Health Quality Planning Commission Annual Report

Creating a Healthy Idaho

November, 2012

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Acknowledgments

The Health Quality Planning Commission (Commission) wishes to thank Idaho's Legislature for its unwavering support of the Commission and its efforts. The Commission would also like to thank Idaho's major health care stakeholders for their selfless contributions to this effort, which include their time and staff resources. Much of the work of the Commission would not have been possible without the generous staff support provided by the Department of Health and Welfare, Regence Blue Shield, Blue Cross of Idaho, Saint Luke's Health System, Saint Alphonsus Regional Medical Center, Health West Inc., Kootenai Medical Center, the Employer's Health Coalition, several physicians, and others.

Foreword

This document is submitted to the Department of Health and Welfare's Director Richard Armstrong, the Legislative Health Care Task Force, the Idaho Senate Health and Welfare Committee, and the Idaho House Health and Welfare Committee to meet the requirements set out in House Bill 494, passed by the 2010 Legislature. This legislation modified House Bill 489, passed by the 2008 Legislature, governing the Health Quality Planning Commission (Commission). House Bill 494:

- Removed the sunset date for the Commission.
- Maintained the primary mission to promote improved quality of care and improved health outcomes through investment in health information technology and in-patient safety and quality initiatives in the state of Idaho.
- Added responsibility for the Commission to monitor the effectiveness of the Idaho Health Data Exchange.

Health Quality Planning Commission Members

Chair Vice President, Chief Quality & Patient Safety Officer, Saint Alphonsus

Dr. J. Robert Polk Hospital, Boise, Idaho

Vice Chair

Dr. Julie Foote Treasure Valley Endocrinology, Boise, Idaho

Committee Members

Scott Carrell Employers' Health Coalition of Idaho, Boise, Idaho

Dr. David Pate President and CEO, Saint Luke's Health System, Boise, Idaho

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(resigned 5/2012)

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(resigned July, 2012)

Executive Director, Health West, Inc., Pocatello, Idaho

Note: Currently there are three vacancies on the Commission. Recommendations to the Governor to fill those vacancies have been made or will be made soon.

Committee Staff

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Executive Summary

The Health Quality Planning Commission (Commission) members began this year by continuing their examination of stroke and its impact on the lives of Idahoans. Members sought information to better understand the extent of the problem, the current environment for responding to stroke, and what options existed for improving the quality of care provided to stroke victims in Idaho. A workgroup comprised of a physician, a clinic administrator, hospital representatives, and a Department of Health employee worked to gather information about what is currently being done and identify where there is need for improvement. The Commission also listened to presentations about neighboring states' efforts to address stroke care. After hearing from the workgroup members and other presenters, the Commission unanimously recommended that the Legislature empower the Idaho Department of Health and Welfare to develop a plan to establish a statewide stroke system of care.

Next, the Commission began examining a different but somewhat related issue, trauma. Both trauma and stroke are health issues that many believe can most effectively be addressed by creating a formal system of care that includes multiple avenues to improve outcomes: prevention, public education, training for all responders at all levels, the use of best practices, data collection, and targeted intervention/improvements resulting from analysis of the data. Integrating various systems of care fits well into an overall quality improvement approach.

Acknowledging the significant relationship between stroke and trauma and the efficiency of potentially addressing both health issues with one system of care, the Commission began its investigation of trauma. A host of subject matter experts presented information about trauma to the Commission including emergency medical services (EMS) representatives and hospital representatives from both of the only two hospitals in Idaho currently designated as trauma centers, Saint Alphonsus Regional Medical Center and Eastern Idaho Regional Medical Center. After much discussion over several meetings, and efforts of the workgroup to examine both the current impact of trauma on Idahoans and the potential avenues of improvement, the Commission recommended that the Legislature acknowledge trauma as a significant public health issue and acknowledge that Idahoans would benefit from the creation of a statewide trauma system of care.

The Commission was challenged throughout this work to find the data necessary to understand both the cost and the impact of stroke and trauma in Idaho. Lack of access to data makes assessing the problem, and identifying successful interventions, difficult. As a result, the Commission has further recommended that the Idaho Legislature create an advisory committee to research what would be necessary to establish a hospital discharge database and an all payer claims database in Idaho. This group would be responsible for recommending the framework needed for the database, describing how it would be governed, and developing an implementation plan.

