Health Information Exchange (HIE) Use Case Design Group
Meeting Minutes

Meeting Date	Meeting Time	Location – Zoom Web Conference
Aug 16, 2017	2:30 pm – 4:00 pm ET	**Webinar link:** https://zoom.us/j/216423119 **Telephone**: (646) 558-8656 OR (408) 638-0968 **Meeting ID:** 216 423 119

Design Group Members					
Stacy Beck	X	Gerard Muro, MD		Lisa Stump, MS, RPh	
Patricia Checko, DrPH, MPH	X	Mark Raymond	X		
Kathy DeMatteo	X	Jake Star	X		
Design Group Support					
Michael Matthews, CedarBridge	X	Allan Hackney, HIT PMO	X	Mark Schaefer, SIM PMO	X
Carol Robinson, CedarBridge	X	Sarju Shah, HIT PMO		Faina Dookh, SIM PMO	X
Chris Robinson, CedarBridge	X	Kelsey Lawlor, HIT PMO		Kate Hayden, UCONN	X
				Kate Steckowych, UCONN	X

Minutes		
	Agenda Topic	**Notes**
1.	**Comments on 8/9/17 Minutes**	The meeting summary for 8/9/17 was approved.
2.	**Review Meeting Schedule**	The acceptance of a tenth HIE Use Case DG meeting on 9/6/17 was reiterated. The agenda for today's meeting was reviewed. It was discussed that the current meeting plan is on schedule to report recommendations to the Health IT Advisory Council on 9/21/17. The library of use cases was reviewed where it was noted that data integration and reconciliation was to be incorporated to the longitudinal health record use case. The registries use case was decided to be a part of the HIE services, and was therefore taken off the list of considered use cases. Patient Generated Data, CHA Dose Registry, and Bundle Management were de-prioritized but will remain in the library.
3.	**Emergency Medical Services (EMS)**	A call between CedarBridge, Allan Hackney, and Ralf Coler (Director of the Office of Emergency Medical Services, Connecticut Department of Public Health) was reviewed. Feedback was discussed regarding the EMS use case as invaluable for EMS responders to have access to patient data such as allergies, medication list, and even disease states like diabetes. Access to advance directives was not viewed as highly valuable. Behavioral health issues showed some value, but not as much as access to a patient's longitudinal health record. It was informed that certain areas of the country are allowing EMS and EMT responders to expand their scope of care to include follow ups, lab draws, medication reconciliation, and other follow up care needs. Two pilot programs in CT are aimed at expanding the roles of EMS and EMT responders by influencing legislature. It was discussed that providing access to billing data also held value as it is challenging for EMS providers to acquire insurance information. The sharing of hospital data to EMS providers was endorsed to aid in the assessment of outcomes. It was emphasized that patients are to be the ultimate beneficiary if EMS responders are more informed of their health status and history. Ambulance run reports were also described as valuable data to be integrated to the HIE.

		A run report was defined as when an EMS team provides a report on patient clinical data, like pulse and oxygen levels, that were collected during their run to the admitting hospital. A copy is also kept for records. It was asked we were aware of studies the demonstrate the value of improved access for EMS responders. No such studies were initially cited. It was suggested to layer in this functionality to the patient longitudinal health record. It was agreed to keep this use case on the list for prioritization.
4.	**Lab Orders**	The Lab Orders use case was described as being relatively straightforward. Although EHRs have the ability to input lab results, many EHRs do not have the ability to construct a lab order. It was emphasized that the HIE ecosystem of lab results must also consider lab orders as well. Few HIEs have explored this use case although delivery of lab results has been deployed and many commercial entities, such as Quest and LabCorp, currently provide the capability free of charge. The value proposition is centered around physician practices and reducing their point-to-point connections with laboratory entities to fulfill lab orders. It was agreed to defer this use case from further prioritization.
5.	**Genomics**	The Genomics use case was discussed as offering an important component to medical treatment and research, despite its barrier of significant cost and relative infancy. Leveraging genetic information to inform clinical decisions has been lagging due to this barrier. In terms of prevention, genetic susceptibility to disease may change the course of treatment plans such as medication selection, preventative management, and treatment regimen. ClinGen is an NIH funded entity that acts as source of truth for clinical translation of genomic data. HIE services can bridge genomics and clinical data within an EHR to meld the two sets of data needed for more impactful genomics research. There are solutions on the market such as "ToBePrecise" that provides this capability. It was emphasized that the genomics use case would be a huge asset to the state to becoming a national leader in genomics. The value proposition can only be realized with large data sets available from tested populations with integrated clinical data. HIE systems can act as a transport mechanisms to entities like ClinGen, ClinVar, and Laboratory Information Systems. Currently, some genetic testing platforms are direct to consumer by private entities. Patients must initiate sharing this information to their primary care physician. Such a linkage could in the future leverage the HIE. It was asked if genetic testing is a more consumer driven process as opposed to new born screening testing that has been widely accepted by clinicians for years. Such a statistic was not known but it was noted that consumer distrust of genetic information for disease susceptibility shared with insurance companies can be a barrier. It was also noted that this use case differs from ancestry DNA testing which has been pushed on the commercial market. It was urged to be bullish on genomics for the future given the landscape CT institutions that could harness such data. It was discussed that many women get tested for the BRCA1 gene outlined in the use case persona because it allows for insight to genetic susceptibility, especially if a patient has lost a family member. It was also noted that some cancer

