Washington State Hospital Association

Washington State Medical Association | WSMA

October 20, 2017

To: Washington State Health Care Authority
Charissa Fotinos, MD
Adam Aaseby
Matt King, JD

OneHealthPort
Rick Rubin

Re: Clinical Data Repository
WSHA/WSMA Provider Community meeting

The Washington State Hospital Association and the Washington State Medical Association appreciate the opportunity to continue to engage in meaningful dialogue with you and your associates on the state's Clinical Data Repository.

As discussed previously, we are hereby providing you with the following documents:

- Provider Community Meeting, Oct. 16, 2017 – Meeting Summary
- Provider Community Survey – redacted findings

At this juncture, the associations recommend convening a meeting with representatives of the Health Care Authority and OneHealthPort, to include association representatives and approximately 6 to 8 representatives from the Provider Community discussion, with a goal of exploring possible solutions to the issues identified.

If this proposal is acceptable, please communicate with Bob Perna of WSMA (RJP@wsma.org) and Zosia Stanley of WSHA (ZosiaS@wsha.org) to pursue arrangements for that meeting. We look forward to further discussion with you all.

Peter Rutherford, MD
Chair, Provider Community Meeting; WSHA

cc: Mika Sinanan, MD PhD; WSMA
Claudia Sanders; WSHA

Meeting Summary

WSHA /WSMA/HIT Collaborative
Clinical Data Repository - Provider Community Meeting
Monday, October 16th, 2017; 9:00 a.m. to 11:00 a.m.
Held at WSHA office and via webinar for remote participants

Goals of the Meeting:

- Review and discuss survey information on critical issues with the state's CDR.
- Provide input into approaches for associations to use with the Health Care Authority to improve the system.

WSHA representatives:
Peter Rutherford, MD; Meeting Chair; Claudia Sanders; Zosia Stanley, JD

WSMA representatives:
Mika Sinanan, MD, PhD; Bob Perna

HIT Regional Collaborative representative:
Karen Curtis, RN

Medical Group Management Association – Washington State representative:
Brett Vandenberg

Meeting Framework
The CDR was developed by the Health Care Authority to respond to real needs by providers for better information. There have been many new developments since this effort was launched. Given these developments and current issues with the system, it makes sense to work with the state on ways to make the system more accurate and protect privacy. It also makes sense to review how this system will continue to provide value as other new systems for information sharing are developed in the future.

Survey Responses: Review and Discussion
The representatives of the organizations invited to today's meeting were asked to complete, prior to the meeting, a three question survey addressing the three critical issues raised by members:
#1- Clinical usefulness of the CDR; Organizations' added cost and administrative burden.
#2- Data accuracy; "Patient matching"; Patient safety.
#3 - Clinical data "Privacy"; potential liability for providers.

The participants received redacted findings from the survey and during the meeting were then asked to offer any further verbal comments. Highlights of the discussion included:

1. The value of having an easily accessible, secure, and accurate means of obtaining data that tells us what healthcare our patients receive outside our own systems is clear. The value and importance of this kind of information to developing effective "accountable communities of health" in our state also seems clear. The participants in the discussion recognized that providers should work with the HCA and OneHealthPort to address technical challenges and determine ways to reduce the burden on providers. Some of the technical challenges and costs to individual healthcare systems and providers to participate are daunting.

2. Members were interested in the role of the MCOs. Have they been part of the discussion and should they be involved moving forward?

3. The CDR initially will be focused, and for the foreseeable future, on the Medicaid population. Organizations with fairly low Medicaid patient populations question the return on investment in participating in the CDR.

