

Steering Committee

REMINDER: please print your own hard copies of meeting materials

Meeting Date: Friday, May 16, 2008
 Time: 2:00 pm to 5:00 pm
 Location: 931 Spring Street, Conference Room

Committee Members: Greg Bergner, MD, John Bachman PhD, Dick Derby, Jim Ellsworth, Gayle Erb-Hamlin MPA, Jon Lehrman MD, Shannon Truesdell MPA RN

Invited Guests: Rob Quadri, Sandra Dunn MSc, Dana Davies, MPH, Maria Chaves, Kim Dickson, Trever Lee

<u>Time</u>	<u>Topic</u>	<u>Outcome</u>	<u>reference</u>
2:05	1. Welcome, Introductions and Agenda Review		
2:10	2. Changes or additions to minutes from March 12, 2008	Decision: approve, modify or reject	Pages 2 - 4
2:15	3. iREACH demonstration & update <i>Kim & Trever</i>	Review & discuss	Page 5 - 6
2:55	4. Blue Shield of California Foundation convening report out -- <i>Jim & Dick</i>	Review and discuss	Handouts @ mtg
3:10	5. ACCEL contingency planning -- <i>Dana & Sandra</i>	Review of current state and identification of plausible scenarios	Attachment
4:00	b r e a k		
4:10	6. Community Engagement Planning - <i>Dana</i> Case Studies and brainstorming	Input for 2008 community engagement plan	Pages 7 - 15
4:25	7. Project & staff updates: • Staff report - <i>Sandra</i> • EMPI - <i>Maria</i>	Review & discuss	Pages 16 - 22 -
4:40	8. IT Support - Policy	Decision: approve, modify or reject	Page 23
4:50	9. Closing and Next Steps		

Facilitator: Dana Davies
 Action items from last meeting: none
 Next meeting: Wednesday, June 11, 2008, 2:00 - 4:00 PM

ACCEL Project Reporting for May 2008


Project Name	Care pathways and iREACH implementation
Project Manager	Trever Lee (IT), Kim Dickson
Reported by	Kim Dickson, Trever Lee


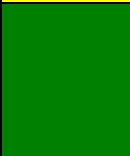



Project Summary

Comment on all yellow/red indicators and progress notes below

The phasing in of pathways going “Live” on iREACH has been extremely helpful, as each pathway brings new learning that assists in improved development and configuration of the next. Currently NBSHCC, SHCC, AER, and OMH are all live on iREACH and PMHC is only days away from going live on the Western Slope. The next step is to create a good Quality Assurance system regarding: the proper use of iREACH, the proper implementation of the pathways, and standardized data entry to ensure quality reports. The identification of necessary reports and iREACH reporting capability are also key elements of our work at this point.

Milestone Update

legend  Complete  In process  Not yet scheduled

Major Milestone	Status color	Comp date	What/where	Comments
Training and Testing for PMHC with MHD, PHD, and CHC		5/12/08		PMHC training will occur with the key players on 5/12/08. Tribal will be individually trained when PMHC has passed the testing phase.
NPP Go live		2/19/08 2/29/08 4/10/08 4/21/08	PHD, MHD & Marshall CHC Tribal Clinic Barton	
Annual Eligibility Review (AER)		3/3/08	PHD	Newly developed and implemented to capture renewals of coverage. This pathway is PHD centric.
Securing Health Care Coverage		2/19/08 3/4/08 4/10/08	SLT & WS	This pathway is PHD centric. iREACH is not intuitive and CHW's have struggled with the standardization required in entering data, so that the end data results are accurate and meaningful.
Newborn Securing		4/25/08	SLT	10+ referrals have been entered into iREACH. Referrals must “mature”

Health Care Coverage				(birth of baby) before remainder of pathways can be completed. Active QA is required to ensure TFP Referral Specialist is entering referrals accurately.
Obtaining a Medical Home		2/19/08 3/4/08 4/10/08	PHD & Marshall CHC Tribal	Encountered small iREACH programming issues that were easily correctable in iREACH and have not hindered implementing this pathway.
Pediatric Mental Health Consults		5/13/08 5/16/08	WS - Testing Go Live SLT - in Fall	Case Studies complete and iREACH configured for testing. Go Live in SLT will be delayed until Western Slope has Pathway running smoothly on iREACH.
Utilizing a Medical Home		tbd		The referral process has struggled in the Marshall OB unit, but was revived last month with the intervention of Jon Lehrman. Now receiving a steady referral flow from OB. Elements of the pathway will likely change due to pending First 5 funding. May reserve resources for programming this pathway into iREACH until after the First 5 program is established.
Utilization & Retention		tbd		Nearly finished identifying necessary reports. Identifying iREACH reporting capability. QA reports are also being identified.
Report Creation		tbd		

eHealth Initiatives and Community Engagement

Community engagement in HIE may include three different constituencies – and is often in this order:

1. Providers
2. Employers
3. Consumers

While engagement strategies may differ considerably, it is clear that there are many common themes and concerns:

- WIIFM
- Shared understanding of purpose, scope, and benefits
- Definition of privacy and how it is ensured
- Information ownership and control

Providers

While engaging clinicians is regularly identified as a very difficult challenge by 20 percent of HIE initiatives and as a moderate challenge by 62 percent (eHealth Initiative 3rd Annual Survey), it is nevertheless a primary focus among all HIE's. Ultimately, in a successful scenario, providers will become customers. In addition to the themes above, how the HIE will impact practice and concerns about cost and workflow are important elements to address.

