

RI HIT STEERING COMMITTEE

AGENDA

January 20, 2021

8:00 am

Welcome and Introductions

Review of the Minutes

Review and Approval of Steering Committee Documents

Presentation and Discussion:

- Projects in the Steering Committee Scope

- CMS Interoperability and Patient Access Requirements

Next Steps and Next Meeting (Wednesday, February 10 at 5:30 pm)

Public Comment

RI HIT STEERING COMMITTEE MEMBERSHIP

Members:

Co-Chair: Cedric Priebe, MD

Co-Chair: Assistant Secretary Ana Novias

Stacey Aguiar

Director Nicole Alexander-Scott, MD

Dennis Bailer

Marcela Betancur

Garry Bliss

Jay Buechner

Mice Chen

Shamus Durac

Craig Elice, DDS

Carrie Bridges Feliz

Andrea Galgay

Commissioner Patrick Tighe

Zachary Gerson-Neider

Amar Gurivireddygari

David Hemendinger

Affiliation:

Lifespan

Rhode Island Executive Office of Health & Human Services

UnitedHealthcare

Rhode Island Department of Health

Project Weber Renew

Latino Policy Institute

Prospect Health Services RI

Neighborhood Health Plan of RI

Coastal Medical

Rhode Island Parent Information Network

Pediatric Dentistry Ltd.

Lifespan Community Health Services

Rhode Island Primary Care Physicians Corporation

Office of Health Insurance Commissioner

Rhode Island Foundation

Blue Cross & Blue Shield of Rhode Island

Brown Physician's Group

RI HIT STEERING COMMITTEE MEMBERSHIP

Members:

Joseph Imbimbo
Ben Isaiah
John Keimig
Phil Kahn
Jonathan Leviss, MD
Gary Ligouri
Mike Oliver
Rebecca Plonsky
Director Kathryn Power

Megan Ranney, MD
Neil Sarkar
Director Ben Shaffer
Scott Soucy
Brian Tardiff
Larry Warner
Kyle Wohlrab, MD
Pano Yeracaris, MD

Affiliation:

Tufts Health Plan
The Providence Center
Healthcentric Advisors
Care New England
Providence Community Health Centers
College of Health Sciences, University of Rhode Island
The Claflin Company
Integrated Healthcare Partners
Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
Brown Emergency Medicine
Rhode Island Quality Institute
Rhode Island Medicaid
Genesis Healthcare
Rhode Island Division of Information Technology
United Way of Rhode Island
Women & Infants Hospital
Care Transformation Collaborative Rhode Island

DRAFT DOCUMENTS TO CONFIRM

- 1) Steering Committee Charter
- 2) RI HIT Steering Committee Accountability
- 3) RI HIT Steering Committee Member Roles and Responsibilities
- 4) RI HIT Steering Committee Member Expectations
- 5) Proposal for RI HIT Steering Committee's First 6 Months of Work
- 6) RI HIT Steering Committee Decision-Making Criteria
- 7) RI HIT Steering Committee Decision-Making Process