Finally, the Commission continued evaluating the effectiveness of the Idaho Health Data Exchange (IHDE). Last year, pharmacy and medical measures of effectiveness were agreed to. However, little analysis has been done to date for two reasons; the cost of such

an analysis is very high and the relatively low participation rate in the IHDE makes it difficult to assess its true impact on health outcomes. However, with participation in the IHDE growing over the last several months, an analysis of utilization is a logical next step. Additionally, the IHDE has made a decision to outsource evaluation work in the near future. As a result, the Commission fully expects that it will be better positioned to report on actual quality measures as they relate to the success of the IHDE by this time next year.

The Commission has more work to do. It remains cognizant of its role and the opportunities it has to improve care for Idahoans and create a healthy Idaho. All Commission members are committed to continuing to examine ways to meet this challenge.

Background

The Health Quality Planning Commission (Commission) was established by House Bill 738 during the 2006 legislative session, extended with House Bill 238 in the 2007 legislative session, and extended again in 2008 with House Bill 489. The purpose of the Commission is to "...promote improved quality of care and improved health outcomes through investment in health information technology and in patient safety and quality initiatives in the state of Idaho." ¹

The Commission is a committee of eleven individuals selected by the Governor's office and led by Senator Compton. These eleven members have varying levels of investment in health information technology, different viewpoints about the health care system, and represent a broad sweep of the Idaho health care system. Members include hospital CEOs, providers, private payers, businesses, and employers in Idaho. Meetings are led by the Chairperson, Dr. Polk, and the Director of the Department of Health and Welfare, Richard Armstrong, attends all meetings. The Commission also has a staff liaison from the Department of Health and Welfare.

During the first two years of its work, the Commission focused on establishing a plan to implement a health information exchange for Idaho. A 501(c)(6) not-for-profit corporation, the Idaho Health Data Exchange (IHDE), was established. Its status as an independent, legally established entity that is responsible to a board of directors with members from a broad base of stakeholders will help ensure that its primary commitment is to the common good.

In 2010, with the passage of House Bill 494, the duties of the Commission were slightly modified. That legislation removed the sunset date for the Commission, maintained the emphasis on promoting health and patient safety planning, and added responsibility for monitoring the effectiveness of the IHDE. House Bill 494 restates the Commission's responsibility for making recommendations to the Legislature about opportunities to improve health information technology in the state, as well as recommending "...a mechanism to promote public understanding of provider achievement of clinical quality and patient safety measures." ²

House Concurrent Resolution No. 39 was also passed during the 2010 legislative session. That resolution encourages the Commission to study stroke systems of care in Idaho and develop a plan to address stroke identification and management.

The Commission spent the last year focusing on the next phase of its original and current legislative directive to look systematically at issues of health quality and safety. A summary of that work follows.

² The sixtieth Legislature of the State of Idaho, House Bill No. 494, as presented by the Health and Welfare Committee

¹ The fifty-eighth Legislature of the State of Idaho, House Bill No. 738, as presented by the State Affairs Committee

A Focus on Stroke

The Health Quality Planning Commission (Commission) ended its last reporting year engaged in examining stroke and its impact on Idahoans. This was in response to House Concurrent Resolution No. 39, passed during the 2010 legislative session, which encouraged the Commission to study stroke systems of care in Idaho and develop a plan to address stroke identification and management.

Synopsis of What the Commission Learned about Stroke in the Previous Reporting Year

Stroke touches many individuals and families each year. In Idaho, stroke took 628 lives in 2009 and was the fourth leading cause of death. Since 2005, Idaho has ranked sixteenth in the nation for stroke deaths. Stroke is the fourth leading cause of death in Idaho and accounts for six percent of Idaho residents' deaths. Stroke is also the leading cause of long-term disability. The Pacific Northwest region has a higher death rate from stroke than the rest of the United States due to its rural nature. Only half of Idaho's population lives within 90 minutes of a Joint Commission's Primary Stroke Center.

In October, Nichole Whitener, Neuroscience Service Line Director from Saint Alphonsus Regional Medical Center, gave a presentation about the Saint Alphonsus Health System Stroke Center. The Commission also learned about the history of the American Heart and Stroke Association in Idaho and the Idaho Heart Disease and Stroke Prevention Program. This included a review of Idaho's Health Disease and Stroke State Plan for 2009-2013.

