the larger plan.</p> <p>The group will also work on expanding Telemedicine. In VT it is currently being used for psych, education, etc.</p> <p>Simone encouraged the group to look at the work plan and identify areas that need more attention including work that will focus areas not covered by the recent proposals. The first two proposals touch on a number of goals, specifically improving data quality and source systems.</p>	<p><b>Members of the work group are asked bring information to the next work group meeting about what is happening in telemedicine/tele monitoring/telehealth. Heather Skeels recommended Co-Chairs talk to Terry</b></p>

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	<p>Larry Sandage reviewed accomplishments and goals yet to be accomplished. Some or all of rows 1-4 will be accommodated by the recent proposals. Rows 5&amp;6 are the two areas that need more focus going forward. Michael Gagnon added that there are aspects of the first 4 rows being worked on but there are more details that have not been addressed in the approved projects.</p> <p>The group discussed the following points:</p> <ul style="list-style-type: none"> <li>• Some goals are also being addressed either by requirements of payers and through other work groups.</li> <li>• VITL is addressing goal 4 and that is ongoing and part of the HIT plan.</li> <li>• There is a difference between having a tool and patients using it in a meaningful way- need to move toward unified tools across providers.</li> <li>• Technology is currently introduced in siloes- how do we integrate approaches in a way that is easy to use and consistent? Consider the end users and their technological abilities.</li> <li>• Regarding patient portals: <ul style="list-style-type: none"> <li>○ It is worth looking into building a statewide patient portal (much like NY), with one user interface and login? The State MMIS system is going to have one; this may be a place to start.</li> <li>○ Timelines are often too restricted to coordinate this kind of effort. VITL has the capabilities to create this kind of portal but there was not enough time given the mandates so hospitals had to create their own.</li> <li>○ Kaiser and Mayo Clinic may be worth exploring, but may not cover LTSS.</li> <li>○ DVHA is working on the Medicaid portal and someone from there should talk with VITL.</li> <li>○ Medicaid MMIS is going out to bid soon and the contract has to be awarded in the next year so it can go live in 2016. It is expected to also link to the Health Service Enterprise (HSE).</li> <li>○ There is crossover between proposals for the HSE. The work group will need to make sure not to duplicate efforts.</li> <li>○ Some clarification is needed around dates for vendor selection for the MMIS.</li> <li>○ It would be useful to share HSE in total. The timeline is going to dictate what we can and can't do and this could push the State into a fragmented system.</li> </ul> </li> <li>• Regarding hospital's meaningful use: where is Medicaid and Medicare how many people are on either of those tracks? <ul style="list-style-type: none"> <li>○ Steve can send the list of Medicaid meaningful use, but not Medicare.</li> </ul> </li> </ul>	<p><b>Robinowitz.</b></p> <p><b>Group to review the work plan to identify any clear gaps in what has not been accomplished to date and identify any high priority projects that would help not only their organization, but also the greater goals of HIE.</b></p>

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	<ul style="list-style-type: none"> <li>○ Providers can only be one and hospitals can be both. Aggregating this would be helpful. There are a lot of providers have not started meaningful use or the attestation process.</li> <li>○ To providers meaningful use funds are important.</li> <li>○ Can the group leverage the 90-10 funding they are receiving for the MMIS system? The cost may outweigh the amount of funds and might not be worth it.</li> <li>● The group will continue to think about how we can create efficiencies for now, and what we can do to plan for the future.</li> </ul>	
<b>5. Telemedicine/ Telehealth/ Telemonitoring: Intro</b>	<p>The group discussed the following:</p> <ul style="list-style-type: none"> <li>● The DFR report (attachment 5) states that a telemedicine “facility” in statute can include an office, as well as a hospital. Communications need to be made over secure transmissions so Skype is not an option.</li> <li>● Concerning insurance reimbursement: in a crisis situation or bad weather the “facility” is what the provider says it is though there is variation across payers.</li> <li>● The group would like more information from VNA and how the home bound are monitored.</li> <li>● Receiving updates to House Bill 272, an act related to telemedicine.</li> <li>● Using outcomes data for home health monitoring and how to leverage that to improve upon the technology. Peter Cobb was identified as being a good person to reach out to home health agencies to retrieve the data.</li> <li>● Regarding definitions for in facility and out of facility: the current mandate is that a patient needs to be in one facility setting and the consulting specialist needs to be in another setting. Right now that is not considered patient’s home because they might not have the technology to have the level of monitoring.</li> <li>● Currently payments are based on the facility code which needs to tie to the Q code (the patient’s space to receive the service). There are two payments made under a telemedicine exchange. For MVP, the doctor can bill for use of the space, and then a specialty consult bills to show the telemedicine exchange.</li> <li>● Richard Slusky noted that as we move away from fee for service, providers should have much more flexibility and less billing restrictions.</li> <li>● Amy Putnam noted there is more latitude with commercial payers, and Medicare is limiting, using a specific type of technology.</li> <li>● There are several upcoming conferences related to telehealth: New England Telehealth Resource</li> </ul>	<p><b>Georgia/co-chairs will send an email to the work group with more of a background on telemedicine including technical definitions, statutes and upcoming conference information.</b></p> <p><b>Work group participants should send summaries to staff and co-chairs of telemedicine efforts their organizations are involved with so the work group can try to assemble a baseline of what VT has which we can then extend to what we don't have and would like.</b></p>

