Health Quality Planning Commission Annual Report

Creating a Healthy Idaho

July, 2013

Table of Contents

Acknowledgments

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 maintained the primary mission of the Commission which 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. House Bill 494 also added responsibility for the Commission to monitor the effectiveness of the Idaho Health Data Exchange.

Health Quality Planning Commission Members

Chair Dr. J. Robert Polk	Vice President, Chief Quality & Patient Safety Officer, Saint Alphonsus Hospital, Boise, Idaho
Vice Chair Dr. Julie Foote	Treasure Valley Endocrinology, Boise, Idaho

Committee Members

Scott Carrell	Executive Director, Idaho Health Data Exchange
Dr. David Pate	President and CEO, Saint Luke's Health System, Boise, Idaho
Zelda Geyer-Sylvia	President and CEO, Blue Cross of Idaho, Meridian, Idaho
Tim Dunnigan	Dean of the College of Health Sciences, Boise State University
Dr. Ted Epperly	Program Director and Chief Executive Officer Family Medicine Residency of Idaho, Boise, Idaho
Dr. Rich Rainey	Medical Director, Regence BlueShield of Idaho, Boise, Idaho
Representative John Rusche	Idaho House of Representatives, Minority Leader
Lorraine Olsheski	Executive Director of Quality and Risk Management, Kootenai Health, Coeur d'Alene, Idaho

Note: Currently there is one vacancy on the Commission. A recommendation to the Governor to fill that vacancy will be forthcoming.

Committee Staff

Michele Turbert	Program Research and Development Analyst, Department of Health and Welfare, Boise, Idaho
Rachel Strutton	Administrative Assistant II, Department of Health and Welfare, Boise, Idaho

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 Dr. J. Robert Polk. These eleven members all share an interest in investment in health information technology. They come to the Commission having experiences with the health care system at many different levels, and represent a broad sweep of the Idaho health care system. Members include hospital CEOs, providers, private payers, educators, and an Idaho Legislator. Meetings are led by the Chairperson, Dr. Polk. The Director of the Department of Health and Welfare, Richard Armstrong, attends all meetings. The Commission also has the support of 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, 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 Idaho Health Data Exchange. 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. As a result of the investigations that followed, the Commission sent a recommendation to the Legislature in October 2011 to empower Health and Welfare to develop a plan to establish a stroke system of care.

Attention then shifted to examining other time sensitive health issues. This revived discussion of how Idaho could access data to better understand the true scope and cost of various health issues in Idaho. A summary of that work follows.

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[1] The fifty-eighth Legislature of the State of Idaho, House Bill No. 738, as presented by the State Affairs Committee
[2] The sixtieth Legislature of the State of Idaho, House Bill No. 494, as presented by the Health and Welfare Committee

Time Sensitive Health Conditions

Synopsis of What the Commission Learned About Time Sensitive Health Conditions in the Previous Reporting Year (July 2011 through June 2012)

The Health Quality Planning Commission (Commission) began and ended its last reporting year examining two time sensitive health conditions: stroke and trauma. This was in part 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. The Commission gathered information and data about stroke, stroke care, and the impact stroke is having on Idahoans from a variety of sources. They examined options for setting up a stroke initiative in Idaho as well as possible ways such an initiative would be governed and funded. Once all the information on this was reviewed, the Commission sent a recommendation to the Legislature in October 2012 that the Idaho Department of Health and Welfare be charged with developing a plan to establish a stroke system of care statewide in Idaho.

After completing its review of stroke and its impact on the health of Idahoans, the 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 the structure that is developed for trauma. The integration of various systems of care, one for stroke and one for trauma, fits well into an overall quality improvement approach.

The Commission established a workgroup to examine how Idaho could develop a coordinated approach to implementing a statewide trauma system that would result in improved health outcomes for victims of trauma. The workgroup recommended 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. Phase two of the work would involve emergency medical services (EMS) and some necessary statewide EMS system enhancements. Issues such as training volunteers and coordinating local resources would need to be addressed.

