

Health System Innovation Stakeholder Summit
 July 15, 2015
 Tribal Committee Notes

Topic	Discussion	Next Steps/Follow-Up
Introductions		
Discussion Questions (110 minutes total)		
	<p>Focus of Committee: What data-sharing project can be developed and implemented that will address gap(s) in patient care in tribal communities that cross government boundaries?</p> <p><i>(Example: The Point of Sale Registry for narcotic prescriptions accessed by state, private, federal, and tribal entities.) Discussion points revolved around why POS is successful. All of these entities can see who is getting prescriptions, where etc. Given its purpose, is there a project that we can similarly suggest that will work across governments and include off-reservation, urban Indian population in New Mexico?</i></p>	
What aspects of this project make it do-able now?	<p><u>The long-term core project that was identified by the team:</u> Trying to develop a medically integrated system of independent providers and services that is the equal to that of Kaiser/Mayo and larger integrated systems.</p> <p><u>Factors that (will) make the data exchange project do-able:</u></p> <ul style="list-style-type: none"> • Available data: Through clinics that are both 638+ federally qualified health centers (FQHC) (also called 330 clinics), there are three data systems— Government Performance Results Modernization Act (GPRA), Uniform Data System (UDS), and the Resource and Patient Management System (RPMS). We can drill down to review risk factors, diagnoses codes, demographics—to get trend data for comparative purposes. <u>Note:</u> <i>if tribes don't fully have electronic medical records (EMR) in place (working off paper client files), they have RPMS.</i> • Through GPRA, UDS, RPMS, we can look at population data to assess if native communities are advancing in health improvement compared to other populations. • Other data systems in use that can be accessed: <ul style="list-style-type: none"> -School-based health centers—Children's Functional Assessment Rating Scale (CFARS); - Healthcare Effectiveness Data & Information Set (HEDIS), - the NM Department of Health Indicator-Based Information System (IBIS) 	

	<p>-State Tumor Registry</p> <p>-Hospital data systems: there are different EMRs used among these facilities</p> <ul style="list-style-type: none"> • Health insurance carriers are a good way to see what patients are going through them, where patients are going and what their health needs are. • Native populations are getting health care away from tribal or IHS clinics. Some go to Albuquerque to Federally Qualified Health Centers (FQHC/330 clinics). • Data sharing is occurring informally--with leaders of different organizations looking at same information from respective regions and organizations. • NM has a small enough population to be innovative. • Patient portal is offered; you can print records and take it with you as a means of sharing information with a new place. • We should go to Kaiser and Mayo Clinic, or at Presbyterian to see how they provide medical services. Presbyterian Medical Services (PMS). <i>(Keep in mind we are looking at the data exchange elements that are working.)</i> 	
<p>What gaps/needs will the project address?</p>	<p>A tribal health data exchange system will facilitate better communication, helping address a lack of clinic-to-clinic/provider-to-provider communication.</p> <ul style="list-style-type: none"> • Example #1 of a need: Native patients must often carry their own paper medical records from clinic to clinic (IHS, 638, etc), which is very inconvenient. There is no sharing of information between 638 units and IHS (observation of the participant). • Example #2: Native patients often have to serve as their own patient navigators and patient advocates. (One participant carries a binder of her medical records and has found that providers rely on what is in the binder—lab records, etc. in order to address her (patient) needs, and to reduce duplication of services and procedures.) This participant felt there is a need to connect everyone, including providers, clinic services, and patients, in order to get everyone on the same page. The proposed data exchange project could eliminate the need to physically carry one’s own medical records between appointments and providers. • This project could eliminate the burden of taking time away from work and family to request a copy of the patient medical record be sent from former clinic to new clinic. <p><u>Note</u>: a question was raised. <i>Based on these two examples, isn’t this already being done? The role of care coordination staff?</i> Participants felt there was still a gap and need because lots of native patients must still carry their records around from clinic to clinic.</p> <p>A tribal health data exchange system will enhance the perception of tribal health systems as being credible by external health centers and organizations, as well as by patients, especially in urban settings.</p> <ul style="list-style-type: none"> • Pueblos who have adopted 638 generate faster payments to external healthcare organizations. This demonstrates pueblo healthcare systems as a 	

new and credible participant in tribal health. This also creates competition with IHS, which although more established, has more delays in payment.

- There's a growing population of urban tribal members who prefer to go to First Nations, First Choice, and homeless clinics (330, Federally Qualified Health Centers). American Indians are no longer relying solely on the IHS Albuquerque clinic and are moving among FQHCs as well as 638/IHS facilities.

There is a need for targeted public health campaigns to address disease-based education (ex: chronic disease risk reduction), as well as resources available to affected communities and sub-populations.