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	<p>Center- June 10<sup>th</sup> (David Reynolds is the key note speaker); American Telemedicine Association conference May 15<sup>th</sup> in Baltimore.</p> <ul style="list-style-type: none"> <li>Federal grants were also awarded to four regional telehealth resource centers and Terry Robinowitz has been involved.</li> </ul>	
<p><b>6. Grant Program ‘referrals’ discussion</b></p>	<p>Georgia explained the grant applications were placed into three categories: those awarded, those that did not meet the criteria, and those referred to work groups. Several proposals are coming to HIE that align with the work group. The Core Team will provide guidance to work groups around their expected responsibility. Applicants may report to work groups, but the work group will not be managing the grant awards.</p> <p>Applicants are sending summaries to Georgia as well as revised budgets. The summaries and contracts will be posted to the website once finalized. Georgia is working on a cover memo with background information.</p> <p>Applications that were referred to other work groups will connect back to the HIE work group but the guidance will be customized. The intent from the Core Team is to maximize the good ideas in each proposal. Richard Slusky suggested that co-chairs discuss areas of work group overlap on the monthly calls.</p>	
<p><b>7 VITL Presentation: Data Warehousing Roadmap</b></p>	<p>Mike Gagnon presented Building a State-Wide Data Warehouse (attachment 7).</p> <p>The following points were noted:</p> <ul style="list-style-type: none"> <li>Any organization connected to VITL could connect to this information and would have permission to use the data.</li> <li>You can improve data to do the mapping- each organization can map their test to the standard. There will be gaps and it will improve overtime. It’s not meant to be claims, it can do most of the terminology. LOINC is required for stage 1 and 2 meaningful use.</li> <li>“Data Cleansing” refers to correcting spellings of towns, etc. making analysis easier.</li> <li>Organizations or their contractors will be trained to use the tools to perform the analysis, VITL will not run the analysis.</li> <li>Organizations can access any data that you have consent to access or that is de-identified across</li> </ul>	

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	<p>other agencies.</p> <ul style="list-style-type: none"> <li>• The warehouse is refreshed in real time.</li> <li>• Insurers are getting data through their members and certain data can only be captured by physically going into offices etc. For payers to have access to this data would be beneficial and could potentially eliminate chart audits.</li> <li>• Pharmacy data is received through a service that connects to the warehouse and it aggregates the information for VITL. NCPDP is a mechanism to move the data, but there are well defined mapping algorithms to get from that to RXnorm. VITL is working on VT prescriptions database too. It's uncertain whether there is a way to track prescriptions that are ordered but not filled.</li> <li>• For data marts: VITL can generate a data set or give access to live interfaces.</li> <li>• Timeframe for fixing data: terminology mapping is real time; days for Data Quality, which will constantly be improved.</li> <li>• If something is passed in lab results, only half contain codes. The data mart concept puts LOINC codes in one spot.</li> <li>• Data not in typical clinical message types will go through a separate track. CDC may catch up and additional reporting won't be necessary. More message types are coming. You can also access clinical notes as well. There will be a business intelligence tool to run reports and use text extraction tools.</li> <li>• Data marts will be designed for each stakeholder.</li> <li>• For a statewide data analysis: you would configure the data mart by what you are trying to analyze, the type of data versus the organization. There are 3 million messages a month.</li> <li>• The Master Patient Index (MPI) match rate is only 93%. This can be improved in data quality services, but it should exist in the MPI.</li> <li>• Bi-State is using their own warehouse: can they use the same HIE infrastructure they purchased from the EHR vendor? Data extraction can't integrate from CDC but this may be possible in the future. The alternative is that VITL can continue to do subsets, in group pilots and it would depend on VITL to feed data, but would lose the ability to decentralize data.</li> <li>• Informed patient consent: no consent is required to move data into the network, but consent is required to view and it's a global opt in for de-identified data. If it's identified data, consent is required for every patient, or if you're an organization, you have to own the data.</li> <li>• The budget is for the state fiscal year starting July 1, 2014. Reductions account for the overlap.</li> <li>• The group will continue to discuss this topic at the next meeting, including the total cost over</li> </ul>	

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	time and the subscriber fee, per year per person.	
<b>8 Public Comment</b>	No further comments.	
<b>9 Next Steps, Wrap-Up and Future Meeting Schedule</b>	Next Meeting: May 7 <sup>th</sup> 9:00 – 11:30 am. AHS - DVHA Large Conference Room, 312 Hurricane Lane, Williston.	