

New Mexico Health Information System (HIS) Act Advisory Committee Meeting  
State Library Building Pinon Room, Santa Fe, NM  
2 June 2016 2:00pm – 4:00pm

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HIS Advisory Committee Members present:

Denise Gonzales, member – Con Alma Foundation  
Steve McKernan, member – UNM Hospital  
Janice Torrez, member – Blue Cross Blue Shield of NM  
Susan Gempesaw, member – Presbyterian Healthcare System  
Marc Epstein, member – NM Health Connections  
Mike Landen, member – NMDOH  
Judith Williams, member – Health Data  
Nandini Kuehn, member – Health Consumer, Healthcare consultant  
Kristina Fisher, member -- Think New Mexico  
Mike Nelson – HSD

Members not present:

Stuart Castle – Health Consumer  
Jeff Dye – New Mexico Hospital Association  
Bill Patten – Holy Cross Hospital (Taos)

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  
Dick Mason – Health Action NM  
Prasamsa Dhakal – Intern at Think New Mexico  
Jay Maharath – Intern at Think New Mexico  
Marcos Duran – Intern at Think New Mexico

2:00 p.m. Introductory Remarks by Department of Health

Dr. Mike Landen, NMDOH State Epidemiologist

2:10 p.m. Introductions

2:20 p.m. Review of Health Information System Act and SB323

Dr. Vicky Dirmyer presented on HIS SB323:

- A. Enacted in 1989, Health Policy Commission were stewards, charge of the act moved to NMDOH in 2012.

Three major changes to the HIS Act in 2015:

1. Creation of an Advisory Committee (§24-14A-11, NMSA 1978)
2. The department can provide data at a facility level (previously only at the patient county of residence level) (§24-14A-8, NMSA 1978)
3. DOH is charged with creating a website by Jan 2018 (§24-14A-6.1, NMSA 1978)

- B. Other topics of discussion:

1. Public Health Act – A key part related to data collection for NMDOH.
2. Data Source:
  - a. Emergency Department Data – Collected on an annual basis from non-federal EDs/hospitals – disseminated in the year following the data collection year.
  - b. Syndromic Surveillance Data – The (near) real-time collection of ED data for surveillance of clustering of health conditions. This dataset has been used for injury surveillance during the Southeast NM winter storm, suicide clusters throughout the state, and will be potentially used for opioid morbidity surveillance. Currently 75% of hospitals are participating (the remaining hospitals are smaller and lack the technical resources that the bigger hospitals have—NMDOH is working with these smaller hospitals to get them onboard).
3. Vital Records Act (birth and death data)
4. The HIS Act is quite broad and in the definitions section (§24-14A-2, NMSA 1978), the list of data sources is expansive. In the future, NMDOH would like to explore collecting outpatient data at some point.
5. The Advisory Committee was created because of the three major changes Dr. Dirmyer addressed. This Committee purview is the whole act.

- C. Request by committee member for a two-minute historical background?

There were two legislative approaches during the 2015 Legislative session, that merged into one bill, SB323.

- D. Request by committee member to discuss current ED data collection.

It was not clear if ED data was being collected from facilities (yes it is collected, currently collecting 2015 data from facilities). Notation by NMDOH, ED data is collected under the Public Health Act and not the HIS act. There is potential that ED data collection could be moved under the HIS act. That can be discussed by the advisory committee. Currently, only hospital inpatient discharge data (HIDD) is collected under the HIS act.

Committee Member: It would be important to have a single mechanism for collecting all hospital data.

- E. Request by committee member to discuss the involvement of the Health Information Exchange (HIE).

Currently, the HIE does not assist NMDOH with the collection of HIDD or ED data. The HIE does assist with the collection of syndromic surveillance data.

- F. Request by committee member to discuss the capacity of the smaller facilities?  
Agreement that different facilities have different capacities dependent on location and size of the facility. Something to keep in mind.
- G. Request by committee member to discuss all the available data sources collected by NMDOH?  
It was determined that this would be a good topic for the next meeting.

2:40 p.m.      Advisory Committee Membership Requirements and Responsibilities (NMAC 7.1.28)

- A. Key Notes in Administrative Code:
  - 1. Minimum of 7 individuals and a maximum of 13.
  - 2. Members serve for two years, can be reappointed for consecutive terms.
  - 3. Meeting are open to the public. Members and others can speak at any time during the meeting.
- B. Request by committee member to post the meeting minutes and list of committee member names on the NMDOH website.
- C. Discussion on the frequency of meetings?
  - 1. Request to meet once a month. All committee member in agreement with monthly meetings.
  - 2. Request to alternate meetings between ABQ and Santa Fe.  
Next meeting will be in ABQ.
  - 3. Minutes, Agenda, and Advisory members will be put up on the website.
- D. Request by committee member to discuss the overall goals of the advisory committee, what are we trying to accomplish?
  - 1. Empowerment of individual consumer. Empowerment of the Legislators. Understand and bring to life financial reasons and the decision making today. Issues we face, quality, cost shifting, obscuring what counts as quality. Unique opportunity to represent the consumer, the payer, the provider – data drives everything and we need to get something out there so it is good enough. Strong advocacy. Jan 1, 2018 deadline.
  - 2. Keep front and center the ‘What’. Mobile platform. NMHIC, make plans to display data.
- E. Committee member brought up that cost data is already publicly available through the Hospital Compare.gov website. Member was unsure if the website was still active. Other members thought that cost data was not available on the website. Group decision to research the website and discuss at the next meeting.
- F. Committee member made an observation about current websites: the consumer would have difficulty accessing and understanding this data; policy persons may be better equipped to dig through publicly available data and understand, but the average consumer may have trouble.
- G. Questions posed by a committee member:
  - What kinds of standard reports would we like from our system?
  - What data is needed [by the public]?
  - How does the public access information?