A workgroup was formed to look closely at best practices related to stroke and to identify key barriers to improving stoke care in Idaho. The barriers identified included a lack of resources dedicated to stroke systems of care in Idaho, the impact that the rural nature of our state has on care, and a lack of access to data to provide baseline information about how stroke is truly impacting Idahoans. For example, there is currently no way of knowing the number of people in Idaho who have a stroke and survive it. There is good data about Medicare recipients but not others. There is no data about younger, insured people. Some hospitals keep some data and others do not. As a state we don't have a system for gathering this data. Some structure exists within Idaho to examine stroke, but it's not sufficient and it's poorly resourced with little to no statewide or regional regulatory oversight.

The Commission heard presentations about what an ideal stroke system of care would involve: having all areas of care working together including stressing prevention, recognizing symptoms, training emergency medical services (EMS) personnel, using stroke system protocols in the emergency room, rehabilitation, and using customized patient education materials.

Current Year's Work

To develop a plan to address issues related to stroke, the Commission identified the following tasks:

- Identify what data is currently available in Idaho to inform this work and what the barriers are to sharing specific information.
- Identify how to fill the gaps in existing information to define the scope of work that has to be done. For example, it's important to know how many Idahoans have strokes each year. Currently, we only know how many die from strokes, and this information is not accurate as many die from the consequences of the initial stroke, such as pneumonia, so pneumonia is listed as the cause of death on the death certificate.
- Examine the cost benefits of various options for gathering more information and assess how access to this information may lead to better care.
- Determine what steps are necessary to set up a stroke initiative in Idaho similar to those in neighboring states.
- Review options for governing such an initiative and make a recommendation to the Legislature about who in Idaho should be responsible for the work. This includes identifying what the staffing requirements would be to develop a plan to address stroke identification and management.
- Discuss with the Idaho Hospital Association what their potential role in any initiative might be.
- Refine the existing draft recommendations.

The new reporting year began with a focus on the unfinished tasks. More information was gathered and presented to the Commission on the costs related to the Montana Telestroke. Information was gathered from the Idaho Hospital Association on their potential role in supporting a database that includes data on stroke in Idaho hospitals. The Idaho Health Date Exchange also shared information on their current capacity to support a stroke initiative. Workgroup members continued to provide information to the Commission and much discussion and exchange of ideas followed.

Once all the information needed was gathered, including the work from the previous reporting year, the Commission unanimously agreed that establishing a stroke system of care in Idaho would improve the quality of care and health outcomes for Idahoans. The Commission then crafted a recommendation requesting the Idaho Legislature empower the Department of Health and Welfare to develop a plan to establish a statewide stroke system of care. This recommendation was sent to the Chairs of the Senate and House Health and Welfare Committees, as well as the Chair of the Health Care Task Force. A synopsis of the full recommendation follows.

Synopsis of the Recommendation on Stroke

A stroke system of care involves coordinating stroke care along the entire continuum of prevention, rehabilitation, and recovery. Such a system would provide each patient with seamless transitions from one stage of care to the next with the highest quality at each step. A stroke system of care improves each link in the chain of survival and recovery and can significantly increase the proportion of patients who receive improved stroke care and outcomes.

The Commission requests the Idaho Legislature empower the Department of Health and Welfare to develop a plan to establish a statewide stroke system of care. This plan would address short-term and long-term goals in the areas of public awareness and knowledge, emergency medical services response, and healthcare system response. It would identify a proposed structure to govern a stroke system of care, the costs, and the potential cost savings. The plan should reflect the Commission's goal to support existing structure, relationships (e.g., statewide EMS physician commission), and evidence-based practices that serve to promote stroke care in Idaho.

Trauma and Trauma Care in Idaho

After completing the review of stroke and its impact on the health of Idahoans, the Health Quality Planning Commission (Commission) shifted focus to trauma and the value of creating a trauma system of care as a means of decreasing the negative impact of trauma on the health outcomes of Idahoans. Trauma was a logical area of focus because it's often the first system of care developed in states and other systems of care, such as one for stroke, can benefit from what is developed for trauma. The integration of various systems of care fits well into an overall quality improvement approach.