PROJECT CHARTER: STATEWIDE HIT STEERING COMMITTEE

Project Lead	Amy Zimmerman	Project Members & Roles	Membership is representative of a broad range of community stakeholders, including patients, community based and healthcare support organizations, a large range of healthcare providers, payers, employers, privacy/security experts, and state agency representatives. (See job description for Roles). Also, creation of an ad hoc Sub-Committees, to more deeply review issues for SC discussion and review.
Purpose	Technology should serve as an enabler. To help reach RI's overarching health goals, the Steering Committee will align and coordinate stakeholders' feedback, perspectives, and insight to guide statewide HIT decisions, investments, and efforts on state-led and state-wide projects. Emphasize health equity and eliminating all types of health disparities, using a race and ethnicity equity lens.		Potential Metrics Short-term: Number of sectors represented in the SC decision-making; Number of projects addressed by the SC; Number of roadmap tactics on track for completion (red, yellow, green); Longer-term: Reduction in perceived provider burden (tracked by surveys); Reduction in duplication of effort
Opportunity Statement	The RI HIT Statewide Strategic Roadmap and Implementation Plan is the result of a year-long stakeholder engagement process to gather input on the state's 3-year vision for HIT. Stakeholders clearly state that RI needs a process by which to continue to evaluate HIT needs and make strategic implementation decisions. The Steering Committee will be the center of this ongoing Governance structure with decision-makers from both the private and public sectors working together. They will help maximize the implementation of the proposed roadmap projects, toward our overarching health goals. This charter and related documents lay the groundwork for fulfilling this governance process.		Risks & Obstacles <ul style="list-style-type: none"> HIT stakeholders have requested this governance process, to create sharing decision-making. But with no formal authority to implement the Roadmap, it might be difficult to gain consensus on the right priorities to operationalize implementation. Difficult to fully represent the large number of stakeholders with different perspectives and HIT interests. Challenging to truly engage patients or health consumers to get their input. State's limited bandwidth to staff a very large Steering Committee and potential sub-committees. Funding and project sustainability at risk, especially with new CMS funding plans
			Key Deliverables <ul style="list-style-type: none"> Annual implementation plans, to follow up the Roadmap Monthly meetings, with preparation that includes homework by stakeholders, preparation by staff, and follow-up by both. Ongoing sets of decisions about which HIT efforts need to be developed jointly, or aligned and coordinated, and prioritized Quarterly tracking of implementation activities of key HIT projects, including the Quality Reporting System, Prescription Drug Monitoring Program, etc. Sustainability Plan

RI HIT STEERING COMMITTEE MEMBER ROLES & RESPONSIBILITIES

Regular members:

- Attend the meetings, actively participate, and bring their expertise as the appropriate representative of their organization
- Be prepared to update the Steering Committee on IT activities of their organization, as a part of Knowledge Sharing
- Read the preparation
- Respond to requested follow-up
- Be a liaison back to their organization for two-way communication

Co-Chairs:

- All of the above, plus:
- Communicate with the state agency staff on meeting agendas and planning as a part of the Planning Committee
- Participate in meetings of the state HIT interagency Coordinating Committee for planning purposes, when appropriate

Sub-Committees: The purpose of the sub-committees are to have deeper dive discussions to tee up and respond to issues for Steering Committee consideration. The sub-committees will be determined by the Co-Chairs, and will be made up of majority Steering Committee members or designees of SC members, with other subject matter experts. Staffed by state HIT Staff Team.

RI HIT STEERING COMMITTEE MEMBER ROLES & RESPONSIBILITIES

Who are the Steering Committee members representing or speaking for?

- The members are expected to be at the table to present the perspectives of their organizations and their own knowledge and expertise – which is why they have been asked to join the Steering Committee.
- There will be some decisions on which the Steering Committee member is not authorized to speak for their organization until they get sign-off from others. The Co-Chairs and the state team will build in enough time for members to get this sign-off before shared decision-making on joint projects.
- Because the Steering Committee cannot be large enough for every stakeholder to have a seat, the Co-Chairs will use the open meeting format to seek input from other stakeholders, and for large decisions, will seek out stakeholder input in other ways, including request written feedback prior to Committee discussion and consensus-seeking.

Who are the Sub-Committee members representing or speaking for?

- Because the Sub-Committees will be having deeper dive discussions to tee up and respond to issues for Steering Committee consideration, it will behoove them to take a broader perspective, and to consider community-wide needs as they define topics for the larger Committee.
- They will be expected to bring the experience they have gained from their organizations – and to keep their organizational positions in mind – but the sub-committee will benefit from their reflecting a broader perspective in their analysis.