Employers

As stakeholders in the development of HIEs, employers are a somewhat more remote constituency since the HIE's impact on issues employers consider vital can be seen as much more indirect and/or downstream. Large, self-insured employers who are active in purchasing and business/health coalitions are more likely candidates when seeking active participation. Outreach to employers requires clarity about the specific purpose and/or outcome.

Consumers

Most of the literature relating to community engagement and HIEs focuses on consumer privacy. To date, however, there are comparatively limited examples of success/best practices largely owing to practical limitations of time and resources to both engage and then respond to consumer input. Emerging outreach approaches are consumer councils, consumer-directed focus groups, and consumer and patient representatives on RHIO governing bodies. It is suggested that long-term success for HIEs will rely on consumer demand and that committing to informing and engaging this constituency is a vital investment. The eHealth Initiative Blueprint: Building Consensus for Common Action (Feb 2007) makes specific recommendations for consumer engagement for 2008 and beyond.

Community Engagement Planning: defining the elements

1. What is the purpose?
2. What constituencies in the community will be the focus?
3. What are the key messages to be conveyed?

4. What is the desired outcome?

iHealth Reports, prepared for CHCF by Avalere Health, June 2007

Privacy, Security, and the Regional Health Information Organization

VIII. The Consumer Perspective

Improving patient and consumer services is a major focus of the RHIOs and is at the foundation of their privacy and security policies. Nevertheless, the exchanges are struggling to engage and include consumers in planning and development in a way that will be most effective. With that in mind, the authors took a closer look at the relationship between RHIOs and consumers, the current and potential role of consumers, and the issues ahead.

Collaboration Is Limited

Few RHIOs today seek the advice of consumer experts, patient advocates, or patients as they develop policies, including those related to privacy. Yet experts and some RHIO representatives agree that consumers are key constituents. Collaboration between consumers or advocates and RHIO leaders can help an exchange develop comprehensive and appropriate privacy policies and practices. There are several reasons why such collaboration is uncommon. They include difficulty in engaging representative or knowledgeable consumers, limited resources to conduct consumer outreach and education, and the fact that many individuals and consumer groups do not understand or believe in the benefits of health information exchange. RHIOs and patient advocates alike are struggling with these issues and considering various countermeasures.

The RHIOs in this report acknowledge the importance and complexity of developing comprehensive and transparent privacy policies, many of which directly affect and concern patients. They address the array of privacy issues very differently and their policies are not always readily available or transparent to consumers. Diverse philosophies about patient rights, control, and choice make it even more difficult to manage these issues. A patient's right to view and access data can be contentious. While many consumers may expect to have automated access to information about themselves, most RHIOs are not prepared to enable it. One RHIO in this study enables such access by exporting data to the individual's personal health record, but this capability is a longer-term proposition for others.

Some experts and consumer advocates argue that patients should be able to visit their provider electronically and access all of the information about them in the RHIO, not just information the provider houses. Many health care stakeholders agree, but they note that related policies and processes — how patients are authenticated and view data and how to make sure not to overload patients with information, for example — are extremely challenging and beyond the scope of most RHIOs. Moreover, such access may create more burdens for RHIOs, like the cost of developing the necessary infrastructure and educating patients about data content. (See Appendix A regarding efforts by the American Health Information Community and the Health Information Technology Standards Panel to address these issues.) The RHIOs in this study use diverse strategies to engage consumers. Some are struggling to identify and engage the most appropriate and representative consumers and to define consumers' roles in information exchange.

The North Carolina Health Information and Communications Alliance, Secure Architecture for Exchanging Health Information (SAFEHealth), Michiana, and the Rhode Island Health Information Exchange reach out to and engage consumers differently. But it is still unclear if RHIOs generally want to involve, or can accommodate, educated consumers in planning.

Best Practices and Principles

Patient privacy advocates and some RHIOs believe that addressing privacy issues and potential consumer concerns early in a RHIO's development is crucial. Consumer and privacy experts agree that RHIOs can build on privacy models like the Connecting for Health Common Framework, HIPAA, and others. The Common Framework, in particular, has received much attention; increasingly, RHIOs and other health care stakeholders are referring to this model for recommendations on consumer choice, entity authentication, and architecture for health information exchange. Consumer-focused best practices are not yet evident in RHIOs. But several organizations, including the Markle Foundation, the National Consumers League, and the Health Privacy Project, have established consumer-directed principles that could serve as best-practice models and guide future RHIO privacy policy.

