ISAC Update

April 24, 2018

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TSGAC Representative to ISAC

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Purpose of ISAC

The Information Systems Advisory Committee (ISAC) is established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems.

Current Membership

Permanent members

1. IHS Chief Information Officer
2. National Indian Health Board Member
3. Tribal Self-Governance Advisory Committee Member
4. National Council of Urban Indian Health Board Member
5. National Council of Chief Medical Officers Member
6. National Council of Executive Officers Member
7. National Clinical Councils Member
8. IHS Office of Environmental Health and Engineering Representative
9. IHS Information Systems Coordinator Committee Representative

In addition, 8 members consisting of IHS staff, Tribal Leaders, and Urban program managers will be appointed to serve staggered 2-year terms.

TOPICS

Key Current Issues at ISAC

(2017-2018)

(2018-2020)

Key Upcoming Issues at ISAC

1. KEY CURRENT ISSUES AT ISAC (2017-2018)

June 28-29, 2017 (Chicago)
October 24-25, 2017 (Oklahoma City)
March 14-15, 2018 (Phoenix)

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ISAC Revised Charter

The ISAC Charter has not been updated in years, is vague on certain issues (e.g. assigning non-permanent members, approvals required for membership), and needed a review of the permanent membership.

- Proposed Charter:
  - Tribal chair will change every 2 years, rotating between 3 positions:
    - TSGAC rep, DSTAC rep, Area Rep. Order still to be determined.
  - Includes text re. conformance with FACA (Federal Advisory Committee Act)
  - STRATEGIC Changes to membership.
- Will require a 2/3 majority vote of currently filled seats on ISAC to approve the new charter. <u>Vote is imminent.</u>

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ISAC Membership Changes

CURRENT MEMBERSHIP

1. IHS Chief Information Officer
2. National Indian Health Board Member
3. Tribal Self-Governance Advisory Committee Member
4. National Council of Urban Indian Health Board Member
5. National Council of Chief Medical Officers Member
6. National Council of Executive Officers Member
7. National Clinical Councils Member
8. IHS Office of Environmental Health and Engineering Representative
9. IHS Information Systems Coordinator Committee Representative

Plus 8 members consisting of IHS staff, Tribal Leaders, and Urban program managers

PROPOSED MEMBERSHIP

1. IHS Chief Information Officer
2. Board member, National Indian Health Board
3. Direct Service Tribal Advisory Committee Member
4. Tribal Self-Governance Advisory Committee Member
5. National Council of Chief Medical Officers Member
6. National Council of Executive Officers Member
7. National Nurse Leadership Council Member
8. IHS Information Systems Coordinator Committee Member
9. IHS Chief Information Security Officer
10. IHS Chief Health Informatics Officer
11. IHS Deputy Director for Quality Health Care
12. Director, Division of Facilities Operations, OEHE

Plus 12 at-large members, one from each IHS Area consisting of elected Tribal Leaders (or designees) appointed by the respective Area Director.

EHR Recommendations / Process

Unanimous recommendation that IHS pursue a COTS solution for the future IHS HIT system.

June 2017

CY17 Activities included:

- *Modernization Workgroup*
- *RFP process*
- *RFI process*

RPMS Development

Most RPMS work is now outsourced.

- IHS has awarded a single contract for all future RPMS development.
- IHS has let a contract for RPMS training and documentation support.

RPMS development plans are somewhat limited.

- Electronic Prescribing of Controlled Substances (EPCS) is expected to be generally available to RPMS sites in mid to late 2018.
- Moving from Ensemble 2012 to Intersystems HealthShare Platform
- Upgrading Clinical Quality Measures (CQMs) fell off the development roadmap for RPMS. ISAC recommended that IHS prioritize this. CQMs will be upgraded sufficient to meet the needs of Medicare's Quality Payment Program (QPP).
- IHS has decided NOT to make RPMS compatible for Meaningful Use (MU) Stage 3.

