NM Health Information System (HIS) Act Advisory Committee Meeting
Blue Cross Blue Shield Building, Albuquerque, NM
21 July 2016 2:00pm – 4:00pm

HIS Advisory Committee Members present:
Janice Torrez – Blue Cross Blue Shield of NM
Susan Gempesaw – Presbyterian Healthcare System
Michael Landen – NM DOH, Chair
Kristina Fisher – Think New Mexico
Bill Patten – Holy Cross Hospital (Taos)
Judy Williams – Health Data
Nandini Kuehn – Health Consumer, Healthcare consultant
Jeff Dye – New Mexico Hospital Association

Members not present:
Stuart Castle – Health Consumer
Denise Gonzales – Health Consumer
Steve McKernan – UNM Hospital
Mike Nelson – HSD
Marc Epstein – NM Health Connections

NM Department of Health Attendees:
Vicky Dirmyer – Health Systems Epidemiology Program
Paige Best – Health Systems Epidemiology Program

Public Attendees
Carlton Albert – NM EMS Region One, AASTEC
Brigid Quinn – Think New Mexico intern
Amy Barber – Blue Cross Blue Shield of NM
Lynne Weeks – Blue Cross Blue Shield of NM

2:00 pm   Introductory Remarks by Department of Health

                 Presenter: Mike Landen, NMDOH State Epidemiologist

2:10 pm   Introductions

2:20 pm   Review of Hospital Level Data as Reported by other States

                 Presenter: Vicky Dirmyer, Health Systems Epidemiology Program Director, NM DOH

                 Reviewed hospital level data as reported from four states:

1. Washington (http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS): Reports annually on # of Discharges, Length of Stay (LOS), Total Charges, Payer data at a facility/hospital level.
2. Oregon (https://www.oregon.gov/oha/analytics/Pages/Hospital-Reporting.aspx): Reports quarterly on a number of variables including # of discharges, net revenue costs, uncompensated care, number of emergency department (ED) visits, etc. Oregon has an All Payers Claims Database (APCD) – on an annual basis, publishes by facility, reports on ~50 measures like the cost for vaginal delivery.
3. Arizona (http://pub.azdhs.gov/hospital-discharge-stats/2012/index.html): Generates reports with common indicators (# of discharges, mean LOS by procedure, etc.) from their website AZ Hospital Compare. The most recent data available to the public is 2012 data.
4. Texas (https://www.dshs.texas.gov/thcic/publications/hospitals/Statisticalreports.shtm): Reports annually, at aggregate state level but not by facility. Does not have Total Charge data. Most recent report was 2013.

• Summary for facility level data: Some of the states do not provide data specific to health condition or procedure so how do you relate this at a patient level? If not at the patient level, how is the data useful?
• Potential Facility level variables to consider for New Mexico publication:
   # of discharges
   # of deaths
   # of births
   Proportion of C-section deliveries to vaginal deliveries

Discussion Point 1: Request by committee member to consider quality indicators, by facility, as a statistic to report out. A second request by multiple committee members is to consider the audience of these reports; are they the general public, service providers, policymakers, researchers, etc.? There was concern about reporting the number of deaths by facility as multiple factors can contribute to a patient's death. One such factor to consider is a severity index measure. Similar concern over the number of births; this number can be influenced by the size of a hospital (many small hospitals are giving up their maternity programs). Concerns over C-sections as well; how will these be defined? Planned or unplanned? More discussion needed on these variables.

Discussion Point 2: Need for standardized definitions for any variable that is publicly disseminated at a facility level. Need to be clear about the methods for calculating the measure.

Discussion Point 3: Need for cost data at a facility level. The public needs to know about both quality and cost measures. Some websites do provide cost information (price estimators) to their members (BCBS, Presbyterian Health are two examples).

Next Steps: Create a list of potential measures to disseminate at a facility level for further input from the committee. Identify primary audience.

2:40 pm   Review of Charge vs. Cost Data

Presenter: Vicky Dirmyer, Health Systems Epidemiology Program Director, NM DOH

1. AHRQ/HCUP uses Charge-to-Cost Ratio for their cost calculations. These calculations do not include physician fees. AHRQ defines cost (in their charge-to-cost ratio) as the actual expenses incurred in the production of hospital services, such as wages, supplies, and utility costs. Limitations: Not patient specific. Does not account for payer information.

2. Reviewed the CMS Hospital Compare website (https://www.medicare.gov/hospitalcompare/search.html) which is for Medicare patients only and uses payments to estimate cost of care. Payments are defined as all payments made for care starting the day the patient enters the hospital and continuing for the next 30 days. Payments can include payments made to the hospital, doctor's office, skilled nursing facility, hospital, as well as patient co-pays. Benefits: Payment information is patient specific and payer specific (Medicare).

What is the best method at getting at cost for the consumer? Three options:

- Charge-to-Cost Ratio
- Payments (Hospital Care)
- Claims Data

Discussion Point 1: It is hard to drill down to a very specific procedure or health condition. Claims data may not be able to tease out individual health conditions. Need to consider the audience. A committee member mentioned the creation of a site that provided to the public information on costs for health care. There was very little traffic to the website.