These principles advise that consumers:

- Know what information about them is in a health information exchange.
- Have access to the information and be able to correct or amend it.
- Understand how the information will be used, who has access to it, and how it can be tracked.
- Control whether and how the information will be shared.
- Be aware of their authority concerning the information, for example, knowing about consent policies.
- Ensure they are notified of breaches in a timely manner and that effective legal remedies are available to them.

As approaches to privacy issues evolve at RHIOs, many consumer advocates would like consumers to play a greater role in developing policies related to privacy and other issues, such as personal health records and pay for performance. Ways to reach out to and engage consumers are emerging. They include consumer councils, consumer-directed focus groups, and consumer and patient representatives on RHIO governing bodies. Slowly but increasingly, states are collaborating with RHIOs to better understand the priorities and concerns of key health care stakeholders, including consumers. State-based workgroups, for example, give consumers an opportunity to be visible and participate in the dialogue. There are other barriers to stimulating broader consumer interest in RHIOs. Advocacy groups may not see health information exchange as central to their mission, or they and consumer groups may not see its potential benefits. The tremendous gap in consumer awareness — poor health literacy, for example, and consumers not realizing that complete medication lists and lab results are important — may ultimately hinder exchange efforts. Organizing workgroups that represent a wide array of interests is one way to communicate with and educate consumers, and to create a broader constituency in favor of health information exchange. Unfortunately, local and national advocacy groups and organizations do not have the financial and human resources to educate all consumers in a coordinated fashion. Perhaps the federal government could support such efforts, as well as forums in which consumers suggest how RHIOs can engage them.

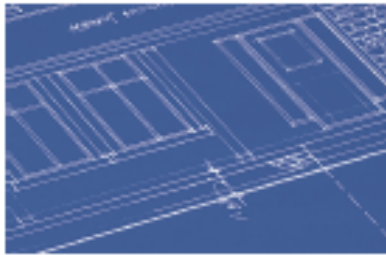
Reconciling state privacy laws, more federal legislation to promote the development and

strengthening of local privacy-breach policies, and specifying who is accountable and what the appropriate remedies are when breaches do occur are among other consumer issues that warrant further attention. Some RHIOs face much more restrictive privacy laws than RHIOs in neighboring states do, which suggests that state laws need to be reworked to make them consistent. There is already movement on this front. Under a contract with the federal Office of the National Coordinator for Health Information Technology, several interests are exploring privacy and security barriers, such as conflicting state laws. These interests include the Confidentiality, Privacy, and Security Workgroup of the American Health Information Community; the Health Information Security and Privacy Collaboration; and RTI International, a research institute. (See Appendix A for more details.)

Interviewees disagreed about whether HIPAA's pre-emption of state privacy laws should be re-examined, but they agreed that HIPAA is only a floor for privacy policy and regulation. Both consumer privacy experts agreed that enforcing the HIPAA Privacy Rule is essential and suggested that the Federal government is not doing so effectively. Patient-consent policies also raise concerns. According to some experts, a RHIO's no-opt policy could prompt a patient to conceal personal health information, not seek care, or seek care elsewhere. Under no-opt, for example, a patient who opposes information exchange and whose physician is unwilling to treat her without complete data may have to find a doctor outside the RHIO. Furthermore, patients who opt out of an exchange, if they have that choice, could limit a hospital's or other provider's ability to deliver high-quality care because potentially critical information would not be accessible. RHIOs should enlist multiple stakeholders to weigh these issues and design the most appropriate privacy and security policies. Excluding consumers or soliciting their input only after the fact may make the process more challenging and tenuous for everyone involved.

Shortcomings at the Federal Level

The U.S. Government Accountability Office released a report in February 2007, titled "Health Information Technology: Early Efforts Initiated but Comprehensive Privacy Approach Needed for National Strategy," on how the U.S. Department of Health and Human Services (HHS) is incorporating privacy into its national health information technology strategy. According to the report, HHS, through its Office of the National Coordinator for Health Information Technology, has spurred efforts to develop solutions for protecting personal health information. But HHS has not come up with a comprehensive plan for integrating those efforts into its strategy and has not set a clear timetable for such integration.



ENGAGING CONSUMERS

Health IT and health information exchange (HIE) can provide the knowledge and tools to enable consumers to fully engage in their own care in partnership with providers and the larger health system. Such tools allow consumers to do more for themselves, including making informed behavioral choices, knowing when to seek outside care, and coordinating the care they receive from multiple sources. Health IT can create a new standard of care in which delivering information, self-care tools and decision aids to the patient

are as integral to high quality care as providing tests, medications and treatments.

