HIE Steering Committee

Claims Pilot Subcommittee

Meeting #7 – July 9, 2021

Agenda

- Review New Use Cases: Point of Care
- Next Steps

Role of Subcommittee Members Re: Use Cases

- Learn about each of the use cases presented by fellow subcommittee members
  - *What is the user trying to accomplish? How does this relate to or inform my use cases?*
- Weigh in: support editing, culling, prioritizing
  - *How could this be augmented to be clearer? Is it missing anything? Where does this fit in your sense of priorities?*
- Support assessment of technical feasibility by VITL and MMIS partners

Use Case Categories - Definition

- Clinical uses – Individual:
  - These use cases focus **on how data/information is used in a clinical setting to support clinical decisions** made **between an individual and their provider**.

- QI/operational - Organization:
  - These use cases focus **on how data is used by an organization** and can be grouped into two categories. 1) How a health care organization uses data **to improve its processes/workflow** and improve panel management for groups of patients. 2) How a program uses data **to enhance operations** such as setting payment levels for value-based payments or making policy decisions on how the program operates.

- Evaluation – Population health:
  - These use cases focus on whether a program, policy, or intervention achieved what it meant to achieve. The **outcomes are used to support decision making**; can be more dynamic and flexible that reporting, though often rely on similar nationally recognized measures; see below.

- Reporting – Population Health:
  - These use cases are **measures** often agreed upon at the beginning of a program/ agreement/demonstration **to be monitored by an overseeing entity**, e.g., the federal government. Generally, these **measures are drawn from nationally recognized measures**.

Use Case Review

Reporting rates for preventive cancer screening (colorectal, cervical, breast) in support of improving quality of care

USER STORY

Actor(s): Population Health Manager (PHM) at FQHC, Bi-State Analyst

As a Population Health Manager (PHM) at FQHC working in collaboration with Bi-State Analyst,

I want to use the linked Clinical and Claims Data,

So that I can identify the FQHC patient who is a dental patient and find out when the patient went for his/her last dental visit, and the amount spent under the annual Medicaid cap.

As a Bi-State Analyst working in collaboration with the Population Health Manager (PHM) at an FQHC,

I want to use the linked Clinical and Claims Data,

So that the PHM can identify patients who are overdue for preventive cancer screening based on a search of both the clinical data and the claims data for appropriate screenings. The practice can then be more efficient in its outreach to its patient panel.

There is value in using both claims and clinical data for the cancer screening because the FQHC records additional clinical data in the EHR that is relevant, such as reasons for not screening (e.g., in hospice care) or older historical screenings, that may not be in claims. With the linked clinical and claims data, the Bi-State Analyst will get all of the data from the VHIE with patient identities already reconciled in the VHIE. This process will be more efficient than the current process where Bi-State Analyst gets clinical data from each FQHC individually and claims data from DVHA.

As a Population Health Manager at FQHC working in collaboration with Bi-State Analyst,

I want to use the linked Clinical and Claims Data to identify patients who have been to the Emergency Department.

The claims can provide diagnostic data on the reason for a patient getting admitted to the ED including those conditions that could have been addressed in primary care setting. The linked clinical record could provide previous health outcomes or treatment records that could support individual treatment recommendations, or at the panel level, identify early indicators that could improve a practice's management of patients with similar profiles.

USE CASE: QI/Operations - Organization

Reporting rates for preventive cancer screening (colorectal, cervical, breast) in support of improving quality of care

ORGANIZATIONS

1. Bi-State PCA assists FQHCs in Vermont with quality improvement projects, including supporting data analysis and reporting.
2. Bi-State obtains Claims data from DVHA.
3. Yes, we use Claims to identify patients who have or have not received certain services and to supplement the data in FQHCs' EHR systems.

CHALLENGES/PAIN POINTS

1. We have access to EHR data from our member FQHCs. We then obtain Medicaid claims from DVHA for matched patients, and we integrate the two data sets using the unique recipient identifier.

2. Challenges:

a) We do not have Medicaid identifiers for 100% of patients, and the VHIE EMPI could do a better job of matching FQHC patients with the DVHA Medicaid recipient population.

b) FQHCs and other primary care providers could benefit from notifications based on claims about their patients who need more attention (e.g., chronic care management). This would require an integration of those two data sets.

c) FQHCs need more detailed data from specialists (e.g., results of a diabetic eye exam by an ophthalmologist) to flow back into their EHR systems; could the claims data be used for this?

d) Bistate does not have access to Commercial Payers and Medicare Claims. Having access to that data could help FQHCs to do outreach of all patients in need and not limit the outreach to just one group (Medicaid)

GOAL

1. FQHCs need to track many patient populations based on conditions (e.g., diabetes) and severity (in control vs. out-of-control blood sugar). Other examples: Patients overdue for cancer screening; patients overdue for depression screening; patients with potentially undiagnosed hypertension; medical patients with no dental provider; patients who should be enrolled in chronic care management; patients with chronic opioid use.
2. Two examples of integrating Clinical and Claims data:

a) Patients' overdue for preventive cancer screening; claims can be searched for screenings that were not recorded in the clinical chart.

b) Patients who have been to the emergency room for a reason that might be addressed in a primary care setting, but they did not go to their primary care provider before or after the ER visit.

