HIT Operational Plan Update
September 22, 2020

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213-929-4232
Access code 276-910-015 #
Agenda

• Broadband
  – Broadband as a social determinant of health
  – Broadband map, funding sources/needs and subcommittee
  – Better Health Together funding of broadband access

• FCC Coordinated Care Pilot

• Clinical workflows/business processes in accessing the PMP

• Accessing and Integrating PMP Information Using FHIR

• Consent Management

• CDR Update

• 2020 Behavioral Health Provider Survey
Broadband as a Social Determinant of Health
Access to Broadband and health outcomes in WA state

Dr. Ofer Amram
Assistant Professor, Nutrition and Exercise Physiology
Adjunct Professor, Paul G. Allen School for Global Animal Health
Identifying Disparities in Health Outcomes

WSU study finds mortality rate higher in Eastern Washington

Wed., Jan. 30, 2019

Spokesman.com
Identifying Disparities in Health Outcomes

EASTERN WASHINGTON HEALTH PROFILE - JANUARY 2019

Age-adjusted mortality rates for the 10 leading causes of deaths in Washington were higher in eastern Washington than western Washington.

For 6 out of the 10 leading causes of death (i.e., Alzheimer’s disease, unintentional injuries, chronic lower respiratory diseases, diabetes, suicide, and chronic liver disease and cirrhosis) were higher in eastern Washington when compared to the United States average rates.

Preventable causes of deaths, such as unintentional injuries, chronic lower respiratory diseases, and diabetes, were higher in eastern Washington than western Washington, as well as when compared to the United States average rates.
### Identifying Disparities in Health Outcomes

#### Age-adjusted mortality rates (per 100,000), both sexes, 2011-2015

<table>
<thead>
<tr>
<th>Disease</th>
<th>Eastern WA</th>
<th>Western WA</th>
<th>WA</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-causes</td>
<td>716.17</td>
<td>659.79</td>
<td>672.17</td>
<td>733.1</td>
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<tr>
<td>Cancer</td>
<td>158.98*</td>
<td>155.96</td>
<td>156.58</td>
<td>158.50</td>
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<tr>
<td>Heart Disease</td>
<td>146.93</td>
<td>134.50</td>
<td>137.23</td>
<td>168.50</td>
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<tr>
<td>Alzheimer's disease</td>
<td>44.76*</td>
<td>43.45*</td>
<td>43.75</td>
<td>29.40</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>45.18*</td>
<td>35.58</td>
<td>37.71</td>
<td>43.20</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Diseases</td>
<td>46.65*</td>
<td>37.85</td>
<td>39.82</td>
<td>41.60</td>
</tr>
<tr>
<td>Cerebrovascular diseases(Stroke)</td>
<td>37.57</td>
<td>33.40</td>
<td>34.36</td>
<td>37.60</td>
</tr>
<tr>
<td>Diabetes</td>
<td>24.53*</td>
<td>20.78</td>
<td>21.61</td>
<td>21.30</td>
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<tr>
<td>Suicide</td>
<td>15.27*</td>
<td>13.98*</td>
<td>14.24</td>
<td>13.30</td>
</tr>
<tr>
<td>Chronic liver disease and cirrhosis</td>
<td>13.44*</td>
<td>10.37</td>
<td>11.02</td>
<td>10.80</td>
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<tr>
<td>Flu - Pneumonia</td>
<td>10.97</td>
<td>9.60</td>
<td>9.91</td>
<td>17.80</td>
</tr>
<tr>
<td>Overdose</td>
<td>12.40</td>
<td>13.35</td>
<td>13.14</td>
<td>16.30</td>
</tr>
</tbody>
</table>

*Represents rates higher than the national average
## Identifying Disparities in Health Outcomes

<table>
<thead>
<tr>
<th>U.S. Rate - Rank</th>
<th>Cause of Death</th>
<th>ICD-10</th>
<th>Rural Rate</th>
<th>p-value</th>
<th>Significant</th>
<th>More Deprived</th>
<th>p-value</th>
<th>Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heart Disease</td>
<td>I00-I09, I11-I13, I20-I51</td>
<td>Lower</td>
<td>0.783</td>
<td>No</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
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<tr>
<td>2</td>
<td>Cancer</td>
<td>C00-C97</td>
<td>Lower</td>
<td>0.01</td>
<td>Yes</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
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<tr>
<td>3</td>
<td>Alzheimer’s disease</td>
<td>G30</td>
<td>Lower</td>
<td>&lt;0.001</td>
<td>Yes</td>
<td>Lower</td>
<td>0.645</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Unintentional Injuries</td>
<td>V01-X59, Y85-Y86</td>
<td>Higher</td>
<td>0.022</td>
<td>Yes</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
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<tr>
<td>5</td>
<td>Chronic Lower Respiratory Diseases</td>
<td>J40-J47</td>
<td>Higher</td>
<td>0.407</td>
<td>No</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Cerebrovascular diseases (Stroke)</td>
<td>I60-I69</td>
<td>Higher</td>
<td>0.918</td>
<td>No</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes</td>
<td>E10-E14</td>
<td>Lower</td>
<td>0.249</td>
<td>No</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
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<tr>
<td>8</td>
<td>Suicide</td>
<td>U03, X60-X84, Y87.0</td>
<td>Higher</td>
<td>0.005</td>
<td>Yes</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
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<tr>
<td>9</td>
<td>Chronic liver disease and cirrhosis</td>
<td>K70,K73-K74</td>
<td>Lower</td>
<td>0.732</td>
<td>No</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Flu - Pneumonia</td>
<td>J09-J18</td>
<td>Lower</td>
<td>0.665</td>
<td>No</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
</tr>
<tr>
<td>-</td>
<td>Overdose</td>
<td>X40-X44, X60-X64, X85, Y10-Y14</td>
<td>Lower</td>
<td>0.009</td>
<td>Yes</td>
<td>Higher</td>
<td>&lt;0.001</td>
<td>Yes</td>
</tr>
</tbody>
</table>
PATHS TO DISPARITY