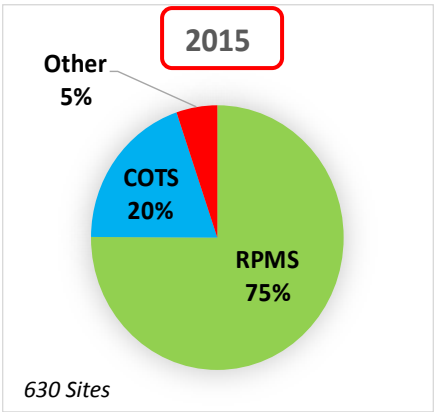
2. KEY UPCOMING ISSUES AT ISAC (2018-2020)

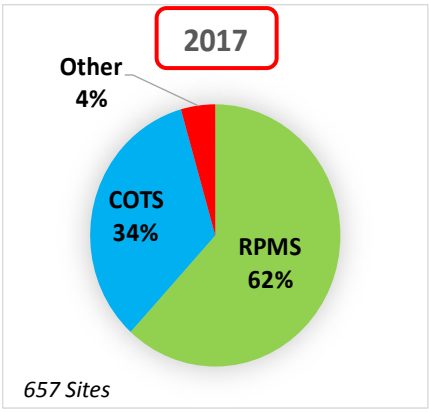
September 2018 Anchorage

Observations

1. There is already a significant migration from RPMS to COTS EHR in tribal facilities.

Changes in EHR Technology have almost solely occurred at Tribal Sites.
RPMS-EHR Usage has dropped 20% at Tribal sites in the last 2 years
COTS EHR Usage has increased 72% at Tribal sites in the last 2 years





Source: Area Data Call 20170324

AREA Picture

Tribal sites in Alaska are nearing 100% COTS EHR

ALASKA AREA

	2015	2017
RPMS	121 (62%)	57 (29%)
COTS	72 (37%)	142 (71%)

Tribal sites in other Areas are nearing 20% COTS EHR

ALL AREAS (Except Alaska)

	2015	2017
RPMS	352 (81%)	348 (76%)
COTS	52 (12%)	79 (17%)

Source: Area Data Call 20170324

nextgen healthcare athenahealth Greenway Health Cerner Allscripts

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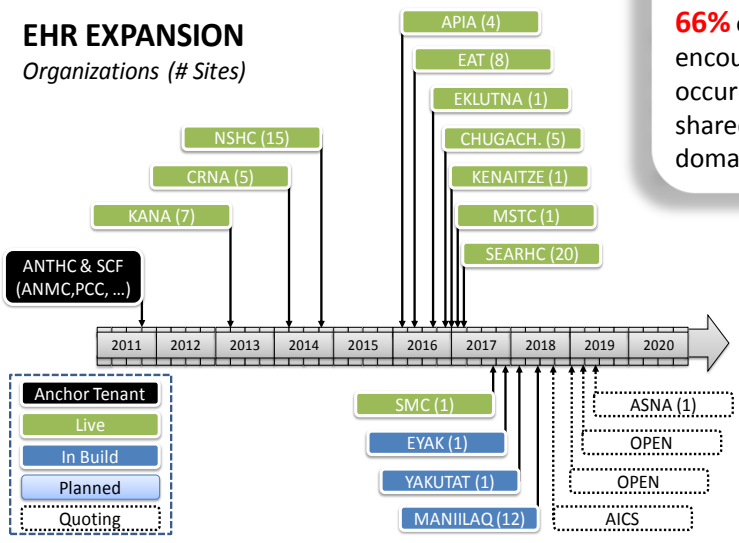
Alaska Area includes individual EHR systems and shared EHR systems.

EHR EXPANSION

Organizations (# Sites)



Alaska Tribal Health System

66% of all encounters now occur in a single shared EHR domain.

Alaska Native Tribal Health Consortium

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Why Move to a COTS EHR?

1. Improved patient care and quality
2. Increased revenue
3. Greater functionality, features, and solutions
4. Workflow optimizations
5. Data and analytics
6. Integration to 3rd party systems
7. Sharing EHR systems
8. Modern technology (API, CommonWell)
9. Other …

Observations

1. There is already a significant migration from RPMS to COTS EHR in tribal facilities.
2. The selection of a COTS EHR is extremely difficult – more than just selecting technology.

Considerations for Vendor Selection

Vendor Selection(s)
- One or many?
- Pricing
- Hospital versus Ambulatory EHRs
- Local hospital EHR
- Domain model
- Simplifying and centralizing services
- Functionality

Ancillaries … Change?
- Lab, Rad/PACS, Pharmacy, Dental, Optometry
- Interfaces?

Additional Functionality & Solutions
- ePrescribing, Referral Mgmt, Care Mgmt, LTC, EPCS, Telehealth, Portal, API, FHIR, eSignature

Services
- Procurement, Build / Deployment, Training, Support, Vendor Mgmt, Optimization

Reporting, Data and Analytics
- Operational, Quality, Strategic

Apps
- Portal, Smart on FHIR, API

Observations

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2. The selection of a COTS EHR is extremely difficult – more than just selecting technology.
3. A COTS EHR will still require significant custom development.

