



Minutes
Health Information Technology Standards Advisory Committee
(HITSAC)

Thursday, July 30, 2009

Virginia Information Technologies Agency (VITA)
Commonwealth Enterprise Solutions Center
Multipurpose Room
11751 Meadowville Lane, Chester, VA 23836

Attendance

Members present:

Dr. Marshall Ruffin, Chair
Daniel Barchi
Geoff Brown
Dr. Alistair Erskine

Members absent:

John Quinn

Others present:

John McDonald, Deputy Secretary of Technology
Liz Linka, Office of the Secretary of Health and Human Resources
Nadine Hoffman, HITSAC Administrator

Chair's Report

Call to Order

Chairman Ruffin called the meeting to order at 10:10 a.m. in the Multipurpose Room at the Commonwealth Enterprise Solutions Center (CESC) in Chester. At the request of Chairman Ruffin, Ms. Hoffman called the roll and confirmed the presence of a quorum, with four of five members present. Chairman Ruffin indicated that John McDonald, representing the Secretary of Technology, would arrive for the afternoon session, and Liz Linka was present to represent the Secretary of Health and Human Resources.

Chairman Ruffin requested a motion to approve the minutes from July 16, 2009. Mr. Barchi made a motion, seconded by Mr. Brown, and the motion was approved by a voice vote. Mr. Barchi requested the minutes reflect Chairman Ruffin's statement that the minutes were the finest minutes of any organization in which he has participated.

New Member

Chairman Ruffin welcomed a new member, John Quinn, to HITSAC. The ITIB recently approved Mr. Quinn as the final member, but he could not attend the meeting. Mr. Quinn is one of the founders and the chief technology officer of HL7, focused on interoperability standards in healthcare.

Committee Charter

The Committee reviewed the HITSAC draft charter developed during the July 16, 2009, meeting, available here:

http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30_2009/draft%20HITSAC_Charter.pdf. The Committee read and discussed the eight guiding principles and made a number of suggestions for changes in language, including developing concrete steps related to IT standards to achieve a health IT exchange (HIE), creating specific references to achieve congruence with federal health IT standards, ensuring semantic interoperability with federal health IT standards, considering and adopting other standards if needed, and ensuring patient-centered interoperability for health IT standards. Changes will be made to reflect the suggestions and will be available for members at the August 20, 2009, HITSAC meeting.

Member Reports-Neighboring States

North Carolina

Mr. Barchi provided an overview and summary of the status of health IT efforts in North Carolina. The Governor of North Carolina instituted a large working group of up to 60 individuals from government, health care, academia and private industry to consider the federal stimulus needs and existing health IT in the state to determine a future path. The group prepared a document reflecting its studies, available here:

http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30_2009/NC_HIT_Task_Force_Report.pdf.

The Committee discussed the report's documentation indicating North Carolina has extensive information concerning the planning of an IT structure, but little in the way of concrete implementation or execution plans. Mr. Barchi summarized the main findings as follows: (1) a focus on health information exchange; (2) electronic health records standards; and (3) regional extension centers.

Finally, Mr. Barchi remarked on the report's reference to the Community Care of North Carolina as a 3,200-member provider network as a means to expand to all possible providers. Upon questions from Chairman Ruffin, Mr. Barchi advised North Carolina does not have a specific reference to standards and no specific governance structure, but a vision to be a state-driven activity with possible private partnerships for execution.

Maryland, District of Columbia, and Northern Virginia

Mr. Brown provided a report concerning the status of health IT in Maryland, the District of Columbia, and Northern Virginia, located here:

http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30_2009/RHIO.pdf.