AGE-ADJUSTED ALL CAUSE MORTALITY RATES 2011 - 2015

Age-adjusted all-cause mortality rates in Eastern Washington as compared to Western Washington and to the national average.

- U.S. rate = 732.1
- 730
- 731

Mortality per 100k

Age Group (Unadjusted)

Per 100k Population:
- < 89
- > 897-< 825
- ≥ 825

Video Tutorial

Per 100k
Population

Rate: 1880.8 Per 100k

Region: Selected Census Tract:
- Eastern
- Western

1880.8 - Per 100k (16 selected)

Slide to highlight census tract with a rate of over 1880.8 per 100k (16 selected)
PATHS TO DISPARITY

Post hoc comparisons indicated that the mean for mortality related to all-causes was significantly lower (p < 0.001) in census tracts with more than 800 residential fixed connections per 1000 households (M = 716.45, SD = 380.82) compared to other census tracts.

The mean for mortality related to all-causes did not significantly differ between tracts with 0-500 or 500-1000 residential fixed connections (M = 897.15, SD = 537.95) and tracts with 1000-1400 residential fixed connections (M = 828.30, SD = 339.46) per 100,000 households.

Slide to highlight census tract with a rate of over 5185.1 per 100k (0 selected)
Access to Broadband

**FCC data on Broadband**: residential fixed high-speed connections with at least 10 Mbps downstream and at least 1 Mbps upstream per 1000 households.

**Census tracts were stratified into**:
- 600 or less residential fixed connections \((x \leq 600)\)
- 600 to 800 residential fixed connections \((600 < x \leq 800)\)
- 800 or more residential fixed connections \((x > 800)\)
## Age Adjusted Mortality

<table>
<thead>
<tr>
<th>Disease</th>
<th>&lt;= 600</th>
<th>600 &lt; x &lt;= 800</th>
<th>&gt; 800</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Causes of Death</td>
<td>753</td>
<td>774</td>
<td>648</td>
</tr>
<tr>
<td>Cancer</td>
<td>169</td>
<td>174</td>
<td>155</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>157</td>
<td>152</td>
<td>137</td>
</tr>
<tr>
<td>Alzheimer Disease</td>
<td>32</td>
<td>39</td>
<td>39</td>
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<tr>
<td>Unintentional Injuries</td>
<td>47</td>
<td>41</td>
<td>30</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease</td>
<td>47</td>
<td>45</td>
<td>31</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>38</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>Diabetes</td>
<td>23</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td>Suicide</td>
<td>17</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>13</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Flu - Pneumonia</td>
<td>10</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Overdose</td>
<td>14</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>
PATHS TO DISPARITY

Access to Broadband in Washington State - A Brief Report

- Mortality related to most of the ten leading causes is much lower (statistically significant) in locations with higher access to broadband (800 residential fixed connections per 1000 households).

- However, the Federal Communications Commission data on access to broadband is likely to overestimate access.

- Report: https://www.chaselab.net/BroadbandCT/BroadbandCT.htm
PATHS TO DISPARITY

p-Value = <0.001
CHaSE Lab: www.chaselab.net

- Research related to space, place, and health
  - Social determinants of health and health equity
  - Access to health and other services
- Big data
- Visualization
Questions
Broadband map, funding sources/needs and subcommittee
We strengthen communities

HOUSING HOMELESSNESS
INFRASTRUCTURE
BUSINESS ASSISTANCE
ENERGY
PLANNING
COMMUNITY FACILITIES
CRIME VICTIMS & PUBLIC SAFETY
COMMUNITY SERVICES
Washington State Goals
SB 5511

• By 2024, all businesses and residences have access to 25 Mbps download and 3 Mbps upload

• By 2026, all communities have access to 1 Gbps symmetrical service at anchor institutions

• By 2028, all businesses and residents have access to 150 Mbps symmetrical service from at least one provider

• Suggest policies to achieve these goals with collaboration from State Broadband Strategic Planning Group
Citizens and Businesses

- 884,000 homes without fiber
  Est. $2.5+B
- WSBO Plan, Policy
- PWB Programs
- UTC Evaluation
Anchor Institutions

- Schools
- Libraries
- Health Care
- Public Safety
- Essential Services
- Industries
- Government
Broadband: What We Already Know

**Demand for growth**
- User choice is best service if available/affordable
- Skills/tools are important
- Education, healthcare, and workforce increasingly dependent on broadband
- We no longer require studies to reiterate these facts

