



ILHIE Authority Advisory Committee

Meeting Minutes

April 4, 2012

Attendance

Year 1 Appointees		
Name	Organization	Location
Bill Odman (Co-Chair)	St. Mary's Good Samaritan	Telephone
Gail Amundson	Quality Quest for Health; Central Illinois HIE	Chicago
Kelly Carter	Illinois Primary Health Care Association	Telephone
Jennifer Creasey	AARP	Telephone
Carla Evans	UIC School of Dentistry; U of IL Medical Center	Chicago
Patrick Gallagher	Illinois State Medical Society	Chicago
Roger Holloway	Northern Illinois University/IL-HITREC	Telephone
Peter Ingram	Sinai Health System	Telephone
Terri Jacobsen	Metropolitan Chicago Healthcare Council, MCHIE	Telephone
Stasia Kahn	Fox Prairie Medical Group	Chicago
Marvin Lindsey	Community of Behavioral Healthcare Association of Illinois	Chicago
James Mormann	OSF Healthcare	Telephone
Fred Rachman	Alliance of Chicago Community Health Services; Chicago Health Information Technology REC	Telephone



Kim Sanders	Southern Illinois University Carbondale	Telephone
Patricia Schou	Illinois Critical Access Hospital Network (ICAHN)	Telephone
Esther Sciammarella	Chicago Hispanic Health Coalition	Chicago
David Stumpf	Professor Emeritus, Northwestern University, Woodstock Health Information & Technology	Chicago

Year 2 Appointees		
Name	Organization	Location
Danielle Byron	Community Counseling Centers of Chicago	Chicago
Alan Gaffner	Greenville Regional Hospital & Fair Oaks Nursing Home	Telephone
John Lewis	Northern Illinois University/Illinois Health Information Technology Regional Extension Center	Telephone
Derek Wallery	Marque Medicos	Telephone

State of Illinois Employees		
Name	Organization	Location
Laura Zaremba	Office of Health Information Technology (OHIT)	Chicago
Mark Chudzinski	Office of Health Information Technology	Chicago
Mary McGinnis	Office of Health Information Technology	Chicago
Cory Verblen	Office of Health Information Technology	Chicago
Ivan Handler	Office of Health Information Technology	Chicago
Krysta Heaney	Office of Health Information Technology	Chicago



Saroni Lasker	Office of Health Information Technology	Chicago
Saro Loucks	Office of Health Information Technology	Chicago
Dia Cirillo	Office of Health Information Technology	Chicago
Danny Kopelson	Office of Health Information Technology	Chicago
Christopher Eaton	Office of Health Information Technology	Chicago
Michelle Saddler	Department of Human Services	Chicago
Alice Richter	Healthcare and Family Services	Chicago
Mary Driscoll	Department of Public Health	Chicago
Gwen Smith	Healthcare and Family Services	Springfield
Julie Doetsch	Healthcare and Family Services	Springfield
Alicia Hawkins	Healthcare and Family Services	Springfield

I. Roll Call and Introductions

Mark Chudzinski, General Counsel of the Office of Health Information Technology (OHIT), opened the meeting of the Advisory Committee (“Committee”) of the Illinois Health Information Exchange Authority on April 4, 2012 at 1:05 pm, hosted at the State of Illinois J.R. Thompson Center in Downtown Chicago, with a telephone conference call-in number and video connectivity with the Prescott Bloom Building, Directors Room 3rd Floor, Springfield Illinois. It was noted that notice of the meeting and the agenda were posted on the OHIT website and at the Chicago meeting location no later than 48 hours prior to the meeting. Roll was taken, and the ability of those attending by telephone to hear and participate was confirmed. Bill Odman the Committee Co-chair, welcomed the Committee members and members of the general public, who would be welcome to address the Committee during the Public Comments portion of the Agenda at the conclusion of the meeting.

II. Approval of Minutes

The minutes of the meeting of the Committee of February 14th, 2012 were approved.



III. ILHIE Authority Board Update

Bill Odman – Bill reported that the material covered at the Authority meeting had to do with The Committee of the Whole, who decided to form the Regional Health Information Exchange Workgroup.

Terri Jacobsen – provided an update on The Committee of the Whole and the Regional Health Information Exchange Workgroup. The committee discussed the relationship between the ILHIE and the Regional HIEs, including progress in local efforts, who was involved and their use cases. The group decided to arrange a separate meeting with the Regional Health Information Exchanges, OHIT and their respective vendors to clarify efforts and to not duplicate technological efforts. Also discussed was the cross exchange of CCDs, MPI issues and discuss consent and related issues that might come up out of a business relationship. The first meeting will be April 11th, 3-5PM.