RI HIT STEERING COMMITTEE MEMBER EXPECTATIONS

Member Expectations – Attendance, Terms, and Expectations

RI Steering Committee Membership Proposal

- **Membership:** Membership will be reviewed periodically, but no less than once each calendar year, by the Steering Committee (SC) and EOHHS to determine if membership is adequate to support the above stated purpose and goals of the SC
- Members can appoint alternates, but members are expected to attend if at all possible. If an organization has an alternate, the same person should serve in that role, to maintain consistency.
- **Attendance:** Members shall notify the SC Chairs if they will be absent for any meeting.
- Members are expected to attend at least **75% of meetings** within a calendar year and avoid unexcused absences of three consecutive meetings. Failure to meet the attendance criteria shall result in a notice to the member from the SC Co-Chairs on behalf of the SC that a termination process is being initiated, allowing ten business days for the member to either commit to participation requirements or to be excused from the SC.
- If the member is non-responsive to the notice, the Co-Chairs will recommend removal of the member from the SC at the next SC meeting. In this event, the SC will deliberate and take such action as the SC deems appropriate. Any vacancy resulting from actions in this section will be filled with consultation from the Co-Chairs and the Health Cabinet.

RI HIT Steering Committee Ground Rules and Group Norms, for Discussion by Steering Committee

As a member of the Rhode Island HIT Steering Committee, I am committed to interacting in the following manner.

- Considering the opinion of others, along with my own.
- Working with colleagues in a collaborative manner.
- Relating to others with an open mind by assuming good intent.
- Focusing on consensus-building; making decisions with others.
- Being jointly responsible for completing tasks.
- Reacting calmly when in disagreement.
- Engaging respectfully to resolve conflict.
- Engaging in creative problem solving; assuming there is more than one “right” way to move forward.
- Co-creating solutions.
- Completing the onboarding package, using innovative techniques, and upholding the ways of working.

RI HIT Steering Committee DECISION-MAKING PROCESS

DETERMINING CRITERIA FOR DECISION-MAKING

1. How will issues come to the committee?

- Submitted by members, community stakeholders, or other state agency leaders to the Planning Sub-Committee for review

2. Decision-Making for Moving Forward – The following set of questions are available for the Steering Committee to use for the disposition of issues brought forward for their review (to be decided with a rubric). Disposition could be approval, approval with changes, disapproval, or remanding to the Planning Committee for more analysis and review.

1. Is it part of the Roadmap, or does it fit in a Roadmap Strategy?
2. Does the policy decision, data-sharing decision, or project help achieve the state's healthcare goals?
3. Will the technology or policy change work to meet the purpose? Is it feasible?
4. Is it needed? Who does the project or decision benefit, and how much? How is the size of its impact – how many people will it serve?
5. What impact does it have on the health of individual Rhode Islanders, on the quality of care provided to them, or on their patient experience?
6. Under a race/ethnicity equity lens, does it benefit communities of color? Does it mitigate disparities? Are we certain that it does not increase disparities?
7. Does it promote synergy? Will it particularly lead to new or increased collaboration or alignment in the community?
8. Who will use the project or the data?
9. What impact will it have on healthcare providers? Will it reduce (or increase) provider burden? Will it improve patient outcomes?
10. What is the cost? Can we afford it? Does it lead to a return on investment, either financially or with promotion of quality care?
11. Funding and sustainability. Does it qualify for matching funds, and do we have that match?
12. If the state will lead the project, can the state procure the project?
13. Is it time sensitive? Do we have the time we need to implement it?
14. Is it duplicative – in other words, are there similar efforts underway? Is there a potential to create misalignment?
15. Is this required by federal or state law or regulation? Does it have an existing governance structure? Does it require new state legislation or regulation?
16. What is its complexity and the relative risk in carrying out the project or instituting the policy?

AS REQUESTED: EXPERIENCE FROM OTHER STATES

Connecticut

- **HIT Advisory Council**
 - Created by statute
 - Broad stakeholder representation, including state agencies and private stakeholders (very large-- ~30 members)
 - Well-developed use case process to explore issues and make recommendations to the council
 - Low autonomy and low authority over stakeholders-- serves as central convening and discussion venue
 - Advisory to Office of Health Strategy, one of many HHS-related state agencies
- **Public-private HIE services organization in process of development**
- **Many independent projects/initiatives underway**