Impact of Trauma on Public Health

- Trauma is the greatest cause of disability in the United States.
- Rural residents are 50% more likely to die from trauma than their urban peers.
- Falls are the leading cause (37%) of trauma, with motor vehicle collisions a close second (31%).
- Trauma is the number one cause of death in the age group 1-44 years in Idaho.
- Mortality rate for trauma within the 1-44 years age group is greater than all other causes of mortality combined.
- Idaho has a higher death rate from trauma than the national average, 43% versus 41%.
- In 2009 in Idaho there were 665 lives lost to trauma (2009 Idaho vital Statistic Report).

Finally, here is some additional information relevant to Idaho. Forty-five states in the United States have a trauma system of care, including all states that touch Idaho's borders. Idaho unfortunately is not in this majority. Also, Idaho has two hospitals verified as trauma centers, Saint Alphonsus Regional Medical Center in Boise and Eastern Idaho Regional Medical Center in Idaho Falls.

What is a Trauma System of Care?

A trauma system of care is an organized, coordinated effort in a defined geographic area that delivers the full range of care to all injured patients and is fully integrated with the local or regional emergency medical system. The true value of a trauma system is derived from the seamless transition between each phase of care, integrating existing resources to achieve improved patient outcomes. Trauma systems are regionalized and developed based on the unique requirements of the population served (such as rural, urban, or Native American communities), making efficient use of health care resources. All trauma systems of care include a focus on pre-hospital prevention, care during the acute care phase, and rehabilitation.

Trauma systems, both state and regional, provide a way to optimize care and ensure the system provides the best services available by providing continuing medical education, prevention outreach, research, and quality assurance standardization. Critical access hospitals and tertiary trauma centers are equally important to an effective system.

The benefits of having a trauma system have been studied over the last twenty years showing a reduction in mortality rated following the implementation of a statewide trauma system. States such as Oregon and Washington have reduced mortality rates as much as 20% with the implementation of their trauma systems.

EMS and Trauma Care

John Cramer from the Bureau of EMS gave a presentation to the Commission on developing a statewide trauma system. The value of having a trauma system of care was acknowledged, but potential challenges were identified as well, including:

- The difficulty counties and rural areas would have coordinating services to fill all the needs in their areas with a full trauma system of care.
- The impact that the mechanism for funding a trauma system may have on EMS.
- The training requirements for personnel.
- The complexity of planning a coordinated approach that includes all agencies involved: counties, EMS, and hospitals.

Some of these challenges have yet to be addressed and are indicative of the work ahead should Idaho move forward in developing a trauma system for the state.

A Proposed Phased Approach to Establishing a Trauma System

The Commission established a workgroup to examine how Idaho could develop a coordinated approach to implementing a statewide trauma system that would address concerns and lay the groundwork for an effective system of care that would result in improved health outcomes for victims of trauma.

The workgroup provided a presentation to the Commission and is recommending a phased approach for this work. Phase one would primarily include hospitals and provide a structure and means for all hospitals, small and large, to receive a national trauma center designation. The existing tiered level of trauma center designations allows a role for all hospitals that is appropriate to the size and resources of each hospital. For example, a level one trauma center would provide leadership and be able to provide care for every aspect of injury from prevention to rehabilitation. A level four trauma center, generally a hospital located in a rural setting, would stabilize, treat and transfer patients to a higher level facility only if needed. Use of trauma protocols of care and constant education on optimal trauma care, ensures that all participating hospitals are able to treat patients appropriately and with adequate resources. Participation would be voluntary and include developing supportive relationships with local EMS and voluntary transport agencies. Phase two of the work would involve the necessary statewide EMS system enhancements. Issues such as training volunteers and coordinating local resources would be addressed.

Next Steps

After completing its review of the information provided by the workgroup and others, the Commission has chosen to continue discussion of the workgroup's recommendation but will likely recommend the creation of a statewide trauma system.