Discussion Point 2: How to define cost? There are many interpretations and applications. Ultimately the patient is interested in the out-of-pocket costs to themselves for a procedure. The patient is not aware or does not consider the hospital operation costs.

Discussion Point 3: Once again there is the need to consider who the audience is for this data. Researchers will be very different in relation to their data needs compared to the general public.

3:00 pm   Review of Cost Comparison Websites

Presenter: Lynne Weeks, BCBS – Transparency Suite of Products live demo of Blue Cross Blue Shield's Member's website.

Discussion Point 1: The website was very user-friendly and included lots of additional information, not just cost data.

Presenter: Kristina Fisher, Think New Mexico
Review three transparency websites: New Hampshire, Maine and Colorado

1. New Hampshire (quality and cost): Medical, Dental and Pharmacy. APCD state, run by New Hampshire Insurance (http://nhhealthcost.nh.gov/).

- Allows users to select insurance type and medical procedure. Results are estimated costs by facility. For insurance, users are able to include information on deductible amount and co-insurance information.
- Website includes information on quality. Users can select from a list of measures. Quality indicators are categorized as "Below the Average, "Average", or "Better than Average."

Positives of website:
• Easy for lay user to use and understand
• Inclusion of both cost and quality data. Suggestion would be to have the two measures side by side as opposed to separate searches.

2. Colorado (https://www.comedprice.org/#/home) – very new only 2 years old. APCD not state run (run by foundation).
- Home page – different audiences on the same page. Left hand side for consumers and right hand side is for researchers and policy makers.
- Three steps to complete for cost data estimates: selection of a service, information on location of facility, and patient insurance information (limited choices).

Negatives of website:
• Data for only four medical procedures.
• Most quality measures are 'average' so doesn't tell the consumer much.

3. Maine (http://www.comparemaine.org/)– one of the first states to provide cost and quality data.
- Clean homepage.
- Includes over 100 procedures.
- Includes patient experience and quality factors.
- Show prices by insurance company.
- Easy to use, cost and quality right together
- Lack of quality variables, need to add more options.

Positives of website:
• Simple, easy, and clean website.
• Public can research cost and quality together.
• Maine provides a video tutorial on how to use the website.

Discussion Point 1: What is the traffic on these websites? Kristina will contact each jurisdiction and inquire on this topic.

Next Steps: Each committee member will review the websites. For next meeting the committee will discuss likes and dislikes for each of the websites.

3:20 pm   Role Determination of the HIS Act Advisory Committee

7.1.28.8   ADVISORY COMMITTEE MEMBERSHIP REQUIREMENTS AND RESPONSIBILITIES:

A. **Advisory committee membership: The advisory committee shall be comprised of a minimum of seven individuals, and a maximum of 13, who shall be appointed by the secretary, and shall include:**
   1. the secretary or the secretary's designee, who shall serve as chair of the Committee;
   2. data source or data providers;
   3. health care consumers or representatives from health care consumer groups; and
   4. health data experts.

B. **Duties and responsibilities: The advisory committee shall convene on at least a quarterly basis to:**

   1. review and recommend to the department methods for the effective dissemination of health information reports, to include the availability of reports that would be of interest to the public;
      • *Advise on dissemination of reports, potential places for reports to be posted and/or suggested mailing lists for reports.*
      • *Recommend reports that are currently not being produced by NMDOH.*
      • *Advise on the content and appearance of a website for health information.*

   2. review health information reports and recommend amendments for the purpose of rendering reports most useful and understandable to a lay audience;
      • *Review annual HIDD report and recommend additional analysis if needed.*
      • *Review published Epidemiology Reports, recommend new report topics if needed.*
      • *Review existing annual emergency department reports, recommend reports using emergency department and outpatient data.*

   3. recommend reports that will address public concerns regarding health information and access to health care; and

- *Recommend reports that are currently not being produced by NMDOH.*
- *Recommend topical areas of research that may be informational and useful to the public.*
- *Advise on variables to disseminate at a facility level.*
- *Advise on the implementation of an All Payers Claims Database (APCD).*

4. Advise the department in carrying out the provisions of the Health Information System Act.
   - *Continue to attend advisory committee meetings.*

Discussion Point 1: Change the 4th point under section B3. Implementation implies that something is already in place. Change to "Advise on how to obtain cost data."

Discussion Point 2: Is an APCD needed in order to collect cost data? Some of the committee agreed but others wanted to know more about what is currently in place. An example would be the BCBS tool that was presented. That site has cost data already incorporated; accessible only for its members. There is worry that there will be duplication of effort.

3:45 pm   Next Steps/Future Meetings

Mike Landen:

1. Develop an Indicator list to get committee's advice on.
2. What are the ways/methods to come up with cost data?
3. What is the website that people like best?
4. Next meeting will be Tuesday 30 August 2016 at the State Library in Santa Fe from 2-4pm.
5. The following meeting will be Thursday 6 October 2016 in ABQ, 2-4 pm. Place to be decided.

3:50 pm   Public Comment

Discussion Point 1: The duties outlined in the statute that created this committee should be the guide. Need to make sure that the committee stays on task as it is easy to get caught up in one area. Need to keep in mind what is happening in communities and how the data can support these communities in their healthcare efforts. Also, must be leery of a duplication of effort. Look into what already exists and use that material to move forward.

4:00 pm   Adjourn