**Funding**
- Current map data is inaccurate and prohibitive to funding
- Shovel ready feasibility studies must include specific build costs, performance, gaps filled, sustainable metrics
- Our duty to invest in scalable, future-proof networks to meet 15+ year demands
- Acknowledge substantial existing private and public investment

**Infrastructure**
- Need to be technology agnostic
- Economics of broadband infrastructure
- Desire is for fiber, fiber capacity grows exponentially each year
- Disruptive technologies continue to emerge
Supporting the Broadband Delivery Lifecycle

1. PLANNING
   Coordinate statewide planning, stakeholder collaboration, inform policy

2. IDENTIFYING
   Maintain comprehensive state mapping data and feasibility

3. FUNDING
   Facilitate access to all available funding opportunities

4. DELIVERING
   Ensure future-proof networks to meet state goals

5. SERVICING - FUNDING
   Support sustainable operational programs and digital equity
PLANNING: Current Collaborations

- Broadband Action Teams
- Counties
- Department of Commerce, Public Works Board, Utilities and Transportation Commission
- Digital Equity, I-_ACT
- Emerging Technologies (Amazon - Kuiper, Microsoft - Airband, SpaceX - Starlink)
- Emergency Support Fund #2
- FCC Precision Ag Task Force
- Healthcare - OCHIN/FCC Healthcare Connect Fund, Behavioral Health Institute
- Higher Education, WSUE
- Incumbent/Rural Providers
- Information Technology Disaster Resource Center
- Municipalities
- Nonprofit, Northwest Open Access Network, Avista Foundation
- Office of the Chief Information Officer, Washington Technology Solutions
- Office of Superintendent of Public Instruction
- Port Districts
- Public Utility Districts
- School Districts
- Schools, Health and Libraries Broadband Coalition
- WA State Library, Division of the Office of the Secretary of State
- Washington Tribes
- United States Department of Agriculture
- Washington Independent Telephone Association
- Washington State Department of Transportation
- Best Practice - State Broadband Leaders Network, National Telecommunications and Information Administration, Pew Research Center
IDENTIFYING: Statewide Mapping Project

- Crowdsourse speed test data capture
- MLabs data
- FCC 477 data
- CAF II Award areas
- RDOF opportunity areas
- Incumbent Provider service territories
- Other Provider coverage areas
- Fiber infrastructure state of Washington

- State of Washington assets
- Federal assets
- EDA Zones
- Opportunity Zones
- Broadband funding awarded areas
- Type of infrastructure for last mile service
- WISPs and coverage areas
- PUD networks
- Port networks
- Rural Electric Authority

- State legislative districts
- Congressional districts
- Anchor institutions
- Tribal areas
- 2028 areas served at 150/150 Mbps
- NTIA mapping
- Additional data categories as available
IDENTIFIED: UNSERVED / UNDERSERVED

INCUMBENT PROVIDER

YES
IN PROCESS
IN PLANNING
How Can We Help?

NO
NO FUNDS
NOT VAILABLE
OTHER
How Can We Help?

PUBLIC PRIVATE PARTNERSHIP

ALTERNATE PROVIDER
FUNDING: Feasibility/Construction/Services

- Become #1 State in the nation for receipt of federal funding
- 2020 federal funding windows closing
- FCC Rural Digital Opportunity Fund (RDOF) $16B, $4.4B
- USDA Rural Development Broadband ReConnect Loan and Grant Program $550, $600M
- Pending Stimulus
- FCC 2.5GHz Rural Tribal Window
- PWB Construction Cycle $16+M
- USDA Distance Learning and Telemedicine $50K-$1M
- USDA Community Connect
- State Universal Service Fund
- Private / Undiscovered
- PWB Feasibility awarded $50K
- 2019 PWB Feasibility awarded $450K
Federal Funds Awarded

- **Mason Public Utility District 3**
  $2.4M  
  *USDA ReConnect Round 1*  
  High-speed broadband to 250 households and home-based businesses in unserved Grapeview community. Three Fingers Rural Broadband Fiber Project provides middle- and last-mile fiber-optic service to each premises located within the targeted area.

- **Hood Canal Communications**
  $2.3M  
  *USDA Rural Utilities Service Community Connect Grant*  
  Lake Cushman, fiber to the home project, speeds up to 1 Gig/second, cable TV, phone service to the area.
Current WSBO Project Support

- Bellingham
- Bullman Beach
- Clallam County
- Clark County
- Ferry County
- Stevens County BAT
- Pend Oreille County
- Counties without access to RDOF
- First Washington
- Island County
- Jefferson County
- King County
- Kittitas County
- Lewis County
- Pacific County
- Pierce County
- Lummi Tribe
- Makah Tribe
- Colville Reservation
- Spokane Tribe
- Hoh Tribe
- WA Drive-In WiFi Hotspots COVID-19 emergency response collaboration
- 2.5GHz Rural Tribal Window
- Connect Whatcom!
- Daily introductions to new projects
Budget - Infrastructure

• Not enough state dollars to address infrastructure needs
• State fiscal contribution will support awarding of federal funds
• Continue to support ongoing private investment in networks where possible and feasible
• Anticipate strong push from private partners to double down on infrastructure concurrent with state directive
Next Steps

• How you can help: Take the One Minute Washington State Broadband Access and Speed Survey:
  • Search on: WA state broadband
  • Takes you to: https://www.commerce.wa.gov/building-infrastructure/washington-statewide-broadband-act/speedtestsurvey/

• Be ready for funding opportunities:
  • Shovel Ready Projects Identified and brought to the attention of WSBO
“What gets measured gets done!”
Thank you.

