



Health Information Technology (HIT) Workgroup

Wednesday, August 19th 2015 - 9:00 a.m. - Noon
One Davis Square, Conference Room 134

MEETING SUMMARY NOTES

Today's Expected Results

- Review West Virginia's current HIT Landscape, including strengths and constraints
- Discuss and reach consensus on SIM-related HIT infrastructure elements
- Identify next steps, materials and expertise needed for future sessions

Co-Chairs: Jon Cain and Ed Dolly

Recorder: Becky King

Participants: 17 people - 10 in person and 7 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
Welcome, Introductions and Opening Remarks	<p>The second SIM HIT Workgroup meeting opened with welcoming remarks, a review of the agenda and expected results, as well as the mission of the workgroup. Self-introductions followed, along with a review of ground rules and roles of the SIM Project Coordinator, co-chairs and recorder.</p>
Recap of July Workgroup Meeting Results	<p>Joshua Austin, SIM Project Coordinator, shared a PowerPoint presentation with the workgroup highlighting the workgroup summary report process and key themes from the initial SIM workgroup meetings held in July. Key results from all five workgroups were put into a SOAR Chart; one main point from each section was highlighted.</p> <p><u>S</u>trengths: Engaged, well-connected health care stakeholders <u>O</u>pportunities: Adopting a value-based approach to health care payment at the federal level encourages / requires change(s) at the state level <u>A</u>spirations: Movement from a fatalistic attitude to one that places a high priority on health and wellness <u>R</u>esults: Standardize and align health care quality measures among all payors and providers</p> <ul style="list-style-type: none"> • A crosscutting issue raised across workgroups, especially in HIT, was the need to more clearly define the term, “value-based.” This term will be broadly defined as “a payment model where the amount of payment for a service depends in some way on the quality or cost of the service that is delivered.” <i>Source: Center for Healthcare Quality and Payment Reform’s Payment Reform Glossary</i> • Mr. Austin also reviewed the HIT July Workgroup Survey results and noted an extremely strong 62% response rate. There is a high-level of consensus on developing defined data governance: integrity and security of information systems. Low scores were also reviewed, which showed less consensus around 1. Creating a translational hub using a regional approach by utilizing existing hospital systems and 2. Regulatory barriers at the State and Federal levels, which prevent successful deployment of telehealth. • An addendum to the meeting summary notes from July was distributed, which included member feedback through Qualtrics on the eight Workgroup Charter questions. This process was implemented for this meeting because not every small group was able to address each of the Workgroup Charter questions in July.

<p>SWOT Analysis: West Virginia's Current HIT Landscape</p>	<p>Jon Cain, HIT Workgroup Co-Chair, presented a one-page <i>SWOT Analysis of West Virginia's Current HIT Landscape</i> and facilitated large group discussion and identification of additional issues. Workgroup member additions from the meeting discussion are bolded. Produced in chart form in Appendix 1.</p> <p>Strengths</p> <ul style="list-style-type: none"> • Existing technology and a governance structure is in place to leverage data, including WVHIN, the Medicaid Data Warehouse and the hospital system infrastructure • Health Information Technology (HIT) framework is being created to facilitate capture, exchange and utilization of clinical and outcome data to drive health improvement and incentivize value-based payment • Enhanced funding available to continue onboarding other areas of need • Few burdensome state / federal regulations for the successful deployment of telehealth • Technical platform for state health information exchange (i.e., WVHIN) • Significant advancement in the adoption and use of HIT systems enhanced by incentives from the Centers for Medicare and Medicaid Services and technical support from the Office of the National Coordinator for HIT <p>Weaknesses</p> <ul style="list-style-type: none"> • There is lacking interoperability among current HIT infrastructure—a problem that is not unique to West Virginia • A sustainability model or plan is not in place for WVHIN (also a threat) • Provider HIT fatigue, increased costs and lost time with systemic changes and additional requirements (e.g., HIPPA compliance audits and ICD-10 implementation requirements) • Due to business operating rules, data quality is at risk • Data governance structure needs to be reinforced • Limited system and business resources to support adoption and use of HIT, particularly in small and rural practice settings • Rural HIT infrastructure (e.g., lacking broadband and connectivity) • Have yet to develop a shared vision of security / confidential data • Early stages of data integration and use for health transformation under traditional practice / payment models
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- Costs to adopt, implement and upgrade EHR systems and use the health information exchange
- Limitations on reimbursement / payment for telehealth and remote patient care

