



HIT Workgroup

Wednesday, September 16th 2015 – 1:00 p.m. – 4:00 pm
Thomas Memorial Hospital Education Center – South Charleston, West Virginia

MEETING SUMMARY NOTES

Today's Expect Results:

- Recap the August HIT Workgroup meeting and outcomes from other SIM Workgroups
- Identify vision concepts and long-term directions for HIT
- Review and provide feedback on the 1.0 data flow and communications diagram, and identify gaps and next steps
- Review measures from the Better Health Care Workgroup and Highmark Blue Cross Blue Shield Quality Measures and reach agreement on initial 1.0 targets
- Strengthen working relationships among workgroup members

Co-Chairs: Jon Cain and Ed Dolly

Recorder: Becky King

Participants: 8 people – 8 in person; technical difficulties prevented electronic participation

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
Welcome, Introductions and Opening Remarks	The third SIM HIT Workgroup meeting opened with welcoming remarks. Joshua Austin, SIM Project Coordinator, was recognized for his role as liaison between all workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members.
Recap of Workgroup Meeting Results To Date	<p>Mr. Austin provided a PowerPoint presentation summarizing the results of all SIM workgroups to date. Five key themes for the SIM model design have emerged. These are as follows:</p> <ol style="list-style-type: none"> 1. Must include care coordination / coordinators 2. Must be an integration of behavioral health and physical health 3. Must be alignment of provider and payor quality measures 4. Must include telehealth / telemedicine 5. HIT must be a backbone, aid to this model design and its deployment <p>There was large group discussion regarding the HIT SWOT Analysis. A recommendation was made to explore data regarding provider and patient perceptions concerning the value of EHRs. Several workgroup members will further research this issue, and then send any changes or revisions to the HIT SWOT Analysis to Mr. Austin. Other issues were raised about the target population of the SIM plan, the intersection of care coordination and managed care and the difficulty of integrating telehealth due to barriers, such as scope of practice and statutory and payment challenges. These issues will be further explored as part of the SIM planning process moving forward.</p> <p>As a follow-up to the last HIT Workgroup meeting, it was also noted the behavioral health data exchange toolkit task team did not meet. Additionally, the response to the data inventory template request was extremely low.</p>
Setting the Stage for Today: A Vision of Our HIT Roadmap	<p>Co-Chair Ed Dolly presented the following SIM HIT vision concepts, as well as a focus question, for consideration and large group discussion. The <i>Guiding Principles for Nationwide Interoperability</i> was included in participant packets as a reference document.</p> <p><i>Five years from now, what system do we need in place to collect, utilize, validate and exchange data to transform and support our coordinated care model?</i></p>

Vision concepts

- The HIT system is not a single system but a “system of systems”
- West Virginia will leverage, maximize and build upon existing HIT systems
 - Conduct an inventory of what is currently being collected across systems
 - Identify common data that is being gathered and shared
 - Use existing data
- Flexibility will be important in advancing interoperability
- Focus on being standards-based
- Protect privacy and security
- Coordinate and communicate patient health records (dependent on outreach and support)

Key points from large group discussion are highlighted as follows:

- Quality assurance needs to be comprehensive to be accurate – a component module to access quality is needed
- Statute was created, but was not mandated, for an all payers claim base, which is a constraint
- A clearer understanding of the constraints of the current system is needed, in addition to current limitations. We currently have an incomplete picture of what we need for a health model transition – there is little clinical data / cost data and the data flow is incomplete
- Data is “siloes” because we are dealing with the original design
- A strong governance structure will need to be defined
- Focusing on outcomes will be important
- A strategic goal of HIT is to access service standardization / utilization, which is outside the realm of SIM
- The goal of SIM is to manage patients’ health over a continuum and improve the health of patients – one patient at a time
- Current data systems are being used for different functions and it will be a challenge to align functionality