This is what hospital data looks like in NM which is different than [other state].

3:00 pm      Review Hospital Specific Data

Presentation by Dr. Dirmyer

- A. HIDD – currently collecting 268 different data elements. Data is collected on a quarterly basis. We have 15 specialty facilities. 37 General Hospitals.
- B. Revenue charges are collected in HIDD; note charge data is definitely not cost data.
- C. Annual Report is publicly available on the NMDOH website.
- D. Discussion -- Look at HIDD data through the lens of health status. The Annual Report is for health outcomes. Is the aim health status or health outcomes? A committee member stated the focus should be on health equity. This would be dependent on the audience and what their needs are. Very unique public health perspective. Focus on all parts of the service delivery system to improve health outcomes.
- E. The annual report includes many graphs, one is age and sex for NM residents. NMDOH can make comparisons between NM and the US overall. For U.S. data, 2010 is the most current year of data. In 2014, results showed that NM had lower hospitalization rates compared to the U.S., but this needs to be explored more. There is the ability to analyze hospitalization by certain diagnoses codes (health conditions). For example, looking just at septicemia. NMDOH can look at other parameters like length of stay.
- F. HIDD is limited to non-federal hospitals: VA and IHS are not included. Therefore, the HIDD is limited in its surveillance capabilities. NMDOH is working with neighboring states for hospitalization data on NM residents who are going to TX, CO, and AZ for their health care.
- G. ED data – currently there are 81 variables. The administrative code for ED is very different than HIDD. HIDD data is very specific in formatting of variables, not the same for ED. In 2015, NMDOH requested Total Charges and Procedures for ED data. An ED Annual Report is also posted on the NMDOH website.
- H. Syndromic Surveillance, near real time data from ED data. NMDOH receives data from facilities every 24 hours. NMDOH hopes to have all facilities reporting by 2017. It can be challenging for facilities to be reporting ED data in two different systems.
- I. Question by non-member: How does NMEMSTARS relate to this? These EMS data are authorized in the EMS ACT – theoretically NMDOH could move it under the HIS ACT.
- J. NMIBIS – a public website where HIDD data (de-identified) currently resides. NMIBIS provides the back-end engine for a number of system: a) environmental public health tracking—links hospitalization data to environmental data, b) behavioral health portal, c) race to the top

information. Ten states work together to improve IBIS. NMIBIS allows users to query the data. NMDOH also provides indicator reports (200) for certain health conditions.

- K. Epi Reports are distributed on a monthly basis. Just another resource that uses HIDD or ED data. Another mechanism for providing health outcome data to the public.

3:15 pm      All Payers Claims Database (APCD)

- A. Previous work: NMDOH and HSD, within the SIM grant, collaborated on work around an APCD. A consultant was hired and the conclusion was that the HIS Act with rules be used for the creation of an APCD. The initial costs would be around \$700K. At this time, there is no current funding source. NMDOH is looking for some state IT funds.
- B. The HIS act states that by Jan 2018 there needs to be a website for cost and quality data. At this time, NMDOH does not collect cost data.
- C. Discussion: A committee member stated that CMS collects all claims regardless of payer. Another committee member mentioned that Florida has an APCD.
- D. About 20 states have an APCD.
- E. Discussion around the use of cost to charge ratios. Committee member mentioned that their facility applies this ratio to their own data. In-house calculations indicated that the ratio was pretty accurate: 95% or 99% accuracy rate for cost. Generic ratio doesn't work well when you have multiple hospital causes/conditions. The ratios vary by specific health cause/condition.
- F. Question to committee: how important is the cost data to this group? There was agreement that cost data is important to the committee. In an APCD, every single claim that is generated is made available and what was paid out of it. Health information exchange is not claims data.
- G. Consumer database, still want to know what will be paid. How much is someone going to pay net? Which hospital is more expensive? Discussion, hospitals don't have control of costs, but rather insurance companies, employment status, and other variables are incorporated into costs. Claims are adjudicated differently. Challenge to the consumer.
- H. Goal: We want to empower individual consumers; how close can we get to actual costs? Should there be tools for consumers by the health plan, the benefit, deductibles, the out of pocket costs? States and APCDs cannot aggregate to that kind of level.
- I. Suggestion: Pick maybe two to ten procedures or interventions that are very common. An example could be the cost to have a baby in NM. How does that compare nationally?

3:35 p.m.      Website

- A. NMDOH has the IBIS website. This could be used as the back engine for a website.
- B. NMDOH has been in discussion with RWJ for a small grant that would assist with the creation of a website.
- C. Homework: what are some examples of good websites that provide data on cost or quality of healthcare? What states are providing this type of data? The objective would be to not invent a new NM website from scratch. The committee needs to discuss a timeline for the website to go live. Would it be possible to broaden the website to a mobile platform?
- D. Some insurance companies already have transparency tools for comparing the cost for looking at procedures. Accumulate some good examples.

3:40 p.m. Next steps

- A. Meet monthly: Next meeting July 21 at 2pm in ABQ.
- B. Next meeting will be to show data sources available to NMDOH, APCD data, cost related data, hospital compare website, BCBS NM website sample, topics for future meeting, and what our timeline will be toward January 2018.

3:45 p.m. Public Comment

- A. Question from non-member: Cost to consumer, how will that be possible given so many criteria factor into cost? Cost is dependent on insurance and benefits among other variables. For ERISA groups, how do benefits and plans factor into cost. ERISA plans don't have to participate in APCD [supreme court finding].
- B. Question from non-member: New Mexico is a very diverse state. Discussion of IHS and its relation to healthcare in NM. Need to make sure that all groups are acknowledged and participate in healthcare decisions for NM.

4:00 pm Adjourn