Russ.Elliott@commerce.wa.gov
564.999.0326
Better Health Together funding of broadband access
Mission: To radically improve the health of the region.

2013
Established as a 501(c)(3) with a Board comprised of community leaders from across the region

12,082
Square miles

93%
of eastern Washington residents have health care coverage

$57M
in Medicaid Waiver funds earned for the region

~175,000
Medicaid recipients

100+
6 County-based Collaboratives with over 100 partners
Increasing Behavioral Health Access

**Goal:** Utilize $5,236,872 in remaining Integrated Managed Care Funds to increase behavioral health access in the region.

**The funds should:**

- Support health equity
- Be targeted, not spread, for maximum impact
- Utilize data to drive community decision-making
- Target the population(s) most likely to show improved health outcomes and cost savings
- Have a multi-sector impact and promote multi-sector engagement
- Leverage other funds and investors
- Have an impact that outlasts the dollars and moves transformation forward
Maximizing Broadband Competitiveness

- Work with county and Tribal Broadband Action Team to identify projects/areas of need
- Join forces with WA Broadband Office, GEO Partners LLC, an expert in network and financial modeling, and Learn Design Apply Inc (LDAI), an expert in grant consulting and proposal writing.
  > Identify projects. Using the State's broadband mapping system, and input from communities, utilize GEO's grant filtering tool, each potential project will be evaluated for Reconnect and RDOF points
  > Prepare preliminary modeling to show the cost range of a proposed broadband implementation
  > State will rank in order of the most likely to succeed in a competitive grant environment.
  > Successful projects will then undergo GEO's detailed design study and various options and cost models will be generated which provide sufficient detail to move into the actual grant writing phase.
  > Grant applications will be written in conjunction with the communities by LDAI to produce and submit.

Cost per project = $11,500
Background
Medicaid 1115 Waiver

In 2017, CMS granted the state of Washington a Waiver on how they spend up to $1.5 Billion Medicaid funds.

The Waiver is divided into 3 key sections:
• Health System Transformation through Accountable Communities of Health (ACH)
• Long Term Supports and Services
• Supportive housing and supportive employment

Transformation work through ACHs focuses on:
• Build health systems capacity
• Integrated physical & behavioral health services
• Coordinate care management to serve the whole person
What is an ACH?

• Each ACH, through community partners are taking on a locally established portfolio of projects.

• ACH’s regionally manages Medicaid Waiver funds as they achieve milestones and show improvement in key health outcomes.

• Projects require collaboration across multiple sectors in order to be successful.
## Investment Strategy

- **Behavioral Health Access Data**: Completed region-wide Behavioral Health Inventory
- **Telehealth**: Investments in capacity to help clients access services via Telehealth.
- **Multi-Sector Criminal Justice Pilot**: Launched $2.5M to support community alternatives to incarceration
- **Workforce Development**: Provide financing support to Behavioral Health providers for SUDP Certification Program

<table>
<thead>
<tr>
<th>IMC Allocation</th>
<th>$5,236,8972</th>
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<tbody>
<tr>
<td>Strategy 1: Behavioral Health Access Data</td>
<td>$100,000</td>
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<tr>
<td>Strategy 2: Telemedicine</td>
<td>$750,000</td>
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<tr>
<td>Strategy 3: Multi-Sector Criminal Justice Pilot (Rural)</td>
<td>$500,000</td>
</tr>
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<td>Strategy 3: Multi-Sector Criminal Justice Pilot (Spokane)</td>
<td>$2,000,000</td>
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<tr>
<td>Workforce Development</td>
<td>$40,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$3,390,000</td>
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</table>
Broadband Background

- Broadband has been a long recognized need in rural Washington
- COVID pandemic made things worse
- Washington state does not have good data for demonstrating the lack of coverage though common knowledge of need
- In July of 2020 launched a [statewide testing mechanism](#) to provide real time data for connectivity
- State broadband strategy includes maximizing competitiveness in federal funds via USDA and FCC funding strategies
Next Steps

1. Work with Broadband Action Teams in each rural county to identify projects
2. Map projects
3. Apply for funds
4. Fix Broadband in rural communities!
FCC Coordinated Care Pilot
Funding Opportunity: Connected Care Pilot Program

• FCC will soon request applications for the 3 year $100M Connected Care Pilot Program to provide connected care services:
  – to respond to a public health epidemic, or
  – for opioid dependency, high-risk pregnancy/maternal mortality, mental health conditions (e.g., substance abuse, depression, anxiety disorders, schizophrenia, eating disorders, and addictive behavior), or other chronic conditions.