The Commission concluded that a trauma system would improve the cost effectiveness of trauma care delivery, reduce the incidence of inappropriate or inadequate trauma care throughout the state, prevent unnecessary suffering, and reduce the personal and societal burden resulting from trauma. It would allow for the adoption of best practices related to trauma care, which meets the charge of the Commission as stated in House Bill 494. It has been shown to have longstanding value and includes a self-measuring tool in the trauma registry that would provide the data necessary to show if the system is actually improving care.

After completing its review of the information provided by the workgroup and others, the Commission chose to continue discussion of the workgroup's recommendations into the next reporting year.

Current Year's Work

The Commission continued discussing both stroke and trauma, and ultimately researched the option of creating one system of care that would address stroke, trauma, and heart attack. During this review it became apparent that the creation of one system of care designed to address all three of these time sensitive health conditions offered many advantages for the state.

A system of care is an organized, coordinated effort in a defined geographic area that delivers the full range of health care to all affected patients and is fully integrated with the local or regional EMS system.

The value of a system of care is that it can provide a seamless transition between and among each level of care, integrating existing community and regional resources to achieve improved patient outcomes. In Idaho, with its great geographic distances between health care facilities and regional referral centers, it is a cost effective way of making efficient use of Idaho's scarce health care resources and would bring much needed training to areas of the state where it has not been easily accessible in the past. A system of care focuses on the broad spectrum of patient care from prevention through the acute care phase, stabilization, resuscitation, definitive care, and rehabilitation. Of note, all three conditions, trauma; stroke; and heart attack, dictate the need for time sensitive interventions to produce successful outcomes.

As a result of its research, in December 2012 the Commission recommended that the Legislature adopt a concurrent resolution on time sensitive emergencies in Idaho. This recommendation was introduced during the 2013 legislative session. In support of that recommendation, House Concurrent Resolution No. 10 was passed. It empowered the Department of Health and Welfare to convene a workgroup to create an implementation plan and framework for a statewide system of care to address trauma, stroke, and heart attack. The implementation plan will include a phased approach that will begin with a trauma system and use what is developed for trauma to build stroke and heart attack systems. That workgroup has been established and is currently working on this charge. The Commission expects to hear an update on their progress at the August 2013 Commission meeting.

Statewide Healthcare Databases

Throughout all of the Commission's discussions over the past several years the question of how to understand the true scope or cost of various health issues in Idaho has always risen to the surface. It is difficult to get an accurate picture of the health of Idahoans without data. It is also difficult to accurately measure the true impact of any intervention designed to address a particular health condition. Idaho is not a state rich in 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 later. Without such data, it's difficult to understand the true burden of stroke in Idaho. This problem has presented itself with almost every health issue the Commission has examined.

As a result, in 2011 the Commission requested that the Idaho Legislature create an advisory committee to research what would be necessary to establish an all-payer, all-claims database in Idaho. This recommendation was not moved forward by the Legislature.

However, the problem of lack of data persisted in the Commission's review of time sensitive health conditions. The Commission invited Denise Love, Executive Director of the National Association of Health Data Organizations (NAHDO), to give them an overview of what options are available for collecting health data, what other states are doing to gather data, and the costs of this work and how it is being funded. Ms. Love spoke to the Commission about two types of databases: a hospital discharge database and an all-payer, all-claims database.

What is a Hospital Discharge Database?

A hospital discharge database 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. According to Ms. Love, however, for it to be effective it must be mandatory. This has been Idaho's experience to date as several years ago the Hospital Association began a voluntary hospital discharge database and very few hospitals participated. Ms. Love also noted that while the information must be protected, it must also be available to participants and the state to analyze for opportunities for improvement. Across the United States, Idaho and Alabama are the only two states that don't currently have an active statewide hospital discharge database.

The plus side of collecting hospital discharge data is it would provide a wealth of information on the health of Idahoans that is currently unavailable. It also puts Idaho in a competitive place to be able to apply for grants the state otherwise might not qualify for. Ms. Love presented information about how other states can manage collecting data without it being a huge burden on hospitals. The goal is to balance the burden of collecting this data long term so that it can be done effectively and efficiently. The estimated cost of building a database is approximately $300 thousand.