While there were many areas of consensus, the broader vetting process identified some priority areas where consensus has not yet been established. Nearly all stakeholders agree strongly in principle that consumers should be able to control their own health information, but the specific policies and mechanisms to implement this principle have not yet been well defined, let alone broadly accepted or developed.

For example, there is not consensus in the industry regarding the level of consumer control with regard to de-identified health information for non-direct care purposes such as research. In addition, when it comes to consumer control of personally identifiable information, some stakeholders are concerned about giving more control than HIPAA currently requires, particularly in the areas of information necessary for treatment, payment or administrative operations. There is also ongoing discussion regarding the interpretation and application of HIPAA itself. Finally, as we seek to mobilize patient data in order to improve quality, safety and efficiency of healthcare delivery, questions arise such as which providers should have access to what types of data, under what circumstances. This applies to both identifiable information and de-identified information, which could be used for analysis, aggregation and reporting purposes beyond what is needed for direct patient care.

The consent process should include a dialogue between patients and their clinicians regarding access to detailed identifiable clinical information. In addition, policy issues remain regarding the use of personal health information – identifiable or otherwise – for purposes other than direct patient care. All of these critical issues should be addressed as part of a multi-stakeholder consensus process, which we call for under strategy number five.

Principles

The following principles, strategies and actions are designed to catalyze the development of health IT applications and the flow of information to support them in a way that emphasizes the fullest possible engagement of consumers in their own healthcare.

- 1. Consumer Engagement in Healthcare:** Engaging consumers is critical in improving health-care safety, equity, timeliness, quality, efficiency, and patient-centeredness. Health IT and health information exchange should support informed consumer action and decision-making about health and healthcare, in partnership with providers. The absence of health IT and health information exchange serves as a barrier to achieving these goals. In addition, consumers need clear information, shaped by their input, about health IT, health information exchange, and how to participate more fully in their own health and healthcare.
- 2. Consumer Access and Control of Personal Health Information:** Consumers have the right to access all of their personal health information in an understandable form, as well as to annotate and request corrections to this information. Providers, payers and others who hold personal electronic health information have an obligation to make that information readily accessible or to facilitate its availability to the consumer. Individuals should be able to limit when and with whom their identifiably personal health information is shared.



3. **Consumer Access to Electronic Health Information Tools and Services:** Tools that engage consumers through the mobilization of electronic health information should be universally available to consumers regardless of whether or not they have health insurance, serve consumers' varied needs, be integrated in the delivery of care and conveniently available outside of care delivery settings. These tools should also be designed explicitly to meet the needs of diverse groups including the economically and geographically underserved, disabled, older, and culturally diverse populations.
4. **Consumer Privacy:** Consumers have a right to privacy of their personal health information, consistent with all applicable federal, state and local law. *(See also additional principles in Privacy, Security and Confidentiality.)*
5. **Consumer Trust:** Consumers must be able to trust that their personal electronic health information is kept and used, with appropriate consent, in a secure, reliable and auditable manner. All stakeholders in healthcare who handle personal health information must make their policies regarding privacy and information use public, understandable and easily accessible.
6. **Consumer Participation and Transparency:** All entities that govern, oversee, operate and/or create policy for the electronic exchange of health information should be transparent and open to meaningful consumer participation.





Strategies and Actions Engaging Consumers

Engaging Consumers Strategies	Engaging Consumers Actions
CONSUMER ENGAGEMENT IN HEALTHCARE	
1. Compile and analyze research, literature, and best practices relevant to successful consumer engagement in HIT/HIE.	1.1 An existing, trusted Federal Agency and/or NGO should compile and analyze research, literature, and best practices relevant to successful consumer engagement in HIT/HIE. (2007-2008)
2. Lay out the value case for HIT and HIE (including benefits & risks) from consumers' perspective.	2.1 Consumer Organizations, NGOs and Federal Agencies should lay out the value case (including benefits and risks), for HIT and HIE from the consumer perspective, with an emphasis on the potential impact on quality of care. Consumers should be included as an integral part of this process through an extensive community consultation technique. (2007-2008)
3. Develop an outreach and education plan for consumers and providers.	3.1 A multi-stakeholder entity or forum (convened by an NGO) should develop an interactive outreach and education plan for consumers and providers that communicates the value case for HIT and HIE, how to evaluate and use particular tools and services, and how to participate more fully in one's own health and health-care. Consumer Organizations, with foundation support, as well as Quality Organizations, and other stakeholders should assess, encourage, and validate efforts to implement these strategies for the benefit of consumers. A community consultation technique should be incorporated into the outreach process. Implementation must also take into account the diverse needs of consumer populations, including varying levels of health literacy. (2008)
4. Execute the outreach and education plans.	4.1 Consumer Organizations and other stakeholders should execute an outreach and education plan for consumers. (2008-2009) 4.2 Provider Organizations should execute an outreach and education plan in partnership with the organizations leading the consumer outreach and education plan. (2008-2009)
CONSUMER ACCESS AND CONTROL OF PERSONAL HEALTH INFORMATION	
5. Create consensus principles and standards that support consumer-control of electronic personal health information.	5.1 Consumer Organizations, Provider Organizations and NGOs should launch an open, transparent process involving every stakeholder of healthcare from both the public and private sectors to gain consensus acceptance around the following common principles and processes to support consumer control of electronic personal health information (2008-2009): A. Consumers should have easy access to review, add notations and suggest corrections to existing information in their own records. B. Consumers should be able to limit which of their health information could be shared with which providers, in a manner compliant with HIPAA, when applicable.