		treatments leverage genetic testing to ensure treatment efficacy before administering to a patient. This use case was described as filling a patient need which has not already been met, thus willing to be paid for. There was contradicting opinions to keeping this use case for prioritization. It was decided to keep this use case on the list for further consideration.
6.	**eConsult**	The term eConsult was defined as electronic communication between a Primary Care Physician (PCP) and specialist with secure messaging capabilities. The messaging allows chart notes, image results, and other patient data to be sent for review. Specialists respond within 24-38 hours of initiation for recommendations. Specialist can empower the PCP with specialized treatment information so the patient can forego seeing the specialist, thus saving time and money for everyone involved. It was discussed that eConsults improve patient outcomes by reducing delays in treatment. eConsults also break barriers for underserved populations to access specialists through their PCP. It was noted that only 34% of specialists report routinely receiving care plans from PCPs whereas 62% of clinicians reported reliably receiving information from specialists, thus causing risks in communication error. The New England Journal of Medicine was noted to have published a study where eConsult workflows improved access to specialty care and reduced scheduling constraints. It was discussed that eConsults would cause significant cost savings for the Medicaid population of an estimated $27.5 million. It was asked if insurance payers would also reimburse eConsult services versus solely Medicaid reimbursement which is in place. It was confirmed that health care plans outside of Medicaid are paying for eConsults in some situations. It was agreed to keep this use case on the list for further consideration.
7.	**Review Use Case Prioritization Scoring Template and Methodology**	It was reviewed that the group started with 30 use cases and excluded six (including Lab Orders from this meeting), thus will prioritize 24 use cases through the scoring and ranking process. eCQM and IIS (Submit and Query/Retrieve) were added during the Health IT Advisory Council, bringing the total to 26. It was discussed once the top ten use cases are identified, the consolidation process will move on to consider business, financial, legal, and policy factors. These considerations will require another wave of review to distill the list of use cases from 10 to the final 3-5. The prioritization methodology will consist of two activities. One is a subjective approach where each Design Group member will select their personal top ten use cases, ranking them through a SurveyMonkey link. Responses will be scored in inverse fashion where a use case ranked as first will gain ten points, second gains nine points, and so on. A composite score will be assigned to each use case and a final top ten ranking will be provided to cross reference the results of other activity. The second activity will be a quantitative approach. This activity was described as a scoring matrix that allows scoring of each use case based on the 8 prioritization criteria elements. For each criteria element, each use case will be scored as “+” positive, “0” neutral, and “-“ negative against a baseline criteria. Each use case will be given a composite score where “+” is one point, “0” is no points, and “-“ is negative one point. The first two criteria elements (value to patients and value to other stakeholders) are considered inclusion criteria which will be weighed

		against other respondents to create three buckets: unanimously included, further discussion needed, and excluded. Those use cases requiring further discussion will be brought forth to the group to be debated on for inclusion. A top ten list will then be produced after compiling the scores and inclusion criteria from all respondents. Questions were raised regarding the subjective nature of providing scoring value and meeting the baseline criteria. It was proposed to include five points of scoring (ie. "++" and "+") rather than three, but was discussed this would only further complicate the scoring process. It was decided to distribute both the survey and excel matrix to design group members to be completed and emailed back to Cedarbridge no later than end of day on Monday 8/21/17.
8.	**Meeting Wrap-up and Next Steps**	End of day Monday 8/21 will be targeted to collect all responses. It was mentioned that reminders will be sent out both on Friday 8/18 and Monday 8/21 to send responses.

Action Item	Responsible Party	Due Date
Provide Session 7 Meeting Summary	Greg	8/21/17
Complete SurveyMonkey and Excel Score Card	ALL	8/21/17
Provide reminders to DG members to complete SurveyMonkey and Excel Score Card	Greg	8/18/17 and 8/21/17
Commercial eConsult reimbursement information emailed out	Greg / Kate	8/21/17

Email out:
Information regarding coverage for eConsults outside of Medicaid.

http://www.blueshieldcafoundation.org/sites/default/files/u19/eConsult%20GPS_032916.pdf