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

Meeting Date	Meeting Time	Location – Zoom Web Conference
Aug 9, 2017	2:30 pm – 4:00 pm ET	**Webinar link:** https://zoom.us/j/657371924 **Telephone**: (646) 558-8656 OR (408) 638-0968 **Meeting ID:** 657 371 924

Design Group Members					
Stacy Beck	X	Gerard Muro, MD	X	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		Mark Schaefer, SIM PMO	X
Carol Robinson, CedarBridge	X	Sarju Shah, HIT PMO	X	Faina Dookh, SIM PMO	
Chris Robinson, CedarBridge	X	Kelsey Lawlor, HIT PMO		Kate Hayden, UCONN	X
				Kate Steckowych, UCONN	X

Minutes

	Agenda Topic	Notes
1.	**Comments on 8/2/17 Minutes**	The meeting summary for 8/2/17 was approved. It was agreed upon to extend the HIE Use Case Design Group meetings to Session #10 on 9/6/17. It was discussed that the term “prioritization criteria” will be used rather than “decision criteria”. The use cases for the session on 8/16 will include Genomics, EMS, eConsult, and Lab Orders. Next week will also include a discussion on the weighting and scoring criteria to be applied to the 26 use cases to reach a list of prioritized 10 use cases. Next steps were discussed as layering in legal, policy, financial, and business recommendations to the top 10 list which will then be considered to reach a final 3-5 use cases.
2.	**Medical Orders**	The basics of medical orders were discussed: post-acute care when delivered by skilled care under the direction of a physician must include an approved plan of care or medical order by a physician. Any deviation to a care plan must also be signed off. Most EMRs have portals to approve these plans or orders, thus a physician working with many different agencies will have to work off several portals to post orders. It was discussed that the current method of medical orders utilized fax systems, where a physician must scan and file these orders into the EHR rather than enter directly into the electronic record. The process often takes two weeks to get a physician to sign-off even if it is as simple to change of dosage on a single visit. Providing a consolidated portal to post sign-off would be useful. It was suggested to include audit and state compliance measures to allow better traceability. Both the Department of Social Services (DSS) and Department of Public Health (DPH) audit all signed medical orders. It was discussed that this use case applies to home health, skilled nursing facilities, and any other care environment where skill is provided under the supervision of a physician not from the same organization. These services are provided for Medicare and Medicaid. It was emphasized the technical complexity of this use case may hinder its feasibility and assumes the implementation of a longitudinal health record. It was agreed to keep this use case on the list.

3.	**Bundle Management**	Bundle services aid in the components useful to the physician and health system to manage bundled payments. This cluster of services is on the front end, downstream to the provider who is knowledgeable about follow up care. If an event arises, the system can alert the care team or bundle management team for early intervention. It was explained that CMS assigns responsibility for the cost of care and follow up care, including readmissions, thus incentivizing the bundle care team for effective care transition. Orthopedic and cardiology specialties most often experience bundle payments. It was pointed out that the feasibility of this use case is complex, but the sub components are part of other use cases previously discussed. It was discussed that physicians know what is expected of them for bundled procedures and are always notified if a patient is on bundled care through a phone call because bundled care pays out on efficiency. Due to the complexity of components to stand-up bundle management, it was agreed not to include this use case in the list.
4.	**CHA Dose Registry**	It was discussed that the CHA Dose Registry aims to report instances where a patient receives radiological procedures for reporting purposes. Dosing information that comes from disparate sources to be matched at the patient level and assessed can be leveraged in times of need for additional radiological procedures. It was discussed that dose registries can also be used for quality benchmarking against other radiologists and entities. The use case persona was not compelling for describing the radiation exposure of a chest x-ray, thus was suggested to describe a CT scan instead. It was emphasized the real value will be a cumulative dose record so that patients are aware of how much radiation they have accumulated over the years to be available to the primary care physician or in the emergency room which may change how radiation orders are decided. It was proposed that this use case is too specific for one utility and may not be high in the prioritization list and is dependent on the longitudinal health record capability. Institutions have now implemented third-party applications that capture the radiation dose information to integrate with registries whether it is CHA or American College of Radiology. Typically, radiation dose information is not captured or captured consistently. It was agreed not to include this use case in the list due to these inconsistencies.
5.	**Review and Discuss Outline of Use Case Prioritization Criteria**	It was discussed that the first prioritization criteria is the patient, the proverbial North Star and integral to the Quadruple Aim. As the group works through the use cases it was suggested to also consider the quadruple aim of healthcare transformation which is also part of improving physician satisfaction. The implementation of value for three to five use cases allows the greatest chance to be successful to find those with the broadest appeal and need. Decisions need not be fiscally driven, but the more stakeholders that desire to have same issue solved will pose much greater chances to be successful. The speed of implementation must be considered to respond to the Health IT Advisory Council's erosion of confidence to deliver. Complexity of business process and realizing value may also take years even for a "quick win". It was emphasized that prerequisite services must be included in the prioritization criteria and to be mindful of Infrastructure layers like identity management. It was recommended to segregate the criteria by those that

		are technical and value related. By categorizing the prioritization criteria in this way a matrix can be constructed: value low and high vs. technology implementation low and high to find the use cases that land in the golden quadrant. Related use cases can then be matched within the same quadrant to create increased synergy. It was discussed to include the criteria of if a use case had been successful in another state or not. This suggestion was considered but would be difficult to quantify thus was not agreed upon. Instead it was agreed for design group members to do personal research to understand the background of successful use case implementations for state HIEs. The weighting of criteria was discussed to weight patients and providers at the maximum amount of 10 and the other criteria in a way to cumulatively not outweigh these stakeholders. It was also suggested to combine the eCQM crosswalk criteria under the integration requirements criteria to broaden the scope of this class of criteria.

6.	**Next Steps**	1. Create a scoring strawman
		2. Go through the final 4 use cases next week
		3. Fine tune the prioritization criteria
		4. Suggest a scoring and weighting approach
		    a. Finalize this next week
		    b. Do this offline and take input
		5. Publish list of use cases for reference as members begin to go through the use cases as part of the scoring exercise.

Action Item	Responsible Party	Due Date
Scoring strawman with weighting approach	Michael	8/11/17
Update prioritization criteria	Greg	8/11/17
List of use cases	Greg	8/11/17