4. Some reported that the multiplicity of many EHRs means the CDR would be useful and would have benefit if the data are accurate. Others questioned whether the development of the state's CDR is necessary, especially moving into the future, as major HIT vendors are in the process of developing initiatives that appear to provide comparable data aggregation;
   e.g.: Carequality - http://sequoiaproject.org/carequality/members-and-supporters/
   Commonwell - http://www.commonwellalliance.org/faqs/
   CareEverywhere / Epic - https://www.epic.com/careeverywhere/

5. There are doubts across the provider community as to how efficiently the CDR information can be accessed for individual patients. Unless embedded in existing EMR applications and integrated into normal workflows, most practitioners would not have adequate time to access the CDR portal and retrieve clinical data while maintaining expected workflow efficiency.

6. While a key goal of the Healthier Washington initiatives is the integration of physical medicine and behavioral health, it was noted that many behavioral health organizations (BHOs) still use paper-based charts. Integrating the CDR into a paper chart workflow seems especially problematic, until such time as EHR technology is incorporated into BHOs.

7. The HIT market for larger organizations is dominated by Epic and Cerner. It appears that those two vendors will drive the adoption curve for organizations based on these platforms. Smaller practices and organizations using other vendors currently do not have the budget or infrastructure to accomplish the necessary accommodations to participate in the CDR. Within the wide range of HIT vendors – one estimate is over 60 different products – the level of support of Washington's unique CDR varies widely.

8. To date, there has not been any meaningful opportunity for providers to examine the CDR's presentation of clinical data. Similarly, the CDR may not facilitate the sort of data analytics activities that are increasingly required of providers, such as tracking quality measures and population health management.

9. Organizations are absorbing considerable labor costs and costs imposed by HIT vendors in attempting to participate in the CDR project. Larger organizations have dedicated HIT staff and infrastructure, yet their budgets are also being strained.

10. Rural health clinics and federally qualified health centers are adapting to the new alternative payment model - 4th iteration (APM4) and have added demands on their infrastructure and budgets. There does not seem to be discussion across the HCA on areas where the CDR could be useful and decrease the need for other reporting systems. For example, can quality measures needed for APM4 be pulled from the CDR?

11. If participation in the CDR is a contractual requirement imposed by the HCA and the contracted managed care organizations (MCOs), smaller practices and organizations that cannot absorb the costs of participating in the CDR may be forced to discontinue treating Medicaid patients, further constraining access to care for this population.

12. Substantial error rates have been reported in "patient matching" accuracy: 12% or higher. In attempting to address concerns with "patient matching", some healthcare groups reported a lack of responsiveness or insufficient guidance during attempts to resolve this critical safety and efficacy concern. What does a provider do when it has identified an error in matching? How can the data be corrected?

13. Data sensitivity across the three tiers – *Normal; Restricted; Very Restricted* ("NRV") – continues to be an unresolved area of concern. Rather than relying on the classification of clinical data to provide protection, a simpler solution may be found in protecting who has access to the data. Providers are concerned as to whether their EHRs can differentiate clinical data across these three tiers of sensitivity in an automated fashion, and if not automated, how and by whom that would be accomplished:
    - Is the practitioner expected to designate those tiers within the record?
    - How would visits for mixed diagnoses be handled (e.g. patient with a broken finger and HIV)?
    - Clinical records can contain both ICD codes and SNOMED codes, adding to the complexity of identifying and acting upon higher tiers of data sensitivity.
    - Even if specific ICD codes could be linked to these tiers, what if the record also contained prescription drug information used for higher tier conditions (e.g.: HIV, STDs)?
    - In hospitals/health systems, clinical data can be separated across departments, making management of sensitive data even more complicated.

Proposed Next Steps

While acknowledging that individual organizations will be making their own respective decisions on how to move forward with participating in the CDR, the survey and today's discussion added to the overall understanding of the operational challenges associated with the CDR.

1. The associations' staff will be sharing the finalized version of the Meeting Summary and the redacted findings from the survey with HCA and OHP.

2. The associations recommend convening a meeting together with HCA and OHP, to include association representatives and approximately 6 to 8 representatives from today's discussion, with a goal of exploring possible solutions to the issues identified.