

NM HSI Summit, August 19, 2015  
Tribal Committee

Topic	Discussion	Next Steps/Follow-Up
<p><b>Introductions</b></p> <p><b>Review of the Charge from Summit 2/ Summit 3: Proposed Data-Sharing Project</b></p> <p><b>Content of discussion focused on whether we are going in the right direction; preparation for a meeting roundtable with tribal leaders and I/T/Us (Indian Health Service, 638 tribally owned health clinics, and urban Indian health clinics)</b></p>	<p>Pass around sign-in sheet and collect at end of session</p> <ol style="list-style-type: none"> <li>1. Introductions:               <ol style="list-style-type: none"> <li>a. Two lieutenant governors present: Kurt Riley, Acoma Pueblo (graciously accepted to be part of the SIM Steering Committee) and Dwayne Herrera, Cochiti Pueblo.</li> <li>b. Other attendees (please see-sign in sheet).</li> </ol> </li> <li>2. Summits' update given to attendees by Aiko since there were some people that were new to the committee and the SIM Summit. Overview: <u>Presentation of follow-up information from Summit 2.</u> The stakeholder group was charged with identifying a successful model that focused on data-sharing across boundaries. The group identified the Point of Sale (POS) Narcotics Registry. This example was chosen because a provider can see information about patients whether they are at a CVS pharmacy, IHS clinic, 638 clinic, hospital, doctor's office, etc. Shandiin presented information on why the model works so the group can evaluate the data-sharing project identified at Summit 3 for whether we are on the right track.           </li> </ol> <p><b>POS Pharmacy Narcotic Registry:</b> The registry works because it is based on a series of laws designed to curb the diversion of controlled pharmaceuticals from their intended purpose to illicit activities. All agencies that provide these pharmaceuticals must operate within these laws. Features of interest in the registry:</p> <ol style="list-style-type: none"> <li>a. Easily accessible</li> <li>b. Tracking measures in place</li> <li>c. Ideal infrastructure</li> </ol> <p><u>Presentation of follow-up information from Summit 3</u> The workgroup was charged with identifying a data-sharing project that could be successful and have minimal barriers related to the exchange of information across agencies and organizations. The group decided on a data-sharing project that focused on continuity of care for patients that would:</p> <ul style="list-style-type: none"> <li>-increase provider-to-provider communication on patient medical histories, labs, etc,</li> <li>avoid duplication of services</li> </ul>	

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-address fragmented healthcare, and  
-reduce patients having to physically carry their medical records to providers and be patient navigators for themselves by way of having paper records with them when they go to provider appointments).

**Tribal Health Data Sharing Pilot Project:** In reviewing with the workgroup what exists in terms of health information exchange, Shandiin provided information on two exchanges (IHS and NMHIC—the New Mexico Health Information Collaborative) in order to get feedback on whether the proposed project is going in the right direction.

Based on what Shandiin learned, the proposed project might be to develop and implement a data sharing project between healthcare settings (IHS/HIE) and an existing information exchange system (NMHIC) with minimal barriers. The proposed project may be an opportunity, similar to the POS, to facilitate information exchange across different healthcare facilities using different electronic record systems (e.g. eClinicalWorks, NEXTGEN, Allscripts). See attached PowerPoint slide presentation.

3. Facilitator Summary (Are We Going in the Right Direction With This Project?). Based on feedback,
  - a. There is value in this project: improving patient experience and the continuum of care.
  - b. Long-term Goal: to create a seamless data exchange system
  - c. What is missing?
    - i. Need to hear from NMHIC and learn more about what this health information is, does, etc. Bring NMHIC in for a presentation.
    - ii. Need to look at the bigger picture: measure the social determinants of health
    - iii. Look at the IRB: What are the approvals that are required? Is this a project that functions as research or can it be the quality improvement patient care project that was identified during Summit 3?

Questions About the Continuity of Care Data-Sharing Project

1. Is there a Native American cohort in this data set? Based on review of the NMHIC website, an IRB is required prior to approval for any data sharing since it is intended for research purposes.