• Focus on improving telehealth access for low-income Americans and veterans
## Eligible Providers

<table>
<thead>
<tr>
<th>Located in rural or non-rural areas and include</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools</td>
<td>Community health centers or health centers providing health care to migrants</td>
</tr>
<tr>
<td>Local health departments or agencies</td>
<td>Community mental health centers</td>
</tr>
<tr>
<td>Not-for-profit hospitals</td>
<td>Rural health clinics</td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>Consortia of health care providers consisting of one or more entities in the first seven categories</td>
</tr>
</tbody>
</table>
Purpose of Funding

• 85% of the cost of eligible services and network equipment, which include:
  (1) patient broadband internet access services,
  (2) health care provider broadband data connections,
  (3) other connected care information services, and
  (4) certain network equipment (e.g., equipment necessary to make a supported broadband service function such as routers).
Background/Resources

- Complete the FCC Form 460 found at: [https://www.usac.org/rural-health-care/resources/forms/](https://www.usac.org/rural-health-care/resources/forms/)


- Search for:
  - [the six-page document](https://www.usac.org/rural-health-care/resources/forms/) does lay out the ground rules for who’s eligible and how to apply for three-year grants for pilot projects.
Clinical workflows/ business processes in accessing the PMP
Project Goals

**Exand PMP integration statewide**
- Enroll **60-80 small/medium practices** and provide technical assistance
- Evaluate **practice facilitation** for integration process
- Evaluate **sustainability** of PMP integration

**Explore the value of the PMP**
- Examine PMP integration at the **dispenser level**
- Assess utility of PMP integration and data to communities

**Incorporate lessons from other state PMP systems**
- Comparator **evaluation** of 6-7 state PMPs to generate recommendations
1. PMP Integration and Practice Level Evaluation
PMP Integration Process

1. Practice elects to implement using a DOH approved Integration Partner (Logicoy or DrFirst)

2. Practice elects to implement a One-Click, No-Click or plug-in solution

3. Practice elects to not integrate

EHR connects to PMP directly to the HIE (only large HCOs using Epic & Cerner)

To integrate:
- Establish proxy ID (CMO or Facility)
- Compile all provider ID info
- Complete required configuration templates
- Submit ticket to Logicoy and/or DrFirst
- Submit ticket to EHR vendor (if needed)
- Complete IT integration/configuration work
- Obtain WA HIE OHP ID*
- Complete connection

*To obtain WA HIE OHP ID:
- Log into OHP to submit ticket
- OHP returns contracting info
- Contracting completed and signed at practice
- Log into OHP to submit signed contract
- OHP reviews contract
- OHP reroutes contract back to clinic for signature

PMP access through the SAW

WA DOH PMP
Pilot Program

- Pilot intervention between DOH, UW, Comagine
- 24 practices with 17 different EHRs
- 7 practices fully integrated
- Identify challenges and generate lessons learned for this expansion
Getting integrated with Comagine

- Developing a customized plan based on practice
- Acting as a trusted advisor
- Providing “plain language” interpretation of legislation
- Acting as a liaison between practices, EHRs, HIE, and 3rd party integrators
- Providing project management support
- Working with IT personnel, leadership, and prescribers at each practice
Practice Enrollment

- Primary care: 41%
- Specialty: 29%
- Behavioral health/SUD: 15%
- FQHC: 5%
- Tribal/IHS: 4%
- Long-term care: 1%
- Community access hospitals: 1%
- Rural health: 4%

90 practices
890 prescribers
35 EHR systems
Practice Integration Results

Integration outcomes
- 28 practices integrated by project end (8/20/20)
- 387 prescribers with access
- 42 practices on track to be integrated

Barriers to integration
- 12/16 dropout practices cited cost as main barrier
- Other barriers:
  - Lack of cross-border access
  - COVID-19 impact
  - Vendor delays

New PMP challenges
- Integrator issues
- DOH “proxy” ID
- Non-provider PMP access
- Athena Health-specific issues
Evaluation Process

Enrollment
- Comagine enrolls practice into project

Baseline Survey
- UW team conducts baseline survey

TA
- Practice receives technical assistance from CM

KII
- Practice completes key informant interview (optional)

Post-Survey
- Practice completes post-implementation survey
Coaching and Integration

Survey Participation
- Overall 83% survey response rate
- 89 respondents in either baseline or post

KII Participation
- 14 interviews with 11 practices

Baseline Prescribing/PMP Use
- Majority of respondents prescribe opioids every day/week
- Majority reported checking PMP every day/week
- Many perceived benefits of PMP integration

Coaching Support
- >70% reported being very satisfied/satisfied with coaching
- Most helpful with vendor communication, keeping organization focused on project
## PMP Adoption and Utilization

<table>
<thead>
<tr>
<th></th>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PMP Adoption</strong></td>
<td>Coaching</td>
<td>Cost</td>
</tr>
<tr>
<td></td>
<td>Ability to see proof of prescriber use</td>
<td>EHR vendors</td>
</tr>
<tr>
<td></td>
<td>Align with state regulatory requirements</td>
<td>Slow process</td>
</tr>
<tr>
<td><strong>PMP Utilization</strong></td>
<td>Integration with EHR</td>
<td>Regulatory burden/risks</td>
</tr>
<tr>
<td></td>
<td>Increased work efficiency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>State reports of patterns of misuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ability to generate multi-patient reports</td>
<td>Lack of integration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>State's regulatory burden</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Missing data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Problems with care coordination</td>
</tr>
</tbody>
</table>
Lessons Learned

- **Coaching** can effectively support policy implementation

- Current integration process is burdensome
  - Cost is #1 barrier
  - EHR vendors difficult to work with

- Future policy work
  - Integration process needs to be *streamlined*
  - Address lack of confidence in PMP data
  - Mitigating costs
  - Increased awareness and education
2. PMP Integration on the Dispenser Level
Interview Findings

Most PMS integrate through Appriss and/or Logicoy

Biggest barriers to increased utilization: cost of queries, lack of standards

Legislative requirement to query PMP increases utilization

Interoperability between states is beneficial

Lack of marketing and communication between pharmacies, state, and developers

Working with individual state HIE would be very cumbersome
3.