- If there are good data from local areas, we can identify primary health concerns in those communities.
- With client records, we can see how related some diseases and/or diagnoses are (such as diabetes and peripheral vascular disease) to better inform communities of the need to seek medical help for both issues, rather than just one (ex: consider other specialties like wound care for diabetic ulcers). Providers should also be more aware of this.
- More effective public health promotion campaigns should increase awareness among populations about how certain indicators of disease/symptoms may be related to other diseases.

<p>What is the purpose of data exchange, and what data will be exchanged?</p>	<p>Purpose:</p> <ul style="list-style-type: none"> • A Data exchange system will address all three Triple Aim goals (SIM grant) by enhancing the patient experience of care, and quality of care on a population level. This would be accomplished by: <ol style="list-style-type: none"> 1. Reducing or eliminating the burden placed on patients to facilitate their own paper-based data exchange (<i>through an ineffective process of carrying and maintaining their own medical records</i>). 2. Reducing or eliminating unnecessary duplication of labs and other clinic services which can be costly. 3. Improving patient care by offering effective continuous care as each provider will have their client medical history available at each appointment. <p>Data to Be Exchanged at the Patient Level:</p> <ul style="list-style-type: none"> • Medical record information <p>Population health level data:</p> <ul style="list-style-type: none"> • Quality measures that are used by different agencies can offer guidance as to what the data ought to look like: GPRA, UDS, CFARS, HEDIS. • 638 uses GPRA and 330 uses UDS for measures. UDS is what HRSA uses as well. • UDS can compare patient population data across the board whereas GPRA will not. UDS map has good resources to reference. UDS “Mapper” is a good database to reference- 	
<p>What are the benefits to the participants?</p>	<p>The Tribal data exchange will need to demonstrate and answer the following questions: What is in it for me? What is in it for my community?</p> <ul style="list-style-type: none"> • Patients will no longer need to carry or furnish their own medical records between different facilities/providers. • A Data exchange system will enhance patient experience with customer service at tribal clinics, which will in turn, encourage patient participation in healthcare. • Knowing relevant clinical information puts American Indians at a huge advantage from a provider’s perspective, because racial assumptions can be eliminated. • These data could generate larger population data about corresponding diagnoses and better direct efforts to address these on a Public Health level. • Better data about disease specific information can generate targeted education. NM-IBIS mentioned and DOH’s ability to generate targeted 	

	<p>Community health assessment. NMDOH already has capability of doing this and fulfills data requests regularly for tribes, pueblos, and nations.</p> <ul style="list-style-type: none"> • Population data will show trends that can guide efforts to better target approaches and funding. • More accurate information will help with additional grant funding to report on clinical-base data for grant goals and deliverables. • (When a data sharing project is fully implemented) Tribes will need to build capacity and infrastructure, possibly by going after foundation funding and universities. Tribal data sharing can create solid programs and good data. Many places where tribes have not gotten a fair share, like the CDC, HSRA, and other agencies fund the state. There is a trickle-down effect and tribes get the last drop in a cup that starts with the state. There’s a need for tribes to be at the rim of a full cup receiving the greatest funding. This way, tribes can build capacity and infrastructure because there are good data. This will allow direct funding to go directly to tribes (or a consortium of tribes) and not to state organizations. There’s a misplaced motivation in the state to go into and after funding available for tribes. <p>How Will Tribal Health Programs Benefit?</p> <ul style="list-style-type: none"> • 638s, FQHCs: Will be able to drill down to gaps in services, highest needs— then customize programs for the community. • Project may establish a need among I/T/Us (IHS, Tribal, Urban clinics) agencies at a government-to-government level, to share data for the purpose of learning whether we are progressing or regressing in achieving health outcomes. 	
<p>What are current barriers to sharing these data?</p>	<ul style="list-style-type: none"> • Reluctance in native communities to release information and data. A caution was made in terms of historical data sharing methods that have led to misuse of information by outside agencies and organizations. • Data is “personal” in small communities. While a small number of people may be lost to diseases (e.g., cancer), they are personally known to family, friends, and relatives. There is a high mortality impact. • Different data collection systems are used and will not interface with each other. • IHS does not like using WIFI. • IHS does not itemize their claims. There are relatively few revenue codes, although there are many diagnosis and procedure codes. Breakdowns of data are not possible, which prevents insight into what happens at IHS clinics • IHS HIPAA policies. IHS leans heavily on confidentiality and privacy which may prevent or hinder an IHS commitment with Data Sharing exchange process. • Ensuring security is another barrier. • In terms of allowing providers access to EMR, they have an inability to separate out information. Patients own their medical record and don’t want providers to “over-reach” and get information about family members, etc. 	

