

**CENTER FOR HEALTHCARE TRANSPARENCY**  
**Meeting Summary**  
**Regional Data Center Collaborative**  
**SubGroup 3: Clinical Data**  
**September 17, 2014**

**Attendees:** Beth Newsom, CIVHC, Brad Lehmann, HealthBridge, Molly Cahall, GCHC, Kimberly Mueller, HealthInsight, Jay Besse, LSUHSC, John Fielding, LHCQF, Judy Loren, MEHMC, Matthew Gigot, WCHQ, Jared Nashida, WCHQ, Jo Musser, WHIO

**Staff:** Kristin Majeska, Harriett Wall, Mary-Isabel Aromando

Introductions: participants shared recent clinical data challenges and successes.

Challenges: Patient matching; dealing with various sized practices submitting the same types of data to a portal (varying levels of comfort with data submission); transitioning from single data warehouse to a federated warehouse system; patient tracking when encountering different patient identifiers; taking the wealth of data and making it invaluable to individual physicians, clinical and claims data controlled by two separate entities – difficult to blend those in the political environment, extracting data from EHRs can be challenging for practices, especially small physician practices; not all EHRs are “speaking the same language”.

Successes: Maintaining a data system while improving process efficiencies; interfacing with school-based health centers so their data is represented; making progress with multiple data stakeholders; getting state/regional data stakeholders in productive collaborative relationships.

**CHT Context**

CHT is designed from the bottom up so that users can determine the best way for data to be managed and used in their communities. CHT is the only truly multi-stakeholder initiative working toward transparency defined by public reporting. This group, focused on the clinical data piece of transparency, is part of the Regional Data Collaborative which, in turn, is a piece of the larger project.

What are we willing to experiment with to get to the larger shared goal? Group members will be asked where they are currently in this process and where do you see your work in one, three or five years? The intent is that members will learn from each other’s experience. There are also regions of the country where there isn’t a lot happening regarding public reporting. We hope learning captured in this project will be used accelerate transparency in these “white spaces”.

Goals of the CHT include wording about “cost and quality”. Suggestions from a group member that in healthcare, “price” may be more accurate. Relative resource value or median price may be the more likely outcome of the CHT initiative. The Executive Committee will be discussing the use of terms and ensuring the consistency of the language used during work on the project.

**Review of Role and Deliverables:**

Topics for clinical data Subgroup:

- working with entities that supply clinical data
- standards for data feeds
- standards for assessing accuracy and completeness of data
- considerations for claims and patient reported data integration

- potential impact of emerging technologies.

We may also want to look at data collection processes and how that looks in small physician practices. For example using tactics like building definitions into data capture spreadsheets, discouraging “pre-cleaning” of data, creation of data finishing guidelines.

How do organizations identify where there may be issues around how data is coming into the organization?

Measure consistency will be primarily addressed at the Full Group level and by the Public Reporting Subgroup

Would this group consider patient safety measures? Most group members were not currently dealing with patient safety measures and recommend it not be included in this Subgroup.

Security for clinical data – are there aspects of security that would not be covered in another group that are unique for clinical data? True dates and identifiers have been omitted for some members in an effort to minimize exposure to a potential breach. Technical aspects of securing data might be applicable to this group’s work. Creating agreements and meeting security requirements of clinical data might be a good addition to this group’s goals. This group will meet with Subgroup 1 later in the project to address security issues.

Working with entities that supply clinical data – may get more diverse as we begin to do this work. We should reflect on the vendor perspective.

Interfacing behavioral health entities into the HIE. Patients are concerned about how a PCP will handle their needs based on their record indicating they have seen a behavioral health clinician. This may be better addressed by SG 5 (Public and Private Reporting). There is also the concern of the patient accessing behavioral health records without a clinician to help them interpret the information. Is behavioral health data a special case in the work of each of the five subgroups? Sensitive populations - behavioral health, substance abuse, reproductive services – all may need consideration by each subgroup in terms of handling data.

Other goals may emerge as the group begins the work.

### **Next Steps/Information Request from Subgroup Members**

Members are asked to provide the following to [hwall@nrhi.org](mailto:hwall@nrhi.org) by October 10<sup>th</sup>

Two examples of clinical measures you report (publically or privately) or plan to report that you believe consumers or purchasers particularly value, with brief description of data sources, data elements, and primary use cases

### **Logistics**

Group members can submit materials via email to [hwall@nrhi.org](mailto:hwall@nrhi.org) or to the online repository once set up. Members are welcome to sit in on other subgroup meetings and/or invite other colleagues to the clinical Subgroup based on the topic.