

Steering Committee Meeting Agenda

REMINDER: please print your own hard copies of meeting materials

Meeting Date: Wednesday, November 12, 2008
Time: 2:00 pm to 3:30 pm
Location: 931 Spring Street, Conference Room
Dial in number: 888-566-8440, passcode 228780#

Committee Members: Greg Bergner, MD, Dick Derby, Jim Ellsworth, Jon Lehrman MD, Shannon Truesdell MPA RN, Neda West

Staff/Guests: Maria Chaves, Sandra Dunn, Dana Davies, Rob Quadri

<u>Time</u>	<u>Topic</u>	<u>Outcome</u>	<u>Reference</u>
2:00	1. Welcome, Introductions and Agenda Review <ul style="list-style-type: none"> Member updates 		
2:10	2. Changes or additions to minutes from October 8, 2008	Decision: approve, modify or reject	
2:15	3. Care Pathways QA plan	Decision: approve, modify or reject	10/08/09 SC Mtg mat'ls
2:20	4. HIE Project Update - Jon & Greg <ul style="list-style-type: none"> Goals & objectives Clinical data set Axolotl demo - Rob 	Prepare for December vote to adopt goals, objectives, phasing	Email by COB Monday 11/10
2:45	5. Staff Updates - Sandra, <ul style="list-style-type: none"> Grants: CHCF, AHRQ, TCE, BSCF Revenue modeling EMPI - Rob/Maria AHRQ Year 3 Evaluation Report 	Shared understanding	Email by COB Monday 11/10
3:00	6. HIE capital campaign <ul style="list-style-type: none"> Brainstorm possible audiences, approaches Review briefing tools 	Member commitments for action	Email by COB Monday 11/10
3:25	7. Wrap up & next meeting Dec. 10	Call for agenda items	

Update: Health Information Exchange (HIE) Implementation Project

Steering Committee meeting: 11/12/08

1. The ACCEL HIE Clinical Advisory Committee met on 10/23 and 11/4. On 10/23, committee members confirmed and prioritized the clinical data set identified from the ACCEL business case performed in 2006.

Clinical data set	1 st priority	2 nd priority
To support inpatient and outpatient care delivery	<ul style="list-style-type: none"> o Patient demographics o Medications o Allergies o Problem list (current & past) i.e. diagnoses list o Immunizations o Information on previous and/or current providers including mental health o Discharge summaries 	<ul style="list-style-type: none"> o Test results o Visit history o Advanced directives

In addition, the group also identified key capabilities for addition as high level requirements for an HIE solution:

- Information on who patient's previous and/or current providers are and the ability to send patient information to those providers
- A summary of relevant patient information without having to wade through multiple systems and paper charts
- Share information from disease registries
- Share information/populate disease registries

EDC PHD representatives also put forth the following specific needs for high level requirements:

- Tracking of care coordination and health status for specific populations such as pregnant women, high risk infants, children in foster care
- Tracking of communicable diseases including the ability to recognize sudden increases in incidence and ability to send alerts in a timely manner
- Aggregate data (de-identified data) to
 - support analysis of incidence/prevalence of chronic conditions;
 - enable development of targeted interventions towards populations at risk; and
 - assess outcomes and effectiveness of selected programs and interventions.

2. The ACCEL HIE Clinical Advisory Committee also met on 11/4 and received a pre-RFP system demonstration of the Axolotl Elysium system. The purpose of the system demonstration was to understand potential vendor capabilities and to spark committee members thinking on what to build into the ACCEL HIE.

The HIE Clinical Advisory Committee will meet on 11/20 and 12/4 to discuss:

- HIE workflow impacts on stakeholders with and without EMRs and what it will take to maximize electronic data contribution to the HIE; and
- beginning development of an evaluation plan (process and outcome measures) for the HIE overall and for capabilities installed 12/09.

These discussions will contribute critical high level requirements for the HIE solution.

3. High level vendor investigation is in progress to determine the range of price points and associated HIE capabilities. This information will provide helpful information for vendor selection and sequencing of HIE capabilities over time.
4. Development of a draft RFP is in progress with targeted completion by the first week in December. Interviews with HIE representatives is in progress for lessons learned during their RFP process and reflections on implementation of HIE capabilities.
5. DRAFT ACCEL HIE goals for 2009 are:

Guiding Principles: Development and execution of an implementation approach that sequences installation of HIE capabilities and maximizes the utility and adoption of the ACCEL HIE solution at each phase.