PMP Integration on the Community Level
How can we make PMP data useful for community stakeholders?

- Incorporate PMP data into hospital health improvement efforts
- **Alternate views of data** for prescriber peer comparison
- Increased **dashboard usability** (timeliness, granularity)
- Training and **outreach** on PMP resources/dashboards
- Including **Opioid Treatment Program data**
- Include **diverse stakeholder** perspectives in conversations about PMP
4. PMP Integration Sustainability
Outcomes

- Adoption, utilization, integration perceived as straightforward
- High satisfaction/confidence in data
- Practices view PMP as helpful clinical tool

Some issues include
- Data delays
- Lack of communication surrounding system upgrades
- Inaccurate MME calculations
5. PMP Integration on the State Level
Considerations for WA State

▷ Consider **collaboration with other states** for evaluation
▷ Explore methods of implementing automatic **border state searches**
▷ Explore uses of PMP data beyond prescriber/dispenser system use
▷ **Add value** for clinical and pharmacy users
▷ WA HIE is **unique** from other HIE-centric PMP states
Thanks!

Questions?
Accessing and integrating PMP information using FHIR
• Brief reminder of project motivation/goals
• Project journey this quarter
  • EA feedback and iterative development
  • FHIR conference & dissemination
• COSRI App improvements
• Implementation plans (& sustainability)
  • Free-standing version – 2 underserved clinics willing
  • Epic version – Prov Epic site pilots(?)
• Impact/Lessons Learned
  • COSRI potential impact for WA clinicians/DOH
  • Re-use of FHIR interfaces, Smart on FHIR apps
  • 21st Century Cures Act
• Feedback/Discussion
• WA State Opioid Response Plan: **To use data to detect opioid misuse.**

• WA State PMP database houses **statewide dispensing records** for Schedule II, III, IV and V drugs.

• 2019 UW survey of providers found low adoption of PMP data use due to **cost and integration barriers**. (Baseman, UW SPH)

• 2019 WA State Legislature Report calls for **enhanced decision support.**
Why Needed: Guidelines and Rules

**CDC GUIDELINES**

*Focus on chronic pain patients*

1. Opioids are not first-line therapy
2. Establish goals for pain and function
3. Discuss risks and benefits
4. Use immediate-release opioids when starting
5. Use the lowest effective dose
6. Prescribe short durations for acute pain
7. Evaluate benefits and harms frequently
8. Use strategies to mitigate risk
9. Review PDMP data
10. Use urine drug testing
11. Avoid concurrent opioid and benzodiazepine prescribing
12. Offer treatment for opioid use disorder

**WA REGULATION & RULES**

*More nuanced with complexities and slight variations –*

- Focus on **phases of pain**, not just chronic
- Focus on ambulatory care is the same, but with a slightly different **patient exclusion criteria**
- **Co-prescribing rules** in WA include more than just benzodiazepines – also barbiturates, Soma, and other sedative-hypnotics (CDC #11)
- PMP Access requires more **specific steps and documentation** in WA (CDC #9)
- For chronic pain patients, WA rules allow a **higher MED** than the CDC guidelines (120 vs. 90)
- Required **screening for prior overdoses**, which comes from the EHR data

*WA House Bill 1427 (2017), WA Senate Bill 5380 (2019)*
Overarching funding to improve PMP usage comes from the CMS Support ACT through the Washington Healthcare Authority.

As part of that WHA project, Washington State Department of Health (DOH) has partnered with UW CIRG to ease access and improve health impact of the information in the PMP.

Integrated application for accessing PMP.

Provides decision support based on WA rules and CDC guidelines, and decreases overhead and cost barriers associated with vendor-based EHR-integrated applications.

Open source, freely distributable. COSRI extends and contextualizes software from CDSSConnect project, led by AHRQ

Why us...? Interesting & complex problem (technical, content, organizational), support public health, university mission
### Goals for one-year project (FY 2020)

<table>
<thead>
<tr>
<th><strong>CAPACITY DEVELOPMENT</strong></th>
<th>Support FHIR technical capacity in FHIR in government, academic and private stakeholders</th>
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</thead>
<tbody>
<tr>
<td><strong>SOFTWARE FOR PMP ACCESS</strong></td>
<td>Standards-based interoperable software to improve access to and utility of WA PMP (COSRI, using FHIR)</td>
</tr>
<tr>
<td><strong>LOOK NATIONALLY</strong></td>
<td>Disseminate and evaluate strategies in context of national initiatives and standards activities</td>
</tr>
<tr>
<td><strong>ACT LOCALLY</strong></td>
<td>Evaluate software tools and implementation strategies within WA State context/disseminate</td>
</tr>
<tr>
<td><strong>DASHBOARD</strong></td>
<td>Develop approaches to support WA Opioid Dashboard work in conjunction w/ DOH staff</td>
</tr>
</tbody>
</table>
Q4 HIGHLIGHTS FOR DISSEMINATION, EARLY ADOPTERS, CAPACITY, FUTURE

