

**Health System Innovation
July 15, 2015 Summit
Health Information Systems Committee**

Attendance:

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Topic	Discussion	Next Steps/Follow-Up
Introductions	Names in red attended Summit III	
Discussion (110 minutes total)		
Brief report-outs and up-dates from work groups that have met • Clinical Data • Population Data	<p>~ Last meeting: report outs on some of the missing information, discussed measures and what measures currently exist and how to define those and identified tasks that need to be accomplished to get to final list of measurements</p> <p>~ Pop data group addressed: what you can get from clinical vs. pop health data and how do they tie together.</p> <p>Comment: The group also needs to discuss claims data. Reply: another, new committee is being formed to discuss APCD development with help from a contractor.</p> <p>~ Question: Was there any discussion on meaningful use requirements? Answer: This was discussed in one of the committees.</p>	

<p>Presentation on “Privacy” by Randy MacDonald</p>	<p>How can health information be used and disclosed? It’s a 4 step process. ~ 7 Recurring themes:</p> <ul style="list-style-type: none"> • health information is private and use/disclosure is restricted by law, • ownership of data is irrelevant though how it is used and disclosed is relevant, • each and every use and disclosure requires a legal justification, • HIPAA regulations govern the use and disclosure of health information, (if another law is more restrictive, that law “trumps” that of HIPAA) • NM has 5 different statutes to follow in relation to how information can be used and disclosed. • HIPAA is the basic framework for the privacy protection of health information, this includes numerous standards for uses and disclosures • Must analyze intended use and disclosure to assure compliance with the HIPAA regulations. <p>~ It’s difficult to separate the specially protected data (i.e. mental health) from the standard protected data; may need to follow the most restrictive means necessary for all the data.</p> <p>2009 NM Electronic Medical Records Act was passed but didn’t alter the rules of privacy under state law.</p> <p>~ Question: How would the APCD work in relation to privacy? A: You would have to look and examine each use and disclosure and determine its needs.</p>	
<p>Committee tasks and approach to complete Committee work given the timeframe and deliverables</p>	<p>Committee members need to get on the same page about what the work of this committee is about—which is that we need to provide a health information technology plan and the feedback of this group is important. The information will show how this nests into the specific deliverables for the HIT plan.</p> <p>Look at overarching measures (4 measures) and the core measures that are necessary; identify the list of gaps; infrastructure needs; and an inventory of existing laws and regulations. A governance framework is also needed.</p> <p>In the Policy/financial arena, the committee needs to define general privacy/security requirements and standards, including risk assessment, management and security as a subtopic under 3.a.</p> <p>Also need to work on general technical standards/principles needed for implementation guidance. Include business continuity as part of archival and recovery processes (4.a.iii)</p> <p>Need to think about technical assistance to providers.</p> <p>Comment: The tasks listed above are very data-focused and don’t</p>	<p>Take a look at the archival meeting; Terry will work to get this information to present at the next meeting.</p> <p>Identify areas/providers that need incentives to share EHRs for clinical and population health data, and how we can provide assistance with the tools and the training (Sharon, Galina and David).</p> <p>Randy, Maggie, Tom, and Phil will help with research on ONC interoperability.</p>

	<p>include specifics around use, especially in telehealth. It was noted that this is included in the project plan.</p> <p>Legislative issue that's tied to a memorial...Bob Mayer's committee was developed and the committee should take a look at the archival meeting. (Terry assigned to get this information to present at the next meeting).</p> <p>Committee needs to add in/consider risk assessment and risk management, as there will always be risk involved and how can it be managed in a reasonable way (include under defining security requirements). Randy will help to research this.</p> <p>In terms of security: confidentiality, integrity, and access (3 HIT perspectives), what is the committee trying to define. Answer: This is what we need to define to include how clinical data will be rolled up into population health data, at the base level sharing core clinical data across the health system</p> <p>Comment: We need further talk with the ONC to discuss interoperability in order to exchange data and use them in a meaningful way. Congress has also defined what else they would like to see by 2018. Response: we're looking at what we can leverage from the ONC; standard clinical data sets have been discussed as well (Randy, Maggie, Tom, and Phil to help with research on ONC interoperability).</p> <p>Identify areas/providers that need incentives to share EHRs for clinical and population health data. Identify how we can provide assistance with the tools and the training (Sharon, Galina and David).</p> <p>Define what technical assistance will be provided for general clinical data sets and assistance; expectations may also need to be defined for data frequency (Tom).</p> <p>How do we get affordable broadband exchanges within/among small providers? Many can't afford it or do not have the infrastructure to do this. We're trying to address this from different federal initiatives (how can we align these?) -Statewide health workforce committee presentation in August (Dale).</p>	<p>General clinical data sets and assistance towards this (defining what we will provide TA on), expectations may need to be defined for data frequency (Tom)</p>
<p>Measurement Discussion</p>	<p>Draft list to provide to other groups to for their reactions. Do we need the addition of a column of stewardship?</p> <p>Diabetes, obesity, and tobacco are the main measurement focus identified in the NM response to CMS for SIM, overall health, quality, and cost of care are included.</p> <p>Diabetes measures: (eye exams with patients with diabetes and patients with retinopathy/macular edema; persons getting service and the prevalence of the disease in those who have the disease). These could maybe be a subset of the eye exam measure; eye professional vs. general blindness among diabetics; amputation included under</p>	<p>Additional outcome measures for obesity</p> <p>Look at meaningful use measures</p> <p>Review Medicare/Medicare reporting requirements</p>

