

# IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

## Meeting Notes

<b>CLIENT:</b>	State of Idaho	<b>MEETING DATE:</b>	June 6, 2013
<b>SUBJECT:</b>	HIT	<b>LOCATION:</b>	Maverick Room
<b>ATTENDEES:</b>	<b>Present:</b> Scott Carrell, Peggy Evans, Michael Farley, Michael Gaul (for Steve Garske), Platt Thompson, Tina Voves, Tim Heinz <b>Facilitators:</b> Andrew Wilson, Jack Peters <b>Absent:</b> John Kee, Yvonne Ketchum, Joe Skeen, Scott Smith, Rick Turner	<b>DISTRIBUTION:</b>	

## Decision Items

- Critical elements of the health information technology (HIT) transformation blueprint. Work group members indicated they were not aware of the purpose of the State Health Innovation Plan (SHIP) and the fact that the result is so far reaching and long term. They expressed the need to go forward to their executive teams to examine the details so they can provide meaningful input.
- The HIT work group discussed holding weekly meetings Wednesdays at 4:00 PM GMT (3:00 PM PDT).
- The HIT work group agreed to meet in person on the following dates:
  - 6/27 (Peggy is on vacation)
  - 7/23 (Steve/Michael out)
  - 8/22 (Scott unavailable in AM)
  - 9/12
  - 10/17
- Incorporate in-flight projects into the HIT analysis. This will help us understand what efforts are currently underway that we can leverage into the HIT solution. This will assist efforts and drive to the specific aspects of the project that need to be built based on the larger efforts. This makes us more competitive since it ties to national initiatives.

- Engage broad audience including the Eastern part of the State, EIRMC, Portneuf Medical Center in our Work Group.
- As we develop the overall HIT target and strategy, consider incorporating a framework of meaningful use similar to electronic health record (EHR) framework: Stage one is data usage, stage two is clinical and how to improve care, and stage three is quality and how to bring about change in order to improve outcomes and reduce costs.
- Identify achievable HIT aims by developing and implementing goals in phases. For example the first phase could address clinical data and associated analytics/metrics. The next phase could be to marry claims data to the clinical data. This would be achievable, measurable, and allow buy in from all entities.
- Develop talking sheets to bring others in participant organizations up to speed.

### Follow-Up Items

- Document Current state vs. Future (desired) state and identify gaps between the two.
- Schedule weekly teleconference meetings Wednesday's at 4:00 PM Mountain Time.
- Reach out to the HIT work group members that were not able to attend the June 6 meeting. Forward notes and ask to review and provide feedback. Be sure they know about the weekly and monthly meetings.

### Notes

- Introductions.
- Purpose of project, discussion of Work Groups and Focus Groups.
- Reviewed schedule and purpose of today's meeting.
- Reviewed HIT goals (see presentation slide).
- Work team members discussed potential collaboration with teams from other states, e.g. Delaware. A collaborative environment exists today even though there is competition.
- Michael indicated that given the long term perspective of healthcare development (core strategy for healthcare) he would like to go back to his CIO and CEO at Kootenai and get their input into the longer range vision. All parties need to consider this. The aim would be to deliver something that pulls/ties all entities together in the long term solution. This needs to engage everyone. For instance, Eastern Idaho was not involved today. Develop talking point sheets to reach out to the various members. The Focus Group materials can be developed without the involvement of all the parties, but the overall project needs to include a broad audience (include Eastern part of the State, Portneuf Medical Center, and EIRMC).
- Leadership changes at Kootenai have had a very positive effect on overall engagement with the IDHE and the ID Department of Health.
- Medicaid data processing is contracted with Molina.
- IHDE plays a large component. Assume IHDE will be incorporated into the overall HIT solution.
- Doctors sometimes want to dive into the weeds right away – and we lose many of them in that process. Instead, start high-level then bring down with us and then we can state the initiatives with the solutions we provide.

- Entities have to have access to safe, protected, available data. The entity housing the data has to be trustworthy and non-biased. We need to develop the HIT strategy incorporating “Switzerland”-like thinking.
- Getting all entities to play is going to be a big part of this project’s success.
- A possible way to get entities to participate may be to offer incentives, then revisit this policy over time. Additionally, we may want to propose incentives for quality to engage providers in trying something new.
- Analytics is critical – due to competitiveness with border entities (e.g. Coeur d’Alene). This is critical since Idaho is losing membership to Washington.
- Idaho providers don’t have access to costs/outcomes and data across providers and it is unclear if they did whether this would be an advantage. Need some level of transparency including data and patients so they can decide where to go.
- Idaho is a rural State – the feds are currently focused on rural.
- Privacy and security – requirements need to be strongly considered. This is as important as Triple Aim. Questions that should be asked: What do you do on an ongoing basis proactively to ensure privacy and security, e.g. do you perform audits, etc.? Performing privacy and security audits is a high priority at the federal level.
- Can we take off the table some rudimentary elements, like connectivity? We are a rural state and there are pockets of areas that do not have connectivity? Discussion --- a connectivity project connecting schools and counties resulted in small communities across the state now being connected.
- Data is needed for competitiveness and larger provider groups would be willing to pay for good analytics.
- Larger theme – sustainability of solution. Engagement of all entities.
- IHDE – has utilization analytics although they can’t produce clinical analytics at this time. However they are looking into producing clinical analytics as well as marrying claims data from payers. This is seen as being very beneficial and a way to achieve the Triple Aim.
- Triple aim – quality starts with primary care physician (PCP) providers. How do you get them to have better care teams, better data, and better analytics?
- Focus group questions developed (see hard copies of flip chart notes for each group).
- Other factors that have an influence:
  - Regional competition: areas in North Idaho bordering Washington. The IHDE is already including Washington providers and is planning on additional ones.
- Goal should be to expand participation in the exchange.
- Regarding the IHDE: What metrics are available now from PCP and non-PCP providers? Would it help to see Medicaid (largest payer) population claims data analytics (short term)? Medicaid is willing to do this immediately (short term gain)?
- If the quality improvement group has data that they can look at now and identify improvements, we can measure this.
- IHDE – Eastern Idaho critical access hospitals aren’t participating due to thin margins and the cost associated with connecting with the exchange. This could change based on economy of

scale once more entities participate. We need to understand what it will take for all entities to utilize the IHDE.

- Some concerns about the people that weren't at the table today and the fact that we need them to be onboard with how we are proceeding and not throw up road blocks later.
- Additional work group members:
  - Michael Gaul - [Mgaul@kmc.org](mailto:Mgaul@kmc.org)
  - Tina Voves - [TVOVES@BMC.Portland.IHS.GOV](mailto:TVOVES@BMC.Portland.IHS.GOV)
  - Platt Thompson - [ThompsonP@dhw.idaho.gov](mailto:ThompsonP@dhw.idaho.gov)