Statewide Healthcare Databases

Entwined throughout all of the Health Quality Planning Commission's (Commission) discussions over the past two years has been the question of how to understand the scope or cost of various health issues in Idaho, and how to measure the impact of any intervention without good access to data. For example, we know how many Idahoans die from stroke, but there's no data available about how many have had a stroke and survived, what their care after the stroke entailed, or how many have died of complications from a stroke. Without such data, it's difficult to understand the true burden of stroke in Idaho. This led the Commission to examine the role of two types of databases that can allow measurement of quality and cost. The first is a hospital discharge database and the second is an all payer claims database.

What is a Hospital Discharge Database?

Many states that have statewide databases that contain healthcare cost and quality data began their journey by first establishing a hospital discharge database. This is a system that collects data from hospital discharge files. While there is much state-to-state variation in specific data items and definitions, these administrative files typically contain information about patients (e.g., age, gender, race/ethnicity, location of residence, expected source of payment); their care (e.g., diagnoses and procedures), and their stay in the hospital (e.g., admission and discharge dates or length of stay, source of admission, discharge disposition, and charges). The advantage is that this data is already present and already electronic. It can be submitted to a central agency to gather the data and perform analysis of it. Clearly quality improvements may be done by having such a database. For it to be effective it must be mandatory and the information must be protected but at the same time available to participants and the state to analyze it for opportunities for improvement. Across the USA, Idaho and Alabama are the only two states that do not have any type of statewide database.

What is an All Payer Claims Database?

An all payer claims database (APCD) is a system to collect data from existing claims transaction systems used by payers and health care providers (facilities and practitioners). The information typically collected in an APCD includes patient and provider demographics and clinical, financial, and utilization data. Statewide APCDs are typically created by a state mandate and allow for detailed analysis of both the quality and cost of care. This type of database is much more complex and difficult to establish than the hospital discharge database. States that have formed a hospital discharge database usually discover within 1-2 years than an all payer claims database is also needed to cover the entire spectrum of care.

Why Do We Need Statewide Healthcare Database?

Comprehensive data about the quality and cost of health care will allow state policy-makers to monitor efforts to reduce health care costs and improve both care quality and population health. Complete data can show statewide variation in care, including whether evidence-based guidelines and best practice clinical standards are being followed and how they affect cost and quality. Data can then be grouped by community to show variations across counties, regions, or other areas. Access to this information helps health

care policymakers to identify communities that provide cost-effective care and allows them to learn from those successes. It allows for targeted population health initiatives and assessment of those initiatives. Another major advantage is the ability to understand, in ways not previously possible, how and where health care dollars are being spent. With such information, Legislators will be able to make well informed decisions about health care reform issues. As health care reform initiatives are enacted across the country, states have an unprecedented opportunity to make lasting, effective policy decisions. But such decisions require information. With escalating health care costs, the enactment of the Patient Protection and Affordable Care Act (PPACA), and declining state revenues, states are facing pressure to reduce health care costs while also providing services to the uninsured. States that have access to comprehensive information about their state are in a position to enact better policies and to track these policies' impact and effectiveness over time.

A key advantage of using billing data is that it is relatively inexpensive to develop a data system because these data are generated automatically for every medical encounter in a standardized format (UB 04 or HCFA 1500 forms). It also does not create an additional data collection burden for the provider because data is collected from the payers (e.g., health insurance companies and third party administrators).

Benefits for the businesses involved include:

- Supporting providers' efforts to design targeted quality improvement initiatives and enabling them to compare their own performance with those of their peers.
- Allowing businesses to choose insurance products for employees based on price and quality.

Consumers also benefit by having greater access to information that helps them and their health care providers make informed decisions about the effectiveness of treatments and quality of care.

After learning about the value of a Statewide Healthcare Database, the Commission unanimously agreed that in order to establish a complete picture of Idahoans' experiences with the health care system, Idaho needs a data collection system.

Synopsis of the Recommendation on a Statewide HealthCare Database

In order to establish a complete picture of Idahoans' experiences with the health care system, the Commission believes Idaho needs a data collection system of all health care hospital events and claims paid by all payers across the state. Using hospital and billing and claims data allows purchasers, policy makers, and health care consumers to have increased access to information without putting an additional reporting burden on providers because the information is already present for a hospital discharge database and is collected from payers for an APCD. The Commission acknowledges that creating the APCD is much more difficult than a hospital discharge database but recommends that both be created, with the first one being the hospital discharge database. Hospitals are the most expensive sites of care and much of the quality improvement today occurs in that setting. In the future though, the great strides in quality will come with prevention in

the ambulatory setting, and hence the APCD will be necessary. Collecting and distributing complete, uniform information would:

- Give policy makers the information they need to make informed decisions and target investments for state dollars.
- Set standards for system improvement.
- Assess quality improvement initiatives at the community level.
- Help the public understand how well providers achieve clinical quality and patient safety standards, both inpatient and ambulatory settings.
- Support provider efforts to design targeted quality improvement initiatives.
- Enable providers to compare their own performance with those of their peers.