<p>7. Make a variety of types of useful tools and services available to consumers.</p>	<p>7.1 Federal Agencies, NGOs, Provider Organizations and other stakeholders (including the public and private sectors) should continue to develop free health content in digital form about a variety of conditions and in a variety of formats. (2007 - ongoing)</p> <p>7.2 Congress should provide explicit long-term funding support to Federal Agencies such as the National Library of Medicine and the National Institutes of Health to develop free health content in digital form about a variety of conditions and in a variety of formats. (2007-ongoing)</p> <p>7.3 Federal Agencies (CMS) should provide personal health information tools (or financial support to acquire them) to all Medicaid and Medicare beneficiaries. (2012-ongoing)</p>
<p>8. Design content, tools, and interfaces to support different consumer needs, including but not limited to different languages, levels of health literacy, cultural perspectives, geographic access needs, and physical disabilities.</p>	<p>8.1 HIT Vendors should use focus group input and product testing that addresses consumer preferences in product development, taking into account the wide variety of consumer needs. (2007-ongoing)</p> <p>8.2 Provider Organizations and Researchers, with support from NGOs (foundations), should develop prototypes of useful electronic health information tools, with an emphasis on those that help consumers and providers to make decisions based on scientific evidence. Information from these efforts should feed into the development of guidelines described in 9.1. (2007-ongoing)</p> <p>8.3 Federal Agencies (HHS) should research the development of tools to meet the specific needs of various underserved populations, in collaboration with Consumer Organizations. Information from these efforts should feed into the development of guidelines described in 9.1. (2008-ongoing)</p>
<p>9. Develop tools that explicitly help people to make evidence based decisions about their health.</p>	<p>9.1 NGOs, in coordination with Federal Agencies (AHRQ) should study and develop guidelines and best practices for involving consumers in decision-making based on scientific evidence (e.g. information prescriptions, patient decision aids, and reminders/action items). These guidelines should be incorporated into the product certification process (See 5.5). (2007-ongoing)</p>

CONSUMER PRIVACY

<p>See Principles in Privacy, Security and Confidentiality</p>	<p>See Principles in Privacy, Security and Confidentiality</p>
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CONSUMER TRUST

<p>10. Develop, post, and adhere to Notices of Information Policies that explain how health information is handled.</p>	<p>10.1 NGOs should analyze how HIPAA applies to HIT/HIE and recommend how gaps in coverage need to be addressed. (2007-2008)</p>
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	<p>10.2 Given the lack of a comprehensive privacy-protective policy framework, any entity that may have contact with electronic personal health information (State and Community HIE Collaboratives, Health IT Vendors, Health Plans, Payers, Providers, etc.) should develop and publicly post a Notice of Information Policies. (2007-ongoing)</p> <p>10.3 A Federal Agency (such as the Federal Trade Commission) should be responsible for enforcing Notices of Information Policies. (2007-ongoing)</p>
<p>11. Establish accreditation processes for HIE networks and services and certification of HIT tools.</p>	<p>11.1 An NGO and/or Federal Agency should work with accreditation organizations to develop "policy standards" for State and Community HIE Collaboratives that establish compliance with the consumer principles described in 5.1. These "policy standards" should address attributes and/or procedures (for example, whether an HIE conducts its business in a transparent way). (2008-ongoing)</p> <p>11.2 An NGO and/or Federal Agency puts into place a process to establish compliance by HIEs and others providing related services with the consumer principles described in 5.1. (2008-ongoing)</p>

CONSUMER PARTICIPATION AND TRANSPARENCY

<p>12. Define organizational requirements for consumer participation and transparency and require compliance with those requirements.</p>	<p>12.1 An existing, trusted entity (NGO, Consumer Organization or Federal Agency) should define and catalog the types of entities that govern, oversee, operate and/or create policy for the electronic exchange of health information and produce recommendations regarding the appropriate level of consumer participation and requirements for transparency that should apply to them. (2007-2008)</p> <p>12.2 An NGO, Quality Organization and/or Federal Agency should put into place a process to establish compliance with consumer participation and transparency requirements by entities described in 12.1. (2008-ongoing)</p>
<p>13. Strengthen and expand the cadre of consumer organizations well-versed in HIT/HIE policy issues at the national, state, and local level.</p>	<p>13.1 A trusted, existing NGO should organize/support development of a larger cadre of consumer organizations well-versed in HIT/HIE policy and coordinates their activities for maximum impact. (2007-ongoing)</p> <p>13.2 State and Community HIE Collaboratives and NGOs (foundations) should pay for individual consumers to attend HIT conferences in the states and at the national level, in order to support their education and participation in HIT and HIE initiatives. (2007-ongoing)</p>