What is an All-Payer Claims Database?

An all-payer claims database 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 includes patient and provider demographics and clinical, financial, and utilization data. These statewide databases are usually 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. However, states that have formed a hospital discharge database usually

discover within one to two years that an all-payer claims database is also needed to cover the entire spectrum of care. Currently there are 16 states that have this type of database. Establishing an all-payer claims database can be challenging, especially compared to a hospital discharge database. Denise Love noted that most states begin with a hospital discharge database, soon add emergency department data, and eventually begin to look at ways to move on to an all-claims database once the value of accessing data is established. It was suggested that if Idaho chooses to add a database, it should start with a hospital discharge database.

Why Does Idaho Need a Statewide Healthcare Database?
The Commission noted that collecting and distributing complete, uniform information from this data 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.

- Support provider efforts to design targeted quality improvement initiatives.

- Enable providers to compare their own performance with those of their peers.

Access to data would 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 would also facilitate value-based, cost-effective purchasing of health care services by public and private purchasers.

Recommendation in 2013
The Commission still believes Idaho needs a data collection system. After much discussion, in March 2013 the Commission recommended that the Idaho Legislature authorize the Department of Health and Welfare to investigate creating both a hospital discharge database and an all-payer claims database. Additionally, the Commission requested that the Idaho Department of Health and Welfare establish an advisory committee that would create a phased development and implementation plan for both databases and present the proposed plan for funding within one year of the authorization date. This plan would include a recommendation about the framework needed for the databases, describe how it would be governed, estimate costs, and propose options for funding.

Evaluating the Effectiveness of the Idaho Health Data Exchange

In 2010, House Bill 494 added monitoring the effectiveness of the Idaho Health Data Exchange (IHDE) to the Commission's responsibilities. To that end, the Commission received a presentation from Scott Carrell, the Executive Director of the IHDE, on its current goals, utilization, and long-term plans. A written report was also submitted to the Commission and is attached here for your reference.

Since the last Commission annual report to the Legislature, IHDE has continued to use its grant funding under the American Recovery and Reinvestment Act (ARRA) to support its implementation of a statewide health information exchange in Idaho. To recap, in mid-2010, the IHDE was successfully awarded ARRA grant funding totaling $5.9 million. This award is helping the IHDE accelerate its strategic plan and to electronically connect Idaho providers, hospitals, and ancillary service providers across the state. To date, the IHDE has drawn down nearly $3.6 million with plans to use the remaining funds by the time the grant expires.

A business plan has been developed and will continue to be revisited as the grant period nears its conclusion. There are other variables contributing to this reassessment such as adoption rate, functionality additions, other revenue generating possibilities, etc. The IHDE has enrolled several new hospital and provider organizations. The current participant enrollment and/or connections consist of ten hospitals, six laboratories, three payers, and system access for 1,200+ provider group users. Adoption and use of the system has notably increased. Currently, the total number of authorized users is continuing to increase. As of March 2013, there were 1,890,561 patient records available in the IHDE.

The IHDE financial plan involves annual targets which will translate to a sustainable operating level. Efforts to meet these targets include adding more system functionality (i.e., image exchange, interstate connections) to enhance the needs of the healthcare community. Additionally, strategic partnerships and EMS vendor relationships are being pursued to broaden IHDE's exposure in Idaho.

Not only is the IHDE supplying a viable solution for small provider practices to be connected, but health systems too are seeking further value from the IHDE. Given the amount of health system acquisitions of provider practices and clinics, the IHDE has been involved in helping solve the information technology system challenges to connect these various facilities.

The IHDE contracted with Boise State University to complete an independent evaluation of the exchange. Part of that evaluation included a client satisfaction survey to assess the usability of the virtual health record (VHR), as well as to measure the positive and negative impact of the use of the VHR. The results of the survey skewed toward a positive assessment of the usability of the VHR. The second part of the evaluation by BSU was a claims review with the goal of measuring the impact of the VHR on the prevalence of ordering of duplicate lab and radiology tests as well as measuring the

impact of the VHR use on emergency department costs. The results of this portion of the evaluation will not be available until June.

