The Office of the National Coordinator for Health Information Technology

Advancing Interoperability at the State Level Through CMS' Innovation Accelerator Program

ONC Annual Meeting November 29, 2018

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Agenda

- Overview of CMS Innovator Accelerator Program & ONC Engagement
- Understanding Health IT Opportunities within Medicaid Programs
- Applying 42 CFR Part 2 and HIPAA in Medicaid Program Design

Overview of CMS Innovator Accelerator Program & ONC Engagement

Background: Medicaid IAP

- Innovation Accelerator Program (IAP) is a collaboration between CMS Centers for Medicare and Medicaid Innovation (CMMI) and Centers for Medicaid and Chip Services (CMCS)
- Provides targeted support and technical resources to state Medicaid programs and their partners to advance states' activities related to payment and delivery system reforms
- Technical support is tailored to address specific state needs and includes:
  - Tool development
  - Cross-state learning opportunities
  - National dissemination of lessons and best practices to support Medicaid-focused innovation

Medicaid IAP Program & Functional Areas

Medicaid Delivery System Reform

PROGRAM AREAS

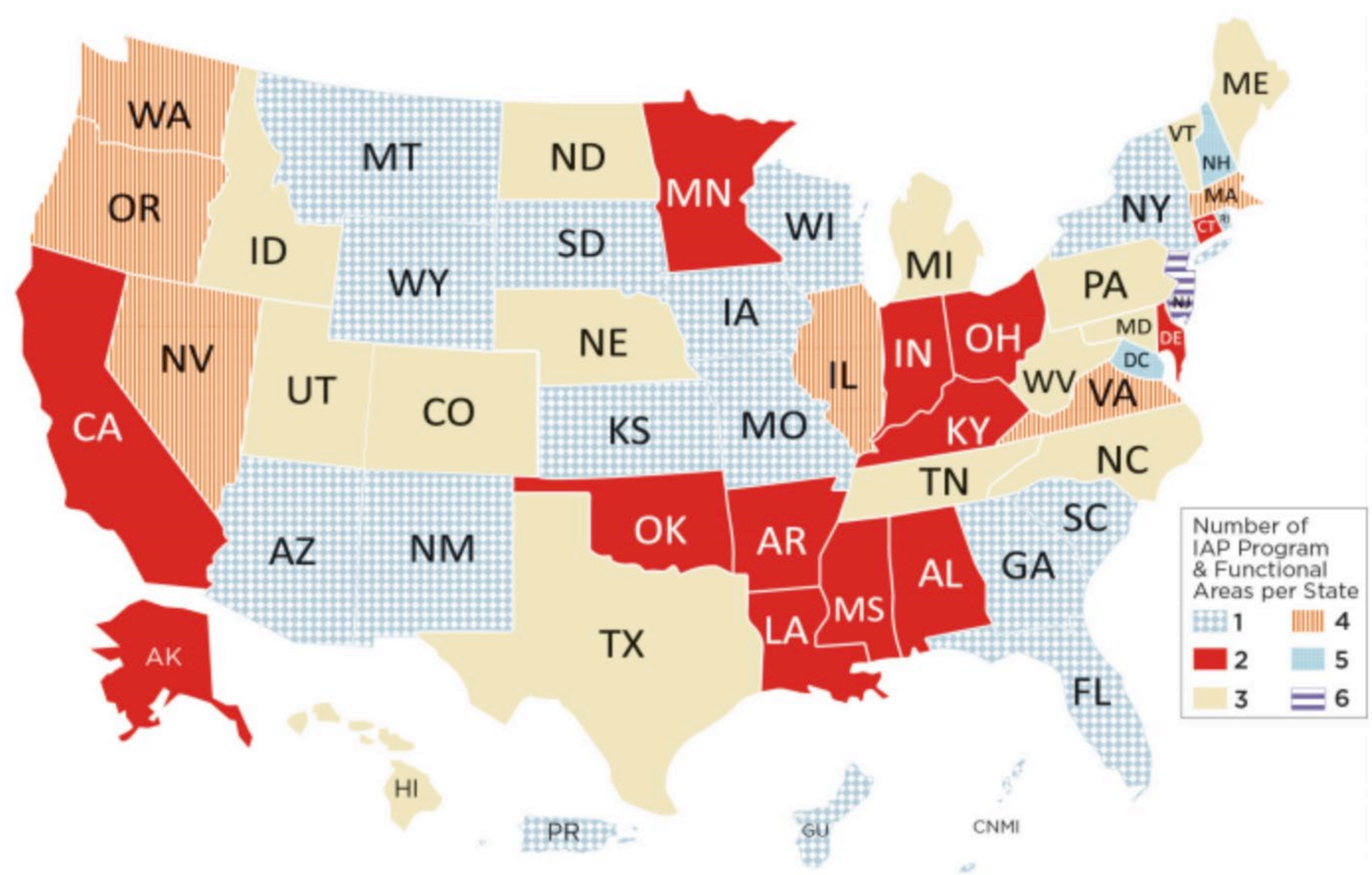
Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs	Promoting Community Integration Through Long-Term Services and Supports	Supporting Physical and Mental Health Integration	Reducing Substance Use Disorders