2019
Provider Survey

HIMSS (MAR)
Prototype with Epic Integration

NACCHO (JUL)
Public Health Free-standing demo

MAY - AUG
Early Adopters
Engaging early adopters to help us identify priorities for the first release

Implementers
Developing plans

AUG - SEPT
Initial EA Release
Software release supporting EA clinical workflows. Feature mods. Security approval. Epic app store/testing

UW FHIR Conference
HL7 Connectathon

AUG - SEPT

FUTURE

EA Implementation
Iterative prioritized improvements identified by early adopters. MVP

Dissemination
WSPHA presentations (incl. dashboard), further work w/ sites, and OHP

Busy 4th quarter…
2020 UW FHIR® Conference

University of Washington, Seattle
*Hosted remotely via Zoom*

September 11 - 12, 2020

Conference and FHIR Workshops
Getting FHIREUp: Welcome and Opening Remarks

CDS Connect - AHRQ Pain Management Summary
Chris Moesel MITRE

Clinical Opioids Summary with Rx Integration (COSRI) Objectives
Bill Lober University of Washington

ONC and EHR Interoperability with eCR and COVID Reporting
Emily Linn University of Washington

StayHome.app - a patient-centered, FHIR-native, COVID-19 app
Hannah Burkhardt University of Washington

Bryn Rhodes Database Consulting Group
Jan Flowers University of Washington

Barriers to Adoption
Laura Marcial RTI
## 2020-09 Public Health Track

Created by Sarah Gaunt, last modified by Cynthia Bush on Sep 13, 2020

### Table of Contents

- Submitting Work Group
- Communication Channels
- Justification and Objectives
- FHIR Versions
- Clinical input requested
- Related tracks
- Public Health Track Leads
- Expected participants
- Scenarios
- Report Out
  - Electronic Case Reporting
    - eCR Now FHIR App
    - eCR electronic Reporting and Surveillance Distribution (eRSD)
    - MedMorph / eCR
  - Birth & Fetal Death Reporting (BFDR)
  - Birth Defects Reporting (BDR)
  - Death Reporting (VRDR)
  - Integrating Cancer Reporting
  - Opioids CDS - Clinical Opioid Summary App with Rx Integration (COSRI)
  - COVID-19 Medication Reporting
**PH – Opioids – Summary**

- **Goal:** Test w/ EHR in HL7 Connectathon context
  - IHE x 10 years, this app for HIMSS, NACCHO. Testing technical blocker; we have two highly motivated WA sites. Always want to learn from others.
- **Participants –** U of Washington, WA State DOH, and Epic, plus Tech Asst
- **Achievements from Connectathon**
  - Fixed SoF app launch, issues will translate to production deployments
  - More learning about R4 variation, Epic and other implementations
  - Developed fix configurable in React app using our containerized SoF hosting (hard)
- **Next Steps to supporting our early adopters, and standalone SoF launch**
  - Phase 1 testing completed. Functional testing pushed to Phase 2
Test Jackson, M, 51

Mr. Jackson is a general contractor who has serious chronic back pain from a work-related injury years ago. He also experiences intense anxiety at times. His primary health goal is to keep his pain and anxiety under control so that he can continue to work. He has tried physical therapy and other treatments, but continues to come to the clinic for pain control.

WA State rules require providers review PMP data when prescribing
This guidance is **not intended** to apply to patients undergoing end-of-life care (hospice or palliative), inpatient treatment, or active cancer treatment. However, some suggestions may be helpful in managing any patient.
<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Quantity</th>
<th>Written Date</th>
<th>Dispensed</th>
<th>Prescriber</th>
<th>Pharmacy</th>
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<td>TEST DOCTOR</td>
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<td>ZOLPIDEM TARTRATE 10 MG TABLET</td>
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<td>2018-Sep-20</td>
<td>TEST PRESCRIBER</td>
<td>TEST DOCTOR</td>
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<td>ZOLPIDEM TARTRATE 10 MG TABLET</td>
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<td>2019-Apr-25</td>
<td>HID PRESCRIBER</td>
<td>TEST DOCTOR</td>
</tr>
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</table>
### EHR Opioid and Related Medications

#### Opioid Medications

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Quantity</th>
<th>Written Date</th>
<th>Dispensed</th>
<th>Prescriber</th>
<th>Pharmacy</th>
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<td>Methadone Hydrochloride 10 MG Oral Tablet</td>
<td></td>
<td>2019-Nov-01</td>
<td>2019-Nov-14</td>
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<td></td>
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</tbody>
</table>

#### Non-Opioid Medications

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Quantity</th>
<th>Written Date</th>
<th>Dispensed</th>
<th>Prescriber</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carisoprodol 250 MG Oral Tablet</td>
<td></td>
<td>2019-Dec-01</td>
<td>2019-Dec-30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Stool Softeners and Laxatives

- Absence of stool softeners/laxatives with presence of at least one opioid medication.
- CDC guideline #3: To prevent constipation associated with opioid use, advise patients to increase hydration and fiber intake and to maintain or increase physical activity. Stool softeners or laxatives might be needed.