Mr. Brown reported on the Chesapeake Regional Information System (CRISP) operating in Maryland as a not-for-profit partnership between medical health systems and other regional

stakeholders. Chairman Ruffin asked if the state government was involved, and Mr. Brown replied that it was not yet a part of CRISP. Mr. Brown also indicated there is pending legislation to mandate participation in CRISP and for potential funding. Upon Chairman Ruffin's question about who would have responsibility under the pending legislation to design the architecture of the network, Mr. Brown said CRISP was the proposed party but no final legislation has passed. Further, in response to Chairman Ruffin's question, Mr. Brown reported CRISP had initial seed money from the individual participants and received a state grant.

CRISP adheres to national standards as they are validated. Chairman Ruffin summarized the understanding that CRISP is a federated design with a health data bank, necessary record locator service, and master person index.

Mr. Brown reported that a regional health information organization ("RHIO") in Washington, DC, composed of six community health centers and the emergency departments of two hospitals, operates a centralized repository system for health IT records. The District government authorized an initial grant to implement the centralized system. The RHIO is currently working toward developing standards, a governance structure, and future funding. Chairman Ruffin remarked on the benefit of having District government involved in funding the project and the architecture of Microsoft Amalga that is in place. In response to questions from Chairman Ruffin, Mr. Brown responded there is no pending legislation and that the RHIO is still in the process of formalizing their structure as a not for profit. Mr. Brown responded that Microsoft was a vendor providing Amalga.

The Northern Virginia RHIO, as reported by Mr. Brown, is a formal entity initiated roughly 16 months ago to focus on developing a standard space architecture to ensure connectivity with any other future RHIOs or other providers. A state grant funded the initial model. Further, the grant funded File for Life as a senior-assisted program where health record information is contained on a card or magnet for emergency medical technicians ("EMT") to quickly learn of vital information. The funding allowed for automation of this process. Second, the grant funded a project for emergency departments to access patient health records through a network of commercial providers. This process has been tested and will go live in the Inova health system in Fairfax in November.

In response to Chairman Ruffin's questions, Mr. Brown responded that the Northern Virginia RHIO is a not-for-profit limited liability corporation. Further, there is a governance structure in place as well as a mechanism for enforcing standards. The RHIO is run as a utility, but there is not proven business model yet. Also, data for medications is coming from Sure Scripts. Additionally, the state grant provided \$100,000 with members putting forth additional funding. Currently, the pilot exists under the available network system to ensure patient privacy concerns are addressed. The RHIO has contacted multiple vendors to discuss future security concerns outside of one systems network, but no specific standards or systems have been identified.

In response to Dr. Erskine's questions, Mr. Brown advised the core information system will not be outside of the provider's normal workflow system. The goal is to ensure the provider does not need to go outside of the normal workflow to query patient information. In addition, some information will flow in a discrete fashion while some will come in a blob of text.

West Virginia

Chairman Ruffin presented information on West Virginia Health IT initiatives, located here: http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30_2009/WV_Health_Information_Network.pdf. West Virginia differs from other models presented as it started with legislation passed in 2006. Of note, West Virginia has created a corporate structure, has a

governing model, has a funding mechanism in place, participated in a couple of federal contracts, and is now preparing to win federal stimulus funding. West Virginia's goals include a fully operational statewide network while ensuring privacy, automation of drug interaction and allergy alerts, automation of preventive medicine alerts, electronic access to exam results, disease management, disease surveillance and reporting, educational offerings, health alert systems related to homeland security, links to evidence-based medical practice, medical record information transfers or health record exchanges, physician order entry, prescription drug tracking, registries of vital statistics, health registries and other goals as listed in the link above.

The West Virginia Network (WVHIN) is a utility operated by the health care authority of the government. It has some contract and employment freedoms from normal state regulations. The statute specifies the appointment of a board that includes representatives of health care, private industry and government. WVHIN has adopted the federal health architecture as a hybrid model. It centralizes the continuity of care data but federalizes the discharge summaries and operative reports. It has a record locator service that is operational, but the state is waiting for stimulus funding to implement and mandate the network's use.