Staff Report (MAY 2008)

Grants mgmt -

California HealthCare Foundation Specialty Care Network - activities

- Provider Capacity workgroup has identified and secured 4 specialist to join workgroup – Neurologist, Dentist, Pain Specialist, GI
- MCPC, EDCCCHC, Barton Community Clinic, Tahoe Family Physicians are collecting specialty referral data until June 13
- White papers/research on ‘Shared Group Appointments’ and ‘Telehealth’
- May 8th WS site visit with David O’Neill, Sr. Project Officer
- Work pending:
 - May 31st interim CHCF grant report
 - Planning for (week of June 23rd) workshop & other group sessions with Sarah Redding)
 - ACCEL orientation materials for Specialty participants

Blue Shield of CA Foundation

- April 22 HIE convening attendance; ‘Promising Practice’ poster board on Notification of Privacy Practice
- Final report submitted
- Opportunity to request short term additional funds, approximately \$50,000

AHRQ

- 2nd quarter, year 3 update report submitted
- Confirmed PI (Bergner) will be speaker Sept. 08 on “Cross Agency Patient Care Pathway Program Using Enabling IT”

Pending grants work

- May 31st – CHCF grant report
- June 16 & 17 CHCF grantee convening & Specialty Roundtable Practice Protocols
- July 1 (or shortly thereafter) – AHRQ 3rd quarter report
- August (?) Carry Over \$ request – AHRQ
- August 31 – CHCF two-year Implementation Plan
- September 30 – CHCF final financial report
- Within 90 days of AHRQ grant end (September 29, 2008)
 - Final Financial Status Report
 - Final Invention Statement & Certification
 - Final Progress Report
- Other potential work – BSCF application for interim funds, Pacific Care/United Healthcare work if grant awarded

ACCEL website activated - <http://www.accedc.org/index.asp>

Privacy & Security (P & S) Workgroup

- Resolved ‘patient consent topic’ for pediatric mental health referral with iREACH
- Draft policy work – ‘Release of Information’

Summary of NPP & iREACH Go-live Dates

- February 19 – Public Health Dept, Mental Health Dept & Marshall (NPP only)
- February 29 - EDCCHC
- April 10 – Tribal Health
- April 21 - Barton

Other Activities

- Bergner & Dunn teleconference briefing to Redwood Health Information Collaborative
- Grant budget reconciliation w/ support from Public Health Department
- With Quadri, vendor negotiations regarding EMPI
- Ongoing ACCEL team iREACH implementation issue identification and redress + defining iREACH reports to be programmed

Topic needing greater & clearer agency engagement

- Monitoring at each registration zone how consistently ACCEL NPP is being applied, where and how Opt-outs are maintained/monitored
- Insuring ACCEL policies are being applied at their agency consistently

Steering Committee Review & Approval Calendar for ACCEL Program Manual

	Steering Committee (SC) Approval		
	Method	Target	Actual
I. Definitions	SC	12-10-07	12-10-07
II. Privacy & Security			
• Notification of Privacy Practices	SC mtg	10-12-07	11-16-07
• NPP Simple Language	SC mtg	10-12-07	11-16-07
• Fact Sheet	SC mtg	10-12-07	11-16-07
• Opt Out Form	SC mtg	10-12-07	11-16-07
• Talking Points	SC mtg	10-12-07	11-16-07
User Set Up			
• Authorized User Confidentiality Agreement	SC mtg	12-10-07	12-10-07
• Confidentiality Patient Information	SC mtg	12-10-07	"
• User Set Up Application	SC mtg	12-10-07	"
User access			
o Authorizing & Requesting Access	SC mtg	12-10-07	"
o Access Removal	SC mtg	12-10-07	"
o Physical Security of ACCEL System	SC mtg	12-10-07	"
Patient information Request	SC mtg	6-08	
III. Steering Committee - Governance			
Charter	SC mtg	08- 07	09-04-07
Memorandum of Understanding	SC mtg	09 - 07	11-07
MOU Exhibit I.			
• EMPI			
• Technology	SC mtg	4-9-08	
• Data Synchronization	SC mtg	4-9-08	
• Care Pathways	SC mtg	2-13-08	2-13-08
• Technology	SC mtg	2-13-08	2-13-08
• Securing Health Care Coverage	SC mtg	2-13-08	2-13-08
• Obtaining a Medical Home	SC mtg	2-13-08	2-13-08
• (Newborns) Utilizing a Medical Home	SC mtg	2-13-08	2-13-08
• Pediatric Mental Health Consults	SC mtg	2-13-08	2-13-08
• Newborn Securing Health Care Coverage	SC mtg	2-13-08	2-13-08
• Annual Eligibility Review	SC mtg	2-13-08	2-13-08
Governance Agreement	SC mtg	12-10-07 01-09-07	1-9-07
Changes to Program Manual	SC mtg	02-13-08	2-13-08

