Community Stakeholder Meeting
Sep 19, 2012

Participants (signed-in)

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<td>Kathryn Amacher, DO</td>
<td>Five County Medical Societies</td>
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<td>Elisa Ashton</td>
<td>California Health and Human Services</td>
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<td>Sarah Carrillo, PharmD</td>
<td>UCSF and Office of Health Information Integrity</td>
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<td>ConnectHealthcare</td>
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<td>Sundeep Desai, MD</td>
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<td>Maryann Eckhout</td>
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<td>Kathy Ficco</td>
<td>St Joseph Health System</td>
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<td>Daniel Glaze, MA, PMP</td>
<td>Glaze &amp; Associates, for CHHS</td>
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<td>Justin Graham, MD</td>
<td>NorthBay Healthcare</td>
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<td>Jim Hauenstein</td>
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<td>Alice Hughey</td>
<td>Napa County Health &amp; Human Services Agency</td>
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<td>Mons Jensen</td>
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<td>Jeremy Mann, MD</td>
<td>Adventist Northern California Network</td>
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<td>Melinda Miers</td>
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<td>Bob Moore, MD</td>
<td>Partnership HealthPlan of California</td>
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<td>Suzanne Ness</td>
<td>Hospital Council of Northern and Central California</td>
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<td>Lynda Pezzola</td>
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<td>Paul Sampedro</td>
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<td>Carl Thomas</td>
<td>Solano Coalition for Better Health</td>
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<td>John Wise</td>
<td>Sonoma County Health Department</td>
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Introductions

Alice Hughey, Assistant Director, Napa County Health and Human Services Agency, on the Board of ConnectHealthcare. Our interest is in achieving interoperability between behavioral health records and primary care records.
Suzanne Ness, Regional Vice President, Hospital Council of Northern and Central California. We serve 44 hospitals in the northern part of the state.

Jim Hauenstein, CIO, Enloe Medical Center in Chico, CA. We are just starting our venture for HIE and I am here to learn.

Paul Sampedro, Program Director for HIE at St Joseph. I represent our approach to connecting to communities in Texas, Southern California and Northern California. We are already working with several HIEs in the community, some of which have Cal eConnect grants. There are lots of interesting challenges. I am here to see how we can be a party to this HIE as well.

Maryann Eckhout, Executive Director, Napa and Solano County Medical Societies. I work for about 700 physicians in these two counties.

John Wise, Information Systems Manager for the County of Sonoma Department of Health Services. We are interested in this network and others to work toward interoperability.

Lisa Ashton, PharmD, Health Sciences Associate Clinical Professor, UCSF, and Office of Health Information Integrity, CHHS, working with Pam Lane. We are here to see now a community partnership gets formed. What do the real people do?

Melinda Miers, Assistant Director, HIE, Adventist Health. I work in Corporate IT Services for Adventist Health in Roseville. My current focus is delivering information to non-affiliated physicians.

Sarah Carrillo, PharmD, Pharmacy Resident working with Lisa Ashton at California Health and Human Services.

Dan Glaze, a consultant. I am currently working for California Health and Human Services as Program Manager for HIE.

Mons Jenson, IT Director at Feather River Hospital, one of the 18 hospitals in Adventist Health System. I am here to understand who is doing what and how Adventist Health would participate, at the hospital level or the corporate level.

Jeremy Mann, MD, pediatrician, and newly appointed Chief Medical Officer for Ambulatory Services for the Northern California Network, which is Mendocino, Lake and Napa.

Jack Horn, Executive Director/CEO Partnership HealthPlan. I am here to see how we can help make this dream come alive.

Robert Moore, MD, Chief Medical Officer, Partnership HealthPlan and on the board of ConnectHealthcare. Our particular interest at Partnership, besides improving the general efficiency of
care, is to support coordination of care. Coordination of care for complex patients requires hospitals, payers and outpatient providers to share information.

**Carl Thomas**, Executive Director, Solano Coalition for Better Health, and Alternate board member. We are here to support all the partners and to find efficiencies through HIE.

**Sundeep Desai, MD**, Chief Medical Information Officer for the SacSierra Region of Sutter Health. I will speak with you shortly about what we are doing at Sutter Health.

**Lynda Pezzola**, IT Client Services Liaison for Sutter Solano Medical Center and Sutter Davis, for Solano and Yolo Counties.