TRADING PARTNERS AND SYSTEMS

1. Systems:

a) FQHCs' EHR systems
b) DVHA's GlobalScape
c) Bi-State's Qlik software

2. Partners:

a) FQHCs
b) DVHA

DATA TO EXCHANGE

1. Medical and Pharmacy claims from Payers for the past 5 years, for patients matched to the FQHC patient population of interest.
2. Data needed:

a) Eligibility
b) Clinical Data
c) Insurance
d) Immunization
e) Encounters(Visits)
f) Procedures
g) Vital Signs
h) Lab results
i) Diagnosis Codes
j) Social Determinants of Health Data
k) Income
l) Medications
m) Patient demographics

USE CASE: QI/Operations - Organization

Reporting rates for preventive cancer screening (colorectal, cervical, breast) in support of improving quality of care

DATA GOVERNANCE

1. Bi-State has a data use agreement with each FQHC and with DVHA.
2. If Bi-State were to receive data from the VHIE, we would establish a secure connection like VITL does with others. Bi-State would need to review its agreement with FQHCs to ensure it covers this data use.

FREQUENCY

Monthly.
If Weekly is possible that will be nice.

USE CASE TARGET DATE

As soon as the linked data is available in VHIE.

MMIS DATA PIPELINE

TBD with Technical Team

DATA FORMAT (Source to VHIE)

TBD with Technical Team

TRANSPORT MECHANISM

TBD with Technical Team.

DATA RECIPIENT FORMAT (VHIE to End User)

Preferably, text files.

CONSENT SPECIFICATIONS

Not Applicable because Bi-State is working as a Business associate for FQHCs.

LEGAL AGREEMENTS

TBD with Legal team about agreements between VITL and Bi-State.

Discussion/Feedback

Debrief on Use Case Gathering Process

- What did you do to prepare?
- What helped you successfully participate in the process?
- What went well?
- What can be improved?
- What should others expect?

Use Cases Summary

	Category	Use Case Name	Stakeholder
1	Clinical - Individual	Prescription Reconciliation, Fulfillment Monitoring	Mary Kate Mohlman
2	Clinical - Individual	Validate the Service Provided	Mary Kate Mohlman
3	QI/Operations - Organization	Panel Management of Individuals with Chronic Conditions– identifying those whose conditions need better management	Mary Kate Mohlman
4	Evaluation - Population	Assessing Quality Improvement Initiatives on Hypertension Control and Outcomes	Mary Kate Mohlman
5	Reporting - Population	Percent of population with Hypertension in control and Diabetes in poor control	Mary Kate Mohlman
6	QI/Operations - Organization	Improving support and Care management for individuals with Hypertension and Diabetes in the State	Katelyn Muir
7	QI/Operations - Organization	Improve Immunization Rate	Katelyn Muir
8	Evaluation - Population	Evaluating the Clinical impact of the Care Coordination Model	Katelyn Muir
9	Evaluation - Population	Evaluation of primary prevention by Health Service Areas (HSA)	Katelyn Muir
10	QI/Operations – Organization	Determine payments made to providers participating in Medicaid value-based payment arrangements.	Pat Jones Erin Flynn
11	Reporting - Population	AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting	Pat Jones Erin Flynn

Use Cases Summary

`	Category	Use Case Name	Stakeholder
12	Clinical – Individual	Help inform Care Management Functions	James Mauro
13	QI/Operations – Organization	Identify Members for Integrated Health Programming including Risk Stratification	James Mauro
14	Evaluation - Population	Evaluate the performance of a Healthcare Reform/Payment Reform Program	James Mauro
15	QI/Operations – Organization	Development of a Healthcare Reform/Payment Reform Program	James Mauro
16	Reporting - Population	Conduct quality reporting that requires clinical data without relying on manual medical chart extractions	James Mauro
17	QI/Operations – Organization	Clinical data to support Utilization Management Program	James Mauro
18	QI/Operations - Organization	Defining more precise scope of a Health Care Organization (e.g., Provider landscape)	Sarah Lindberg
19	Evaluation - Population	Evaluation of Provider Quality	Sarah Lindberg
20	QI/Operations - Organization	Quality and Equity in Health Centers in Vermont	Thomasena E Coates
21	QI/Operations - Organization	Reporting rates for preventive cancer screening (colorectal, cervical, breast) in support of improving quality of care	Lauri Scharf

Next Steps

- Evaluate the subcommittee's work and identify remaining gaps
- Medicaid Use Cases will be presented on 7/30

Use Case Gathering Sessions

#	Interview	Focus of Discussion	Schedule & Status
1	**Katie Muir**, *OneCare VT*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/3/2021 – Completed**
2	**Pat Jones**, *DVHA Payment Reform* **Erin Flynn**, *DVHA Payment Reform*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/30/2021 – Completed**
3	**Ben Green**, *Blue Cross Blue Shield* **James Mauro**, *Blue Cross Blue Shield*	• Commercial Claims	**4/19/2021 – Completed**

4	**Sarah Lindberg**, *Green Mountain Care Board*	• Analytics for -
		  • evaluating the APM
		  • evaluating the Boards regulatory activities
			5/10/2021 – Completed

5	~~**Emma Harrigan**, *VAHHS*~~ **Thomasena E Coates**, *Blueprint QI Facilitator* **Lauri Scharf**, *BiState Primary Care Assoc.*	• Point of care support	**6/1/2021 – Completed** **6/22/2021 – Completed**
6	**Lisa Schilling**, *Medicaid Operation* **Erin Carmichael**, *Medicaid Quality* **Shawn Skaflestad**, *Medicaid Performance Management/Improvement* **Tim Tremblay**, *Vermont Blueprint for Health*	• Quality Improvement and Reporting for Medicaid and the Blueprint • Overall evaluation of GC1115 waiver	**6/10/2021 – Completed**