Opportunities

- **Identify the value and return on investment of HIT to both patients and providers**
- **Progress that has been made with electronic health records provides a foundation to strategically define clinical data needs**
- **Build a lateral, equitable system of data access and sharing across data systems to address population health**
- Ability to create new business process efficiencies across programs by integrating new sources of data
- Reduction in time to deliver reports across enterprise regarding clients, providers, employers, etc.
- Leverage the WVHIN to facilitate HIT support for transitioning to a value- based model
- Telehealth and mobile / remote tools can be extended to provide needed specialty care in underserved areas of the state and to engage patients at home or work
- Make the Medicaid Data Warehouse the de facto All Payer Claims Database

Threats

- **A sustainability model for WVHIN is not in place**
- **A significant number of providers are retiring and leaving the health care system, which impacts both access to care and quality of care**
- Protecting data from security breach
- Behavioral health care information can be shared in an EHR, but it triggers more robust privacy protections
- Legal misunderstandings, ambiguities in what PHI can be shared among primary care and behavioral health providers
- Providers not seeing the benefit or additional value of an HER
- Patients not seeing the benefit or value of a PHR
- EHR mission creep (e.g., adding data that are not germane or that trigger additional regulatory burdens with little return on investment)

<p>Constraints and Weaknesses of West Virginia’s Current HIT Infrastructure</p>	<p>Large group discussion focused on the constraints of the current HIT system, including:</p> <ul style="list-style-type: none"> • Misinformation, inaccurate perceptions and different legal opinions around data sharing • Electronic health records are currently not user friendly, which is a challenge in creating value and being more patient-centered • Financial and provider capacity issues surrounding HIT • Various data warehouses are in silos, using different analytical tools <p>There was discussion and agreement to establish a task team to identify technical assistance resources, guidance and expertise to develop a toolkit for the purposes of establishing data elements that can be shared for a value-based system and to assist in communication outreach. Chris Budig agreed to provide summary notes from his presentation on telehealth governance issues. Task team members include: Jon Cain, Dave Campbell, Joshua Austin, David Partsch, Mike Morris and Rachel Moss.</p>
<p>Designing West Virginia’s HIT Infrastructure for a Value-Based Model</p>	<p>As a first step in addressing the question, “<i>How can we share data reciprocally from provider to payor to facilitate HIT solution(s) for chronic diseases?</i>” members identified a list of current public and private data systems.</p> <p><u>Public Data Systems</u></p> <ul style="list-style-type: none"> • WV Health Information Network (WVHIN) • DHHR Data Warehouse / Decision Support System (DW/DSS) • DHHR Vital Statistics • DHHR Recipient Automated Payment Information Data System (RAPIDS) • DHHR Family and Children Tracking System (FACTS) • DHHR Medicaid Management Information System (MMIS) • DHHR Master Data Management System (MDM) • DHHR Data Registries (i.e. immunization registry, cancer registry) • DHHR WV Statewide Immunization Information System (WVSIIS) • Local Health Departments • DHHR OpenVista • Veterans Administration / Department of Defense / Indian Health Service Vista • WVU-Integrated Data Repository (IDR)

	<ul style="list-style-type: none"> • WV Education Information System (WVEIS) • Board of Pharmacy • WV Health Care Authority (HCA) • WV Offices of the Insurance Commissioner (OIC) • WV Public Employees Insurance Agency (PEIA) • WV Division of Corrections • WV Workers' Compensation (Brickstreet) • Social Security Administration (SSA) • Centers for Medicare and Medicaid Service (CMS) <p><u>Private</u></p> <ul style="list-style-type: none"> • WV Primary Care Association / Federally Qualified Health Centers (FQHC) • WV Behavioral Healthcare Providers Association • WV Hospital Association (WVHA) • WV health insurance payors, such as Highmark BCBS • Lab company services, such as LabCorp
<p>Next Steps, Action Items and Assignments</p>	<ul style="list-style-type: none"> • Identified task team members who will convene and begin work on the data resource toolkit • Mr. Cain will develop a template, which will be sent to HIT Workgroup members for completion, to further develop the data inventory document (<i>who has access to data, for what purposes, how often are updates completed, interface / linkage with WVHIN</i>). Emerging data sources will also be identified. Workgroup members are requested to provide responses by September 2, 2015. • The SIM HIT Workgroup will reconvene on Wednesday, September 16, 1:00 p.m. – 4:00 p.m. at Thomas Memorial Hospital Education Center in South Charleston, West Virginia.
<p>Parking Lot</p>	<p>None</p>