**HIE Approach of Sutter Health, Sundeep Desai, MD, Chief Medical Information Officer for the SacSierra Region**

We have five regions in Sutter Health. My region is the SacSierra Region. The geography of what we are covering in this meeting overlaps significantly with my region and the Napa and Sonoma Counties overlap with our West Bay Region. Sutter plans from the beginning have been to develop our internal HIE. We also have a need similar to those of many of you to have our independent physicians (not affiliated with us) to be able to get information from us for tests they do with us, inpatient information, ambulatory information, etc. This is a growing need, especially with meaningful use coming along, not an optional measure but as a required measure. We are all striving for the same thing in terms of being able to exchange data. We have been on this task of trying to find a vendor to build our local HIE. We are down to our last few options and our last few phone calls with clients of theirs to verify who we want to select. I expect we will have made a vendor selection within the next month or so. I expect that about the time the ConnectHealthcare HIE is running, as I recall, the second or third quarter of next year, our HIE will be ready. Our strategy is that our HIE will connect to other HIEs.

Q: Are you willing to share the vendors being considered?

A: Not right now because we are still in the RFP process.

Q: Can you share with us your HISs and EMRs for ambulatory as well at the hospital?

A: We use Epic as our EHR for ambulatory and inpatient. For ambulatory, we are have rolled-out through all the regions. Now, we are extending it out to our independent physicians as an offering. In the inpatient arena, two of our five regions have Epic installed. The other three are in progress through 2014. Our goal is to finish all of them by the end of 2014. In terms of how this will connect, it is an ever-evolving plan. We have had a data warehousing strategy for a long time. It is still not meeting all needs but parallel to that will be this health information exchange. I envision that the data will be that from
our EHR plus data from a handful of other clinical systems that will go to our HIE. Our HIE will connect out to our independent physicians and other HIEs.

Q: What about your data warehousing?

A: It seems as though every vendor is coming up with a data warehousing strategy and data analytics. For us, this has been a home-grown effort. All our data is not in an EHR yet. Data comes in from literally hundreds of different systems and to try to coordinate that into the data warehouse has not come to fruition yet to make it clinically useful.

Q: What data do you see being coordinated for the independent physicians? In what direction will the data flow?

A: In the first phase of it, we will be mainly distributing data: lab, rad, transcriptions. Then we will broaden that to information coming inward for orders.

Q: How will you deal with the independent physicians who do not elect Epic? Will this be 20 or 30 different EHR systems, often in small practices?

A: We will rely on the HIE to connect these practices and then we will connect to the HIE to share data. Doing this, we will not have to build all these interfaces. Our goal is to avoid individual connections as much as possible – to avoid the individual point-to-points.

Q: Why did you elect to go to an HIE vendor instead of using the Epic functionality.

A: Epic offers Care Everywhere which is useful for non-Epic users to see Epic data. Epic has a tool for connecting to non-Epic EHRs but that requires substantial overhead to make all the connections. That is why we decided to go with a separate HIE product.

HealthBridge, Keith Hepp, CEO

Background of Keith Hepp

My background is with technology companies. I am a CPA from years gone by. I have been with HealthBridge since even before it began. I was at a vendor who was working with HealthBridge, then I had my own consulting firm and then became an employee and now am CEO. I have been CFO and VP for Business Development. At the start, we were a two-person operation and now we serve a variety of markets. I have been a part of the organization for 16 years now.
Background of HealthBridge

We began at the time that CHINS were dying in 1997. Our primary area is the Cincinnati region – the tristate area which encompasses southwest Ohio, north central Kentucky and southeast Indiana. We are not a state-designated entity. We are clinical and regionally focused. We are believers that HIEs need to be in medical – trading areas. There are a number of other HIEs in our region.

Mark Twain: “When the world ends, I want to be in Cincinnati because everything happens seven days later there.” When it comes to HIE, the hotbed is actually in the Midwest. We also work with other HIEs. Our philosophy is to have organizational regional medical trading areas that collaborate with other regions. In our business model, we work with other regions that are close by. At this point, we work with 50 hospitals and 7500 physicians. We deliver 3 to 6 million clinical messages per month. At the aggregate level, we are sending about 12 million results per month to different partners.
We work with 40 different HISs and LISs. We have eight Epic sites now. Pretty much every HIS and LIS out there we work with. You can see some of the statistics here.