Insurance	SC mtg	12-10-07	12-10-07
Auditing & Reporting	SC mtg	12-15-07	12-10-07
Steering Committee Evaluation	SC mtg	01-9-08	1-9-08
IV. Technical Support			
Unique User Identification & Password Management Policy	SC mtg	1-9-08	1-9-08
Security Awareness & Training Policy	e-vote	3-12-08	3-12-08
Risk Analysis Policy	e-vote	3-12-08	3-12-08
Data Transmission Security Policy	SC mtg	1-9-08	1-9-08
Data Back Up Policy	SC mtg	1-9-08	1-9-08
Data Custodian Roles & Responsibilities	SC mtg	1-9-08	1-9-08
Disaster Recovery Policy	SC mtg	1-9-08	1-9-08
Firewall Use Policy	e-vote	3-12-08	3-12-08
Information System Activity Review and Reporting Policy	e-vote	3-12-08	3-12-08
Media Re-Use Disposal Policy	e-vote	3-12-08	3-12-08
Automatic log off policy	e-vote	3-12-08	3-12-08
Data Integrity and Authentication Control Policy	e-vote	3-12-08	3-12-08
IT Support Model	SC mtg	5-16-08	

- Items in tan are Steering Committee & more sensitive references
- (NOT TO BE SHARED)
- Items in blue are in draft for review or require drafting
- Items in green are P & P for posting on the web
- Items in gray can be requested on a person by person basis

ACCEL EMPI Project
Update: May 16, 2008

legend ■ Exceeds target ■ On target: no concerns ■ Off target: mitigation should return item to target ≤ 2 wks. ■ Off target: Unlikely to meet target

Project Name	EMPI
Project Manager	Maria Chaves
Reported by	Sandra Dunn

Overall Status	■
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Project Status

Comment on all yellow/red indicators in box below

Schedule	■	<ul style="list-style-type: none"> The EMPI workgroup restarted its work on 1/31/08 in developing business requirements which were delivered to InfoCom on 4/14/08. On 4/23, after high level of review of business requirements, InfoCom projected that programming and testing of business requirements would take a minimum of 23 weeks. On 4/24, S. Dunn, R. Quadri and InfoCom agreed to a phased implementation of the EMPI. See page 2 and 3 for details for each phase. <ul style="list-style-type: none"> Phase 1: development of file interfaces between Barton, Public Health, and InfoCom with estimated completion of 9.5 weeks Phase 2: development of privacy requirements and all other iREACH behavioral requirements with estimated completion of 13.5 weeks after completion of phase 1. On 5/7, InfoCom will send technical/functional specifications for Phase 1. Review of specifications will occur on 5/9.
Budget	■	
Scope	■	
Risk/issues	■	

Milestone Update

Major Milestone	Status color	Person Responsible	Scheduled Completion Date	Actual Completion Date
Restart of EMPI workgroup	■	Chaves	1/31/08	1/31/08
Completion of business requirements and sent to InfoCom	■	EMPI Workgroup, Chaves & Lee	3/3/08	4/14/08
InfoCom develops technical specifications	■	Chaves & Lee	3/24/08	
Barton and Public Health develop internal business requirements	■	Chaves, Lee, Quadri, Thompson	3/24/08	
InfoCom iREACH programming	■	Lee, Gruensfelder(InfoCom)	4/14/08	
Barton and Public Health programming	■	Lee, Quadri, Thompson	4/14/08	
InfoCom, Barton, and Public Health testing	■	Lee, Quadri, Thompson	4/21/08	
Go LIVE	■		4/30/08	

<use space below to note accomplishments, developments, ideas>

Details of InfoCOM EMPI development

PHASE I: Total Interface Phase Effort: 9.5 weeks (~2 months)

1. Features:
 - Specific Interface with Barton (assume XML type interface)
 - Specific Interface with Public Health Dpt (assume XML type interface)
 - Common Aspects of Importing Interface Records
 - Screens displaying views of the Received Record Disposition Table
2. Functional Specification (for the above Interface Phase features only)
 - Generate Draft (1.5 weeks)
 - Review and Incorporate Comments (1 week)
 - Milestone: Approved Baseline of Interface Phase I Functional Specification
3. Development
 - Design and locally test Interface Phase I features (5 weeks)
 - Install and test with ACCEL-provided files (1 week)
 - Milestone: Infocom demonstrates Interface Phase I features
4. Deployment
 - Incorporate feedback from demonstration (0.5 weeks)
 - Install and test final Interface I Phase version (0.5 weeks)
 - Milestone: Turn-over to ACCEL for their testing and/or operation