Mark Chudzinski - At the last meeting, the ILHIE Authority Board adopted 3 resolutions regarding the adoption of the regulatory process. It is anticipated in the course of the next 12- 18 months the Authority Board will need to adopt various policies and those decisions need to be made in accordance with Illinois law that provide for rule making. The process was initiated by adopting two regulations that set the parameters the Authority Board needs to follow. The first rule that was adopted, currently in draft form, is a rule that will require the registration with the Authority of local and regional health organizations so the Authority can obtain certain data. As a result, the acting Executive Director has the ability to reach out to the stakeholders who will be affected by this rule to obtain their input prior to the formal rule-making process.

IV. ILHIE Implementation Update

Laura Zaremba – In regard to ILHIE Direct, OHIT has closed out the first quarter with nearly 300 users. The first quarter goals were exceeded by more than 20%. Laura pointed out to early ILHIE Direct subscribers that the directory of users has expanded and is now available. Laura said that OHIT welcomes feedback to improve ILHIE Direct services and wants to encourage utilization. The Regional Extension Centers are focusing on assisting providers in integrating secure messaging into their workflow. In addition, OHIT is in the process of identifying use cases that are a good fit for secure messaging and will share the results of that work as it evolves.

The work with InterSystems and the ILHIE is proceeding slowly and is making progress every week. Laura stated that OHIT is driven by some very aggressive external timelines, not limited to the stages of meaningful use, but also by the HIE Cooperative Agreement with the Office of the National Coordinator. OHIT is probably delayed by about three months in the ILHIE implementation based on the published timeline for 2012. OHIT is going to continue to identify areas in which we can accelerate operations and make up for the delay.



The alpha partners are identified. Since the alpha partners are all busy with their own health IT projects, it takes a little time to get those connections and get moving. There has been a little bit of a delay in getting some of the Medicaid data for the Master Patient Index.

The State received a federal grant for the Behavioral Health Integration Project and OHIT has retained the services of Dia Cirillo to direct these efforts. Illinois is one of five states that were awarded a grant and Dia is here to ensure that all the grant requirements are met. The grant is funded by SAMHSA/HRSA under the Center for Integrated Solutions. The purpose of this grant is to accelerate the rate at which behavioral health and primary health providers can exchange protected data and integrate patient care.

OHIT is also promoting the use of ILHIE Direct as a point-to-point service to exchange data electronically for behavioral health providers. The grant resources are being used to develop the tools that behavioral health providers need to in order exchange health information according to current Illinois law. The tools include the consent form, the data, security and privacy measures that need to be adopted in order to conform to existing law as well as consideration of technology and resource constraints. The work for the grant must be completed by September, 2012.

Michelle Saddler- How do we determine what is a “good number” of users for Direct and how do we determine what’s good penetration as far as marketing is concerned?

Laura Zaremba – The ONC has established goals for each state. The Direct goals are based on the goals of the Regional Extension Centers (RECs). The RECs have a combined goal of 2700 Electronic Health Records users throughout the state. Our federal partners would like to have ILHIE Direct to have at least 30% of that goal, which is approximately 900 users. OHIT would like to exceed that goal.

V. OHIT Communications Update

Cory Verblen – Cory echoed Laura’s statements about ILHIE Direct and increasing usage with the help of the RECs. Presenting use cases to providers and how they can integrate Direct into their daily workflows is a key component of successful utilization.

Surescripts and Walgreens have teamed up to send immunization records via Direct Secure Messaging. One of ILHIE Directs’ providers was one of the country’s first physicians to receive immunization records via this protocol and they will be featured in a future ILHIE Direct newsletter.

The communications department added a page on the ILHIE website dedicated to the Behavioral Health Integration Project (BHIP). The department also conducted a webinar for the statewide BHIP meeting in which nearly 200 people participated. In addition, the



Communications team is constantly updating the website and planning on conducting a “HIE 101” webinar.

Danny Kopelson – The Consumer Education Workgroup’s first meeting is the week of April 24th. Consumer education is a critical cornerstone in successful implementation of electronic health exchange within the state. The work of the Consumer Education Workgroup is to prepare materials so that consumers can make informed e-health consent decisions.