Response from a participant: Have already gone down this path with IHS. What is population health vs. utilization data? There may be no need for an IRB for the proposed data sharing project as it is quality improvement of patient care and not research. Identifying certain aspects of disease states and improvement work may not qualify as research.

Will need to review HIPAA, confidentiality, have language for data-sharing purpose and process.

Overview IHS and data based on the HIE (Health Information Exchange Diagram). IHS's system RPMS is a certified EMR (electronic medical record). It has to communicate with other records.

Challenges/Barriers

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4. Tribal Leaders and I/T/U directors (Indian Health Service, Tribal, and Urban clinic) roundtable will be held at end of September, early October, depending on feast day schedules to now share SIM and the data sharing project. Guidance from the stakeholder group from Summit 1 was to meet with leadership when there was something substantive to share with them about SIM and tribal health concerns. The HSI design is ready to circulate for feedback based on its inclusion in the packet today; the data sharing project requires feedback in order to know if the project is going in the right direction and has value. There is now enough to evaluate if SIM is of benefit to tribal leaders and communities.

The Committee has been holding Zoom conferences between meetings to ensure tribal benefit and strong feedback on SIM. Minutes from past meetings are posted on website.

- The HL7 (direct line) is very limited in who it talks to right now. It has its own internal capability. There is a lot of work on the IT side to get each facility to speak to each other given the different levels of capability. Even IHS facilities may not be able to talk to one another yet. This is a national initiative and will take time and a lot of coordination at IHS and with tribal programs.
- Getting patient results (in order to improve patient experience). In radiology—have to scan referral notes into medical records as facilities can't talk to one another.
- It will be important to not underestimate the time it will take to exchange information among systems. Complexity of tribal clinics and IHS using software and trying to work with multiple facilities and tertiary care facilities. Complexities are significantly larger when tapping into software.
- It is critical to have 2-way, bi-directional information exchange and this is not happening. (e.g. state immunization registry. How do tribes get information out. Information goes in—difficult to get out).
- The rapid, free-flowing exchange of information is difficult and security is very

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		<p>important. How would this be addressed?</p> <ul style="list-style-type: none"><li>• Each system has to follow its data system requirements and regulations. There are proprietary issues with sharing and voluntary sharing could be difficult.</li></ul> <p>Must remember that 638s won't want to deviate from RPMS.</p> <ul style="list-style-type: none"><li>• Data-sharing is one small sliver of the big picture.</li><li>• Billing is where we've made in-roads. Within IHS, as proprietor of RPMS, 638s only have approved certain keys in order to get into the system. And there are all kinds of categories.</li></ul> <p>VA (Veterans' Administration) has its own system. Issues sharing with VA and IHS?</p> <p><u>Potential in this project</u></p> <ul style="list-style-type: none"><li>• This data sharing project in terms of transfer of information could help providers and enhance patient experience of care.</li><li>• Quality improvement work tiered—front line providers want to know who is immunized—information rolled up. Example Question: By age 6, is everyone immunized? If you have 3 pediatricians—who is doing better or worse? If one stands out, what is that provider doing so others can learn and increase their immunizations. All systems questions. Not gathering</li></ul>
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		<p>patient information but populations.</p> <p>In RPMS, can call up variables—for example 3 disease states of interest by age—but not a user friendly process for providers.</p> <p><u>Other Observations</u> We are working with proprietary systems (e.g., RPMS belongs to IHS). There are challenges but a common goal (i.e. claim reimbursements) could unite all the people involved.</p> <p>Need to look at the bigger picture—how can Social Determinants of Health be measured? Looking at clinical care in the project.</p> <p>How will NMHIC protect Native American patients? What if a big pharmaceutical company wants to drill down to use NMHIC data—what happens?</p>
<b>Discussion</b>		
<p>A goal of this meeting is to refine and/or add to the recommendations we have already made to the HSI design. Given your discussion in the mixed Round Tables, we may want to “dig a little deeper” into some of the issues that fall within our committee charge and/or our recommendations.</p>	<p>What was the 1 – 2 key “learning” or “take away” from your round table discussion?</p> <ul style="list-style-type: none"> <li>• What meaning do some of these have for our committee—is it something that we need to address now?</li> </ul> <p><i>*Note: have someone write the “learnings” on flip chart paper—or have the scribe record them.</i></p> <p>:</p> <ol style="list-style-type: none"> <li>a. How difficult computer systems software is in terms of sharing information.</li> <li>b. What is missing across roundtables--looking at root causes not worked into the whole picture? Health equity, Place Matters not worked into any of the formats.</li> <li>c. Talked about cultural competency, sensitivity in documents-need vetting language.</li> <li>d. Sensitivity of initiating Well-being Coordinator job (in the workforce). (This</li> </ol>	

