EHEALTH COUNCIL
April 5, 2017 1:30 P.M. CT – 3:30 P.M. CT
Administrative Services-Lower Level Training Room
1526 K Street, Lincoln, Nebraska
(Including Skype for Business Connections Upon Request)

Members Present:
Marsha Morien, Co-Chair
Kevin Borcher
Kevin Conway
Joel Dougherty
Marty Fattig
Cindy Kadavy
Rama Kolli (Video)
Jim McClay
Dave Palm
June Ryan
Brian Sterud (Video)
Robin Szwanek
Anna Turman (Video)
Heather Wood, Alt. for Linda Wittmuss
Bridget Young

Members Absent: Kathy Cook, Kimberly Galt, Dr. Shawn Murdock, Todd Searls, Max Thacker and Delane Wycoff

ROLL CALL NOTICE OF POSTING OF AGENDA NOTICE OF NEBRASKA OPEN MEETINGS ACT POSTING

Co-Chair, Marsha Morien, called the meeting to order at 1:31 p.m. Roll call was taken. There were 15 members present. A quorum was present to conduct official business. A copy of the Open Meetings Law was located on the back table. The meeting notices were posted on the Public Meeting and the NITC websites on March 28, 2017. The meeting agenda was posted on March 28, 2017.

APPROVAL OF OCTOBER 3, 2016 MINUTES*

Mr. Dougherty moved to approve the minutes as presented. Mr. Palm seconded. All were in favor. Motion carried.

PUBLIC COMMENT

There was no public comment.

Ms. Morien stressed the importance of the council to the NITC. The Council members are ambassadors of eHealth to the State of Nebraska. She also reminded members that they can designate alternates to serve in their absence at meetings.

Prescription Drug Monitoring Program (PDMP)UPDATE
Felicia Quintana-Zinn and Kevin Borcher

The Prescription Drug Monitoring Program (PDMP) went live as mandated on Jan.1, 2017, enabling dispensers to report all controlled substances dispensed as required. The Department of Health and Human Services received two grants which are supporting efforts to develop a PDMP and to prevent prescription drug overdoses.

The Harold Rogers- DOJ Bureau of Justice Assistance grant is supporting PMPD training and PDMP software enhancement. PDMP trainings are being conducted through live webinars, on-demand webinars (went live in March), in-person sessions and downloadable tutorials. Over 750 dispensers and prescribers have been trained since December. Training information is available on the PDMP website at www.dhhs.ne.gov/PDMP.

The Prescription Drug Overdose Prevention for States Grant (PDO-PfS) — CDC grant is supporting the following three strategies:

- **Develop and implement pain management guidelines.** The purpose of pain management guidelines is to promote consistent, safe, and effective pain management standards. The NDHHS Division of Public Health is collaborating with Division of Behavioral Health, Managed Long Term Care plans, Nebraska Medical Association, and physicians on the task force to develop the guidelines. The task force is using CDC and Oregon pain management guidelines as a resource. Task force members are identifying priority areas to include in the guidelines. The guidelines will be reviewed by content area experts and also presented to the professional boards. Once guidelines are approved, they will be disseminated with education provided.

- **Conduct needs assessment and educate on expanded access to naloxone.** Naloxone is an opioid antagonist that blocks or reversed the effects of opioid medication during an overdose event. The goal of the project is to decrease the rate of drug overdose deaths, including opioid and heroin deaths. A needs assessment was conducted with EMS, fire departments, law enforcement, physicians, pharmacists, and substance abuse treatment facilities. The results of the needs assessment will guide education on access and use of naloxone and the development of a media awareness campaign.

- **Enhance and maximize the NE PDMP system.** The PDMP team is working to increase access and use of the PDMP by medical professionals. As of 03/31/2017, 2,894 prescribers, 1,166 dispensers, and 36 designees had been registered to use the PDMP. As of 03/24/2017, 100% of total eligible Nebraska dispensers have registered to report to the PDMP or noted as an exempted pharmacy for the 2017 year. This includes community pharmacies, dispensing practitioners, and long-term care automated pharmacy dispensers. 79.7% of total eligible mail service pharmacies have registered to report to the PDMP or noted as an exempted pharmacy for the 2017 year. The grant is also supporting enhancements to utilize PDMP data for public health surveillance. The enhancements went live on Jan. 1, 2017. As of the end of February of this year, 497,382 dispensed records had been reported to the PDMP.

