Health System Innovation
June 17, 2015 Summit
Health Information Systems Committee

Attendance:

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Topic	Discussion	Next Steps/Follow-Up
Introductions Name, Position, and Organization	Name, Position, and Organization	
Discussion Questions (90 minutes total)		
Brief report-outs of information gathered so far by committee members who volunteered to do this for the group during Summit I (3 mins each/ 20 mins overall): •Status of state's HIE (Tom East) •Data inventory (Kelly Gallagher) •Analytic measures (Galina Priloutskaya) •Regulatory issues (Maggie Gunter) •Data quality and standards (Terry Reusser)	**Data Inventory** – Kelly Gallagher provided a 5 page document identifying individual-level data sources. Agreed that the committee would inventory as much data as we can and later decide what's needed. Identified that providers needed to be part of this committee, e.g. MCOs have provider portals, maybe providers could submit more member data. Members were asked to review the document and provide feedback and additional datasets to Kelly. She agreed to be the collector/focal point of data inventory for the HIS Committee. **Analytic Measures** – Margy presented for Galina. She provided 2 handouts: (1) HealthInsight New Mexico Performance Measure Crosswalk identifying over 80 measures. These measures are not population based, only participant/provider data, (2) Minnesota HealthScores showing MN Community Measurements such as Patient Experience Measures, Quality Measures, and Cost Measures. Decided we need to follow what Minnesota, Maine, Colorado, and/or other states have done. Suggested to share measures with the Population Health Committee. **Regula tory Issues** – Randy McDonald (attorney) has agreed to meet with Committee to discuss privacy, regulatory and security electronic	Members were asked to review the document and provide feedback and additional datasets to Kelly Joannie to share measures with the Population Health Committee. Electronic version of measures is needed from Galina.

•System interoperability (Paula Morgan) 3 minutes per person; 18 minutes total	health information policies. He was unable to attend Summit #2, but plans on attending next Summit. In the meantime, Tom East, Maggie Gunter, and Rick Edwards agreed to work together on policy regarding privacy. NM health privacy laws are more rigorous and supersede HIPPA. Maggie will send a copy of the Electronic Medical Records (EMR) Act of 2009, with hope that Randy can walk us through it. **Data Quality and Standards** – Terry distributed a 13 page document from the ONC concerning Interoperable Health IT Infrastructure national standards for committee to review. **System Interoperability** – Paula emailed a PowerPoint concerning interoperability identifying three levels of interoperability: (1) Business Interoperability, (2) Information Interoperability, and (3) Technical Interoperability and discussed each. **Status of State's HIE** – Tom distributed a PowerPoint titled, New Mexico Health Information Collaborative (NMHIC) The Statewide Health Information Exchange (HIE) Network. Due to limited time, he reviewed how the NM HIE works, the current HIE data providers, and the CMS Care Record Requirements. It was suggested Tom do a webinar at a later date reviewing his PowerPoint, as it provides extensive valuable information.	Maggie will send a copy of the Electronic Medical Records (EMR) Act of 2009 to HIS Committee. HIS Committee members to read document provided by Terry.
Describe the integrated care and wellness approach as you understand it from the presentation this morning? 8 minutes	Specific question was not addressed.	
What are current data and data system strengths with respect to the development of an integrated care and wellness model in New Mexico? (remember PH, BH, OH aspects) 8 minutes	We have good population based health data, but not record level information to support PCMH model.	
What are current data gaps that need to be addressed with regard to an integrated model in the state? 8 minutes	• No real time data to do real time improvements to health system. Record level information is limited. • Need to identify all data sources for diabetes, tobacco use, and obesity. • Lack of "central nervous system", no backbone of data exists. We need to identify what data to pay attention to and what to ignore.	