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<p><i>~Ask each committee member to share:</i></p>	<p>seemed like a new position) when there are all kinds of professionals like social workers, nurses (beyond EMTs, CHRs) who could introduce themselves as Well-being Coordinator. Review carefully so that we don't reinvent the wheel and duplicate what already exists.</p> <ul style="list-style-type: none"> <li>e. Medicaid, Medicare: how it affects Indian Health Services, state, and tribes.</li> <li>f. Observed (conversation around) Fragmented healthcare</li> <li>g. Increasing capacity of health councils was discussed.</li> <li>h. Capitated payments and bundled payments: how that would work in frontier and rural communities.</li> <li>i. How could we use gross receipt tax to support health councils</li> <li>j. How everyone does a different health assessment. We need a common one.</li> <li>k. Not too sure about how SIM will work in urban areas. It seems to be a good plan but how would it work</li> <li>l. Coordination of care is too "top heavy" with coordination</li> <li>m. Most attendees (in one roundtable attended by one of our participants) were new to first meeting. What was observed: Rural communities in same situations as those of us on reservation (e.g. lack of providers, services)</li> <li>n. Metropolitan view: Observed that urban folks may be unsure of who their community is (i.e. definition)</li> </ul>	
<p>Brief report-outs and up-dates from work groups, that have met and/or special tribal meetings that took place, and/or presentations assigned to committee members</p>		

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<p>Committee tasks and approach to complete Committee work given the timeframe and deliverables: <i>August—Does the current version of the HSI design adequately incorporate the recommendations made by and the work done by this committee? If not, please list what needs to be incorporated and provide as part of the summary question (below) responses.</i></p>	<p>As the task was to identify 3-4 recommendations that the workgroup would like the Steering Committee to be aware of in creating the Health Systems Innovation design model, the participants first provided a list of ideas. The group then voted on the top four ideas to share with the Steering Committee. The top four ideas were tied at 7 votes each.</p> <p>Note: the workgroup could not respond to the current version of the HSI design and its adequacy because they received the document for the first time in the participant packet for the summit. There was no time to review the document prior to the workgroup.</p> <ol style="list-style-type: none"> <li>1. Workforce development committee. Question: Who is included under the job title “Well-being Coordinator? Social workers, for example, might want to consider themselves “Well-being Coordinators” as well as other professions. (7 votes)</li> <li>2. How will fee for service be included in the payment model? How does the OMB rate fit into the payment model? (2 votes)</li> <li>3. Indian Health Service is a patient-centered medical home model for continuity of care for most patients (core population of reservations) since it offers an array of services (This is different from urban <del>to</del> and other areas of the state without a unified health system. IHS clinics offer one “house” for services. (4 votes)             <ol style="list-style-type: none"> <li>a. Go to IHS website to see IPC model (Improving Patient Care) IHS has been working for many years on SIM concept and are ahead.</li> </ol> </li> <li>4. PCMH is a comprehensive, coordinated care of services model. IHS is further ahead than any other system in contracting with multiple services. This is</li> </ol>	<p>It is requested that all ideas presented by the workgroup are included in the record for the “report-out” on workgroup recommendations. This is requested as a number of the workgroups, during their presentations, included more than four recommendations.</p>