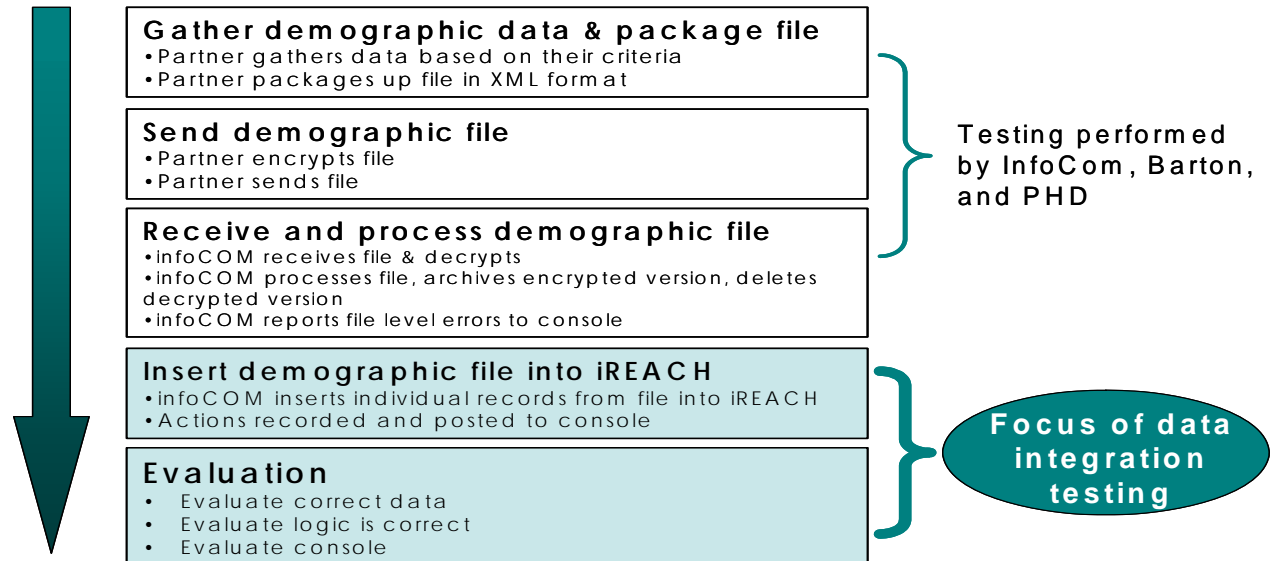
2009 Objectives for HIE Implementation

- Identify key HIE capabilities
- Procure HIE vendor solution
- Develop recommendations for implementation sequencing of HIE capabilities for 2009 and beyond
- Software installation and operational implementation of phase 1 capability(s) for the pilot between Barton Health System, Public Health Department, and the Mental Health Department by December 2009 including:
 - Development of detailed specifications for programming for HIE solution and ACCEL participant systems
 - Development of workflows for stakeholders with and without EMRs which maximizes data contribution to the HIE
 - Review, development, and adoption of policies and procedures
 - Development of an evaluation plan – HIE overall and specifics for capabilities implemented in December 2009
 - Staff training

EMPI pilot project update

Steering Committee meeting: 11/12/08

EMPI processes



- EDC Public Health Dept. and Barton Health System have been sending demographic files to iREACH since early October.
- Data integrity testing and analysis was performed in September. Data integration testing examined:
 - how infoCOM inserts individual records from a demographic file into iREACH
 - how actions were recorded and posted to the console

Seventeen scenarios were developed and tested and the infoCom iREACH system **passed** all the scenarios.

- Monitoring of the “cleanliness” of the EMPI ie redundant data and reconciliation of duplicates is still to be determined.
- Lessons learned
 - To investigate changes on the individual patient record, it will be most efficient for operational staff to begin by viewing changes from the patient’s history table.
 - The central repository architecture of the EMPI will require TBD FTE resources and effort at the originating partner site(s) and iREACH system administrator to monitor:
 - Issues with the development and transmission of the demographic files
 - Identification and reconciliation of duplicates across agencies

Assessing Care Pathway Effectiveness: The Impact of “Obtaining a Medical Home” (OMH) on Emergency Department (ED) Use

Background

The OMH Pathway was designed to increase appropriate use of primary care. After identifying children without a primary care provider when they seek treatment in the Emergency Department a Community Health Worker connects them with a provider who will serve as that child’s (and siblings’) medical home. Cases are closed when the child attends two appointments at his or her new provider site.

Outcome Measures

1. **Changes in average number of ED visits before and after enrollment in the OMH pathway.**
The average number of ED visits to the ED decreased by 0.6 visits/year (Table 1). This decrease is statistically significant at the $p < 0.01$.

Table 1: Average Number of ED Visits

	12 mos. Before OMH Pathway Enrollment	12 mos. After OMH Pathway Enrollment
Average	1.5	0.9
% change	-40%	

2. **Changes in number of ED visits by moderate and high-frequency users before and after enrollment in OMH pathway.** Following enrollment in the OMH pathway, children were less likely to be frequent ED users. This decrease is statistically significant at the $p < 0.01$.

