
Health Information Technology and Data Taskforce Meeting Notes

Date:	June 4, 2015	Location:	4150 Technology Way Carson City, NV Room 303
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		

After introductions Jerry Dubberly gave a presentation providing clarification on the State Innovation Model (SIM) objectives and Nevada's proposed goals (to date) for the State Health System Innovation Plan (SHSIP). Components from Connecticut's SIM Design were provided as examples to illustrate how their plan communicated Connecticut's aims and the related primary and secondary drivers affecting those aims, as well as actions steps necessary for CT to achieve their aims. The purpose in providing these examples was to ensure the workgroup understands how their contributions will impact the design of Nevada's Population Health plan and SHSIP.

Mr. Dubberly also gave an overview of the activities of the other workgroups and taskforces from the previous meetings. A separate document listing these topics was provided to the Tasks Forces and Workgroups.

Next, Mr. Dubberly gave a presentation describing the data needs of the NV SIM project. This includes known sources of data that will be necessary to measure population health and outcomes and example data elements that will be needed from each of the sources. The taskforce affirmed its prior discussion that an enterprise master patient index (EMPI) would be needed. The group discussed availability of existing tools that have strong on patient privacy solutions. A recommendation was made that the Chief Biostatistician's office is well equipped to review and advise on algorithms and tools to protect the patient privacy. The need to have a strong analytics tool that utilizes all of these data sources was discussed. This analytics tool is needed to measure population health statistics and improvements in population health.

Joseph Greenway gave an overview of the results to data from the Data Asset Inventory Questionnaire that was distributed to the group subsequent to the last meeting. Mr. Greenway reported six responses to date. Data available includes: hospital and ASC claims; Medicaid claims, eligibility & incentive program data; child welfare & services; mental health; juvenile justice; and pre-hospital EMS data. These are all available through a data extract except the pre-hospital EMS data. Additional data needs identified but not yet met include: clinical data; physician visits; skilled nursing/long term care; and urgent care centers.

Mr. Greenway offered the mission of the initiative is to increase quality of and access to healthcare without increasing costs. The vision was described as to design and implement a healthcare plan that is patient-centered, and value-driven (based on outcomes). To accomplish this mission and execute on the vision, the needed implementation was described to be a holistic approach beginning with prevention and wellness programs. Followed by exploration and analysis of high cost high volume areas such as chronic illness, mental health, and super-users. Finally, track quality by linking practices to outcomes.

Mr. Greenway also provided data showing Nevada's health care quality was ranked as weak with opportunities to improve access to care and treatment of certain diseases and conditions.

Mr. Greenway described the next steps for the taskforce as:

1. Finish investigating what data sets are available and what fields they have.
2. Discuss what gaps remain and what can be done about them.
3. Find out the national standards (codes, diseases, disparities...) for patient-centered, value-driven health care.
4. Find out the national practices for implementing these standards
 - a. payments based on best practices by facility
 - b. Tracking patients through full event of care (hospital shares data with follow-up care)
 - c. Adjusting payments over the long haul based on ongoing outcome studies.
5. Apply to Nevada what makes sense.

A discussion was had regarding the need to make sure we are looking beyond Medicaid and CHIP and including data from commercial payers and other sources as well. The group was reminded that the SIM initiative is a multi-payer effort. There is a need to get greater attendance and participation by the commercial payers. Chris Watanabe mentioned her concern that we especially need to capture the 18 years of age and younger population that is covered through commercial health plans. DHCFP has invited commercial payers, but they encouraged the taskforce members to offer additional contacts that may be made to encourage participation. Reference was made to a previous grant in Nevada which attempted to collect multi-payer data. However, it is believed that there was considerable objection to the effort by America's Health Insurance Plans (AHIP), and the effort did not move forward.

Jan Prentice asked Mr. Greenway if he had access to the research that was performed under the grant to aggregate health data in Nevada. Mr. Greenway will check to see if this research is available.

Chris Watanabe reminded the group that data is not health information technology. The group needs to remember the difference and be careful in the terminology we are using in our discussions and communications. Ms. Prentice offered that we need to discuss both but use the proper terms.

The discussion turned to measuring clinical quality and outcomes data. Mr. Greenway asked Truven to provide additional information regarding the large number of performance measures available through their system solution. Truven stated they have about 1000 measures available in their system. These measures have existing coded methodologies and uses administrative claims data. No clinical data such as lab values is being pulled into the methodologies at this time.

Collection of the clinical data from the health information exchange (HIE) was also discussed. It was pointed out that Nevada's HIE is an opt-in program, and patient data would not be contributed unless the patient gave the express consent to contribute the data. It was speculated that 75% of patients aren't represented in the HIE because they do not understand and consent. Use of the NV HIE with less than complete data may skew the population health measures and possibly make the population health look worse than it is. The group asked to refer the opt-in status of the Nevada HIE to the Policy and Regulatory Taskforce for consideration.ⁱ

Keith Parker from Health Insight reminded the group that collecting and reporting clinical measures is a requirement for meaningful use in the Medicaid incentive program for electronic health records. Given the systems capture and report the data, there should be a way to get the clinical data from the provider systems. Mr. Parker informed the group that through the Quality Reporting Document Architecture (QRDA), Category III reports include numerators and denominators for aggregate data, and the patient identified is not included. QRDA III data is required to get the EHR incentive payments. In a follow up discussion, the distinction was made that the system must have the functionality to report the data, but that does not mean providers are actually reporting the data.

Ms. Prentice asked if all Nevada providers are EHR compliant. Mr. Parker estimated an adoption rate of about 50%, but it is trending upwards. He stated Medicaid and Medicare providers will start seeing penalties in 2016, so there may be an increased rate of adoption this year.

Revisiting the QRDA III data, clarification was offered that this required functionality is limited to those providers eligible for incentive payments which are limited largely to physicians and hospitals.

Jerry Dubberly offered that Nevada is not the only state trying to solve the issue of how to best measure population health and improvement. We have asked CMS to share best practices in other states that may be helpful to Nevada. Ms. Prentice stated that in a meeting in Baltimore, other states claim to have been successful, but the details were not readily available at that meeting. Mr. Greenway suggested a review of the Colorado SIM plan due to similar challenges in the two states. This could be an opportunity to learn from them.

The magnitude of this effort was discussed by the group. Dave Stewart mentioned that he has been involved in several different data initiatives, and pulling this data together is monumental. Such an effort was described as a process and not an event. This led to a discussion to make sure that there is buy-in and support from executive leadership with the direction of the group.

A recommendation was made to start with one disease state such as diabetes and see what data elements are available, which ones are needed, where they can be derived, what we can measure today, and what we may want to measure in the future. This approach was well-received by the group.

The taskforce meeting ended with the discussion that there is a need for an on-going group to continuously work on data access and population health measurement beyond the development of the SHSIP. The group was advised that CMS has acknowledged that the fully-functional plan will not be in place at the time of the SHSIP submission. CMS seems to recognize that the solution is not immediate, and the sophistication of population health measurement tools and systems will grow over time. Ms. Prentice offered that we need to take advantage of other efforts that are currently working to accomplish the same objective. It is believed that there may be an National Governors Association effort that is relevant to this initiative.

ⁱ Referral to Policy and Regulatory Taskforce