**Network Size & Adoption**

- Delivers more than 3.5 million clinical messages PER MONTH; more than 35 million messages for 2010
- Total of 50+ hospitals, 7500 physicians
- Connectivity with 40+ HIS/LIS; 27 different ambulatory vendors, 60+ versions
- Provide technology infrastructure for four other HIEs – Dayton HIN, CCHIE, HealthLINC, NEKY RHIO
- Cincinnati Network
  - 25 local hospitals in Kentucky, Ohio and Indiana
  - 5500+ physicians
  - 17 local health departments
  - Large commercial, hospital, & physician office labs
  - Diagnostic centers

The next slide shows a map. Our business model is to have local governance but to have common technology spread over different areas. These maps are a demographic of where we are operating.
today. The blue section is Cincinnati (HealthBridge), the red section is Dayton (GDAHA HIE), and then Springfield (CCHIE) and Bloomington where Indiana University is located (HealthLINC), and then northern Kentucky (Northern Kentucky Regional Health Information Organization). We work with the Quality Health Network in Western Colorado under analytics and with MDVIP, a concierge care group for which we do analytics across the country.

Progression of HIE as Relates to Sustainability

Every HIE has to determine, “What is it that we are trying to solve?” We talk to lots of folks that agree that there needs to be connectivity. There is still fuzziness on why we are connecting and if we are connecting, who is going to pay? There are a number of HIE supported by insurance plans where the objective is reduction in expenses. There is a significant amount of work in our region. Anthem has announced it is spending $1 billion across the country. From a sustainability perspective, there are two things:

1. What is it that you are trying to solve?
2. What is the value proposition and who is paying?

In our world, we distinguish pre-ARRA, which was very much a messaging, reduction-of-cost for the lab and rad transactions. The value was to get folks to use a light-weight EHR and to get them interfaced. The pricing model and value stream was very much on the deferred side.

What we believe is that going forward is that the pyramid will be inverted. The basic messaging is becoming less and less on a per transaction cost. We still have a significant amount of value from the EHRs. In our region, we have gone from the connectivity piece to the value added services that an HIE can provide. Now working with ACOs, patient centered medical homes (PCMHs), and plugging into
situations where we can help enhance the provision of care with the right information at the right time. We can help reduce the cost of a $100,000 surgery by using a protocol.

Q: Dr. Moore. You are on the right track by looking at savings from care delivery. It is what we in the insurance world call care coordination. PCMH contains a lot of things besides care coordination but care coordination is where the money is, so to speak. Have you experimented with some companies with payment models around care coordination?

A: Yes. We are a Beacon site and a regional extension center. We are a Social Security participant on a disability determination project with CMS. We were the second organization to sign the DURSA for HIE with the NwHIN. We are live with Direct. We are live with CONNECT. We are very heavy on connectivity. We have a sister company that is a Quality Improvement company which is very much involved in PCMH. United, Anthem and Humana conducted a PCMH pilot here. They proved an actual net decrease in utilization. Some healthplans and some large employers did a pmpm and the pmpm saving was around $4. Our community decided that we were going to be a forerunner of payment reform and we put in for the Comprehensive Primary Care Initiative (Center for Medicare and Medicaid Innovation). This piece has a lot of value and is what we would recommend. It is very competitive and is based on CPMH. Those who will work with us are commercial and others who want to see if we can move the dial. Starting November 1, CMMI is going to be paying $20 pmpm over a four-year project with 75 locations in seven areas in the country. Humana, Anthem, United, Medical Mutual, Aetna, etc., are also paying an average of $8 pmpm. The pmpm declines over time and then there is shared cost savings. We will be measuring what will be the change in the total cost of care. The plans take half and the providers take half. This still uses the fee-for-service payment model but there is significant initial funding to prove this out.

With respect to your question, there are two important points:

1. All of a sudden there is funding to take this pyramid and invert it.
2. If this proves out, CMS can spread the approach. This has many of the characteristics of ACOs but also has the money up front.