Colorado

- **Office of eHealth Innovation**
 - Created by executive order
 - Public/ private governance board
 - Embedded in state government
 - Responsible for statewide HIT initiatives and coordination between two state HIEs
 - Owns statewide roadmap and execution
 - Decision-making on shared investments
 - Contracts with HIEs for specific initiatives and functionality
 - Serves as venue to gather input on state HIT projects
- **HCPF (Medicaid agency) serves as fiscal agent and leverages Medicaid funding where eligible**
- **HIEs responsible for data connections and functionality**

Oregon

- **HIT Oversight Council**
 - Created by statute
 - Public committee with no state employees
 - Reports to Oregon Health Policy Board
 - Advisory to state on HIT initiatives (no direct governance role)
 - Advisory to state on policy/regulatory topics
- **HIT Commons**
 - Public-private governance entity, with apportioned representation of key stakeholders
 - Oversees statewide HIT initiatives within scope
 - Decision-making on shared investments
- **No formal internal state coordinating entity (state HIT coordinator and Office of Health IT play this role)**

CMS Interoperability and Patient Access Working Group Report-Out

CMS Interoperability and Patient Access Final Rule

Policy Requirements

- 1. Admission, Discharge, and Transfer Event Notifications (*applicable April 30, 2021*):**
 - Requires hospitals, including psychiatric hospitals, to send electronic patient event notifications of a patient's admission, discharge, and/or transfer to another healthcare facility or to another community provider or practitioner.
- 2. Patient Access Application Programming Interface (API) (*applicable January 1, 2021, enforced after July 1, 2021*):**
 - Requires payers to have an API (FHIR) that allows patients to access claims (including cost) and a sub-set of clinical data via a third-party app of their choice. (An API is a way for systems to communicate with each other.)
- 3. Provider Directory API (*applicable January 1, 2021, enforced after July 1, 2021*)**
 - Requires payers to make provider directory information publicly available via a standards-based API.
- 4. Payer-to-Payer Data Exchange (*applicable January 1, 2022*)**
 - Requires payers to send USCDI clinical data, at the patient's request, with other payers. (The United States Core Data for Interoperability (USCDI) is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.)
- 5. Digital Contact Information (*applicable late 2020*)**
 - Requires providers to list or update their digital contact information in NPPES. This includes providing digital contact information such as secure digital endpoints like a Direct Address and/or a FHIR API endpoint. (The National Plan and Provider Enumeration System (NPPES) assigns NPIs, maintains and updates information about health care providers with NPIs, and disseminates the NPI Registry and NPPES Downloadable File.)
- 6. Public Reporting and Information Blocking (*applicable early 2021*)**
 - Does not permit Information Blocking as defined by the Office of the National Coordinator (ONC), CMS will publicly report clinicians, and hospitals that engage in data blocking. (Information blocking is when a healthcare provider, health information technology developer, health information exchange or health information network (collectively, "actors") engages in a practice likely to interfere with, prevent or materially discourage the access, exchange or use of electronic health information.)

Interoperability Working Group Priority Recommendations

First Priority - Work with hospitals and community providers on:

- **#1. Admission, Discharge, and Transfer Event Notifications (*applicable Aril 30, 2021*)**
 - Requires hospitals, including psychiatric hospitals need to send electronic patient event notifications of a patient's admission or discharge and/or transfer to another healthcare facility or to another community provider or practitioner; includes psychiatric hospitals
- To successfully implement this requirement, we may need to address **#5 Digital Contact Information** (to enable knowing where to send notifications)

Next Steps:

- Identify providers (i.e. FQHCs, Transitions of Care Workgroup reps) to serve on this working group:
 - Workgroup needs their perspective since they will be recipients of the event notifications (and may already be getting some notifications for some or all of their patients through existing mechanisms like RIQI dashboards)
- Reach out to Hospital CIOs to understand status of planning to meet requirement
- Reconvene workgroup
- Educate health Care organizations and others on need to update digital contact and on Information blocking rule

Interoperability Working Group Priority Recommendations

Second Priority: Work with Payers and Providers on both #2 and #4 as they are related in many ways:

- **#2. Patient Access API (*applicable January 1, 2021, enforced after July 1, 2021*):**
 - Requires Payers to have a API (FHIR) that allows patients to access claims (including cost) and a sub-set of clinical data via a third-party app of their choice
- **#4 Payer-to-Payer Data Exchange (*applicable January 1, 2022*)**
 - Requires payers to send USCDI clinical data, at the patient's request, with other payers

Next Steps:

- Engage all payers in state (including Medicaid) on a workgroup when starting to meet on this topic
- Clarify interpretation of what is meant by “sub-set of clinical data” – do we need a full core data set or just what the payer already has?