What are current strengths in terms of measures/measurements (metrics) with regard to an integrated care and wellness model? 8 minutes	Good starting point for clinical/patient measurements (e.g. NCQA), and as identified from HealthInsight Performance Measures CrossWalk, but not at population level. Also, Minnesota's metrics a good guide.	
What are current gaps in measures/measurements with regard to an integrated model? 8 minutes	• Measures data not aggregated. The data are in silos. • Not population based measures, only patient data available from certain providers • No data on providers who give care.	
What are strengths in terms of functionality of our systems with regard to an integrated care and wellness model? 8 minutes	Specific question was not addressed.	
What are gaps in functionality of our systems with regard to an integrated care and wellness model? 8 minutes	Specific question was not addressed.	
What are strengths in terms of interoperability of systems with respect to an integrated care and wellness model? 8 minutes	• Paula's review helped to define and understand interoperability. The committee needs to identify: (1) What information needs to be shared? What is the current/future status? (2) Refine the information needs/requirements. (3) Identify the technology solution. What exists today that can continue to be used? What new technology to we need? • Interoperability is the ability of two or more components, applications or systems to exchange and use information. • The best analogy for interoperability is a digital nervous system –a backbone that transports the standardized messages both to and from the end points and a brain that analyzes the messages traveling through the system. The interoperability solution helps to reduce redundant data entry, speed access to information and create a real-time flow of information through an enterprise IT system. The key benefit of creating interoperability is to improve	

	the visibility, sharing and re-use of data collection between disparate healthcare applications and devices.	
What are gaps in interoperability with regard to an integrated model? 8 minutes	Specific question was not addressed.	
Workgroup Status and Leaders (15 minutes total)		
Facilitator explains the committees **2** workgroups and their purpose and informs participants that workgroup members will be meeting together between summits to further the work from the summits.	It was decided that the 2 workgroups would be initially created to address data : (1) **Health Data and Information – Clinical Data Focus** – no leader assigned. **Members**: Terry Reusser, Sharon Zuidema, Kelly Gallagher, Tom East, Rita Galinda, Stefanie Vigil, Margy Wienbar, Jessica Moriarty, Tim Simon, and Joannie Berna. (2) **Health Data and Information – Population Data Focus** – no leader assigned. **Members**: Terry Reusser , Sharon Zuidema, David Dieterich, Paula Morgan, Rick Edwards, Kelly Gallagher, Tom East, Rita Galinda, and Joannie Berna A third committee, **Analytics, Functionality, and Technology**, will be created at a later time.	Identify a leader for the Health Data - Clinical Data Focus Workgroup, and schedule a working session prior to Summit #3 on 7/15/15. Identify a leader for the Health Data – Populations Data Focus Workgroup and schedule a working session prior to Summit #3 on 7/15/15.
The facilitator will provide the workgroup sign-up sheets and have people print their contact information clearly.	Workgroup members are listed above. Some attendees did not sign up.	Joannie will follow-up with team members for work group assignments.
Participants will gather, quickly, in the workgroups they signed-up for and will 1) pick a leader and 2) determine a time they can all meet for the first time between June 17th and July 15th. Leader please provide sign-up sheet to the scribe.	This was not completed. This is a follow-up item for the Committee.	Joannie will follow-up with Committee members requesting workgroup leaders and meeting times. Assistance may be needed from Terry and/or Sean.
The participants will receive the contact information of those in their		Joannie to send out HIS Committee notes to all members who attended Summit #2 and those who attend Summit #1

workgroup via e-mail after the summit from HSI staff.		but were unable to attend on 6/17/15.
Report Out Preparation (15 minutes total)		
Select are the 4 key points from the discussion to share with the whole Summit groups. 15 minutes	From presentation flip chart: (1) Good population based health data but not record level information to support PCMH model. No real time data to do real time improvements to health system. (2) Need to identify all data sources for diabetes, tobacco use, and obesity. (3) Lack of "central nervous system", no backbone exist (4) Good measures (e.g. NCQA) • Gap1: Data not aggregated. Data exists in silos • Gap2: Data not population based, only patients that see certain providers are captured in data. • Gap3: No data exists on providers who give care.	