

State Innovation Model (SIM) HIT Workgroup

Wednesday, July 22nd 2015 - 9:00 a.m. – 12:00 p.m.
Marshall University Graduate College – South Charleston Campus – Room 116

MEETING SUMMARY NOTES

Today's Expected Results:

- Develop a clear understanding of the SIM project and workgroup member's role in developing the WV State Health System Innovation Plan (SHSIP)
- Strengthen working relationships among workgroup members
- Review and apply baseline documents ("Workgroup Charter," "Mutual Understandings and Assumptions" and "Baseline Trend Assumptions")
- Begin to address "Workgroup Charter" topics and key questions
- Select preliminary strategies around the focus areas of obesity, tobacco and behavioral health based on selected criteria
- Identify additional workgroup members, next steps and materials and expertise needed for future sessions

Co-Chairs: Jon Cain and Ed Dolly

Facilitator: Becky King

Participants: 21 people – 15 in person and 6 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
<p>Welcome, Introductions and Opening Remarks</p>	<p>The session opened with a welcome and opening remarks indicating that this is the first meeting to launch SIM workgroups, building on work that has been done through the WV Health Innovation Collaborative. Roles of the facilitator, co-chairs and workgroup members were reviewed. Joshua Austin, SIM grant project coordinator, was recognized for his role as liaison among the workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members. A sign in sheet was distributed for any needed revisions.</p> <p>Workgroup members recorded on index cards their response to the following question: “If you had a Magic Wand and could change <u>one thing</u> that would significantly improve or transform ‘<u>your piece</u>’ of the health care system in West Virginia, what would that be?” Workgroup members were asked to identify what “their piece” of the health care system is and the one thing they would change. Workgroup members then found someone in the room that they did not know or did not know well and shared who they are, what entity they represent and their response to the Magic Wand question.</p> <p>Verbatim responses recorded on the index cards follow:</p> <ul style="list-style-type: none"> • Transition from a “your piece” mentality to a universal solution / architecture • Standardized data elements, file layout & interface • Common data elements, standardization • Access to quality, affordable health care • Electronic health records for all citizens of the state • Homogeneity • Use of data sharing across the health care system • Facilitate secure transfer of HIT data between providers and government; also garner trust that data will be used appropriately • Use HIT to make health care “efficient” • More liberal purchasing process

	<ul style="list-style-type: none"> • Increase funding for small, private physicians who do not have the funding to make all of the changes happen; less talk – more action; make changes to the health care system slower and get more buy-in from the ones that it affects • Change payment model to incentivize quality of care and outcomes • Integrated, coordinated data sharing • Truly ensure the security of patient / member data
<p>Setting the Context for Our Work: SIM Overview</p>	<p>A PowerPoint presentation was shared with workgroup members to set the context for their work. “Workgroup Charters” and “Mutual Understandings and Assumptions” documents were briefly reviewed with participants.</p> <ul style="list-style-type: none"> • As part of the review and discussion of the “Mutual Understandings and Assumptions” document, several questions were raised regarding challenges that must be addressed, including the number of physicians who do not have high speed Internet or no connectivity; the need for more public education about health information technology; informed consent and how data is being used and regulatory policies around data sharing. Members suggested the workgroup do a SWOT analysis and prioritize what can be improved upon and what cannot be addressed because of the constraints imposed by CMS and/or existing state / federal law. It was also noted that technical assistance may be requested from CMS and from the Advisory Board Company to help in this process. • In response to a question regarding CMS’s preference of aligning certificate of need processes and criteria to reinforce accountable care and delivery system transformation, it was noted that the Project Management Team is working with the WV Health Care Authority on this topic.
<p>Review of Baseline Trend Assumptions: Small Group Discussion</p>	<p>In small groups, workgroup members discussed the “Baseline Trend Assumptions” document and recorded their responses to three (3) questions related to the document on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.</p> <p>The questions and verbatim responses follow:</p>

Is anything missing?

- Coordination of programs
- Eating habits / baseline
- More patient engagement and education
- Where and how is HIT going to help
- Focus on alternative and non-traditional providers
- Recognizing that policy issues are significant and need to be addressed – when regulatory, legal or policy barriers are mentioned, they should be accompanied by the explicit understanding that we need to address those issues rather than saying it is a problem that people may not be aware of

What do you see as the top three (3) strengths to transforming our current health care system?

- West Virginia is a relatively small state in terms of population and size, making it easier to effectuate change in the health care system
- West Virginia has the biggest opportunity to improve its population health due to its poor rankings and position compared to other states
- The health problems / challenges facing the state are widely documented and understood
- The West Virginia Health Information Network exists to collect medical / health data
- West Virginia is undertaking multiple collaborative efforts to improve its health care system, including but not limited to the WV Health Innovation Collaborative and the SIM grant itself

What do you see as the top three (3) challenges to transforming our current health care system?