**Table 2: Changes in Frequency of ED Use
Before and After OMH Pathway Enrollment**

Frequency	# children 12 mos. Before	# children 12 mos. After
Moderate - 2 visits	31	14
High - 3+ visits	18	12
total	49	26
% change	-47%	

3. **Change in number of moderate and high frequency users before and after enrollment in OMH pathway.** Of the 49 high to moderate frequency ED users **before** OMH pathway enrollment, only 18 continued to use the ED at the same rate. This represents a 47% decrease.

Summary

Enrollment in the OMH Pathway appears to reduce overutilization of the ED by children. The average number of ED visits per child and the total number of children with more than one ED visit per year were significantly lower in the 12 months following OMH enrollment compared to the 12 months prior.

Provider Capacity Workgroup Charter

Chartered by: ACCEL Steering Committee

Background

The overarching goal of ACCEL is to improve the health of El Dorado County residents through improved access to health care services. The Provider Capacity Workgroup has been meeting for over four years to help ACCEL broaden the network of providers in El Dorado County who will extend care to the safety-net population of under- and un-insured residents. The workgroup is comprised of clinicians and staff representing ACCEL's participant organizations. Past efforts have focused primarily on expanding access to health care for children, in response to funding initiatives. The Provider Capacity Workgroup has championed the adoption of care pathways to standardize and streamline the processes of identifying children in need of health care coverage and providing services to provide access to ongoing care in the community. In 2008, ACCEL was awarded a California Health Care Foundation planning grant to examine access to specialty care for the safety net population. This activity has expanded the scope of the Provider Capacity Workgroup by including patients of all ages who may require care beyond the boundaries of primary care. ACCEL is submitting a grant proposal to the California Health Care Foundation for a 2 year program to improve access to specialty care in El Dorado County.

Scope

The Provider Capacity Workgroup assumes responsibility for

- expanding the network of providers, including primary and specialty care, who will care for the safety net population
- identifying barriers to access and potential solutions to resolve them
- designing, implementing and monitoring care pathways that create standardized processes for improving access to care
- educating and informing community clinicians about the needs of the safety net population and opportunities to make improvements through participation in ACCEL's programs

Vision Statement for Specialty Care

By articulating clear expectations defining the roles and relationships between primary and specialty care providers in managing specific conditions, the ACCEL Provider Capacity Workgroup will improve access for patients, irrespective of insurance coverage, who need specialist services. Improvements will include

- increase in referrals that are accepted and seen by a specialist
- reduced time intervals between referral and specialist appointment and
- decreased travel distance for patients
- clearer communication between primary and specialty care providers
- increased provider and patient satisfaction

We will support these improvements through care pathways and work-up guidelines supported by training & CME, communication tools, information systems, technology, and feedback to monitor and reinforce new workflows among clinicians.

Workgroup Members

Name	Role	Affiliation
Greg Bergner, MD	Family Medicine	Tahoe Family Physicians
Sharon Bishop	MSO Multi-Site Manager	Barton Community Clinic
Troy Dickson, MD	Orthopedics	Placerville, private group practice
David Dozier, MD	Neurology	Sacramento with UC Davis affiliation
Jason Eberhart-Phillips, MD	Public Health Officer	El Dorado County
Sharon Elliott, PHD	Acting Asst. P.H. Director	El Dorado County
Jim Ellsworth	Administrator	El Dorado County Community Health Center
Alex Giloff	Practice Manager	Western Sierra Medical Clinic
Phyllis Goldie	Sup Public Health Nurse	El Dorado County
Judith Grant, MD	Family Medicine	Western Sierra Medical Clinic
Darryl Keck	Children's Mental Health Coord	El Dorado County
Jon Lehrman, MD*	Family Medicine	Marshall Center for Primary Care, Placerville
Afsheen Mostofi, DO	Family Medicine	EL Dorado County Community Health Center
Elizabeth Peterson, MD	Pediatrics	Marshall Center for Pediatrics
Dexter Quiggle, DDS	Dentist	South Lake Tahoe
Roberto Solis, MD	Family Medicine	Marshall Center for Primary Care, Cameron Park
John Verzosa, MD	Family Medicine	Tribal Wellness (IHS)
Eve Marie Welch	Physicians Assistant	Barton Community Clinic
Barry Wasserman, LCSW	Adult Mental Health	El Dorado County
Alicia Tobin-Williams, MD	Ob/Gyn	Marshall Center for OB Gyn, Cameron Park

* workgroup lead

Member Commitment

Workgroup members are expected to attend monthly meetings, serving as communication liaison between their practice and ACCEL. They are also asked to assume the role of champion for specific initiatives and to help link ACCEL project staff with resources within their practice.