Health Information Technology and Data Taskforce Meeting Notes

Date:	***May 7, 2015***	**Location:**	*Division of Healthcare Financing and Policy 1100 E. Williams St. Carson City, NV 2nd Floor Conference Room*
Time:	*10:00am – 12:00 pm (PT)*	**Call-In #:**	*(888) 363-4735*
Facilitator:	*Jerry Dubberly*	**PIN Code:**	*1329143*

Purpose: Establish taskforce priorities and establish the strategy that will be utilized to collect and measure population health metrics

The meeting began with introductory comments by DHCFP and brief presentation by Myers and Stauffer to ensure all participants were aware of the Nevada SIM award, its purpose and the timeline. During that presentation, the project charter and its purpose was discussed with the group as well. With the purpose of the meeting being discussed, the discussion moved to discuss the three required components of the population health plan – tobacco cessation, obesity, and diabetes.

- The group was advised that as part of the State Health System Information Plan (SHSIP), Nevada must submit a Health Information Technology (HIT) Plan.
- Joseph Greenway gave a presentation on health care expenditures in various nations.
    - He pointed to the use of health data in their health care delivery system and showed a correlation to expenditures and quality.
    - He discussed the ability to use the CHIA data to find problem areas that will influence the SHSIP. An example of Nevada hospitalizations for mental health diagnoses tripled over a 15 year period. Using the power of the CHIA data to drill down and identify trends and divers is something that can be offered as part of this project. Using this data may help identify best treatment approaches that could possibly be replicated. (Note: In follow up discussion, it was mentioned that the CHIA database does not have all of the mental health hospitalizations due to reporting by the state facilities.)
    - In one analysis, Mr. Greenway matched super-users with hospital utilization data. While this was a very small number of individuals, a coalition working with hospital to triage and address the needs of those individual has saved significant money. This demonstrates the power of using the data to get to the right individuals to case manage or care coordinate.
- Gary Lyons asked about the availability of data to track data for youth in foster care. These youth have multiple health issues. However, CHIA is not collecting personal identifiers at this time.
- There was a discussion regarding CHIA accessing Medicaid data and completing some analysis of children in foster care. These discussions were to be followed up between CHIA, HP, and DHCFP.

- The group was encouraged to consider data points that may be needed beyond the medical data. This data may include information such as juvenile justice, corrections, public health, department of education, etc.
- The need to bring data together beyond what is in CHIA today was discussed. This includes physician, laboratory, pharmacy, etc. data. Mr. Greenway said the database can attached to other databases or the data can be loaded on the CHIA server.
- Since the Medicaid data is in Truven, there was some discussion regarding whether using the Truven system may be more appropriate.
- Since the SIM project involves multi-payers and is intended to influence population health on a statewide level, the need to uniquely identify individuals across payers and encounters which may have different identifiers was discussed. There was a general belief that an enterprise master patient index (EMPI) would be needed at some point during the project implementation.
- The importance of encryption of the EMPI was discussed as well as the use of a technique called "Salting."
- A discussion was had regarding the need to connect the existing data bases to better conduct the operations of the payers today. The example give was better access to vital statistics and records of deaths.
- The SHSIP requires a population health plan. This plan must incorporate baseline measures and periodic measures of progress toward goas. A discussion was had regarding different options on how to access this data.
    - While not HEDIS-certified software, Truven's system has been programmed with HEDIS measures. Given the fact that the Truven system accommodates all claim types, this could be the system to conduct these measures. The fact that it is coded to HEDIS logic is appealing since that provides the reliability and comparability of using a national quality steward.
    - While Truven has the Medicaid data, there was a reminder that we need metrics at a population level – not just Medicaid.
- CHIA has FFS Medicaid claims going back to August 2010 and archived claims back to 2000, so it certainly provides a good source of baseline data for measuring population health. However, it does not have all claims.
- Taskforce would like to focus on master patient index across payers.
- Areas that must be measured include tobacco cessation, diabetes, and obesity. The plan is also envisioned to include behavioral health as well, so behavioral health measures will need to be incorporated.
- The need to provide better health information to providers electronically at the point of care was discussed.
    - Providers do not always have the best patient history available to them at the point of care. Providing a more complete picture of the individual's health information can reduce redundant procedures, lead to better diagnosis and treatment, promote better care coordination, and decrease costs.

- The fact was brought up that the Emergency Medical Service often does not know who the patient is when they do a transport. This is a challenge to consider in developing the HIT plan and expectations.
- The group discussed if the data envisioned in the HIT system would be real-time. The timeliness of the data would depend on the data type. For example, admission, discharge, and transfer data (ADTs) would be near real-time while other data such as hospital claims data (if included) may have a significant delay.
- Part of the SIM effort is also payment reform. Equipping providers with access to health information at a patient level and provider population level is an important component of increasing provider accountability for health outcomes.
- A concern was raised that it felt like we are 'building a solution before a problem is identified.'
    - While we do know that we need access to health information, we don't know what data points yet.
    - The group needs to have more specifics on the needs before the solution is designed.
    - There was acknowledgement that identifying type data, data sources, where data lives today, etc. and conceptually how to pull that data together could be a worthwhile discussion.
- There was a recommendation to conduct an inventory to identify who has what data and figure out if that data is or can be shared.
- Brett Barton and Joseph Greenway were tasked with developing a survey that could be deployed to the group with the responses driving the next agenda of this taskforce. The type information that was discussed as being needed included:
    - Where does the data live?
    - Is it accessible?
    - Do they use window/relational data bases?
    - Are there data dictionaries available?
- There was discussion regarding an attempt a few years ago to assemble an inventory of data. DHCFP offered to check with the governor's office to see if that inventory is still available and applicable.
- Discussion topics for next taskforce meeting include:
    - Results of the survey/questionnaire
    - Follow up regarding the previous inventory after inquiring with the governor's office
    - Update from ther workgroup meetings/specific request