Next Steps

The IHDE will follow these strategic plan initiatives for 2013:

- To pursue 2013 participation targets.

- To support statewide health initiatives (i.e., the Health Quality Planning Commission, patient-centered medical home, Idaho HIT initiatives, telehealth, statewide trauma system).

- Build the Immunization Gateway and connect with the Idaho Reporting Immunization System (IRIS).

- To assess market capabilities in the health information exchange landscape to pursue.

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.

Other Areas of Focus for the Commission This Year

The Commission is continually working to stay informed about changes that are occurring within the health care environment in Idaho and nationally. This information is necessary to understand potential impacts to quality of care and to direct the Commission as it continues to pursue opportunities to promote improved quality of care and improved health outcomes.

Patient Centered Medical Homes

The Commission heard presentations this year on Idaho's efforts to establish patient-centered medical homes, the value of patient engagement in their own health care, and the State Innovation Grant and its potential impact on Idaho.

Brian Peace, a Program Research and Development Analyst and Project Lead with Medicaid, presented to the Commission two times this year on work underway in Idaho to establish patient-centered medical homes. Patient-centered medical homes move primary care from acute-focused, episodic care to a model of pro-active, coordinated preventive care based on the physician-patient relationship. In this model the physician is responsible for providing for all the patient's health care needs or arranging care with other qualified professionals including care for all stages of life. It provides for enhanced access to care via expanded hours, same-day appointments, online services, and new options for communicating directly with the primary care provider. This model strives to coordinate care across all elements of the health care system and the patient's medical community, which may involve specialists, nursing homes, hospitals, etc.

Mr. Peace discussed two related medical home efforts underway in Idaho. First, Mr. Peace presented information about the Idaho Medical Home Collaborative (IMHC) which was established by Governor Otter in 2010 via Executive Order 2010-10 and is overseen by the Idaho Department of Insurance. The IMHC is a collaboration of primary care

physicians, private health insurers, healthcare organizations, and Idaho Medicaid. Additional payers include Pacific Source, Regence Blue Shield, and Blue Cross of Idaho.

The IMHC is expected to make recommendations to the Governor about developing, promoting, and implementing a patient-centered medical home model of care statewide. To this end, the IMHC launched a medical homes pilot on January 1, 2013. The pilot participants include clinics from all regions of the state. Medical homes will initially focus on patients with several categories of chronic conditions: Type I and Type 2 diabetes (when the patient has one or more disorders in addition to the diabetes), mental illness, and asthma (when the patient has one or more disorders in addition to the asthma). The participating clinics/practices are required to receive at least Level 1 National Committee for Quality Assurance Patient-Centered Medical Home Recognition within two years. Pacific Source, Regence Blue Shield, Blue Cross of Idaho, and Idaho Medicaid are all working with pilot practices to provide additional payment for participation, recognizing that the infrastructure and system investments needed to deliver care using the patient centered medical home model requires time and effort to implement. More details about the pilot program can be found on their website at http://imhc.idaho.gov/

Mr. Peace also spoke about the Idaho Medicaid Health Home initiative. That initiative launched on January 1, 2013. The base requirements for participation in both the IMHC pilot and the Medicaid Health Home initiative are the same. These pilots are the result of over two years of hard work by the payers and providers. They are expected to begin a transformation of how health care services are delivered in Idaho, changing the focus to paying providers for outcomes rather than paying using a fee-for-service model.

Patient Engagement

Next, the Commission heard a presentation on patient engagement from Leslie Kelly Hall, Senior Vice President of Policy with Healthwise. Ms. Hall discussed the Patient Engagement Framework, which is a model created to guide healthcare organizations in developing and strengthening their patient engagement strategies through the use of eHealth tools and resources. The framework is the result of nearly a year of collaboration and vetting by over 150 top experts in healthcare, technology, and human behavior, and is designed to help healthcare organizations of all sizes and in all stages of implementation of their patient engagement strategies. This framework is designed to help navigate the path toward more efficient and effective models of care that treat patients as partners instead of just customers.