Custom Development

- Non-standard commercial solutions
  - PRC
  - Telehealth
  - Referral Mgmt
- IHS-Specific needs
  - NDW, GPRA
- Interfaces (e.g. Dentrix, PACS)
- Ongoing RPMS development
- Archiving solutions (RPMS, Lab, VistA Imaging)
- Apps

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3. A COTS EHR will still require significant custom development.
4. A COTS EHR will significantly affect organizations.

IMPACT of a COTS EHR

CLINICAL
- Optimization
- User interface
- Workflows/Documentation
- Quality/Data/Reporting

REVENUE CYCLE
- Optimization
- Patient Accounts
- Coding/Billing
- CAC

TECHNOLOGY
- Remote hosting (Citrix)
- Connectivity
- Devices

PROCESSES
- Change Management
- Release Management
- Upgrades
- Management
- Tier 1 or 2 Support
- Project Management

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3. A COTS EHR will still require significant custom development.
4. A COTS EHR will significantly affect organizations.
5. IHS Services will need to change significantly.

IHS Services

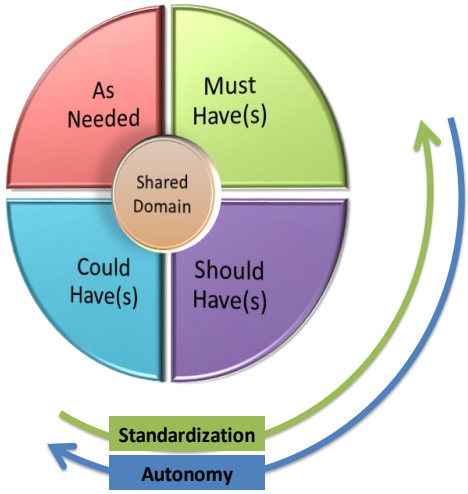
CENTRALIZED?

- Purchasing
- Vendor Management
- Roadmap
- Domain Management
- Project Management
- Management Model
- Reporting
- Legacy Data Mgmt

CENTRALIZED OR DISTRIBUTED?

- Tier 2, 3 support
- Training
- Deployment
- Testing
- Optimization
- Analytics

DESIGN: Standardization



- ✓ Nomenclature
- ✓ Workflows
- ✓ Forms
- ✓ Formularies
- ✓ Solutions (e.g. Lab)
- ✓ Reporting
- ✓ Training
- ✓ Support

A "Richer Growing" Solution

User Experience
- Model experience – Optometry
- Playbook Implementation and Specialty Views

Patient Experience
- Cerner Wellness

Quality of Care
- Smart Registries
- eQuality Check
- eQuality Check Core Measures Upg 5.1
- Sepsis Quality Measure
- 2016 eCQM Implementation

Integration / Communication
- Theradoc Integration
- VitalsLink
- DSM
- CAMM Image Integration
- Interfaces to Enterprise Resource Planning (ERP) systems

Optimization
- Event Set Hierarchy (ESH) redesign
- Rev Cycle Review and Optimization

Data / Analytics
- Discern Analytics User Group

Ready to Begin
- ePrescribing
- Smart Registries
- Direct Secure Messaging
- Code Upgrade (April-July 2017)

Review Underway
- ScriptPro
- PathNet
- Explanation of Benefits (EOB)
- Electronic Signature (eSig)
- HealtheIntent EDW
- HIE Connectivity
- Behavioral Health Solution
- Referral Mgmt Solution
- Advanced Beneficiary Notice (ABN)
- 3M Revenue Tools
- Oncology Module
- Opthalmology Solution
- PowerChart Touch (PC Touch)
- Long Term Care

KEY THOUGHTS

Selecting an EHR Technology is a critical expression of self governance.

What happens when we are limited by our ability to adopt change - not our ability to develop code?

KEY ISSUES 2018-2020

Be very actively involved in the discussion of a COTS EHR solution.

- Requires strong leadership and support from tribal organizations.
- Ensure that all appropriate parties are involved in this process.
- Learn from tribal sites that have already moved to COTS EHR.

All major IT development efforts to be carefully reviewed by ISAC.

- Investments in RPMS need to be scrutinized esp. given the VA plans.

Migration to a COTS product will require significant new funding and rigorous planning.

- To continue RPMS development.
- To fund a process to select and deploy a COTS EHR.
- To upgrade infrastructure to support a COTS EHR.

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