**HIE Value Progression**

In this section, we will talk about the HIE Value Progression and then some things that we recommend that you look at to get the large dollars to make these things happen. The stages, Basic HIE, Intermediate HIE and Advanced HIE follow the steps in what is happening with meaningful use. The basic functions of HIE implemented in Basic HIE support the later stages. One of the reasons that we think we have received funds from the various federal programs and have gotten a lot of attention on the CMMI project is that for basic HIE we have the connectivity needed but if you don’t do the hard work to assure that the data elements like a HA1c are normalized and actually consumable by the connected parties, then in Stage 3 when analytics come into play, using HIE to inform care and fill in
gaps and where there is care in other locations and where risk factors and other adjustments can be made based on having consistent and normalized data. Connectivity is great and a good start, but there is no way to get to Stage 3 without the hard work of Stage 2. We have great respect for ONC and are one of their favorite children, but we are worried that some are skipping level 2 which involves a lot of hard work that is not always obvious in Stage 1.

As we progress, we animate the data flowing in one way. This is Axolotl which we actually run ourselves. Part of the value of getting a viewer was to assure that the data were normalized and made sense. Not sure that it makes sense now. There is some good software: Axolotl, Mirth. If you want to have a common viewer, great. It depends upon what you want to do. It is a good place to start and was important for us.
The next slide is HIE Services.

**HIE Services**

- EHR Integration/Interfaces
- Electronic Results Delivery – Labs, Radiology, ADT, etc.
- Electronic Order Entry
- E-Prescribing
- HIE Portal & User Management
- HIE Technology Support – Master Patient Index, Provider Directory and Record Locator Service
- Summary Record Exchange
- Nationwide Health Information Network Direct and CONNECT Gateway & Connectivity
- Public Health Reporting & Syndromic Surveillance
- Billing and Eligibility Verification
- HIE Consulting, Outsourced Technology & Implementation

We get questions about services all the time. We have been sustainable for a long time. We were capitalized with loans before the days of grants. We will have paid it all back by the end of next year. We are asked, “What is the silver bullet?” The answer is, “There is no silver bullet. We take an infrastructure and put additional profitable nodes on it.” We have been profitable since 2003 and we make between 5% and 12% each year in our core business. There is nothing more expensive than the
first two telephones on a telephone network. The next phones drive down the average cost per phone. Call waiting does not cost much and can be high leverage. To be sustainable, start with the core infrastructure, the clinical messaging system, and then hang additional profitable things onto it at higher margins. We don’t try to make money on all products. We essentially break even on the core services and make money on the add-on services. We have one portal for all lab ordering which leverages the messaging system and a lot of the core infrastructure. Each add-on service is very profitable while we lose a little money on the core services.

The next slide is Innovation & QI Capabilities. What we have done is go from transactional capabilities to ACOs or P for P endeavors. We are a Beacon site. With the Beacon program, we have disease registries, we have a data warehouse and we have some analytical tools. We took a look at the core infrastructure and built alerts and notifications. For example, we can tell you at any time, in real time, when a diabetic patient is seen in a hospital. We have been able to dramatically reduce diabetic and asthmatic readmissions. We are doing some work with quality reporting.

**Innovation & QI Capabilities**

New Suite of Health Care Innovation & Quality Improvement Tools and Services through Beacon Program:
- Disease Registry
- Data Warehouse
- Data Analytics and Business Intelligence
- Alerts & Notifications
- Transitions in Care Assistance
- Quality Reporting Support
- Process Improvement and Workflow Redesign

The next slides show some initiatives that help us provide some functions that we think every institution and plan is looking at: patient attribution, translating data across different IT systems, and risk stratification. What we have found is that insurance companies know stuff about their members, health systems know what happens within their four walls, but pesky patients have a tendency to switch from plan to plan, they have a tendency to go from one health system to another even when there are tight networks. All of these pieces are necessary if you are going to take on risk. We have the capital to build all these tools so we do them for them. For one system, we do much of the work. For another, we do pieces of the process as requested by the client. We do not compete with clients. We augment what they have. There is significant augmentation that can happen.
The next slide shows the infrastructure components. What we have done is take our traditional data feeds, added translation tools. In our prior model of delivery of test results, they were sent to the physician of record. If we were unsure of the patient match, we would add a new patient. With P for P, that will not work so we have added a more powerful matching tool, Initiate. We run tools on a community basis to assure we have all data on a patient.