The query was last executed at May 20th, 2020, 10:22:59 am.
Patient Education Materials

Resources

- Chronic Pain Patient
- Surgical Pain Patient
- Acute Pain Patient
- Sub-Acute Patient
- Naloxone Patient/Public

Clarification of Opioid Prescribing Rules

Visit the rest of the DOH toolkit

CDC guidelines in accordance with Washington State guideline
Washington State guideline exclusively

Please see the CDC Guideline for Prescribing Opioids for Chronic Pain for additional information and prescribing guidance.

COSRI incorporates the Clinical Pain Management Summary application, released as open-source software by CDS Connect project at the Agency for Healthcare Research and Quality (AHRQ). We have extended AHRQ's work to provide enhanced security, improved decision support, integration with state Prescription Drug Monitoring Program databases, standalone operation, and other features. For a description of our open source release, contact info@cosri.app. Support for the development of COSRI was provided by the Washington State Department of Health and the Washington State Health Care Authority through the CMS Support Act.

Development Tools [show/hide]
These development tools are for troubleshooting issues and intended to be used by technical support.
• Implementation plans
  • Free-standing version – 2 underserved clinics eager, all set w/ HIE
  • Epic version – Prov Epic site pilots(?)
• Sustainability
  • Grant funded research to support implementations (pilot data)
  • License to a vendor needing Decision Support product
  • Value add to HIE clinical data repository, as it develops
• Impact/Lessons Learned
  • COSRI potential for WA clinicians/DOH
  • WA Dissemination – WSPHA and OHP
  • Re-use of FHIR interfaces, Smart on FHIR apps for CDR use, Birth Defects Reporting, other PH applications
  • 21st Century Cures Act opportunities and challenges
• Feedback/Discussion
Questions?
Comments?

lober@uw.edu
jenrlee@uw.edu
https://project.cosri.app
Consent Management
Navigating Patient Consent

• HCA led a substance use (SUD) work group last year
  – Published guidance for interpreting 42 CFR Part 2: *Sharing Substance Use Disorder in Washington State*

• Project Phases
  – Phase 1: requirements, WPC sessions, IT Investment Plan
  – Phase 2: request for information (RFI), benchmarking, Part 2 legal and impact analysis
  – Phase 3: request for proposal (RFP), procurement, and initial deployment
SUD Provider Sessions
(with Comagine Health)

• Requirements
  – Six (6) Zoom sessions with SUD provider cohorts
  – Residential, IOP, OP, FQHC, methadone clinic, detox, jail, EMS
  – Decision: deploy baseline solution with modular buildout

• Care Coordination Toolkit
  – Twelve (12) Zoom sessions with SUD providers
  – Looked at data exchanges, barriers, available resources
  – Follow-up: develop care coordination toolkit and webinars
CDR Updates
Clinical Data Repository (CDR) update

1. Working toward onboarding Athena EHR
   – Adapting longitudinal CCD data
2. Working with OHP to develop use cases for DUC approval
   – DUC recently approve HEDIS for MCOs
3. Early stages of developing APCD-like enclave environment for CDR data
   – Mindful of upcoming interoperability rule
4. Pursuing governance modifications for expanding participants, sponsors, and submitters
   – Trust framework agreement, etc.
2020 Behavioral Health Provider Survey
2020 Behavioral Health Provider Survey
Preview of HIT/HIE Findings

Survey profile

- **Target population:** DoH-certified, community-based mental health (MH) and substance use disorder (SUD) treatment agencies providing publicly funded services in Washington state
- **Mode:** secure web (PIN specific), designed and hosted by WSU’s Social and Economic Sciences Research Center (SESRC), with follow-up reminders
- **Link to the survey:** [www.opinion.wsu.edu/ProviderSurvey2020](http://www.opinion.wsu.edu/ProviderSurvey2020), includes copy of survey PDF
- **Questionnaire:** includes 16 main questions on HIT/HIE and 21 questions on EHR functionalities, adopted from SAMHSA and ONC, and meet some expectations of the MH IMD waiver
- **Data collection:** April 17 – August 14, 2020
- **Response rate:** 61.1% (355/581)
2020 Behavioral Health Provider Survey
Preview of HIT/HIE Findings

Preliminary highlights

• 93% of responding BH agencies use an EHR
• Of the 10 EHRs listed in the survey, agencies report using Credible Behavioral Health (20%), Epic (12%), Netsmart, including Avatar/Evolv (11%), Cerner (10%), Qualifacts, including Care Logic (9%); 41% use other EHRs
• 72% use a certified EHR
• 43% report their EHR miss functionalities that would be useful to serve their clients
• Only about a third of agencies report that their EHR allow clients to exchange secure messages with their clinicians, counselors, or other medical staff
• 72% report being very or somewhat satisfied with their EHR
• 93% use telehealth technology
What’s coming up?

• A meeting will be scheduled to provide a more in-depth look at the HIT/HIE findings for BH providers

• Date: TBD
Bi-Monthly HIT Operational Plan Meetings

• 4th Tues. of every other month.

• Next meeting: November 24

• Same webinar, phone number, meeting room. Available at:
  https://attendee.gotowebinar.com/register/6533460124218503425
Questions?

More Information:

Bi-monthly updates will be posted on HCA Transformation website.


Jennie Harvell,
Health IT Section
jennie.harvell@hca.wa.gov