	<ul style="list-style-type: none"> • Different organizations, such as MCOs, are protective over information. • One major issue from an experienced Presbyterian data employee: there's no way to share only targeted information. A patient owned medical record is a better way to go, on thumb-drive and uploaded. • <i>Transparency from host organizations such as the state need to address the following in order to establish trust and meaningful participation: What is in it for community and me- what is driving this and where is it coming from and what is the benefit?</i> 	<p>NMDOH: Health Disparities Annual report. Question: how are data gathered for this report and others like it. (Aiko to follow up.)</p>
<p>How will we address and mitigate these issues?</p>	<ul style="list-style-type: none"> • Need to establish relevancy among agencies for the benefit of making comparisons, there needs to be an agreement to share data. • Care coordination could be an answer, though there are still problems. • Need to have the capability to talk provider to provider. Important. • Must develop a system everyone can trust so that paper records don't have to be carried by patients as they seek care. • Example from US Armed Forces: There is whole system integration because the Surgeon General is the main authority to go to as far as final direction for execution of an action plan. • May be able to capitalize on Armed Forces and their current effort among all branches to integrate medical records. 	
<p>Who needs to be involved to facilitate actions for a favorable outcome?</p>	<ul style="list-style-type: none"> • IHS, 638s, FQHCs 330s. • Tribal representation: tribal leaders; Tribal Councils who are in support; representatives from health boards. • Hospitals. • Kaiser and Mayo. • Federal agencies (coordinating SIM) including IHS and CMS. • Health insurance providers. 	<p>Point of Sale (narcotics registry): Would like to learn more about how the development of POS started and came to be.</p>
<p>What are our next steps?</p>	<ul style="list-style-type: none"> • Need to get IHS to the table for meaningful discussion. • Ask Presbyterian Hospital Medical Group how their model works. Their services are integrated—what about in the rest of the state? • Health insurance • Evaluate EMR and place in project 	

<p>What information do we need from or wish to share with other committees that may affect the success of project design and implementation?</p>	<p><u>What We Want to Share:</u></p> <ul style="list-style-type: none"> • Interface with IHS. There is a transition of services with other private sector providers, 638 clinics, etc. • While all IHS units have tele-health capacity, internet connectivity isn't necessarily available. • The US Armed Forces are going to integrate medical records. <p><u>What We Need to Know:</u></p> <ul style="list-style-type: none"> • Health Information Systems Committee. What information can you provide to us? • Workforce Committee. Would like information about tele-medicine and Community Health Representatives/Workers (CHRs/W). Streaming to allow healthcare in real-time, telemedicine. 	
<p>What questions, if any, does the committee have for the HIS staff?</p>	<ul style="list-style-type: none"> • Who/What is paying for interface of IT? 	
<p>Report Out Preparation (minutes total)</p>		
<p>What 4 recommendations would the Tribal Committee provide to the HSI Steering Committee (at this time) with regard to the design of the state health innovation system?</p>	<ol style="list-style-type: none"> 1. Identify the equivalent federal-level leader who has authority to coordinate health care policy change more rapidly (i.e., Surgeon General who has the authority to facilitate an Armed Forces shift to an integrated health system). IHS must be significantly involved in the process, not just CMS and state governments. 2. There should be investment in infrastructure to participate in telehealth—rural connectivity issues must be addressed. 3. Tribal consultation in this process is needed, consultation as required by law. 4. Provide education about the effectiveness of telehealth programs. 5. Implement a pilot project to demonstrate how the proposed data exchange project will work and how effective it will be. 	

Attendance:

<p>Shelly Begay Molina Healthcare</p>	<p>Kerry Marler BCBS od NM</p>	<p>Aiko Allen, NM Department of Health Tribal Liaison</p>	
<p>Charlene Poola UNM Office for community health</p>	<p>Paula Schaub BCBS of NM</p>	<p>Priscilla Caverly, NM Human Services Department, Tribal Liaison</p>	
<p>Shandiin Wood, NM Department of Health, Office of Tribal Liaison</p>	<p>Janelle Atcity Presbyterian Health Services</p>	<p>David Tempest, MD Jemez Pueblo Health Center</p>	
<p>Michelle Louis Blue Cross/Blue Shield(BCBS)</p>	<p>Theresa Belanger, NM Human Services Department (in another committee during summit)</p>	<p>Michael Bird Health Action</p>	
<p>Barbara Alvarez, NM Human Services Department, Tribal Liaison</p>	<p>Amy Armistad, UNM Project ECHO</p>	<p>David Conejo Rehoboth McKinley Christian Healthcare Services</p>	

Julia Platero, Blue Cross Blue Shield New Mexico	Lucia Lopez, NM Indian Affairs Department	LeAnne Siow Tribal Contractor	
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