Chairman Ruffin noted WVHIN's legal standards as providing immunity for participants from civil actions and from anti-trust or unfair competition liability, which encourages use. Additionally, all participants contributing data will maintain their property rights in the data but grant the other participants license to retrieve and use the data. In response to a comment from Mr. Barchi, Chairman Ruffin indicated there was no language specifically granting other participants the authority to store the data.

In response to Mr. Barchi's question about which portion of the federal stimulus West Virginia is seeking, Chairman Ruffin said the \$2 billion dollars controlled by the Office of the National Coordinator as a health information exchange or a statewide resource center.

Examples of Health Information Exchanges

Chairman Ruffin provided a summary and report on examples of health information exchanges (HIEs) in other states. The report is located here: http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30,_2009/HIE_HITSAC.pdf.

Chairman Ruffin reported that Vermont created a not-for-profit public-private partnership named the Vermont Informational Technology Leaders funded by the Department of Health, the legislature, and community stakeholders. Legislation mandated a funding model to include a percentage of medical claims on private stakeholders. Further, Vermont adopted the federal health architecture of the Healthcare Information Technology Standards Panel ("HITSP") and is communicating data using HL7. Mr. Brown indicated the program is running to his knowledge at this time out of Burlington as a state-run activity.

Chairman Ruffin also indicated Delaware's model is a lot like the Washington, DC, model, with a central store of data. Further, the HIE has a governing board of directors, a consumer advisory committee, and a project management team. Currently, the HIE shares laboratory, radiology, pathology, admission discharge and transfer information, and reports and results for referrals and consults. The funding model provides for a charge on private providers based on the volume of transactions.

Chairman Ruffin provided a summary of Indiana's Health Information Exchange, located here: http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30,_2009/Indiana_Business_Plan.pdf. Indiana's health information exchange began as a private venture funded by a state grant to the Reagan Street Institute. It has received federal funding of over \$20 million

over the years. Indiana has a funding model for grants in 2009 and 2010. Usage fees will be instituted to fund the project in future years, similar to Vermont's model. The Indiana HIE will charge providers to look up information in the exchange. The exchange is using federal health architecture interoperability standards for messaging. Chairman Ruffin noted some of the success may be due to the private entity starting the exchange as a trusted intermediary, namely Reagan Street Institute. Chairman Ruffin also noted the funding model was one that could be considered for Virginia. Tennessee also instituted a usage or transaction fee for providers. Of importance, Indiana does speak of its HIE as a utility that will drive out competitors and therefore is in need of regulation.

Chairman Ruffin reported on the Inland Northwest Health Services HIE. This non-state, not-for-profit entity owned by two competing hospitals uses a common hospital information system as an HIE. The HIE currently shares inpatient and outpatient pharmacy transactions, laboratory orders and results, emergency room admissions, inpatient documentation (including diagnosis and treatment), and administrative information (including billing). The HIE uses a service fee to fund the exchange. This model would likely not be sustainable across a state.

During general discussion, Chairman Ruffin indicated the states appear to be vendor neutral with their standards, and it appears most states have used vendors for support and database software. Chairman Ruffin thought the best model was to put forth standards and allow vendors to compete, and not become dependent upon one vendor.

Chairman Ruffin announced that HITSP is about to endorse specific standards. He urged the committee to study them before the next meeting, when John Quinn will report on HL7 activities in this area. Chairman Ruffin stated the committee must become conversant and knowledgeable with HL7, HITSP, and other health standards moving forward.

Chairman Ruffin suggested HITSAC look at Tennessee for its HIE model and contact the National Governors Association for standards. Mr. Brown further suggested reviewing New York's efforts concerning health IT.

Health IT Updates

Nadine Hoffman briefed the Committee on current health IT projects ongoing in Virginia, located here:

http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30,_2009/Health_IT_Projectslisting.pdf.

Chairman Ruffin advised he would like to see the data elements the Virginia Department of Health collects in International Statistical Classification of Diseases ("ICD") 10 and the data elements and codes used by other registries of the Virginia Department of Health.