Ms. Quintana-Zinn and Mr. Borcher answered questions from members. Member questions included: How are consumers getting educated? Ms. Quintana-Zinn answered that the project has not officially started outreach for consumers yet, that is down the road. Information is available on the website. Amy Reynoldson is the contact for the educational portion of the grant. Members briefly discussed the status of LB 223. The bill is still in committee. Because it is Senator Howard's priority bill, it should make it to general file. Members also asked about how information on the PDMP is being incorporated into the medical curriculum. The team has received some calls to be guest speakers at Creighton and UNMC.

Ms. Byers commented that the project has been a team effort with support from the Legislature, DHHS, NeHII, DrFirst, work groups members, professional groups and other stakeholders.

ONC INTEROPERABLE HEALTH IT SERVICES TO SUPPORT HIE GRANT UPDATE
Anne Byers

Ms. Byers reviewed the "Lessons Learned" from the ONC grant.

- **Recruitment and Engagement of Long-Term Care and Post-Acute Care Facilities (LTPACs) and Critical Access Hospitals (CAHs).** It takes a lot of work to engage Critical Access Hospitals

and long-term and post-acute care facilities.

- **Better Understanding the Needs of Long-Term and Post-Acute Care Facilities.** Work on the Integrated Community project has helped us better understand the needs of long-term and post-acute care facilities and the importance of including long-term care and post-acute care facilities and others providers in the health information exchange. Through the grant, the team has developed several use cases for exchanging health information with long-term and post-acute care facilities. Demonstrating the value of different use cases will facilitate efforts to engage long-term and post-acute care facilities.

- **Integration of Health Information Exchange into the Provider Workflow.** The process developed for the Integrated Communities Project is proving to be useful in engaging providers and helping them integrate health information exchange into their workflow. Having a facilitator to start the engagement process is a key component. It was also very helpful to have a project manager from NeHII as part of the team to provide technical assistance.

  Having all participating providers set up with both Direct and query-based exchange early in the process allows for the implementation of a greater number of use cases. Health information exchange isn't plug and play. It takes time and effort to integrate health information exchange into the provider workflow. For example, the NeHII Community Patient Profile (CPP) is easy to implement, but usage doesn't usually take off unless the CPP can be accessed with single sign on from the electronic health record. Direct has been touted as an easy first step for health information exchange, but in reality it takes time and effort to identify use cases and to work with other health care providers to begin exchanging information.

  Structured interviews were conducted with ADT subscribers to understand how ADT messaging was implemented and used and the impact and user satisfaction with the service.

Discussions from the meeting led to the recommendation to include the importance of a community champion as a lesson learned.

INTEGRATED COMMUNITY PROJECT AND TRAINING MODULES
Gary Cochran, PharmD, SM

With four months left in the grant, the team is in the final stages of the Integrated Community Project. The project identified two integrated communities which consisted of a hospital, clinic, long-term care facilities, and a pharmacy interested in exchanging health information. The team worked with the providers in each community to identify use cases and discuss current work processes/workarounds. NeHII matched available technology to the use cases. Facilities chose the use cases to be implemented. The team worked with the health care providers to integrate the use case into their regular workflow.

The team is also creating four training modules to provide background and direction for facilities considering the adoption of HIE and uses lessons learned from integrated communities. The four training modules focus on:

1. What is HIE and "why" do I care?
2. Is HIE right for me? Finding Value
3. HIE solutions
4. Integrating HIE into your facility

Ms. Bass commended Mr. Fattig for his efforts to contact and encourage facilities to participate in the project. It is beneficial to have champions promoting the benefits of electronic health records and integrated communities.