PHASE II: Privacy Phase Timeline: Would start after the final deployment milestone of Phase 1. Total Privacy Phase Duration: 13.5 weeks (~3 months)

1. Features:
 - Feedback from Interface Phase
 - User Interface Opt-Out Behavior
 - User Interface household member behavior changes
 - Private Agencies
 - Reports displaying views of the Received Record Disposition Table
2. Functional Specification (for the above Privacy Phase features only)
 - Generate Draft (1.5 weeks)
 - Review and Incorporate Comments (1 week)
 - Milestone: Approved Baseline of Privacy Phase II Functional Specification
3. Development
 - Design and locally test Privacy Phase II feature (5 weeks)
 - Install and test with ACCEL-provided files (1 week)
 - Milestone: Infocom demonstrates Privacy Phase II features
4. Deployment
 - Design and locally test feedback from demonstration (1 week)
 - Install and perform overall system test (2 weeks)
 - Deliver training (1 week)
 - Incorporate feedback (1 week)
 - Milestone: Infocom software ready for go-live

Privacy Requirements

Below are examples of privacy requirements for Phase II.

The following defines how iREACH (the system) will react as a part of the NPP & Patient Consent policies.

1. The system will delineate the difference between clients who are designated as Opt-in or opt-out
 - Opt-in means “Client is an ACCEL Participant”

- Opt-out means “Client is NOT an ACCEL participant” (client does not wish to share personal data)
- 2. The system must keep record & history (date/time stamp) of change in ACCEL participation status
 - The user, site, & agency is included as part of the history
 - The system will display client contents based on last/most recent ACCEL participation status
- 3. The system will accept & keep/save any initial client data provided through the interface except when ACCEL participation status is currently opt-out
 - A file cannot change ACCEL participation status from opt-out to opt-in
 - Upon occurrence the change will be rejected and reported to ACCEL Status console
 - A file can change ACCEL participation status from opt-in to opt-out
- 4. The system will only display skeleton data for any household member (anyone not an active client) when they are individually searched & selected
- 5. The system will only display skeleton data for any client and/or householder who is “Opt-out”
 - Skeleton data is defined as Last name, first name, date of birth, & gender
 - This includes any report, any screen, or functionality via the iREACH graphical user interface (GUI)
- 6. The system will only display skeleton data for any household member who is “Opt-out”
 - Family members (e.g. parents of clients) are NOT assumed “Non ACCEL Participants” (opt-out)
 - This is for any report, any screen, or functionality “inside” iREACH via the GUI (reports)
- 7. The appropriate user to change ACCEL participation status from opt-out to opt in is a manager or higher
 - Process requires manual intervention & must be tracked
- 8. If a household member opts out, all household members will be opted out including the client.

TITLE: IT Technical SUPPORT MODEL Policy and Procedure

Category: Technical Support	
Original Effective Date: Revision Date:	Review Date:

This policy and procedure describes the technical support process for Authorized Users of ACCEL’s iREACH application.

Responsibility of Participants

It is the responsibility of ACCEL Participants to provide and identify IT resource(s) who will be the first contact of the Participant’s Authorized Users.

Process

- The Participant’s Authorized User will contact their designated/internal IT resource(s) first to assess their issue. Participant’s designated IT resource(s) will determine if the issue(s) experienced are related to the Participant’s IT infrastructure and/or general internet issues or if it seems to be an issue related to the iREACH application.
 - Note: If the issue is related to resetting passwords, the Barton IS Help Desk shall be contacted.
- If the issue seems to be related to the iREACH application (ie occurs within the iREACH application once the user has logged in or attempted to log in), the Participant’s Authorized User or the designated IT resource shall contact the Barton IS Help Desk by phone at [530-543-5818](tel:530-543-5818).
- The Barton IS Help Desk is responsible for logging the issue into the [ACCEL Help Desk](#) system, determining next steps including vendor involvement, and documenting ongoing progress and/or resolution.
- Target response and resolution times by the Barton IS Help Desk are shown below.

Support model process metric	Definition	Target
Response time	The time between identifying a problem and the time it takes for technical support to take action such as callback.	Same business day
Resolution Time	The time required to identify, diagnose, restore, and have permanent resolution to the problem	Depends on issue severity & content

Ongoing Process Improvement

The Barton IS Help Desk and the ACCEL Program will meet on a quarterly basis to review and analyze issues logged, their resolution (if any), support model process metrics, and to address the following:

- a) The effectiveness of the support model and any process improvement needed such as issues escalation, when to call the vendor versus when issues need to be managed locally, etc.
- b) Recurring or unresolved issues and potential interventions
- c) Any system changes made to the ACCEL system by Barton IS Staff
- d) New development/requests made to Barton IS Staff including functionality not currently in system that will need further ACCEL Program approval for development

The ACCEL Program will report findings to the Steering Committee, as needed.