	<p>population health measures so it may not be necessary for a clinical measure; neuropathy (nerve system disease secondary to diabetes) added to clinical and nephropathy (kidney disease) added to clinical. One possible measure--how many have kidney disease? Should this be included within an administrative category, that is, diabetic patients receiving education?</p> <p>Obesity measures: there are challenges with measuring childhood obesity, with measures used to screen children; and to measure environmental factors (healthy food availability, walkable communities).</p> <p>Tobacco measures: smoking-related mortality outcomes to replace smoking-related morbidity; youth and adult measures to be added under risk factors; cardiovascular system measures for health outcomes.</p> <p>Overall health measures: preventive health measures (# of child well checks, dental exams, etc.); measures by ethnicity and racial groups; behavioral health (diabetic/obese patients who screen positive for depression).</p> <p>Add outcome measures for pharmacy drug utilization data and histories.</p> <p>Quality of care measures: add patient satisfaction measures; add readmission rates; add patient appointment wait times; add consumer satisfaction survey (those receiving behavioral health services).</p> <p>Cost of Care measures: add total cost of care by diagnosis; add total cost of member per year/per month; add cost of care by practices.</p> <p>Interventions (preventive, maintenance, treatment?) may be obtained from other groups as well and may be proposed to this group; if you put an intervention into place how are these measures impacted?</p>	
<p>Clinical and Population Data Gaps</p>	<p>Clinical data is defined as data from medical practices.</p> <p>Clinical data gaps: point of care testing; lab testing results; provider referral results; immunization data gaps; medication data gaps (prescriptions written and filled data); behavioral health; sharing patient information between providers; complementary/alternative health treatment (acupuncture, non-traditional providers).</p> <p>Population data gaps: lack of real time emergency data sharing; incorporate patient medical services provided in other states and outside USA; capture data by NM residency or by provider?</p>	
<p>Governance</p>	<p>Sharon provided an overview of a governance diagram, bringing up the question of who is going to handle all the elements of the system.</p> <p>Two types of governance should be addressed: data governance and health information system governance. Who governs these? Health Information Collaborative, or a HIE for NM?</p> <p>Where and how does the funding model fit in?</p>	

<p>Next steps for the Committee</p>	<p>Share measures with other groups to obtain their feedback.</p> <p>At next committee meeting: describe where Telehealth fits into our tasks; infrastructure, broadband and what strategies are available; provide data gaps to other committees.</p> <p>Governance needs further discussion.</p>	
<p>Report Out Preparation</p>		
<p>Identify at least 4 key recommendations for the HSI model design in your committee's area of responsibility. These will be reported out. 15 minutes</p>	<ul style="list-style-type: none"> • Recommend that the HIS committee provide the list of measurements identified to other committees for their recommendations • Recommend that other committees respond to the following questions: data gap needs (clinical/data we get from practices: point of care testing that doesn't get back to provider, assurance of lab testing results and point of care testing lab results); referral results, immunization data, medication data (fill data), behavioral health data, complementary health; population health data: acute data from EDs (are receiving half of hospitals but not all) on a real time basis, health care received by residents outside of the state • The committee attendees were asked who they would recommend to provide the health information system governance. Consensus was to use the structure currently established for NMHIC, Plus+. The plus+ needs to be addressed as to what that encompasses, including the data governance which is seen separate from the system governance. 	<p>Funding structure</p> <p>Next Summit tasks associated with HIT plan and the use of telehealth</p> <p>Affordable broadband that is reliable and how we can leverage some of those funds</p>