## Joint Commission on Public Health
Data Assessment Break Out Session
January 5th, 2018
2:00 – 4:15 PM
Oklahoma City County Health Department

### Attendees:
Becki Moore (Oklahoma State Department of Health)
Matt Singleton (Office of Management and Enterprise Services)
David Kendrick (University of Oklahoma, MyHealth Access Network)
Monica Rogers (Tulsa Health Department)
Derek Pate (Oklahoma State Department of Health)
Megan Holderness (Oklahoma City County Health Department) via conference call

### ----- Agenda Topics -----

#### 1. Introductions
- The group started the meeting by going around the room introducing themselves and sharing their experience in regards to data and medical records.
- Dr. Kendrick is a physician who has worked in internal medicine and pediatrics. He has a background in engineering as well. He is currently working with MyHealth.
- Mr. Singleton works at OMES and works with data and content.
- Ms. Rogers works for THD and is an advocate for data sharing. She would like to see quality and time data that is evidence based that could be used in her organization to better improve outcomes.
- Ms. Moore currently works for OMES and has a background of mathematics and statistics. She is working with integrating data across all agencies.
- Mr. Pate also works for OSDH. His role is to get clean data to the policy makers and also to figure out how to transform and develop partnerships with sharing.
- Ms. Holderness works as an Epidemiologist at OCCHD. She is currently working with Dr. Kendrick on clinical data.

#### 2. Assets List
- Dr. Kendrick stated that there was a short and long term plan document supplied by Interim Commissioner Doerflinger. The group could go through that but Dr. Kendrick wanted the group to start by doing an asset assessment. He wanted see what assets could be leveraged in public and private sectors and find cost savings.
- The list of data systems was broken down by the following categories: State, County, Private, Federal and Tribal.
- Under State, the following systems were listed: PHOCIS, Public Health Lab, PHIDDO, OSIIS, Vital Statistics, hospital discharge data, public health registries, Healthy Oklahoma, Cyberwarn, PDMP, education system (SLDS, Wave, etc.), BRFSS, Medicaid/OHCA, corrections, behavioral health, HHS, rehab, and juvenile records.
- Under County, the following systems were listed: TASSS, Essence which are both syndromic surveillance and is based on
ER chief complaint visits. These systems are listed under county because State has not invested in TASSS.
- Under Private, the following systems were listed: Homeless information system (which could provide social determinants information), MyHealth, Vendors (EHR, HIE), clinical, claims/admin. This can also include city government although it is unknown what information they utilize.
- Under Federal, the following systems were listed: CMS, IHS, DOD, VA, CDC and census information.
- It was noted that there was not any tribal representation in the commission meeting. We may want to seek them out for their input. It was discussed and it was agreed suggest that the Joint Commission communicate with Tribal Public Health entities of our recommendations.
- Mr. Singleton suggested he will reach out to the Technology Advisory Council and can gather information from them as well.

3. Delivery System
- One problem is there are so many different platforms that many of these agencies use. There needs to be a system in place where information can be delivered and shared. In the past, health exchanges have ebbed and flowed. At one time, there were three different ones. Now there is only MyHealth.
- MyHealth currently has 450 organizations participating. Their data is in real-time with only a few seconds lag. It includes hospitals, clinics, optometrists, state health and pharmacies. It is a non-profit organization. They focus on public side analytics around clinical data. When sharing data, MyHealth releases information without revealing the source data.
- Another issue is that sharing information is not mandated here in Oklahoma. It is not a law requiring them to participate. Ms. Moore had help write the language about creating a decision-making body for statewide interoperability but it is currently not being pursued this year in legislation. New York has made this mandatory and it seems to be working very well. One issue with making it mandatory is figuring out how it should work and which governing group should decide this. Some private organizations could utilize this for their own secondary gain.

4. Issues
- Mr. Singleton asked what the committee is being charged to do by the commission. Are there any questions that the Commission would like this group to be able to answer or address? Dr. Kendrick would like to offer to the commission targets of opportunity and the benefits they will offer. He would like them to decide which they would like us to work on.
- One of the issues is we currently have a data exchange but can’t seem to get data out of the state system in a timely manner. Also, numbers show that half of Oklahoma citizens whether sick or well have multiple records in at least two different systems. We need reliable and consistent data in a timely manner to be able to make decisions.
- There are many pieces of data that we would like to have access to. Currently, it is a challenge getting a history of data on a person in PHOCIS. It is not a true EHR. It is more program centered. It only shows one point in time, not a full and complete medical history on a client. Also, we would like to get diagnosis data and see if there is a spike going on at population level regarding increase/decrease in health. Another area of data
collections would be in areas like WIC to see in what areas the money is being used and what times of the month it is being spent.
- Another issue with different platforms and exchanging data is that there are a variety of data dictionaries that are utilized per agency. We would need to request that from those agencies who will participate.
- There is also an integration gap between public and private sectors. MyHealth is meant to integrate those systems. We also need to work on identity resolution piece across the multiple systems. It comes down to the unique identifiers being used. The education system isn’t allowed to use Social Security numbers. MPI does the same thing based on common demographics across the system.
- Also, multiple systems are conflicting with each other. Which governance model says which system takes precedence?
- There is also syncing issues that OSDH is having with one of their systems. Dr. Kendrick suggested MyHealth assist with that but it will not be a quick fix.

5. Objectives

- Dr. Kendrick would like to be able to bring something to the commission within 60 days. Ms. Rogers and Ms. Holderness can identify what data elements the commission may want to see.
- He would also like this group to determine both long term and short term goals we can accomplish. The ultimate goal is to have data in a timely fashion.

6. Short Term Goals

- PHOCIS – They are working on their API. They are having an issue with identity resolution. This can actually be fixed within 60 days. The system is built and just has this main issue. They are currently having to enter into two different systems until this is fixed. By correcting this, it will save both time and money. This will basically impact OCCHD and OSDH mostly.
- PHIDDO – They are working on the ORU electronic messaging. They had to put it on hold due to funding. However, once they start again, they are weeks away from testing it with a vendor.
- OSIIS – By working on this, it would have a broader impact for everyone in the state. Ms. Moore can’t answer when the MPI will be ready to use. If they have the resources, it can be completed in 6 months.
- Ms. Holderness will ascribe a dollar amount that the fixes to PHOCIS and PHIDDO will save in the long run.

7. Long Term Goals

- Statewide Public Health EHR - One issue is the needs of each organization is different and they may not agree on vendor or what items are more important to have. However, it would be more cost effective if we all used the same system. There currently is no system built just for public health.
- Statewide identity resolution
- Clinical
- Provider directory
- Relationship directory
- Quality measures (BP, BMI by geography, company, demographics, etc.)
- Ms. Moore had suggested that she would love to see a child
health record as a goal. That it would not only include clinical information but also social determinants, social services, behavioral services, etc. to build a registry. It would help in creating policy in regards to WIC, Family Planning, etc.

| 8. Funding sources | The group discussed ways to pay for the long term and short term goals. There is currently 90/10 CMS funds for the implementation of HIE. However, the funds run out at the end of 2021.
- There is also 75/25 that can be utilized for the sustainability of these systems that were built with the above funds. There is no end date for that money. OSDH needs to get their consultant going so they can get a plan together to utilize these funds. |

| 9. Next meeting | The next meeting is scheduled for Friday, January 19th. However, Dr. Kendrick would like to have a conference call next Friday, January 12th. He will contact the committee regarding available times. |