Group Checkout (Verbatim Responses)

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> • Good discussion and identification of various sources of data • Whiteboard brainstorming • Good recap of items and outcomes from last meeting • Great presentation to get everybody on the same page with regard to the fundamentals (e.g. value-based) • Good list of systems / sources available to get data • Nice collaboration of multiple systems within health arena / field • Snacks ☺ • Good conversation with most participating • Worked better than sub-groups • Enjoyed the roundtable discussion—allowed everyone a chance to comment on other’s ideas. 	<ul style="list-style-type: none"> • Need active involvement from more stakeholders across the state in the workgroup • Phone system seemed to be challenging for the remote attendees • Create name cards for table so you can see who you are speaking with—not everyone knows each other • I liked small groups better, but we don’t have to change them with every new question or section • Some people need to speak up • Can we get an update on what any other SIM groups are doing?

Additional Comments

- The concept in this group is to identify IT and tech – what and how do we connect to drive our agenda from other groups?
- I want to reiterate the point of keeping in mind collecting identified and de-identified data. It’s better to build the model to accept the data (behavioral health, etc.) and worry about getting entities to share the data later.

Appendix 1: West Virginia's Current HIT Landscape

Strengths	Weaknesses
<ul style="list-style-type: none"> ○ Existing technology and a governance structure is in place to leverage data, including WVHIN, the Medicaid Data Warehouse and the hospital system infrastructure ○ Health Information Technology (HIT) framework is being created to facilitate capture, exchange and utilization of clinical and outcome data to drive health improvement and incentivize value-based payment ○ Enhanced funding available to continue onboarding other areas of need ○ Few burdensome state / federal regulations for the successful deployment of telehealth ○ Technical platform for state health information exchange (i.e., WVHIN) ○ Significant advancement in the adoption and use of HIT systems enhanced by incentives from the Centers for Medicare and Medicaid Services and technical support from the Office of the National Coordinator for HIT 	<ul style="list-style-type: none"> ○ There is lacking interoperability among current HIT infrastructure—a problem that is not unique to West Virginia ○ A sustainability model or plan is not in place for WVHIN (also a threat) ○ Provider HIT fatigue, increased costs and lost time with systemic changes and additional requirements (e.g., HIPPA compliance audits and ICD-10 implementation requirements) ○ Due to business operating rules, data quality is at risk ○ Data governance structure needs to be reinforced ○ Limited system and business resources to support adoption and use of HIT, particularly in small and rural practice settings ○ Rural HIT infrastructure (e.g., lacking broadband and connectivity) ○ Have yet to develop a shared vision of security / confidential data ○ Early stages of data integration and use for health transformation under traditional practice / payment models ○ Costs to adopt, implement and upgrade EHR systems and use the health information exchange ○ Limitations on reimbursement / payment for telehealth and remote patient care
Opportunities	Threats
<ul style="list-style-type: none"> ○ Identify the value and return on investment of HIT to both patients and providers ○ Progress that has been made with electronic health records provides a foundation to strategically define clinical data needs ○ Build a lateral, equitable system of data access and sharing across data systems to address population health ○ Ability to create new business process efficiencies across programs by integrating new sources of data ○ Reduction in time to deliver reports across enterprise regarding clients, providers, employers, etc. ○ Leverage the WVHIN to facilitate HIT support for transitioning to a value-based model ○ Telehealth and mobile / remote tools can be extended to provide needed specialty care in underserved areas of the state and to engage patients at home or work ○ Make the Medicaid Data Warehouse the de facto All Payer Claims Database 	<ul style="list-style-type: none"> ○ A sustainability model for WVHIN is not in place ○ A significant number of providers are retiring and leaving the health care system, which impacts both access to care and quality of care ○ Protecting data from security breach ○ Behavioral health care information can be shared in an EHR, but it triggers more robust privacy protections ○ Legal misunderstandings, ambiguities in what PHI can be shared among primary care and behavioral health providers ○ Providers not seeing the benefit or additional value of an EHR ○ Patients not seeing the benefit or value of a PHR ○ EHR mission creep (e.g., adding data that are not germane or that trigger additional regulatory burdens with little return on investment)