

Vermont HIE Steering Committee

Gallery Walk Feedback

July 10, 2019

Leveraging Health Information Exchange (part I)

Discussion/ Priorities

Clinical Data Requirements—

What kind of information (“*useful data*”) should be collected and available at the point of care and for care management?

- EMR – beyond minimum data sets
- Clinical notes
- Long Term Care assessments
- Lab orders/results
- Imaging notes, images
- Patient-generated information (“*validated*”)
- Telemonitoring data (*clinical or non-clinical settings*)
- Telehealth note

- Consider utility, quality, ease of collection
- US Core Dataset can lead the way
- “Less is more”
- Mode of delivery matters
 - Readability, accessibility matter
- Need consistent data at point of care
- Discrete data should not be limited to CCDs
- Need SDoH
- VHIE should ingest many formats and funnel in simply manner to PoC

Leveraging Health Information Exchange (part II)	Discussion/ Priorities
<p>Point of Care Documents—What do you need to support transitions of care?</p> <ul style="list-style-type: none"> • Transfer of care summaries (CCD) • Referrals • Prior authorizations • Care plans • Available beds • Other? 	<p>No comments</p>
<p>Public Health Registries—</p> <ul style="list-style-type: none"> • How important is electronic reporting directly from EMR to reduce redundant data entry? • In addition to immunization and cancer reporting, what other types of reporting should be done from clinical systems? • Will you access registry data when available (e.g., via a query for immunization status, cancer reports, etc.)? How current must the data be for your usage? 	<ul style="list-style-type: none"> • Not all information is in the EMR (e.g. flu shots) • Very few EMR ingest outside information • PDMP – utility? Medicaid only? • Need bi-directionality with registries • PRAMS • VT Clinical Registry • Timelines matter (eg, CDC turnaround times) • Registries need significant support structures • IZ [?immunization?] data not in EMR is a challenge

<i>Efficient Health Information Exchange (part I)</i>	Discussion/ Priorities
<p>Data Quality—What are best methods to improve it?</p> <ul style="list-style-type: none"> • Sources validate data before submission to VHIE • VHIE rejects data if it is out of compliance with defined data standards • VHIE works with data from different sources, in different formats--standard and non-standard—to create a consistent output 	<p>High Priority (x2)</p> <ul style="list-style-type: none"> • Statewide standards for quality, federation • Consider VHIE/VITL role: relational? Tech? both? • Feedback to submitter (2-way street) <ul style="list-style-type: none"> • Should have \$ impact • But no \$ incentive for providers to submit data • Thresholds for rejection • Improvement processes <ul style="list-style-type: none"> • Referral process • Who has authority over data quality standards? • Need revision process b/c of dynamic environment • So many technical options
<p>Patient Matching—Which method(s) do you support?</p> <ul style="list-style-type: none"> • Enhance the VHIE record matching capabilities to support additional provider types/venues • Integrate/augment VHIE record matching capabilities with state data/identifiers and support integration with non-clinical data 	<ul style="list-style-type: none"> • Single record/person very ambitious • Super important, super hard • Integrate with PH data: Good use cases <ul style="list-style-type: none"> • developmental services for kids • Substance use disorder • Kids: maternal literacy • Families: linkage across data services
<p>Additional Requirements</p> <ul style="list-style-type: none"> • Couple data standards with requirements and incentives to submit data 	

Efficient Health Information Exchange (part II)	Discussion/ Priorities
<p>Aggregation—Where data is aggregated in a central, shared repository, how should the repository support analytics?</p> <ul style="list-style-type: none"> • Provide analytics as a service, per request • Provide data to be downloaded from the repository per request, and analyzed locally 	<ul style="list-style-type: none"> • A red herring • More federated approach – <ul style="list-style-type: none"> • Don't want to have data delays that limit analyses • Analytics [should be] separated from aggregation • Lots of people want to do analytics • YEAR 1
<p>Access—How should access to clinical data be provided at point of care & for care management?</p> <ul style="list-style-type: none"> • VITL Access (assume EHR integration) • Sent to local EMR on trigger (i.e., before upcoming visit) • Retrieved on request (i.e., request diagnostic reports over past 6 months) • Viewed as single longitudinal record (organized by encounter, by diagnosis, by procedure, etc.) 	<p>Access to good data is most important</p>
<p>Additional Requirements—</p> <ul style="list-style-type: none"> • Want multiple analytical options • VITL provide structured data platform to other analysts (clinical data at this time) YEAR 1 • VITL agrees focus is clinical <ul style="list-style-type: none"> • Better data views • Increased access 	

<i>Evolving Use Cases for Health Information Exchange (part I)</i>	Discussion/ Priorities HIE IS DEFINED AS HUMAN INFORMATION EXCHANGE
<p>Substance Use Disorder/Behavioral Health—Should the VHIE manage sensitive data and if so, how?</p> <ul style="list-style-type: none"> • VHIE SHOULD/should not collect sensitive data • VHIE must segregate/control access to sensitive data appropriately • VHIE must allow analysis of deidentified sensitive data • Other? 	<ul style="list-style-type: none"> • Yes Yes Yes <ul style="list-style-type: none"> • Potential constraints: federal regulations • Project in process @ VITL • Shared Services <ul style="list-style-type: none"> • Redundant with other department efforts, a sort of “arms race” • Duplication is okay because done for different purposes/users • Data subsets could be rationalized through matching • Identity/access management is foundational to all this work • HAVE TO JUSTIFY EFFORT AT CLINICAL LEVEL • State can provide identified/de-identified data • Start incrementally
<p>Social Determinants of Health—How should information be collected? Whose responsibility is it?</p> <ul style="list-style-type: none"> • At point of care, integrated with clinical data (EMR vendor supported) • During case manager activities, outside EMR (care management tool) • From state databases on housing, food assistance, dept of justice, other • Other? 	<ul style="list-style-type: none"> • Can’t do HC reform w/o SDoH (x3) <ul style="list-style-type: none"> • Requires a lot of work on Tech Roadmap • Promoting tools for capture at clinical setting • Question usefulness of population-level data from state; <ul style="list-style-type: none"> • Pop-level is useful for OCV • State data on housing is incomplete, but can be acquired and linked • State data can be identifiable or de-identified • Who collects? <ul style="list-style-type: none"> • Everyone • Have to justify effort at clinical level • Current tools crap [sic], clinicians hate them • Clinical pathways required to make SDoH actionable • Start incrementally

<i>Evolving Use Cases for Health Information Exchange (part II)</i>	Discussion/ Priorities
<p>Quality Reporting—How can it be done while minimizing the burden on providers?</p> <ul style="list-style-type: none"> • The data elements in the Connectivity Criteria should support a greater portion of required quality metrics • Data sets supporting payer quality programs should be harmonized, simplified, reduced • The VHIE should house all the data elements required for CMS submissions (Quality Reporting Document Architecture (QRDA)) and be certified to make submissions on behalf of providers • A common quality data reporting format (QRDA) should be adopted across all payers • Other? 	<p>Agree with ALL the points below</p> <ul style="list-style-type: none"> • A near term objective and on track • YES, x 1,000 • If not calculated by provider, could become trust issue • Data quality has to be trusted • Question whether realistic; this is hard • Yes x2 • Must flow from existing clinical & administrative systems • If in EHR, need to get it out
<p>Additional Requirements—</p> <ul style="list-style-type: none"> • STOP bombarding clinicians with requests • More information on Shared Services 	