

NM HSI Summit, August 19, 2015
Health Information System Committee Notes

| Topic | Discussion | Next Steps/Follow-Up |
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| Introductions | Pass around sign-in sheet and collect at end of session | |
| Discussion | | |
| <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><i>~Ask each committee member to share:</i></p> | <p>What was the 1 – 2 key “learning” or “take away” from your round table discussion?</p> <ul style="list-style-type: none"> • What meaning do some of these have for our committee—is it something that we need to address now? <ol style="list-style-type: none"> 1. In a pay for performance model, we should make sure there are the appropriate measures to identify provider performance. 2. Need proper input; not only input data going in but the data going out. 3. IF there is not a strong infrastructure then we cannot provide effective care. Financially this is where lots of the funding will need to be directed, to infrastructure and technology. 4. Security of the data is key for the privacy of patient data. 5. Use technology to reach public about health services, i.e. immunization availability. 6. How will community-centered health homes be rolled out and implemented around the state? 7. To get the outcome measures needed, we’re concerned about how EHRs are used and will be used. Let’s follow what is currently in place and build off of that. 8. Integration with Tribal IT is a big gap. 9. School based health centers are not mentioned; no IT available. 10. Local government has not been included; there is nothing about what EMS, public safety officers and fire departments do and how they will be involved, or how healthcare and social determinates of health will be addressed at city and county levels. 11. No mention of how data gets shared, of privacy, and no real time capabilities exist unless maybe among providers. 12. Metrics (measures) of health disparities are not mentioned. 13. Need to address the payment aspects in payment models, like incentives for health providers and how HIT is integrated into providing financial support to providers.?????????? 14. We need to link medical outcomes to financial incentives. 15. When EHRs are adopted, use of them should not be garbage in/garbage out. 16. Need a certified EHR to submit/use standardized data. 17. There’s no commonality in health assessments and no mention of what’s done with the information. 18. How do we create a method to share HIPPA protected information across systems, including binational borders? 19. Too many performance measures are public health and population health focused. 20. How do we address basic community health needs of clean water and refrigeration? | <p>Note-Chris Hollis not sure that SBHCs do not have IT. I’ve been told they (some) have it, but don’t know how to use.</p> |

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21. Payment method: who and how will it be paid? How will all the aspects work? Focus on high cost versus low cost of health care, rather than the necessity.
22. Duplication in the metrics. Period of measurements not mentioned. Short term measures don't show change; it's better to have a long period of measurement time to show change in population health data. Baseline needs to be established and ongoing. How do we use the data once collected?
23. How to incentivize the use of centrally located data? How to incorporate it into provider health care procedures? We need to standardize how providers will use data.
24. Utah recently implemented a database for monitoring newborns and tracking immunizations as they age.
25. "Community Centered Health Care" and "Community Centered Well Being" definitions not clear. Are they interchangeable?
26. Who will pay and how will it all work together?
27. No data on/from tribal, across border, individuals with no health care coverage, individuals not on Medicaid. How do we capture this?
28. Do we need a unique personal identifier?
29. Health Care Coordinators shouldn't be assigned from HMOs; others (who?) should assign them.
30. Need reimbursable treatments such as with EMS and crisis intervention. ???
31. Need to integrate mental health/BH into measures and model design. 60% of diabetics have depression.
32. Can providers actually do what's being proposed? CHWs need a special skill set and not anyone can do it.
33. It's false to believe providers will give up their resources and turf.
34. Providers will give what the patient wants vs giving them what they need in order to get rewarded financially and reflect patient satisfaction.
35. Patients should own their data, much like a debit card that contains their personal data. Then they can take the card to providers for access.
36. FCC and FDA provide subsidies to provide telehealth and build broadband and network infrastructures for health care.
37. Need for support time and money for providers to implement and adopt the new practices.
38. How is VA data integrated? Look at building on expertise from NMHIE.
39. If we integrate health care data with APCD then it will become very robust.
40. Integrate health care with city planning, like lighted and safe pathways, healthy foods and access to them, to reinforce community health care.
41. Master patient index goes in line with SSN or patient identifier.
42. Need patient permission to get their data. Oklahoma needs to have patient consent to share data. They have a very effective method of getting patient data. OK has an opt-out of sharing patient data. Laws are different in OK vs NM. New legislation would be required to do what OK does.
43. Tribal is its own entity and we cannot make them participate. They have to consent to participation. IHS is different, federal laws are different than Tribal NM. We need to go to tribal places where data is already being collected. Need to reach out and be willing to share the data we have; it may be a way to get them to participate. Two way sharing would be key. Sovereign nation versus IHS. Not an automatic given with tribal entities. There are some 638 data but it suffers from incompleteness.