Mr. Barchi noted that Sure Scripts is a de facto national standard as it is the only product for electronic prescription systems.

Chairman Ruffin and Dr. Erskine asked for the total number of registries in Virginia and the data formats. Staff will attempt to collect this data for the next meeting.

Chairman Ruffin recessed the meeting at approximately 12:05 p.m. for lunch.

Chairman Ruffin reconvened the meeting at approximately 1:10 p.m. John McDonald was present at this time.

Virginia Department of Health IT Discussion

Dr. Jim Burns, Deputy Commissioner of the Virginia Department of Health (VDH), provided an overview and summary of current VDH health IT related projects and standards. As background information, Dr. Burns informed the Committee that VDH is the third or fourth largest agency of the Commonwealth with 5,000 employees. VDH is present in every locality of the state, maintaining roughly 200 sites providing services. Of these, 140 sites provide a variety of clinical services from an estimated 200 providers.

In attempting to automate processes, VDH has discovered there is not a very good commercial market for central systems. Coding issues particular to Virginia have also presented issues with building specialized codes into a commercial product such as coding for a family for accounts receivable. These unique features have driven VDH development. Many applications do come from a federal funding partner that provides either the application or the requirements.

Dr. Burns provided the Committee with an overview of the applications and scope of data standards VDH is using. A written summary that provides a description of each application and its purpose is located here:

http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30,_2009/VDH_DataStandards.pdf.

Dr. Burns said VDH does not create standards but uses national standards where they exist, and adopts other funders' required standards. VDH uses internal standards for its own development for common elements such as name, address, Social Security number (SSN), etc.

Chairman Ruffin inquired into the VENIS environmental system for restaurant inspection, wells, septic systems, etc., and whether VDH tracked disease information. Dr. Burns responded the health data is not in the application, such as toxins.

Of particular note to the Committee, Dr. Burns highlighted the emergency medical service registries concerning the tracking of medical reports on patients transported to emergency departments. These applications use the National Emergency Medical Services Information System (NEMSIS) standards. The Strategic National Stockpile system tracks pharmaceutical distribution of supplies received from the federal government as an inventory management system. In response to Chairman Ruffin's question, Dr. Burns advised the system uses the data element of the National Drug Codes (NDC).

The Volunteer Management System allows for tracking of volunteers to assist in emergencies. In response to Chairman Ruffin's question, Dr. Burns said he would have to get more information on the coding used for a provider's professional credentialing information.

The Virginia Immunization Information System (VIIS), first developed by EDS in Wisconsin, is used in Virginia and 20 other states in a cooperative. This system uses the Systemized Nomenclature of Medicine (SNOMED) for the nomenclature, the National Immunization Program (NIP) table values for vaccine descriptions, current procedural terminology ("CPT") codes, and CVX (vaccine administered) grouping codes. Dr. Burns, in response to Chairman Ruffin's inquiries, responded that the grouping of vaccines is based on antigens or disease-based groupings. Dr. Burns clarified that the H1N1 virus would be grouped in the same CVX grouping as the seasonal vaccine code. Chairman Ruffin surmised that if the Virginia HIE was up and running, the VDH would like all providers to report all immunizations given. Dr. Burns clarified that VDH would only like reporting at the CPT or actual vaccine level to determine no duplicate vaccines are given or to ensure no vaccination opportunities were missed. A CVX grouping code would not be very helpful for these purposes.

Further, Dr. Burns reported VDH uses the Center for Disease Control (CDC) Health Information and Surveillance Systems Board ("HISSB") codes for geographic area coding. The heart of VDH's systems is HL7. In response to Chairman Ruffin's question, Dr. Burns responded VDH plans to move to version 2.5 of HL7 but no plans to migrate to version 3.0. Virginia may only progress as far as the 20-state consortium for versions. Dr. Burns reported a national registry would have some benefits, but the biggest interest would only be with adjoining states with ongoing day-to-day data-sharing issues. There is not a common file format for data sharing, as suggested by Chairman Ruffin, with each immunization registry of the consortium states.

