Nevada SIM Taskforce Meeting
Health Information Technology and Data Taskforce
September 28, 2015 Meeting Notes

Date:	September 28, 2015	**Location:**	Legislative Counsel Bureau 401 South Carson St, Room 313 Carson City, Nevada
Time:	9:45 am – 11:45 am (PT)	**Call-In #:** **PIN Code:**	(888) 363-4735 1329143
Facilitator:	Jerry Dubberly		

Purpose: Meeting to identify the areas of focus for Health Information Technology (HIT) as a component of the State Health System Innovation Plan.

Opening comments were made by Jan Prentice followed by introductions. Ms. Prentice thanked all participants for their input and support and advised that today's session was the last organized Nevada State Innovation Model (SIM) HIT and Data Taskforce meeting.

Mr. Dubberly provided an overview of the meeting agenda and explained the purpose was to make certain that the problems have been clearly identified and appropriate solutions proposed. He explained that there are outstanding questions for certain components of the solutions requiring additional discussion in this meeting. Mr. Dubberly reviewed the problem statements and proposed solutions.

Problem Statements:

- A robust statewide Health Information Exchange (HIE) is needed to promote sharing of accurate and complete data at the point of care
- A method to measure population health and population health improvement is needed
- Greater adoption of Electronic Health Record (EHR)s by providers
- Not all provider types are eligible for Medicaid EHR incentive payments
- Providers need a centralized, user-friendly method to access patient data that is payer neutral
- Moving to value-based reimbursement requires the availability of provider performance data available to the provider and payer
- Value-based reimbursement calls for outcomes data that is typically not represented in the claims file and can be accessed/identified without regard to who paid the claim
- Unrealized opportunities exist to improve patient engagement and shared decision making through the use of HIT
- There are opportunities to create public dashboards regarding health status of Nevadans and certain key health metrics

SIM HIT solutions:

- Goal: To use the SIM efforts to foster greater HIT and data infrastructure and development in Nevada
- Increased adoption, implementation and meaningful use of EHRs
- Establish the availability and use of direct messaging to all providers
- Support certain functions of the Regional Extension Center (REC)

- Encourage growth and contribution to statewide HIE
- Explore regulatory authority to make HIE opt-out vs. opt-in for sharing of patient health information
- Develop patient portal to promote patient engagement, health literacy, and shared decision making
- Create centralized provider portal offering:
    - Concise patient profiles
    - Provider population health metric dashboard
    - Actionable alerts to bridge care gaps and support value based purchasing (VBP) initiative

Robust Statewide HIE and Expansion of Electronic Health Records (EHRs)

- HealthInsight discussed current and future activities designed to promote the robustness of the HIE and progression of provider participation.

- HealthInsight commented that when discussing patient records those records are "used" versus "attached." The records are integrated to create usable data.

- A REMSA representative commented that even if a provider implements an EHR, the HIE interfaces can be cost prohibitive which causes many providers to stop at the interface phase. These providers do not perceive a benefit or value in paying for the HIE interface. HealthInsight explained that HIE interfaces are expensive and provider motivation is driven by the perceived value of the information available via the HIE. Discussion continued about the financial impact on ancillary providers not directly involved in value based contracting and the motivation to invest in HIE interfaces.

- A speaker on behalf of Center for Health Information Analysis (CHIA) led a conversation on the possibility of Nevada seeking third party collaboration to purchase interfaces for a number of HIE users as opposed to costly individual interfaces. The purchasing power of a large number of interfaces was offered as a potential means of decreasing individual provider/practice interface costs. A Myers and Stauffer representative explained that this model exists today in Arkansas and North Carolina where economies of scale are achieved through leveraging volume discounts for multiple sites. HealthInsight explained its own market analysis and the ability to negotiate lower interface costs using EClinicalWorks and hubs. It was also recommended looking at the type of information, interoperability and interfaces needed for each provider type when looking at reducing interface costs. Discussion ensued about the feasibility of reducing the different types of EHRs to help reduce costs. DHCFP commented that it is clear that "one size fits all" doesn't apply to EHRs and HIE interfaces, and solutions must meet the needs of the provider community.

- A DPBH representative explained the Division is unique as it is also a provider. DPBH prefers that data go through the HIE, but the expense is not sustainable with an existing grant of $100,000. It was further explained that DPBH sees value of the HIE in accessing provider, county and hospital records needed for behavioral health clients in real time. The sustainability of the HIE interface is in question given the lack of grants to fund the costs.

- CHIA suggested a single portal to connect to HIE and link to other operations at a facility (hospital, skilled nursing facility/LTAC), provider practice or lab as a single stop for all users.

- REMSA commented that at the office practice level the issue is the ease of use of technology has grown while the supply of experienced human capital to implement and use the technology has

not. DHCFP asked if shared resources would be beneficial and discussion ensued on the benefits of education and support for small to medium sized offices and the need to include in the strategic plan as an immediate step.

Promotion of REC Activities

- A representative from HealthInsight explained that REC activities mainly deal with smaller practices which require more intensive support and alternative funding alternatives. Given that such practices have limited resources and implementation of EHRs can be expensive and burdensome, the Taskforce was asked to consider the best methods to support practices while encouraging growth and continued contribution to the HIE.

- An Aging and Disabilities Division representative explained how web-based solutions and EHR technology can impact long-term care services. Discussion ensued about the significant value of a robust medical record following a patient whether in the community or an institution.

All Payer Claims Database (APCD)

- DHCFP explained that the APCD is not planned to include fiscal information. Inclusion of fiscal data would be helpful, but payers may be resistant to contribute claims if others could reverse engineer proprietary payment schedules.

- HealthInsight commented that APCDs do not provide quality metrics and information to support population health. DHCFP and MSLC explained that claims in an APCD provide process measures instead of outcomes measures. Outcomes data would require access to data that eventually will reside in the HIE but exists today in electronic health records and provider paper records. The APCD would require significant infrastructure and governance involving multiple payers and data sources. Discussion ensued about the need for a legislative mandate and the level of effort to stand up an APCD.

- A DHHS representative questioned the value of an APCD as a population health management tool over the clinical data provided in the HIE. DPBH commented that claims data could be used as a proxy for hospital discharges but that real time clinical data found in the HIE was more valuable. The need for both APCD data in combination with the HIE and public health registries to create a more complete basis for the population health management tool analysis was discussed.

- HealthInsight suggested that the APCD could be used in calculating the total cost of care while using the HIE for clinical data.

- The Taskforce identified the robustness of the HIE as the most critical priority over the APCD.

Provider and Patient portals

- The Taskforce discussed provider and patient portals, and the ability of the provider portal to serve as a bridge until the HIE is robust and complete.

Next Steps

- The HIT governance and infrastructure must be determined after consideration is given to leveraging what already exists.

- DHCFP may reach out to Taskforce members as the State Health System Innovation Plan is drafted for a November 2015 submission to CMS.