The Patient Engagement Framework is divided into five phases of patient engagement. A synopsis of those phases, as taken from the National eHealth Collaborative website, The Patient Engagement Framework | National eHealth Collaborative, follows:

- Phase 1 - Inform Me: A healthcare provider in this phase demonstrates basic levels of patient engagement with an emphasis on the use of simple tools that make healthcare more convenient and accessible. This also includes providing patients with standard forms, both printable and electronic, and information about advance directives, privacy, and specific health conditions.

- Phase 2 - Engage me: This phase involves more patient/provider interaction. In this stage patients have access to their electronic health record, are encouraged to use fitness trackers and other eHealth tools, and are able to complete administrative tasks online. This phase aligns with Meaningful Use Stage One requirements, meaning that any provider receiving a meaningful use incentive payment for Stage One will have to meet the standards of this phase of patient engagement.

- Phase 3 - Empower me: Providers in this phase begin more collaboration and partnering with patients, using more patient-generated data such as care experience surveys and self-management diaries, and introduces more e-tools such as secure messaging between patients and providers and virtual coaching. It also provides online quality, safety, and patient experience ratings, and ensures participation in a health information exchange or similar efforts to enhance care coordination between provider settings. Phase three corresponds to Meaningful Use Stage Two requirements.

- Phase 4 - Partner with me: The focus here is on the patient and provider co-producing health. Responsibility is shared. It introduces things like home-monitoring devices, patients co-developing their care plans with their providers, and shared decision making that incorporates cost information into decisions. Providers integrate significant amounts of ongoing patient-generated data such as preferences, self-care, wellness, and home health device data into their EHR system. Patient records are connected to public health reporting systems and coordination of care happens seamlessly across primary, specialty, and acute care providers. Phase 4 corresponds to Meaningful Use Stage Three requirements.

- Phase 5 - Support my e-community: This phase is the culmination of a provider's progress in fully leveraging and implementing eHealth tools to connect a patient with their full care team and support his or her care management both in and out of the healthcare setting. Tools and activities here include fully interoperable EHRs and record sharing among providers and non-provider members of the patient's care team, all while granting the patient access to privacy controls. At this phase, patients and caregivers are also provided with online community support from providers, opportunities for e-visits, and information like cost comparisons and outcomes reporting to help patients make more informed decisions about their care and treatment. Providers at this phase will likely be found participating in an accountable-care or patient-centered medical home model. Phase 5 corresponds to Meaningful Use Stage Four (4+) requirements.

The Idaho State Innovation Grant
Finally, this year the Commission heard a presentation from Paul Leary, Division Administrator for Medicaid, on the Idaho State Innovation Grant awarded to the Idaho Department of Health and Welfare in April 2013. The grant is for $3 million and is a model design award. Model design funding is for states that would like to develop transformative payment and delivery reform of their health care systems. It provides financial and technical support to states for their planning and design efforts. The project in Idaho will engage stakeholders in a statewide analysis of the current health care system and identification of practices that can support transformation to a new payment and service delivery model for all health care in Idaho. The grant deliverables will serve as

blueprints for this system transformation. These documents will provide a strategic plan to transform health care in Idaho to an integrated community care model and will articulate the vision of Idaho's health care leaders, providers, and residents. The model will be network based, support the needs of primary care practices, and enhance communication and coordination of care.

This is a six month grant. The transformation plan it develops will serve as the framework for a second grant application to be made by the Idaho Department of Health and Welfare later this year for a Model Testing Grant proposal.

Mr. Leary will be providing updates to the Commission as this work moves forward over the next several months.

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. Idaho Medicaid has experienced unsustainable growth, increasing enrollment 75% over the last decade. Nearly 97% of Idaho is a federally-designated shortage area for primary care and 100% for mental health care. Idaho Medicaid is currently engaged in efforts to study and test managed care approaches, as directed by the Legislature.

The Commission members are committed to maintaining a focus on this changing environment as it moves forward with its work. Commission members remain dedicated to their work and are determined to achieve outcomes that 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.