Dr. Burns reported the basic goal of VIIS is to interconnect all electronic immunization sources in the state so any provider with access will be able to see individual immunization records. VDH does share information in a flat file format standard as part of the consortium. The pilot phase has just completed, and VDH is aggressively pursuing the implementation phase. Mr. Barchi inquired whether a provider signing up for the VIIS would in any way move forward in line to receiving vaccines, specifically H1N1. Dr. Burns replied VDH will be distributing H1N1 vaccine that comes only from the federal government. VDH's probable requirement will be that providers must participate in the VIIS or submit equivalent reporting to allow VDH to comply with federal reporting requirements.

In response to Dr. Erskine's question, Dr. Burns stated that VDH's biggest ongoing problem with any registry is duplication of reports. VDH uses data matching algorithms for probabilistic matching to protect against duplicate reporting, specifically because there is no unique identification number for individuals. The logic built into the system attempts to identify duplications but an actual person must determine if a duplicate truly exists.

Dr. Burns, in response to Chairman Ruffin's question, advised that VDH could be assisted by HITSAC in identifying vaccine code standards and identifying individual identifiers. Chairman Ruffin state that HITSAC could adopt probabilistic matching and a standard codex system for individual identifiers.

The Essence registry requires hospital emergency rooms to report to VDH for symptoms as an early warning sign for homeland security purposes. Dr. Burns reported this system is in its early phases throughout the country. It has allowed VDH to track influenza across the state. The effort began as a project under the Defense Advanced Research Projects Agency (DARPA) of the federal government. VDH is part of a consortium in the capital region where D.C., Maryland, and Virginia share data. VDH is still unsure of the relative benefit of this system as there are many false alarms. In response to Dr. Erskine's question, Dr. Burns replied there is no tie in with this system and laboratory results or biological sensors.

Dr. Burns reported VDH maintains the National Epidemiological Data Surveillance System (NEDSS) funded by the CDC as a nationwide effort to report diagnosed diseases. Providers, including doctors and hospitals, report to the system as well as laboratories, which tend to be the best reporters. ICD 9 and ICD 10 codes are the core of the system. In response to Chairman Ruffin's question, Dr. Burns advised he believed HITSAC could endorse automatic electronic reporting, but the majority of laboratories are already doing this, as they are required to report by *Code*.

Mr. Barchi inquired into whether any vendor ever proposes standards other than national standards that appear to be incorporated in the applications VDH utilizes. Dr. Burns responded that the funder typically sets the standards and 60 to 65 percent of VDH funding comes from the federal government. Therefore, many of VDH's data standards choices have already been set. When VDH does have a choice of standards to develop a product, Dr. Burns cannot remember any vendor marketing a different standard than is typical in the industry.

In discussing the Women's, Infant's, and Children federal nutrition program ("WICnet"), Mr. McDonald inquired into the consortium concept now required by the federal government to receive federal funding and how this affects the construction or adoption of standards. Dr. Burns replied the WIC consortium concept will only have three individual members per consortium at this time. Dr. Burns believes the plan will be for the winner or best system to "take all" for national standards.

Dr. Burns said the Vital Records registry, funded in large part by the federal government, abides by federal standards as well. Births are almost entirely an automated process, allowing for better reporting. Death statistics are an issue because of the variety of places and number of reporters who can report a death. These factors cause issues for automated reporting concerning death notices. All data is shared with the federal government concerning vital statistics.

Overview of MITA Program and Virginia

David Mix, the Medicaid Information Technology Architecture ("MITA") Program Manager, Department of Medical Assistance Services ("DMAS") provided a report on MITA in Virginia. A copy of the presentation is located here: http://www.vita.virginia.gov/uploadedFiles/ITIB/Meetings/2009/July_30_2009/MITA_Presentation.pdf. John McDonald left the meeting at approximately 2:30 p.m.

