Health Information Exchange (HIE) Use Case Design Group

HIE Use Case Design Group Session 2 Meeting Summary

Meeting Date	Meeting Time	Location – Zoom Web Conference
July 12, 2017	2:30 pm – 4:00 pm ET	**Webinar link:** https://zoom.us/j/216423119 **Telephone**: (646) 558 8656 **Meeting ID:** 216 423 119

Design Group Members					
Stacy Beck	X	Gerard Muro, MD	X	Jake Star	X
Patricia Checko, DrPH, MPH	X	Mark Raymond	X	Lisa Stump, MS, RPh	
Kathy DeMatteo	X				
Design Group Support					
Michael Matthews, CedarBridge (3:30 – 4:00 pm ET)	X	Allan Hackney, HIT PMO	X	Mark Schaefer, SIM PMO	
Carol Robinson, CedarBridge	X	Sarju Shah, HIT PMO	X	Faina Dookh, SIM PMO	
Chris Robinson, CedarBridge	X	Kelsey Lawlor, HIT PMO		Kate Hayden, UCONN	
Wayne Houk, CedarBridge	X				

Summary	
Housekeeping	The project charter meeting summary for the HIE Use Case Design Group Kickoff were unanimously accepted by Design Group members. It was noted that the in-person Design Group meeting scheduled for Thursday, July 20 will be canceled, and the regularly scheduled virtual Design Group meeting scheduled for Wednesday, July 19 will remain on the calendar.
Use Case Inventory and Library Discussion	As a reminder, it was noted that the use cases are going to be mapped to specific health information exchange (HIE) services, and that many HIE services will support various use cases. It was explained that use cases will be expanded iteratively to include financial and business considerations, as well as identification of shared infrastructure services such as individual common identification, identity conformance, health directory, and record location services. It was discussed that the All Payer Claims Database (APCD) may be a potential source of data for some use cases, but that this discussion will be tabled for now as the Design Group drills down into what data sources will be necessary for specific use cases. It was recommended that the Use Case Inventory be organized by priority of implementation as the Design Group members review the use cases. It was discussed that use cases must also be prioritized by sustaining value to stakeholders, and it was clarified that in assessing value of use cases, the willingness of stakeholder to subsidize a use case will not be the only metric of value used. It was noted that the Design Group will seek to solve problems that will garner stakeholder participation by choosing the most compelling use cases. The Use Case Inventory (slides 9 through 11) was reviewed and discussed by the Council, and the following comments and recommendations were made: <u>Slide 9:</u> • It was noted that the **Electronic Clinical Quality Measurement (eCQM) and Immunization (submit and query) use cases** have been prioritized by the Health IT Advisory Council. It was noted that the eCQM Design Group created a report of

	recommendations, and the Immunization Information System (IIS) Design Group is currently meeting weekly through the month of July and will create a report of recommendations. • It was noted that the **Emergency Medical Services (EMS) use case** could be considered as two use cases: one for EMS submission of health information, and one for accessing health information. <u>Slide 10:</u> • It was confirmed that the **Medication Reconciliation use case** will involve pharmacists as actors in its development. (Note: A pharmacist from UCONN will be developing the Medication Reconciliation use case). • It was noted that the **Consumer-Mediated Exchange use case** will include input to providers from wearables, in-home devices, etc., and that the consumer/patient portal is more focused on aggregating health data. It was noted that this use case seems more like consumer-supplied, not consumer-mediated, health information. <u>Slide 11:</u> • For the **Research / Clinical Trial use case**, it was noted that there are many registries linking people to the trials, and that patients register through clinicaltrials.gov or other registries. • It was recommended that the Department of Public Health and UCONN be included in conversations regarding the **Genomics use case**. • It was noted that bone marrow matching and tumor registry currently fall under the **Public Health Reporting use case**. • It was noted that on the **Orders / Results use case**, generating any type of integration with lab orders is extremely time-consuming for central labs and physicians, as orders need to be mapped very precisely. It was recommended that orders and results be separate use cases. It was also recommended that the Orders use case focus on labs. • For the **Order Management use case**, it was clarified that order management is difficult in the long-term post-acute care (LTPAC) community, as LTPAC providers generate the order, physicians sign them, and the order is returned to LTPAC providers. It was noted that physicians can be overwhelmed by this process. • It was noted on the **Image Exchange use case** that interoperability is already happening on a smaller scale regionally. • The **Public Health Reporting use case** was flagged as a priority, including tracking lead, communicable diseases, commercial lab reporting, asthma, tuberculosis, etc. It was noted that there must be bi-lateral sharing between DPH and local health departments. • It was clarified that the **Bundle Management use case** should involve identifying the patient, what payment bundle they are participating in, and which providers are responsible for that bundle.
Use Case Discussion	**Advance Directives** • It was noted that the Advance Directives use case was chosen to illustrate a use case that goes beyond just providers and health systems as actors, and that it also shows the importance of process re-design to accompany technology implementation. It was noted that almost two-thirds of adults do not have an advance directive; having great ability to share advance directives will have relatively modest overall impact if there cannot be determined ways to get more people to execute advance directives.