The Consumer Education Workgroup’s purpose is to advise the ILHIE board, to provide a forum for consumer comment, education, and the development of consumer stakeholder consensus in the principle standards and the initiatives relating to the transfer of electronic health information.

The role of the Consumer Workgroup is to distribute information to the consumer audience. Among the tasks of this workgroup are to work primarily with consent issues opt in/opt out communication messaging, develop an educational strategy and seek advice and input. If anyone is interested in joining the workgroup, please get in touch with Danny Kopelson or Cory Verblen. Community members, community organizations, provider organizations and consumers are welcome to participate.

VI. OHIT E-prescribing Update

Mary McGinnis – Illinois has been making steady progress in terms of pharmacies ‘and providers’ ability to e-prescribe. OHIT has been tracking progress for the past two years and each quarter shows improvement from the previous quarter. For example, 92% of all pharmacies in Illinois have the capability to e-prescribe. The next quarterly goal is to increase that another percentage point.

At the time of the initial environmental scan and upon subsequent review of the e-prescribing data (received through the ONC and Surescripts), we noticed there were a fair number of independent pharmacies that were not actively e-prescribing. A target was set to reach out to those independent pharmacies and try to increase the level of e-prescribing. OHIT is beginning to see an increase in the number of independent pharmacies that are enabled for e-prescribing based on these outreach efforts.

Approximately 77% of independent pharmacies are enabled for e-prescribing. An OHIT intern, who is a Doctor of Pharmacy, called 50 independent pharmacies to determine their current e-prescribing capability. The results of those calls and conversations reflected progress in e-prescribing capability in some downstate and small communities. The call reports indicated that there were some small pharmacy acquisitions by larger pharmacy corporations which provided e-prescribing capability that was not previously available. OHIT is also tracking the number of providers, physicians, physician assistants, and nurse practitioners who are e-prescribing. That percentage is a little bit



lower, at approximately 42%. Another goal is to increase the number of providers and practitioners e-prescribing in Illinois.

We are aware that there is a challenge for Medicaid providers and their ability to fully e-prescribe. Medicaid providers can e-prescribe but they cannot perform medication reconciliation via e-prescribing because the Medicaid agency is not currently connected to the Surescripts network. Our partner in this arena, the Illinois Department of Healthcare and Family Services, is well aware of this requirement of Stage 2 Meaningful Use. As part of HFS' Medical Management Information System (MMIS) upgrade, HFS is planning to publish an RFP that includes a Pharmacy Benefits Management component to the MMIS. Because this is a pending procurement, we are unable to disclose any specific details. What we do know is that HFS is preparing an RFP to be released in the summer of 2012. Much of the technology implementation and testing will occur in 2013 so that Medicaid providers can meet the full range of e-prescribing capability per the Stage 2 Meaningful Use requirement in 2014.

The E-prescribing Workgroup held its initial meeting in February and the next meeting is April 18th at 10am. One of the items to be discussed is the development of communication campaign regarding a change in Illinois statute allowing e-prescribing of class 2, 3, 4, and 5 narcotics and controlled substances. More communication and communication of this change in statute is needed for both to providers and pharmacies.

David Stumpf – The DEA requires a two factor authentication for prescribing controlled substances. Do you have systems in place to help with that, and are you going to be tracking that independently?

Mary McGinnis – We are planning to address questions like this to the E-Prescribing Workgroup because their expertise to answer questions of this nature. In addition, the ONC has an E-prescribing Workgroup that is discussing e-prescribing of controlled substances and the complexities around identification management and two-factor authentication of entities. There is expertise within the Department of Human Services and they have been working on this a long time and will bring their leadership to assist in addressing these questions.

David Stumpf – Two-factor identification is not going to be limited to prescribing. I would suggest developing a more generic solution in terms of confidential information regarding behavioral health and similar concerns. It would be nice to have a common solution for these concerns. There are vendors that have superb biometric authentication.

Stasia Kahn – As a physician and I would love to do two-factor identification but sometimes differing technology presents issues for her office. If a physicians' EMR



vendor is not prepared and the hardware is not capable - these are important difficulties. "Is there an EMR vendor and a hardware vendor on the workgroup?"

Mary McGinnis – There were efforts to include an EHR vendor and but they have not been active in the workgroup. OHIT is open to recommendations for adding an EHR vendor to the workgroup. Any member of the committee is welcome to send those names to OHIT. In addition, we are looking to add a physician to that workgroup as well.