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	<p>inherent in federal services. Patients shop services. To the patient, services may not seem fragmented. Also, any member of a federally recognized tribe must be served. (1 vote)</p> <p>5. Do service providers want to participate in PCMH? (7 votes)</p> <p>6. Initial HIS design is missing the <u>perspective from patient viewpoints</u>. Solution: Send design proposal to tribes before it is submitted to CMS. (5 votes)</p> <p>7. Cultural competence is not mentioned—should be assured among providers; also cultural humility (which comes from involving our consumers at the local level) should be assured. (7 votes) Suggestions: Go to tribal councils and ask about a resolution for HSI.</p> <p>8. Provider-centric vs patient-centered (medical home). Which is it? Challenge: it was difficult to change mindsets of providers who in the medical model were the center. Patient-centered means that—the patient is at the center and staff (including providers) are part of a team. Training is needed among providers, including their teams (e.g. medical record staff, nurses) in patient-centered medical home. (7 votes)</p>	
<p>Next steps for the Committee</p>	<ul style="list-style-type: none"> <li>● Guests: Lois Haggard and Kim Faulkner visited with participants about the work in the HIS committee during the beginning of the afternoon breakout session. They wanted the workgroup to be aware of proposed HIS Clinical and Population Health Measures for the HIS Project.</li> </ul> <p>Feedback from the group:</p> <ul style="list-style-type: none"> <li>● Behavioral health measures are very limited; should be improved. Per Lois, these measures will be expanding.</li> <li>● School-based centered data should be incorporated.</li> </ul>	



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	<p>The workgroup was asked to review measures and send any comments or questions to Kim at <a href="mailto:kim.faulkner@state.nm.us">kim.faulkner@state.nm.us</a>.</p> <ul style="list-style-type: none"> <li>• Zoom meetings: will continue even when SIM Summits aren't taking place. The HIS design model will be submitted in a few short months.</li> <li>• Data-Sharing Project</li> <li>• Question: Still need to define the problem for the project.</li> <li>• For direct services, all federally recognized tribal members are served at clinics.</li> </ul> <p>Other ideas: Address gaps in the following areas-</p> <ul style="list-style-type: none"> <li>• How to work with hospitals and health alliance (Acoma). How can the Alliance be involved in HIS project so that ACL (Acoma, Laguna, Canoncito) Hospital has support?</li> <li>• How to keep good doctors in rural areas. Is Project ECHO a solution?</li> </ul> <p>Perspectives of tribal leaders as we prepare for the roundtable.</p> <ul style="list-style-type: none"> <li>• Why should a tribal leader want to participate in this project? What are we getting in return? Patient care.</li> <li>• ..</li> <li>• What are the positive outcomes? (i.e. data is hard to deal with but together we can come up with a solution and can tell our stories)</li> <li>• Why should we contribute to this state initiative?</li> <li>• Tribes have gaps- use grants as short term solutions.</li> <li>• This initiative could be a long term solution to fill this gap.</li> <li>• Collaborations with EHCO could help fill lack of providers.</li> <li>• Collaboration with SIMS could help serve tribal people.</li> </ul>	
<b>Report Out Preparation</b>		
Identify at least 4 key recommendations for the HSI model	<p><i>Scribe: Please record these on the PowerPoint template provided and on the thumb/flash drive you have.</i></p> <ol style="list-style-type: none"> <li>1. <u>Workforce development</u></li> </ol>	

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<p>design in your committee's area of responsibility. These can be new, adapted, or enhanced recommendations based on your discussion. These will be reported out. 15 minutes</p>	<ul style="list-style-type: none"><li>a. Who is included as well-being coordinators? Can see social workers and others interested in using this title. Is this duplicative effort? Are well-being coordinators the CHW/Rs? Wider definition? Avoid reinventing the wheel.</li><li>2. <u>Cultural competency</u> among providers is needed and should be assured. Cultural humility—incorporated from patient level up—including patient feedback on HIS design model.</li><li>3. <u>Provider-centered vs. Patient-Centered (PCMH)</u><ul style="list-style-type: none"><li>a. The Medical care model now is provider-centric. IHS had to train providers (including their teams) because it was challenging to make the shift from having the provider at the center of the model to the patient.</li><li>b. PCMH training is needed so medical care becomes patient-centered.</li></ul></li><li>4. <u>Buy-in from providers</u><ul style="list-style-type: none"><li>a. Do service providers want to participate in the PCMH model? This will affect HIS design.</li></ul></li></ul>	
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