NEW NEHII PRICING STRUCTURE AND NEHII UPDATE
Deb Bass

With NeHII's migration to a new platform, the edge server pricing strategy based upon hospital bed size has ended. Participants were asking for a more tangible, customized method to determine participation fees. A workgroup was formed to develop pricing model and future value added services strategy. The pricing model was finalized in January 2017. Announcements letters were distributed in February and March 2017.

The new pricing module will create a more equitable manner to allocate costs based on a facility's potential use of the HIE. It is not intended as a method to increase revenue. Hospital license fees have remained unchanged since NeHII's go live in 2009. Large health systems paid a three year sustainability surcharge in 2013–2015. All other health systems paid a two year sustainability surcharge in 2014–2015. Five hospitals are paying slightly higher participation fees.

The new pricing module eliminates fees for licensed healthcare professionals to have access to the data. The cost of the exchange is shared evenly between payers and hospitals. The State of Nebraska is considered a payer. NeHII utilized the 2015 Medicare Cost Report and adjusted discharges as tangible numbers. A three-year phased implementation schedule will be used to allow for ease of transition:

- First year - 2017: 2/3s licensed bed model, 1/3 adjusted discharge
- Second year - 2018: 2/3s adjusted discharge, 1/3 licensed bed model
- Third year – 2019: full adjusted discharge

Licensed Healthcare Professionals pricing information:

- All will have free access to the data in the HIE
- If an ambulatory clinic becomes a data provider there will be a $500/month participation fee
- Eliminate site license model for hospitals
- Eliminate 1:3 ratio for allied professionals per provider
- Comparable to free access to the PDMP data
- Letter distributed February 20, 2017 (copy included in the meeting materials)

Hospitals and Health Systems pricing information:

- Based upon adjusted discharge rate
- $4.96 per discharge
- Three year phased implementation schedule
- Letters distributed March 7, 2017
- Calls made to all CEOs
- Limited number saw increases
- For CAH minimum fee of $500/month
- Use SHIP funding to offset HIE participation costs
- Reminder made of free access to all providers

Payers pricing information:

- $25,000 annual fee plus PMPM fee
- Sliding scale based upon number of covered lives
- Eight tiers in the scale
- Lowest tier:1 to 74,999 lives = 0.17 cents PMPM
- Highest tier: more than 450,000 lives = 0.10 cents PMPM
- Includes ADT event notification and other value add services

2016 Annual Report. The report was approved at the March board meeting. The full report is available at http://www.nehii.org/index.php?option=com_docman&view=list&slug=forms-documents&Itemid=54. A Town Hall Webinar will be hosted on May 4, 2017.

2017 Annual Meeting. Planning is in progress for the annual meeting to be held late July or early August. Kearney, Nebraska conference facilities are being considered for the location. Sponsorships are available. Suggestions for keynote speakers would be appreciated. It was suggested to have a panel of participants from the integrated communities, including Mr. Fattig.

OTHER UPDATES/REPORTS

US Government Accountability Office Report - Health Information Technology: HHS Should Assess the Effectiveness of Its Efforts to Enhance Patient Access to Use of Electronic Health Information

Ms. Byers wanted the council to be aware of this report. She was surprised that only 11% of patients access physician or hospital portals. Members agreed that when physicians recommend that patients use the portal and explain the benefits, patients are more likely to use portals. Some EHR vendors have more patient-friendly portals. The group also discussed the future of Meaningful Use Stage 3 and its possible impact on patient engagement.

Mr. Fattig shared that Nemaha County Hospital is working with NDHHS Division of Public Health to pilot Electronic Lab Reporting through NeHII.

POSSIBLE TOPICS FOR NEXT MEETING

Members made the following suggestions for topics for the next meeting:

- Public Health Data, Kathy Cook
- Population Health Analytics and Research
- Telehealth Network
- DHHS Behavioral Health CDS
- Medicaid Data Management and Architecture

ADJOURNMENT

With no further business, Ms. Morien adjourned the meeting at 3:22 p.m.

Meeting minutes were taken by Lori Lopez Urdiales and reviewed by Anne Byers, Office of the CIO/NITC.