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| <p>Brief report-outs and updates from work groups that have met and/or presentations assigned to committee members</p> <ul style="list-style-type: none"> • Randy McDonald (security/privacy regs) • Terry Reusser (governance) • Tom East, Maggie Gunter, Philip Kroth & Randy McDonald (ONC interoperability) • Sharon Zuidema, David Dietrich, Galina Priloutskaya (incentive needs, how to provide assistance with tools) | <p>Governance – Terry will email presentation due to time restrictions. Key point: 2 ways to look at governance: (1) oversight: look at state as a whole, (2) Advisory: policies, legislature, go to state to support community voice be heard. A structure needs to be in place, and we need both types of governances. Governance and advisory focus on 2 different things. Should there be a governance entity? Yes! There must be! Must be a funded entity and oversight on the governance: community representation, but needs to be funded. Must be sustainable. Group needs to weigh in on importance of Governance.</p> <p>Standards – Tom: lots of low level standards: communication of health care data, then high level standards. (Don't understand) Federal advisory organizations, i.e. Medical home specifications, use their specifications and not rework. Need meaningful use requirements. Tom will send to Sharon for distribution. What further work needed? (Can you clarify?)</p> <p>Security and Privacy – Randy: Privacy interoperability is key (see handout). General principles of privacy must be compliant with law and assure all participants that it adheres to the law. Users, submitters of data, patients all need assurance of privacy and security rules. HIPPA rules must be adhered to, especially at the user level. All points of the system must adhere to laws.</p> <p>The CIA sets security and confidential principles (different than federal CIA agency). Where do we need to drill down more? Needs further research. Need written agreements of all parties involved in all aspects of the health data systems at all points of data use and input. Need definitions of governance and interoperability. Governance structures defined at COBIT and ITIL are 2 places to get good definitions. Websites have further information if needed. Jess Moriarty has further information if needed.</p> <p>HIE looked at using SSN but NM law restricts the use of SSNs. Not a feasible option.</p> | <p>Interim meetings needed for the next 2 months since no summits in October, November. Doubletree Hotel meeting rooms still available for us to work between summits. Rooms reserved for SIM use.</p> <p>Need definitions of governance and interoperability.</p> |
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| <p><u>Afternoon Reports:</u></p> <ul style="list-style-type: none"> • Lois Haggard, Mike Landen (measures) • Mike Landen (health data gaps) • Sharon Zuidema (connecting committee work to SIM IT plan) • Terry Reusser, Sharon Zuidema (process to engage stakeholders) | <p>Measures – Mike: will provide a Survey Monkey to receive input from all committees and model design team on the distributed measures. Responders will be asked to rank list the top 5. This will enable the workgroup to whittle down the list. At September summit we'll review final list of measures.</p> <p>Measures fall into 5 major categories: cost of care, quality of care, diabetes, tobacco, obesity. BH has its own category, then there's a "waste basket" or catch-all category, which needs to be tightened up. May not be getting measures on child abuse, and other categories. Not all MAD Centennial Care measures included. These are only the MCO performance measures to LFC.</p> <p>When the final measures are identified, then we need to assure data needs are captured for these measures? Yes, Colorado SIM doing lots manually just to capture data until EHR.</p> <p>Who is entitled to use these data/measures? DOH—but aggregated data used by the health system details not determined. (Please clarify) What about community members that want to do health improvements for their community? They would need access to data to make community decisions. Public information should be available to the public because it's collected from the public.</p> <p>Data repository has 2 parts: to enhance individual health care and to research related data.</p> | <p>Email Lois or Kim with any feedback on measures.</p> |
| <p>Next steps for the Committee &/or interim meeting suggestions (Sharon Z.)</p> | <p>Health data gaps: Emergency department data, getting real time data for hospitals to help with emerging health problems. Data from other states is a data gap. Vicki is working on getting Arizona data. Kansas is also exchanging data with NMHIE. NMHIE addressing data gaps. What about other low income states like Mississippi? (What is all this about—patients being seen in other states??)</p> <p>Engaging stakeholders for HIS group. Interim meeting needed? How to engage overall stakeholders for HIS purposes? Websites?</p> <p>Timeline: Sharon's timeline SME meetings: ~ Gap analysis – all information in needed no later than the 1st week of Oct. ~ Draft including rollout needs to be completed by 10/31. ~ Master design plan must be completed by 11/30. ~ Our plan must be rolled into the master plan that will be presented to steering committee on 12/2 ~ Final design plan presented to governor on 12/4.</p> <p>If you feel you have contributions as a SME let Sharon know. David Deietrich, Rick Edwards and Cam Hall are contractors that may be reaching out to you for information. We have approximately 7 weeks to complete this.</p> | <p>Tom to send Sharon links to standards documents.</p> |

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| | <p>If this is a model design for the future of NM let's build something flexible so we don't need to redo down the line.</p> <p>All handouts will be placed on the HSI website under HIS Committee; links to other websites as well.</p> <p>Sharon's HIT Plan identifies what's needed for model design and tasks required.</p> <p>Since there are no summits in October November, meeting rooms still available for us to work at the Doubletree Hotel in workgroup meetings. Rooms reserved for SIM use.</p> | |
| Report Out Preparation | | |
| <p>Identify at least 4 key recommendations for the HSI model 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.</p> | <ol style="list-style-type: none"> 1. Leveraging existing expertise and strengths (i.e. HIE). 2. Resources Model – people, funding, payment, sustainability, prioritizing projects based on existing resources versus new 3. Infrastructure – insuring IT capabilities across NM 4. Governance – who governs HIT? Oversight 5. Standards – at all points of data from input to user, interoperability <p>Other: Performance measures – what to expect from HIS Committee</p> | |