	<p><u>Questions raised as part of discussion included:</u></p> <ul style="list-style-type: none"> • How do we merge the various “buckets” of data: clinical, payment and outcomes data? • What data are we collecting in a meaningful way? How do we analyze the data in a meaningful way? What are the gaps? What tools do we need? • Who manages the “system of systems”? Is it the data owners? HIT Collaborative? Who has legal authority? <p><u>Initial steps for consideration were explored, and it was noted that these would not be achievable within the SIM planning timeframe:</u></p> <ul style="list-style-type: none"> • Identify and complete an inventory of data elements currently being collected • Set data transaction standards • Establish agreements about how data will be shared • Support different levels of maturity
<p><i>1.0 Data Flow and Communications Diagram</i></p>	<p>There was workgroup agreement that review and feedback on the <i>1.0 Data Flow and Communications Diagram</i> was premature and will be sent to members for review and feedback prior the next HIT Workgroup meeting.</p>
<p>Large Group Discussion and Agreement: Initial 1.0 Targets</p>	<p>Participants reviewed and discussed two documents regarding initial targets: (1) 26 quality measures that Highmark Blue Cross Blue Shield is using for their <i>Quality Blue P4V Initiative</i> and (2) Better Health Workgroup goals and measures for obesity and related chronic diseases. Regarding Highmark’s measures, discussion focused on the need to find commonality among other payor measures and to align quality measures among payors and providers. A few related questions were raised, including: how many of the measures are “meaningful use” measures? Is there a subset to be collected?</p> <p><u>Feedback on Better Value Goals and Measures:</u></p> <ul style="list-style-type: none"> • The following measures on diabetes may be collected at the practice level but would most likely be reported in different ways:

- Increase proportion of people with diabetes in targeted settings who have at least one encounter at a Diabetes Self-Management Program
 - Increase awareness and identification of pre-diabetes
 - Increase awareness and identification of diabetes
 - Increase referrals to self-management programs (ex. Diabetes Self-Management Program)
- From a data collection perspective, there was agreement that these four measures are process measures / educational measures, and it would be the role of care coordinators to collect this information.
 - A key issue for consideration is claims versus grant-based reporting, which is usually aggregated data. Grantor restrictions on data sharing would need to be addressed.
 - Regarding the fifth measure: decrease the proportion of persons with diabetes with A1c greater than 9, it was noted procedures are not currently in place to self-report. A baseline could be established to collect and measure change in this area over time. FQHCs are reporting this type of information to the U.S. Health Resources and Services Administration; the West Virginia Primary Care Association's data repository may also be collecting these data.
 - The following six measures for hypertension were also viewed as process measures and would be subject to the same data limitations as the diabetes measures:
 - Increase awareness and identification of high blood pressure
 - Increase proportion of patients w/ HBP who have a self-management plan
 - Increase proportion of adults w/ HBP who have achieved control
 - Increase the proportion of patients w/ HBP in adherence to medication regimens
 - Increase the proportion of health care systems with EHRs to treat patients w/ HBP
 - Increase the number of patients who have been advised by their health care provider to reduce sodium consumption

	<ul style="list-style-type: none"> • Create a centralized chronic disease registry: A unified chronic disease registry from existing data could be presented through claims by providers and hospitals concerning the same patient. “Chronic disease” would need to be defined and other registries would need to be reviewed to identify gaps.
Final Comments, Next Steps, Action Items, Assignments and Check Out	<ul style="list-style-type: none"> • HIT workgroup members will be requested to review and provide final feedback on the HIT SWOT Analysis. • A task team will better define two of the HIT SWOT Analysis threat issues: “Providers not seeing the benefit or additional value of an EHR (review data by provider type)” and “Patients not seeing the benefit or value of an EHR (review patient research).” Task Team: Joe Letnauchyn, Phil Weikle, Ed Dolly and Dave Campbell agreed to serve on the team. • Further define telehealth for the model design in regard to scope of practice issues, statutory challenges and payment challenges • Mr. Dolly will email the 1.0 diagram to workgroup members for review and feedback. • Mr. Campbell will send the overview presentation of Highmark’s <i>Quality Blue P4V Initiative</i>. • Workgroup members will e-mail feedback on WVHIN’s Privacy Matrix to Dave Partsch at DPartsch@wvhin.org. • An initial meeting of the task team assigned to begin work on the data resource toolkit will be scheduled.

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"> • Great ideas introduced • Especially the unique way of using data already present • Group discussion was good • Integration of other workgroup results • Good discussion of issues – good participation • Overall engagement of discussion 	<ul style="list-style-type: none"> • We understand rules of meeting and don’t need updates • This was the worst location based on tech capabilities – should find better locations • Need to hold to timeline – park discussions • Bring us all together into a single table/round table rather than talk across the room • Hopefully, meetings could be shorter in the future months • Seemed difficult for dial in users to attend/engage in conversation • Dial-in users ability to see newest handouts