David Stumpf – There are vendors that work with multiple EHRs around that kind of solution. I will provide some contact information.

Mark Chudzinski – In regard to vendor participation, it is likely that the vendor's would act more as advisors and not as members of any committee because Illinois' procurement laws limit vendor involvement.

VII. **Use Case Presentation/Discussion**

Bill Odman – We came up with a better definition of how the Regional HIE Workgroup and the Advisory Committee can be advising the Authority Board about the use cases. We would be making recommendations on use cases to move forward based on a level of oversight as to what type of use cases they would like to see and our purpose would be to vet the use cases before presenting them to the Regional HIEs and various stakeholder groups before moving forward. The use cases must have a realistic scenario, the infrastructure that is needed must be identified, and the privacy, security and consent legislature concerning the use cases as well are all parts that must be vetted before presentation. The use case must make sense for what we are trying to achieve in Illinois.

The ILHIE goals, as stated in the strategic plan, are to *"Improve the healthcare quality and outcomes, to improve patient safety, to enhance public healthcare and disease surveillance, to control cost of healthcare, and to reduce health disparities."* It was decided to align the purpose of the use cases as much as possible with these five strategic goals of the ILHIE.

A. **Prenatal Electronic Data Set Use Case, presented by Dr. Ann Borders**

- Submitted by the CHIPRA Child Health Quality Demonstration Grant Project, Illinois Department of Healthcare and Family Services
- A minimum set of prenatal data available to prenatal providers/hospitals electronically
- A valuable information source identifying test results, prenatal complications, and risk factors
- A tool to assist in providing appropriate level of care and avoiding duplicate testing
- Developed by the CHIPRA Child Health Quality Demonstration Grant, Category E, Improving Birth Outcomes



- Included broad stakeholder involvement; Based on ACOG guidelines
- Started as a tool for hospitals; adapted for use by prenatal care providers and emergency rooms
- Created a minimum data set which captured the key information needed for treatment decisions
- Focus on ease of use – organization and labeling of information
- Why is it needed?
- To assure continuity of care:
 - When a woman changes prenatal providers
 - Uses the emergency room
 - Presents for delivery without prenatal care records
- To promote efficiency:
 - Information provided in a standard user-friendly format (1-page, organized, clearly labeled, problem list)
 - Hospital relieved of having to track down a prenatal care record
- To improve quality:
 - Allows provision of appropriate level of care
 - Appropriate care leads to improved outcomes
- To control costs:
 - Reduces duplication of services – services received and test results are readily available – no need to repeat
 - Aligns with HIE Goals
The Prenatal Electronic Data Set aligns with goals of the statewide Health Information Exchange:
 - Improved quality and outcomes
 - Promotes patient safety
 - Reduces cost
- Benefits to Constituents - The Prenatal Electronic Data Set benefits all constituents involved:
 - Patients – better care due to improved continuity of care, quality and outcomes, avoid unnecessary testing
 - Prenatal care providers – information to guide treatment decisions
 - Hospitals – information to guide treatment decisions available 24/7 as needed
 - Payers - improved quality and outcomes, reduced duplication and costs
- Prenatal Electronic Data Set
 - Prenatal information is extracted from EHR to a standardized template and transmitted to a secure registry/repository
 - Prenatal services provided and risk factors identified and documented in EHR
 - Prenatal data is transmitted to hospitals/prenatal providers via Direct Protocol in the standardized template format
 - Data is housed in secure registry/repository
 - Data is updated as new information is transmitted



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- Hospitals and prenatal providers request prenatal data via Direct Protocol (initially)
 - Patients receive risk appropriate treatment and quality of prenatal care improves
 - Prenatal data is available for retrieval from the secure registry/repository by HFS for monitoring purposes and to promote informed decision-making

 - Next Steps
 - Crosswalk the Prenatal Electronic Data Set elements to electronic health records
 - Develop a standardized template
 - Determine appropriate repository
 - Identify key partners
 - Develop a testing plan
 - Universal Solution
 - Although, this technology solution was developed for the Medicaid population, it can be used by other payers for their pregnant women.

Comments: David Stumpf – Stated that this would be an excellent project and urges the Committee to give it a “green light”. The National Quality Forum (NQF) has identified key areas in regard to disparities and overages; prenatal and maternal care was one of these areas, so it has been well vetted at the national level.