- West Virginia's rural geography makes it a challenge to deploy adequate HIT due to lacking technical infrastructure
- Poverty has created a difficult barrier to change West Virginia's health care system
- West Virginia has a culture that does not place a high priority on public health, healthy living and wellness

	<ul style="list-style-type: none"> • Regulatory obstacles exist to sharing health data (i.e., minimum necessary use) • West Virginia has done a poor job educating patients about how their medical information will / could be used and/or stored (i.e., informed consent) • West Virginia collects health data in a piecemeal, hodgepodge manner • West Virginia lags behind other states in broadband connectivity • West Virginia’s HIT infrastructure has significant interoperability issues
<p>Workgroup Charter Key Questions: Small Group Discussion</p>	<p>In small groups, workgroup members discussed “Workgroup Charter” Key Questions and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.</p> <p>The answers provided below are grouped into themes based on the small group discussion / output:</p> <ol style="list-style-type: none"> 1. What data is needed to effectuate a value-based delivery and payment model; how will it be gathered, validated and shared to meet the health improvement objectives? <ul style="list-style-type: none"> • Define value-based data: what does it mean and to whom (payors, physicians, etc.); medical chart; external / environmental causes and social determinants (income, education) <ul style="list-style-type: none"> ○ Gathered: by providers ○ Validated: unknown ○ Shared: collaboration 2. How can data sharing be most effectively supported while maintaining patient confidentiality, data integrity and security of information systems? <ul style="list-style-type: none"> • Have a shared vision of security and confidential data • Tools, certifications, master data management and change management system • Further discuss opt in versus opt out for data sharing • Defined data governance <ul style="list-style-type: none"> ○ Segregation of data elements ○ Integrity and standardization of data

	<ul style="list-style-type: none"> ○ Filtering of sensitive patient health information <ol style="list-style-type: none"> 3. How can interoperability of systems be achieved while accommodating disparate use of non-standardized EHRs, PHRs and mobile technology? <ul style="list-style-type: none"> • Create a translational hub that could be regional, perhaps based at major hospital systems 4. How can payors and providers align to assure HIT is effectively integrated into clinical practice to support health improvement objectives? <ul style="list-style-type: none"> • Enforce quality improvement measures to require improvement of reporting by providers and also ensure this information is translated to other practices to improve health care 5. How can patient portals and personal health record platforms integrate to encourage and improve care coordination and health management between patients and providers? <ul style="list-style-type: none"> • Cannot answer this question since there are so many EHRs and various systems and providers not included in the data network 6. How can use of telehealth and remote devices reduce fragmentation of health care, improve access to care and enhance outcomes? <ul style="list-style-type: none"> • It can reduce fragmentation of the health care system, but regulatory barriers at the state / federal levels, especially those regarding professional licensure boards, need to be addressed first • Telehealth can extend needed specialty care, medical education and behavioral health care workforce to areas of need in the state • Telehealth can cut down on unnecessary emergency room use; it can also work as a cost savings to Medicaid by reducing expensive travel reimbursement
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	<p>7. How can data sources be aligned and integrated (through common claims and clinical data warehouse and analytics engines and platforms) to assure data integrity and the use of actionable data by patients, providers and payors to meet the improvement objectives?</p> <p><i>Please note this question was not addressed in small groups and will be part of a post-workgroup meeting survey, which will be sent to all HIT workgroup members.</i></p> <p>8. What are the prioritized recommendations of this workgroup to better use HIT and data to support the population health improvement objectives?</p> <ul style="list-style-type: none"> • A personal health record that contains all of a patient’s health information from disparate sources, plus the ability to add personal activity information • Address the infrastructure needs of rural communities • Develop a way for patients to store and receive health information that is frequently requested
<p>Potential Strategies Around Areas of Focus: Small Group Discussion</p>	<p>In small groups, workgroup members discussed and identified potential key strategies for each of the three (3) State Health Improvement Plan areas of focus (1) obesity, (2) tobacco use and (3) behavioral health and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.</p> <p>The answers provided below are grouped into themes based on the small group discussion / output:</p> <p>Obesity</p> <ul style="list-style-type: none"> • Implementation of intuitive tools in the EHR / EMR to track obesity • Data classification system to define elements with regard to sensitive PHI such as obesity • Increase patient education to improve perception of the problem in the community • Deploy a provider-based strategy that allows greater access to cost-effective EHRs / EMRs

	<p>Tobacco Use</p> <ul style="list-style-type: none"> • In the EHR / EMR, identify a means to share self-identification as a tobacco user to trigger care-coordinated education / services accorded by severity of use <p>Behavioral Health</p> <ul style="list-style-type: none"> • Integration of behavioral health with primary care (Ex. holistic care; the mind and body are one) • Connect rural providers / locations via telehealth services (i.e., telepsychiatry) • Deploy effective patient education programs <ul style="list-style-type: none"> ○ Learning management system ○ YouTube Channel • Use telehealth and HIT to share information, develop intensive behavioral therapy and virtual networking to support the rural primary care provider; utilize virtual health coaches • During small group reports, it was emphasized that privacy regulations often forbid primary care physicians—who are frequently the only providers in a community—from integrating or coordinating care relating to behavioral health
Public Comments	None
Next Steps, Action Items and Assignments	<ul style="list-style-type: none"> • Conduct a follow-up survey to obtain feedback from HIT Workgroup members on each of the eight (8) charter topic questions because not every small group was able to address each question and question 7 was not addressed by any small group • Develop an initial SWOT analysis based on feedback from key focus questions raised during the meeting • The next HIT Workgroup meeting will be held on Wednesday, August 19th from 9 a.m. until 12 p.m. at One Davis Square in Conference Room 134.
Parking Lot	<p>Items / questions identified at the workgroup session that need further attention are:</p> <ul style="list-style-type: none"> • Conduct a SWOT analysis of the current HIT environment

Suggested Ideas for Additional Workgroup Members:

- Long-term care representatives
- Representatives from Behavioral Health
- Pharmacies
- Primary Care Association
- Primary care physicians