On the next slide, lists a few functions.
On the next slide, under Translations, even in an environment where we are already exchanging data, having a tool which can get the data in and sending it to the next participants, becomes more and more important than just getting results from here to there. As an example, the challenge is not just delivering a CBC measure but creating a profile of measures for a patient. These measures need to have consistent identity. With our system we were able to find a situation where the LOINC code for a test had been retired and replaced in use for Calcium instead of for Cancer. A 4 code for Calcium was fine. A 4 code for cancer was not.
On the next slide, one of the things that we find is that there are lots of different ways that plans attribute patients. The providers want to be able to understand what patient is included in what P for P. The HIE at a macro level can help plans and providers understand how a patient is attributed to the provider. The HIE can add value by showing which patients are attributed to which providers in a plan.

On the next slide, Medical Neighborhood Tracking, which applies to the CMMI project, there is shared savings. There is now an incentive to bring in smaller provider to supply some services such as blood pressure tests at Kroger. We build associations between the providers that serve the patient, here including the Visiting Nurse Association. We want to help the physicians and the plan to use the resources which are existing in the community can effectively, quickly and in a coordinated way care for the patient in a way which we think will bend the dial.

On the next slide, Clinical and Claims Repository, the byproduct of having all these data is having an entire view of, in this case, diabetics, and being able to understand how is this patient doing, how is this physician doing, how is this group doing, how is it doing compared to the community? Part of the metric of this plan is unless everyone increases quality and unless there is total cost reduction, there will be no shared savings. There is a built-in financial incentive for everyone to help everyone else. It is no longer I am going to compete with you and take all the marbles because I want to have all the business. That is not the case anymore because for a high performer to do well based on cost saving, everyone has to do well. For everyone to do well, everyone needs to understand where everyone is at. We are having sessions: What are the high performers adding which are providing good outcomes and how do we spread that out? The only way to have that information is to have the measurement tools in place so that you can determine the positive outcomes so the learning collaboratives will be successful.
Clinical and Claims Repository

CPC Measure NQF #59
Diabetes Mellitus: Ha1c Poor Control (>9%) Summary

In the next slide, Clinical and Claims Repository, shows a drill down from the prior slide.
In the last slide, we show a risk score calculation. We find these are very helpful in having a total understanding about what is happening to a patient as they go from specialist to specialist for complex care. This is important as the patient seeks care in the community so that care can be prioritized appropriately.
We believe that HIE can help participants that are around the table today, not interfere with your business plan, but provide a significant amount of information that can augment it.

Q: Lyman Dennis. How do you get information from the VNA and Doc in a Box? From a portal.

A: This is a perfect use of Direct. The data does not need to be normalized. We get a daily flat file from the VNA of their clients. We built a little applet that compares each ED visit to their list. If there is a match, we send a Direct message to the VNA. We will be getting inbound blood pressures from some other providers. Before these were competition for the primary care physicians, but with cost-sharing, there is a value for having data come in so long as it is trusted.

Q: Lyman Dennis. What approach are you using for analytics?

A: MD HIP is a subsidiary of Proctor and Gamble which provides wrap around concierge services. Providers use many different EHRs. Analytics are used to evaluate their quality systems. For Beacon, wanted a tool. Needed a number of tools: Clinical and claims warehouse -- PluralSoft in Colorado. Ingenix stack for claims analysis. Clinical Architecture out of Indianapolis does the translation. We use for Well Center Registry.

There was discussion among the participants of whether data from other providers (through the HIE) should be loaded to the provider’s EHR or just available for viewing. Melinda Miers thought that medications, labs and x-ray data should be loaded to the EHR. Dr. Moore that imported H&P and progress notes would be better viewed on a separate screen so they could be compared to other patient data.

Q: Kathy Ficco. How do you engage consumers with your HIE.

A: We just recently started engaging consumers. Considered Health Vault and a tethered EHR. They have decided on the second. We are really just starting.

Q: Dr. Moore. Why is ePrescribing on the list of HIE services?

A:

Q: Lyman Dennis. Are you providing services outside your core contiguous areas?

A: Yes. The Colorado Beacon is similar to us. Their Beacon work is on our infrastructure. We are jointly developing it. VIP is in 37 states.