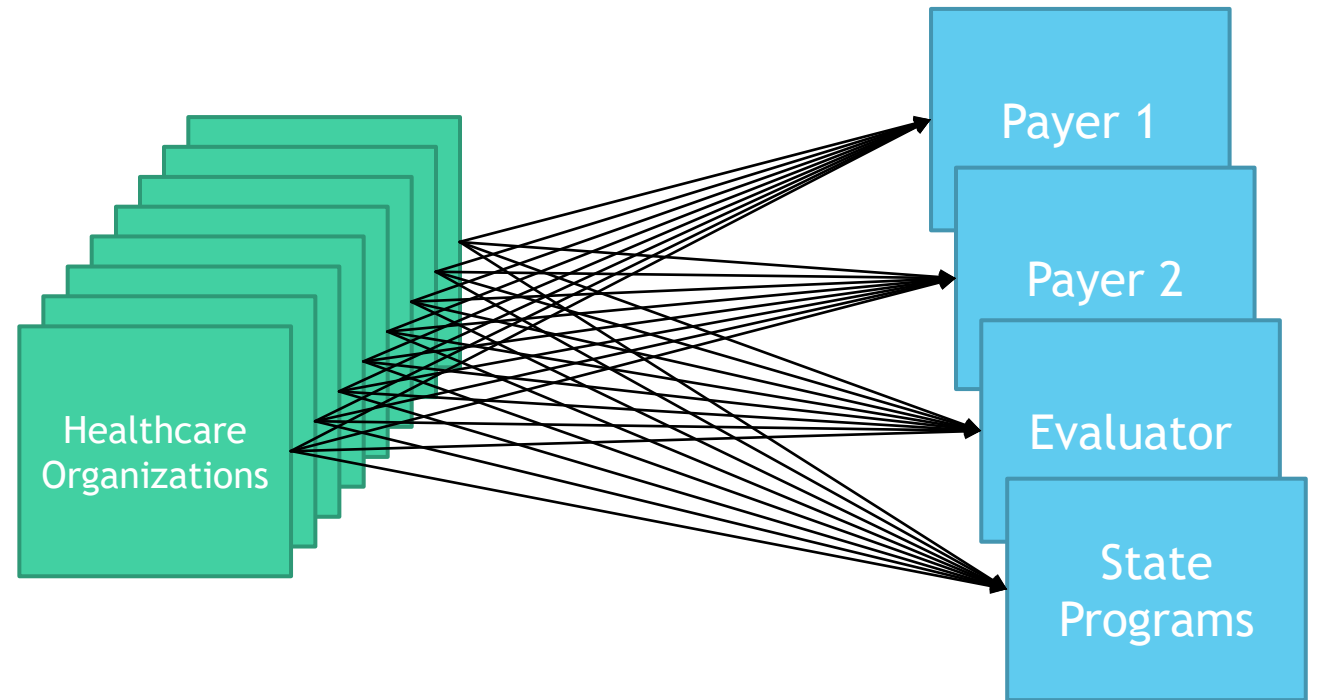
Overview of the RI's Statewide Quality Reporting System (QRS)

HIT Steering Committee Meeting

January 20, 2021

Burden of Quality Reporting Demands

- ▶ Providers have to report on quality measures to many different stakeholders using many different methods and formats.
- ▶ Providers want to maintain control over what information is shared and ensure privacy.
- ▶ Health plans anticipate that electronic clinical reporting will be **required for HEDIS within just a few years.**
- ▶ A lack of collaboration will add to **provider burden** and **administrative expenditures** due if need to set up many interfaces.