The Integrating the Healthcare Enterprise, IHE, is a standards development group has a series of HL7 series 3 templates to collect in a standardized way data about antenatal visits, visits during the pregnancy, labor and delivery and referrals to pediatricians. Standard templates to collect data are part of the work that IHE has undertaken.

The AMA’s Physician’s Consortium for Performance Improvement (PCPI) developed a series of approximately ten metrics for measuring maternity care. These metrics were approved last week by the PCPI. Following the vetting and approval by the NQF, it will not be long before they are incorporated into “meaningful use”.

The March of Dimes has announced a program called “Strong Start”. This is an effort to address disparities and reduce premature inductions, premature births and NICU admissions.

Dr. Arlette Brown is working at OHIT to reconcile the CHIPRA minimum data set with existing standards.

Esther Sciammarella – stated that in the Latino community most women do not get prenatal care after the second trimester. She also noted the higher incidence of C-sections among obese



patients. It is important for physicians to treat this condition earlier before pregnancy to reduce C-section rates.

B. Telehealth Use Case presented by Glenn Groesch, Telehealth ILHIE Work Group

Patient is a 74 year old female living in a remote area with limited transportation and has a history of depression. She travels to a local clinic to seek care from primary care physician. Her local physician recommends a tele-psychiatry consult and schedules patient for a consult via telemedicine. The local physician's office does not have internet access but is close to a Critical Access Hospital (CAH) which hosts a telehealth suite which can connect to telehealth providers. The clinic nurse schedules the patient for tele-psychiatry consult via web-based scheduling tool in an open time slot at the CAH telehealth suite location. Psychiatry administrative support accepts the request and requests additional patient information. The local nurse sends information via secure portal. Psychiatrist connects from their office by video to see the patient. The patient obtains services at the CAH telehealth suite location. Care is provided and the psychiatrist discusses discharge instructions with the CAH staff nurse for implementation. A consultation report is sent back to the primary care provider who requested the service and so supporting the medical home model. Treatment recommendations (lab, X-ray, pharmacy services are provided by the local hospital at the direction of the remote psychiatrist.

The "Exchange"

This use case is similar to the ILHIE specialist use case, except in a telehealth environment. Local nurse accesses the HIE, inputs patient information and notifies psychiatrist records are available. Psychiatrist accesses HIE to retrieve records for use during telemedicine clinic. Psychiatrist interviews patient and documents encounter. Information is placed in EMR and HIE. A local nurse accesses HIE to print prescription and provides script and discharge information to the patient. Medicaid is billed electronically.

Barriers and Recommendations

- The Master Provider Directory should annotate the provider as telehealth capable. In addition, include fields allowing more specific information to be included for providers with telehealth capabilities, such as IP addresses or online contact information for video conferencing services, as well as information commonly required for credentialing and privileging.
- ILHIE should support a HIPAA compliant secure electronic referral process and scheduling. Whether this support is realized in the form of guidelines for the process or provides the services for the process depends on the ultimate strategic mission and scope of the ILHIE. Any studies or surveys conducted by ILHIE should include questions on telehealth needs, interests and utilization.



- The majority of barriers to mental health come as a result of the rules surrounding the release of mental health records. These rules and how they affect the HIE are being discussed by the ILHIE staff, ILHIE Behavioral Health WG, and other national organizations and include:
 - Format for the basic release of information, and how is that release transmitted to the patient's main provider.
 - What is the timeline for release of information? This would affect emergency, acute, out-patient and specialist referrals.
 - Will the current examination results be transmitted back to the local clinic, and what permissions are needed?

David Stumpf - Likes this but thought of a couple of other barriers to consider. One is reimbursement. Second is how can the State facilitate joint licensing to do this across State lines?

Glenn Groesch – Licensing is being addressed and this discussion could go on for hours. As far as reimbursement, Blue Cross Blue Shield does do reimbursements. They do reimburse for Medicaid there are special codes to do that, of course it is not as much as physicians want but that is the state of affairs in Illinois today.

Further comments and questions should be sent to Cory.Verblen@illinois.gov . Cory and Bill Odman will touch base in a few weeks about this.

VIII. Public Comment

Stasia Kahn – informed the Committee about HIE Advocacy Day which occurs May 2nd 2012 in Springfield, Illinois

IX. Next Meeting

May 29, 2012 1-3 PM

Meeting Adjourned

Minutes Submitted by Saro Loucks, Office of Health Information Technology.