Q: Jack Horn. To use a car analogy, you have a Masseratti. And we are at the start. What are some critical success factors in getting to Stage 1?
A: First and foremost, make sure that whatever business you want to accomplish, make sure that you understand. Lots and lots of HIEs make the business foundational mistake of saying, “We are going to reduce our duplicate transactions and our financial model is that the hospitals pay.” If you are an ACO, that is good. If you are not an ACO, not so much. First and foremost is the hard work of making sure the business model is correct.

Second, you want to have community control over the agenda. In a monster state like California, control needs to be at a community level. An agenda setting group needs to say, we are going to do one, two and three as these are things this community needs.

Third, just doing the Direct is a mistake.

Lastly, ruthlessly rip off the business models from other people. There is no longer any need to develop systems. Look at best of breed for your need.

**ConnectHealthcare Update**

- Submitted Cal eConnect Planning Grant
  - Virtual site visit
  - Announcement of award delayed
- LD received a contract to develop an HIE Best Practices Toolkit for planning grantees and completed the project Aug 31.
- ConnectHealthcare submitted an Infrastructure Grant Letter of Intent
- Board Meeting Sep 14 & 18

**Exchange Functions**

The principal exchange functions were reviewed to emphasize the importance of value-added services.

### Exchange Functions

#### Core Services

Core services are those functions needed to operate exchange.

- **Master Patient Index** – to distinguish individual patients since there is no uniform patient numbering system in the US or California
- **Record Locator Service** – once the patient is identified, to determine which provider have records for that patient and how to access those records
- Connectivity to the Nationwide Health Information Network (NwHIN) and CONNECT Gateway
- Secure Clinical Messaging (includes Direct) – for transmission of patient information among providers (e.g., lab results, radiology results, specialty studies). Direct requires a Health Information Service Provider (HISP) directory service.
- EHR Interfaces (not including specific interface configuration, but able to support interface configuration)
- Provider Directory – all types of providers, not just physicians
- Consent Management (opt-in, opt-out)

Basic Exchange Services, Part 1
Basic services are those required for achievement of meaningful use and for key exchange functions.

- Receipt of Structured Lab Results
- ePrescribing
- Sharing of Patient Care Summaries across Unaffiliated Organizations (which are using different EHRs) (discharge summaries, transfers of care, clinical data for referrals)

Basic Exchange Services, Part 2
These include three public health functions required for Stage 1 meaningful use which have not been feasible to accomplish until recently. The state is supporting another approach, developing a gateway for immunization data for seven of the regional registries.

- Immunization Reporting
- Reportable Laboratory Results
- Syndromic Surveillance Data

At the present time, high-volume submitters can submit immunizations directly to the state immunization registry and high-volume submitters can submit reportable laboratory results to the California Reportable Disease Information Exchange (CalREDIE). To the extent capacity is available, lower-volume submitters can submit to either of these organizations.

Additional Services

- HIE Portal – not all HIE providers supply a portal. At least one provider offers such a robust portal that some clients use the portal in lieu of their EHRs.
- Lab Ordering – initiated through the EHR but transmitted through the HIE
- Personal Health Record – to allow patients access to their data. Often includes secure patient communication with his/her physician. Also the Blue Button function
allowing a patient to download a text version of labs, prescriptions, provider and payer records.

- Advance Directives

Value-Added Services
These are services which the exchange may market to provider users.

- Referrals to Specialists -- transmitting the referral information, not the clinical information (which is included in Basic Exchange Services, Part 1)
- Authorizations – typically for expensive specialist, testing or surgical services under managed care or an ACO
- Clinical Data Repository – accumulation of patient data for purposes of disease management, analysis of clinical practice alternatives, etc.
- Transcription Service – to support physicians in practices and hospitals
- EHR Light – to provide a hosted EHR targeted to smaller practices
- Clinical Decision Support / Data Analysis – to help determine best practices from clinical and administrative data
- Meaningful Use Registry – to simplify determination of readiness to submit meaningful use attestation
- Disease Management – to track patients with readily-identifiable chronic diseases to better manage their care
- Enterprise Image Viewer – to allow provider organizations to see radiology images
- Portal to HIE – to allow providers to use an HIE portal to view a longitudinal patient record containing data from multiple sources
- Medication Reconciliation – to allow hospitals and other providers to determine medications a patient is currently taking
- EDI Services – to support administrative data exchange using X12 transactions such as claims submission (837), payment advice (835), benefit enrollment (834), group premium payment (820), eligibility/benefit inquiry (270), eligibility/benefit response (271), claim status request (276), claim status notification (277), service review information (278) and functional acknowledgement (997). Also includes NCPDP telecommunications standard v 5.1 retail pharmacy claims.
- Eligibility Checking
- Provision of Educational Materials Electronically
- Quality Improvement Reporting
- Credentialing Services
- Group Purchasing
- Workflow Redesign for Providers
- Hosted Helpdesk for Providers
- Systems Implementation Technical Assistance
- Clinical Trials Management
Team Workplans

Each of the ConnectHealthcare teams performing projects reviewed their activity plans.