Statewide Quality Reporting of System

Shared Statewide Service that would:

- Support Quality Improvement for patients by allowing providers to identify gaps in care
- Reduce provider burden related to quality reporting
- Calculate measures needed by RI providers; report results and data to various reporting stakeholders
- Evaluate healthcare quality performance across healthcare systems and providers, as part of new payment methodologies

Components:

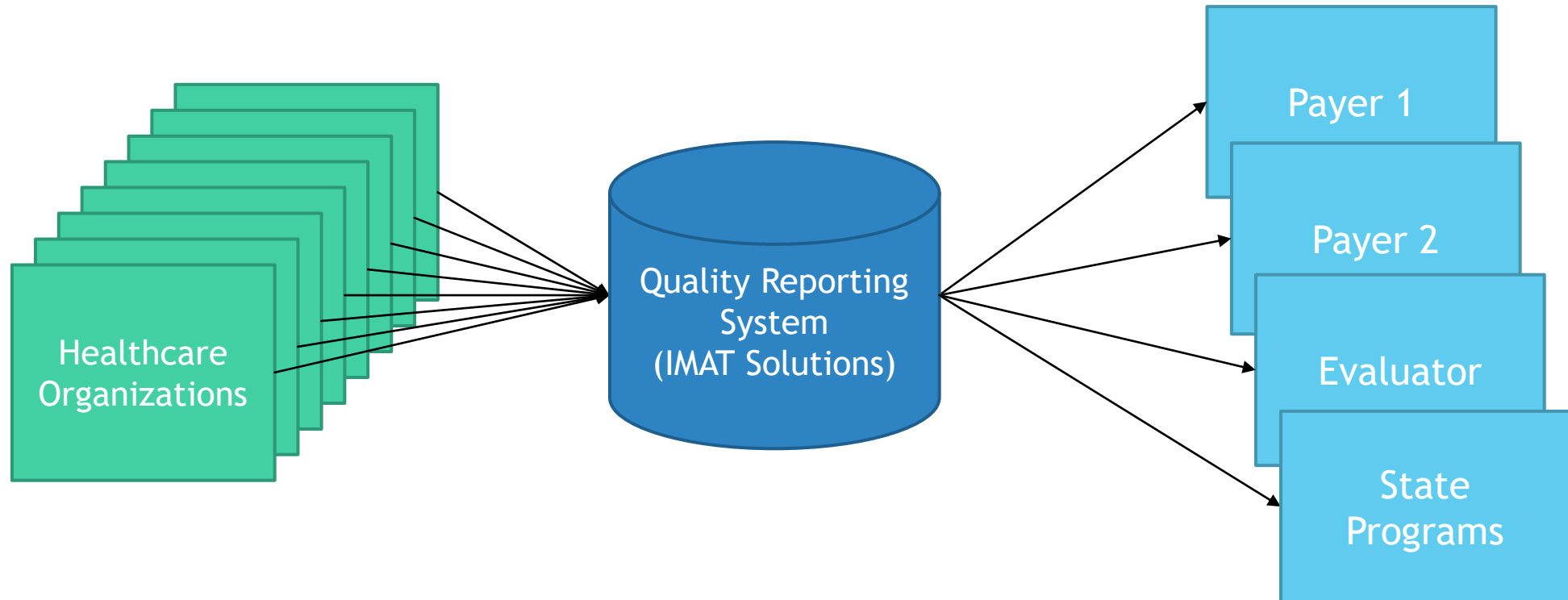
- Align and harmonize quality and utilization measures among payers and government;
- Develop a Data Intermediary to collect, calculate and report out quality measures; send to payers and others as needed

Process:

- Initiated as part of State innovation Model Grant
- State Issued RFP which required the vendor to collaborate with RIQI as the State's HIE entity and use the HIE as data source where appropriate
- IMAT was the vendor selected to implement the QRS system

Statewide Quality Reporting System Approach

- ▶ The QRS (IMAT Solutions) is already positioned to help support secure clinical data sharing and reporting
- ▶ We can leverage statewide infrastructure to reduce provider burden, create efficiencies, save money, and support many use cases



What is the Quality Reporting System (QRS)?