MITA is based on the federal enterprise architecture that Mr. Mix believes is separate from the federal health enterprise architecture. The main purpose and process of the system is to pay and log claims. Currently, every state maintains their own systems with no national standards. MITA is a project to address this lack of national standards. In response to Chairman Ruffin's question, Mr. Mix said the federal government provides guidelines to attempt to ensure interoperability of data among the states, as the states can adopt their own business architecture, technical architecture, and solutions architecture. Specifically, the federal government will provide conceptual data models. There is a governance structure in place already, a business architecture, but no common file formats for MITA.

The Concept of Operations envisions a future where all relevant documentation needed for claims and reimbursement for the provider is automated. All medical records would be available for the physician or provider as electronic health records from other physicians or providers. Therefore, as Chairman Ruffin suggested, MITA is more than just a claims or administrative tool but will use data standards to tie into physicians to automatically generate bills with diagnosis and treatment information, rather than claims forms.

Chairman Ruffin inquired into the standards planned for the system such as the federal health architecture that the Office of the National Coordinator is working on currently. Mr. Mix advised there are numerous MITA work groups in place working on this and other issues facing all of the states moving forward.

Further, the U.S. Secretary of Health and Human Services (HHS) is heading this effort on the federal level with Centers for Medicaid Services ("CMS") being the direct contact.

MITA will utilize three architectures: (1) the MITA National Medicaid EPI HIPAA ("NMEH") workgroup; (2) MITA HL7 Project Workgroup; and (3) the Technical Architecture Committee made up primarily of private industry. In response to Chairman Ruffin's question, Mr. Mix replied that the MITA HL7 group will be discussing and planning actual data models. HL7 will likely be the base model for data sets and models, but the group is currently working on this process going forward.

Chairman Ruffin remarked that MITA appears to want to automate clinical information exchange among providers as well as claims and billing. One architecture would allow sharing of information among providers. This is the same vision as the nationwide health information network. In response to Chairman Ruffin's question about interoperability standards for MITA, Mr. Mix replied he believes that HHS and CMS will utilize the same standards for interoperability to move forward.

Mr. Mix advised Chairman Ruffin, in response to his question, that the Director of CMS would be able to provide a comparison of MITA and the Health Information Network Standards.

Public Comment

Chairman Ruffin called for any public comment. There was no comment from the public.

Agenda for August 20, 2009 Meeting

John Quinn will provide an overview of federal and national health IT, including MITA versus the National Health Information Network; the evolution of HL7 version 3; and model architectures and designs for HIE. Chairman Ruffin expressed his desire to learn from Mr. Quinn how Virginia can be the national leader on adopting health IT standards to help providers and patients.

Ms. Willie Andrews, Assistant Laboratory Director for the Division of Consolidated Laboratory Services (DCLS) will provide a presentation on priorities for DCLS.

Assistant Secretary of Health and Human Resources Thomas Gates will report on Health IT Interoperability Advisory Committee (HITIAC).

Dr. Erskine will brief the Committee on Health IT Research Centers.

Other Business

Chairman Ruffin advised he would like the August 20 meeting to be the last full briefing day for the Committee. Then, on September 17, he would like the Committee to begin reviewing and considering specific standards for adoption.

Chairman Ruffin also inquired into any method to receive or any working group dedicated to one health IT architecture or strategic planning. The members did not believe such a group exists within state government dedicated to health IT strategic planning.

Ms. Hoffman advised she would attempt to gather information on an inventory of state IT health standards currently used by state agencies.

The Chairman also stressed that business and governance standards are a topic to review going forward to develop a state HIE.

Ms. Hoffman briefed the committee on administrative matters, including e-mail accounts.

Adjourn

Chairman Ruffin adjourned the meeting at approximately 3:10 p.m.