The database should facilitate reporting of health care and quality data. Aggregation of this data results in transparency and public understanding of safety, quality, cost, and efficiency information at all levels of healthcare. It should also facilitate value-based, cost effective purchasing of health care services by public and private purchasers.

The Commission requests the Idaho Legislature create an advisory committee to research what would be necessary to establish a database in Idaho as described above. This group would be responsible for making a recommendation about the framework needed for the database(s), describing how it would be governed, and developing an implementation plan.

Evaluating the Effectiveness of the Idaho Health Data Exchange

In 2010, House Bill 494 added monitoring the effectiveness of the Idaho Health Date Exchange (IHDE) to the Health Quality Planning Commission's (Commission) responsibilities. To that end, the Commission received a presentation from Scott Carrell, the Executive Director of the IHDE, on its current goals and long-term plans. A written report was also submitted to the Commission and forwarded to leaders in the Legislature.

At the time of the last annual report, potential pharmacy and medical measures of effectiveness had been developed. One major obstacle to utilization of these measures was that the analysis has some significant complexities. Since multiple payers are IHDE participants, these claims-based measures require the involvement of a third party to combine the claims data from the different payers and to analyze it. At that time, because of the expense of contracting with a third party to combine and analyze the data, there was no such third party engaged, and thus no real measures to report.

Currently, quality reporting has still not been performed. However, the IHDE has been tracking utilization. The system tracks the number of requests for information each month. The results have been very positive. For one major Idaho hospital system, there has been a tenfold increase in utilization since October of 2011.

The IHDE intends to report more on utilization in the future. Some of the measures to be reported include:

- User login rates
- Number of patient records accessed
- Number of patients opting out of participating in the IHDE

Other areas of focus will be:

- Improving treatment and care of Veteran's Affairs (VA) patients as the IHDE plans to connect to the national VA system which will provide easy and convenient access of VA health records for non-VA providers who are caring for VA patients outside of a VA medical facility.
- Identifying any administrative cost savings found through the image exchange pilot with St. Joseph's Regional Medical Center.
- Assessing the impact of Virtual Health Record (VHR) use in an emergency room setting

The IHDE has developed a five year strategic plan that was approved in September 2011. Part of this plan involves hiring more staff to accommodate growth. One position is a business analyst that will help add new data sources (e.g., hospitals) and manage implementing a provider's electronic medical record into the IHDE to obtain clinical results information. Another part of the strategic plan is to engage a third party to complete an analysis on the effectiveness of the IHDE as part of an overall evaluation.

In the interim, we do know that as of December 2012, there were over 300 authorized users of the IHDE and 1,466,778 patient records in the database. The IHDE strategic plan has set a goal to have 1,500 or more authorized users for IHDE, including 25 or more hospitals, five or more labs, and four or more payers by 2015.

The Commission and the IHDE recognize the importance of measuring its effectiveness and intend to continue developing effectiveness reports as more data becomes available and provider participation increases.

Conclusion

The health care environment nationwide is in flux. Change is happening at many levels for health care providers, employers, health insurance providers, and patients. Health information technology is changing the way business is done in hospitals and providers' offices. Medical home models, managed care, accountable care organizations, and payment reform with a focus on health outcomes are all impacting systems of care in the United States and in Idaho. The Health Quality Planning Commission members are committed to maintaining a focus on this changing environment as it moves forward with its work and examines ways to improve Idaho's ability to effectively decrease the negative outcomes of stroke on Idahoans.

The Health Quality Planning Commission members remain dedicated to their work and determined to achieve an outcome that has the potential to result in improved health for Idahoans. They will continue to examine ways to best use the expertise and authority they hold to promote health and patient safety planning and improved quality of care and health outcomes.