Features of the QRS

- ▶ **Compiles data** across data sources to be used for measure calculation holistically for an individual
- ▶ **Calculates measures** needed by RI providers
- ▶ Provides **unified gaps in care** reporting
- ▶ **Report clinical data or measure results** to reporting stakeholders at the right level
 - ▶ Aggregate or Identifiable
 - ▶ Raw data extracts
 - ▶ Measure specific
- ▶ **Consistent approach** to data collection and measure calculation for reporting and/or evaluation

QRS Use Cases

- ▶ Evaluate programs where data needs to be compiled from multiple sources
- ▶ Closing gaps in care with near real-time data in a web browser
- ▶ Support various reporting programs:
 - ▶ Medicaid Accountable Entities
 - ▶ CMS eCQM reporting (ex. Quality payment program)
 - ▶ RI Department of Health Care Community and Equity (CCE) program
 - ▶ Upstream
 - ▶ And more
- ▶ Submit supplemental clinical data to health plans
- ▶ For practices not sending data to CurrentCare right now, IMAT can serve as a pass through

Project Status

- ▶ There has been a significant recent increase in participating sites due to AE onboarding
 - ▶ At this time, all AEs intend to participate in QRS
- ▶ IMAT has certified a total of 27 eCQM (NCQA) 2019 measures at QRDA 1 and QRDA 3 certification (both patient and aggregate level)
 - ▶ 2020 measure certification is in early stages for 27 CMS measures
 - ▶ Approximately 20 additional measures in development for RIDOH, Upstream, and AEs
- ▶ Additional critical use cases are emerging for this system around continuous quality improvement and project evaluation

Who is submitting data to QRS?

Organizations LIVE

- Comprehensive Community Action Plan
- Wood River Health Services
- Providence Community Health Center
- CharterCARE Medical Associates

Organizations in TEST

- Blackstone Valley Community Health Center
- Coastal Medical
- Tri-County Community Health Center
- South County Health

Organizations in ONBOARDING in 2020-2021

- Integra (34 additional interfaces covering 76 practices)
- Prospect Health Services of RI (16 additional interfaces)
- Integrated Health Partners (3 additional interfaces)

Which Electronic Health Records are connecting?

Successfully connected EHRs:

- Athena
- eClinicalWorks
- Greenway
- Nextgen

Additional EHRs in the works:

- Epic
- Mednet
- Meditech
- Care Tracker
- Amazing Charts
- Kareo
- Practice Fusion
- Intergy/Synergy/Sage
- And others

Collaboration between IMAT and RIQI

- ▶ IMAT will send data to RIQI for CurrentCare enrollees for those practices not already connected to RIQI that have onboarded to QRS
- ▶ Since RIQI is already connected to the majority of laboratories serving the state, and IMAT needs laboratory data for QRS, RIQI will send laboratory data to QRS (for all individuals)

Privacy and Security

- ▶ The QRS Vendor, IMAT Solutions, will handle and protect each participating organization's data as their Business Associate and, if appropriate, their Qualified Service Organization
- ▶ Policies and procedures for this system are based on all applicable privacy laws:
 - ▶ HIPAA
 - ▶ State Mental Health Law
 - ▶ 42 CFR Part 2
- ▶ IMAT is capable of conducting advanced data filtering as needed, and is experienced with part 2 data segregation

Which organizations accept QRS data for Reporting purposes?

Confirmed/In Progress

- Neighborhood Health Plan of RI (NHP)
- United Healthcare (UHC)
- Upstream
- RIDOH Care Community and Equity Program (CCE)

Evaluating

- Tufts Health Plan
- Care Transformation Collaborative (CTC) for Community Health Teams (CHTs)

Early Discussions

- Blue Cross Blue Shield of RI (BCBSRI)

Types of Measures Supported

- ▶ OHIC Aligned Measure Set
 - ▶ **Accountable Entity Common Measure Slate will always be supported**
- ▶ Electronic Clinical Quality Measures (eCQMs)
- ▶ NQF measures
- ▶ HEDIS measures (health plans)
- ▶ Custom RIDOH measures for the Care Community and Equity (CCE) Program
- ▶ Upstream custom measures
- ▶ Other custom measures as needed by participants
 - ▶ Future plans include UDS, OHIC PCMH Reporting, other state-supported programs
- ▶ Advanced users can configure custom reports (requires basic knowledge of Python)

Which measures are currently built and available in the system?