- It was noted that when there are advance directives present, there are two approaches to sharing them electronically. The first is using an advance directive registry. It was explained that Centerra is an example of a health system that uses a registry to store and retrieve advance directives, and that they have a contract with US Living Wills to store advance directives rather than storing them in electronic health records (EHRs). A second approach is storing advance directives in EHRs, which requires a need to flag that there is an advance directive stored there. It was noted that without metadata on the document to flag it as an advance directive, it will be difficult to access the information consistently.
- It was recommended by the Design Group that feasibility of implementation be a criterion when evaluating and prioritizing use cases.

Wounded Warriors

- It was noted that the Wounded Warriors use case was selected to demonstrate that an existing interoperability initiative (eHealth Exchange currently and possibly CareQuality and CommonWell in the future) is already in place and there is no need to duplicate infrastructure unique to Connecticut.
- It was noted that there are opportunities to support the Wounded Warrior use case even if Connecticut does not set up its own infrastructure. Firstly, by providing assistance to veterans to help them opt to share their US Department of Veterans Affairs (VA) medical record; and secondly, to increase participation in national interoperability initiatives.
- It was noted that opt-in is required for civilian sector providers to have access to VA medical records, but VA providers can access civilian-based EHR data via eHealth Exchange without opt-in if it is consistent with the consent policy of the civilian sector provider.
- It was noted that the VA chose Cerner as their platform, as the Department of Defense (DOD) did before them, and that this will enable the VA to use other mechanisms for interoperating with the civilian sector. It was noted that CommonWell will allow connectivity with the VA.
- It was noted that the Wounded Warrior use case was put forward because the Health IT Advisory Council wants to leverage initiatives that already exist. It was shared that there are mechanisms that already exist for this but most providers do not participate in eHealth Exchange to interoperate with the VA. It was noted that Yale New Haven does participate at this time.
- It was noted that there will be overlap of various use cases, and that part of the prioritization process will be identifying where there are use case clusters.
- It was pointed out that it will be important to select solutions for which data can be sent at once for distribution to all the appropriate consumers, rather that requiring the same data to be sent for various solutions.

Opioid monitoring

- The Opioid Monitoring and Support Services use case was briefly reviewed and it was noted that it will be important to leverage the system that Connecticut already has in place while further integrating into physician workflow and other community support.
- It was recommended that the Opioid Monitoring and Support Services use case remain on the list of use cases to be prioritized.

Action Item	Responsible Party	Due Date
Edit Use Case Inventory: • Consider making the EMS use case both query/submit • Consider new terminology for the Consumer-Mediated Exchange use case • Make the Orders / Results to be more specific on Lab Orders, and include a separate use case on Lab Results • Clarify Bundle Management use case	CedarBridge Group	Monday 7/17/17
Circulate next round of use cases	CedarBridge Group	Monday 7/17/17
Read through next round of use cases	Design Group members	Wednesday 7/19/17