Community Study

The Community HIE Study Team is composed of Lyman Dennis, Lead, Justin Graham, MD, David Jomaoas, and Jeremy Mann, MD.

The steps in the study are as follows:
1. Service area – write up what has been done with the Dartmouth Atlas study.
2. Collect community statistical data.
3. Document provider distribution. We have hospital and physician data. We need other community provider data.
4. Document health financing programs and imminent changes.
5. Profile IT systems uses by larger providers in some detail.
6. Document current and planning HIE.
7. Develop a report.

Procurement of HIE Services

The Procurement Team is Paul Alcala, Lead, Robert Moore, MD, Paul Sampedro and Lori Sklar.

The steps in the Procurement Workplan are:
1. Determine exchange priorities of participating organizations
   a. Services sought
   b. Interface support desired
2. Assess HIO/vendor options
   a. Full RFI
   b. Collect summary data from selected vendors
3. Draft a business plan
4. Issue RFI to a group of HIOs and vendors
5. Assess proposals
6. Perform due diligence
7. Negotiate agreement and execute
8. Finalize provider rates
9. Finalize business plan

Document Development
The Documents Team is led by Alice Hughey and contains Mitch Wippern and a Cal eConnect consultant.

The steps are as follows:

1. Select Participation Agreement
   a. Likely use Cal eConnect Modular Agreement
      i. Appropriate for California
      ii. Developed with input from the legal team that drafted the Markle Model Contract

2. Adopt the DURSA
   a. Standard agreement is available.
   b. Some changes possible due to change of hosting organization.

3. Develop Policies and Procedures. Draw from:
   a. Markle Model Privacy Policies
   b. Rhode Island Quality Institute Policies
   c. Redwood MedNet Policies
   d. Policies from other sources

Not-for-Profit Filing

The Filing Team is made up of Lyman Dennis, Lead, and Paul Smith of Hooper, Lundy and Bookman.

The steps are to follow the Nolo guide, *How to Form a Nonprofit in California*.

Provider Contracting

The Provider Contracting Team is Suzanne Ness, Lead, Lyman Dennis and Robert Moore, MD.

The steps will be as follows:

1. Profile functions desired by each provider.
2. Determine first movers.
3. Focus on California Model Modular Participation Agreement and the DURSA.
4. Rates will be determined as agreement with HIO or vendor is refined.
5. Review policies and procedures with parties.

Advisors Team

The Advisors Team is constituted of Kathy Ficco, Lead, Kathy Amacher, DO, John Buzolich, Sundeep Desai, MD, and Patricia Rehfield, DO.
The role of the advisors is to review work products and consider community interests beyond current participants.

**Announcement**

The presentations and demonstrations from the Redwood MedNet conference are available at [http://www.youtube.com/user/redwoodmednet](http://www.youtube.com/user/redwoodmednet).

**Financials**

Almost all the dues have been paid by participating providers.

**Strategic Planning Retreat**

There will be a ConnectHealthcare all-day strategic planning retreat at Solano Coalition for Better Health on Friday, October 26, for the Board and Alternates. Advisors will be invited for the last two hours.

**Next Community Stakeholder Meetings**

The schedule for the next three meeting is as follows. Note that these are Thursdays instead of Wednesdays.

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<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Topics</th>
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<tbody>
<tr>
<td>Nov 15, 2012</td>
<td>Adventist Health, St Helena</td>
<td>Redwood MedNet HIO</td>
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<td>Orion Health HIE Solution</td>
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<td>Jan 17, 2012</td>
<td>Partnership HealthPlan of California</td>
<td>Mirth Corporation (HIE Solution, Tools)</td>
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<td>Mar 21, 2013</td>
<td>Northbay Healthcare</td>
<td>Status Update</td>
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