Adolescent Immunization Status (HPV, Meningococcal, and TDAP)
Adolescent Well-Care Visits
Adult BMI Assessment
Appropriate Testing for Children with Pharyngitis
Appropriate Treatment for Children with Upper Respiratory Infection
Breast Cancer Screening
Cervical Cancer Screening
Childhood Immunization Status (TDAP, Hepatitis A, Hepatitis B, HiB, IPV, Influenza, MMR, Pneumococcal conjugate, Rotavirus, VZV)
Chlamydia Screening in Women (16-20, 21-24, and Total)
Colorectal Cancer Screening
Comprehensive Diabetes Care - Eye Exam
Comprehensive Diabetes Care - HbA1C Control (<8.0%) and Poor Control (>9.0%)
Comprehensive Diabetes Care - Medical Attention for Nephropathy
Depression Remission or Response for Adolescents and Adults
Depression Screening and Follow-Up for Adolescents and Adults
Elective Delivery
Emergency Department Utilization
Follow-Up After Emergency Department Visit for Alcohol or Other Drug Dependence (30-Day and 7-Day Follow-Up)
Follow-Up After Emergency Department Visit for Mental Illness (30-Day and 7-Day Follow-Up)
Follow-Up After Hospitalization for Mental Illness (7-Day)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (AUD, OUD, Other, and Total)
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
Lead Screening in Children
Preventive Care and Screening: BMI Screening and Follow-Up Plan
Preventive Care and Screening: Influenza Immunization
Preventive Care and Screening: Screening for Depression and Follow-Up Plan
Screening for High Blood Pressure and Follow-Up Documented
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (Females 40-75, Males 21-75, and Total)
Tobacco Use Screening and Cessation Intervention
Use of Appropriate Medications for Asthma
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
Weight Assessment and Counseling for Nutrition and Physical Therapy

Data Viewing

By providers at individual practices

- ▶ Identifiable PHI
- ▶ All data for own patients
- ▶ For mutual patients with other practices, only the data that contributes to their quality measures

By administrative staff, at practices or otherwise

- ▶ Can be either identifiable PHI or de-identified aggregated views based on legal agreements with participating practices
- ▶ Both types of accounts can exist simultaneously - clinical services director can see PHI, but analyst working on utilization can have an aggregated view to create custom reports
- ▶ Allows for quality improvement efforts at practice and individual provider level

By health plans

- ▶ Attribution file sent to IMAT identifying members by month
- ▶ Limited to lines of business indicated for reporting by participating practices
- ▶ IMAT cleans and transforms data received from practices and labs into format requested by plans
- ▶ Identifiable PHI level clinical data including source CCD if necessary
 - ▶ Supports HEDIS requirements
- ▶ Allows for quality measurement calculation, risk management, and utilization assessment by plans

Cost and Funding

▶ QRS System

- ▶ SIM funded the startup
- ▶ Medicaid is funding the ongoing development and implementation costs
- ▶ Health insurers may fund some components to support reporting to them
- ▶ The goal is to have no direct cost to the provider
- ▶ Long-term funding sustainability approach beyond 2021 will be addressed at HIT Steering Committee, a public/private governance body first meeting on December 17, 2020

▶ Connectivity

- ▶ There is typically a cost to the provider with their EHR vendor to build a connection. So far this has ranged from free to a \$15,000 one-time expense.
- ▶ The state may be able to cover these funds, and supply TA from a contracted EHR consultant, beginning in early 2021

Questions?

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Next Steps:
Steering Committee meets 2nd Wednesdays at 5:30 PM

Next Meeting: Wednesday, February 10, 2021

PUBLIC COMMENT