Functional Areas

- Data Analytics
- Quality Measurement
- Performance Improvement
- Value-Based Payment and Financial Simulations

Source: Evaluation of the Medicaid Innovation Accelerator Program (IAP): Interim Report. ABT Associates, March 2018

State Participation in the IAP Program: 2014 - 2017



Source: Evaluation of the Medicaid Innovation Accelerator Program (IAP): Interim Report. ABT Associates, March 2018

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ONC Assistance to Medicaid IAP

- Since the passing of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, ONC has provided ongoing assistance to CMS Programs and CMS Grantees: e.g.
  - EHR Incentive Program
  - State Innovation Models
  - Alternative Payment Models (APMs)
- For Medicaid IAP, ONC assistance focuses on:
  - Optimized use of health IT
  - Translating the business case for data interoperability in delivery system reform
  - Robust health IT infrastructure to support value based payments and financial simulations

What are types of ONC Assistance to IAP?

- Targeted support for IAP provided via:
  - » Group learning for cohorts of states around common themes and challenges
    - – Webinars
    - – In-person meetings
    - – Affinity Groups
    - – Targeted National Dissemination Reports and Factsheets
  - » Individual and targeted assistance to a state
    - – Review of Driver Diagrams
    - – Review of Work plans
    - – Site visits
    - – Policy Crosswalks

National Dissemination Reports: Toolkits

- **1115 Demonstrations Health IT Toolkit**
- **Health Home Health IT Toolkit**
- **Home and Community Based Services (HCBS) Health IT Toolkit**

https://www.healthit.gov/topic/advancing-interoperability-medicaid

Themes include:

- Promoting Overall Medicaid Health IT Alignment
- Interoperability Standards Advisory (ONC)
- Leveraging the Medicaid Information Technology Architecture (MITA) State Self-Assessment (S-SA)
- Advanced Uses for electronic Clinical Quality Measures (eCQMs)

HCBS Health IT Toolkit

- Designed to support IAP Program Area—*Promoting Community Integration through long-term services and supports (LTSS)*
- Helps states examine critical building blocks needed to develop an optimized health IT ecosystem for advancing HCBS LTSS Medicaid Programs

CMS-ONC Health IT Toolkit for Medicaid Funded Home and Community Based Services (HCBS) Programs - State Toolkit

Version 2.0- September 2018

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https://www.healthit.gov/topic/advancing-interoperability-medicaid

Medicaid Fact Sheets

The Office of the National Coordinator for Health Information Technology

FACT SHEET: Attribution

FACT SHEET: Medicaid Financing Options for Health Information Technology

FACT SHEET: Health IT Considerations for Medicaid Behavioral and Physical Health Services Integration

Why is Behavioral and Physical Health Services Important?

Behavioral health services are costly for states; many Medicaid programs seek to integrate services with other programs to improve overall care, improve the beneficiary experience, and reduce costs. Integrating behavioral health and physical health has shown to reduce fragmentation of services and promote care for adults with depression and anxiety disorders. Without integration, behavioral health problems can go undetected and untreated.

Why use Health IT to help integrate?

There is no one-size-fits-all model for behavioral and physical health integration. Integration can occur across clinical, financial, and administrative domains. Health information technology (health IT) serves as a mechanism to support this integration across different systems—from local and information exchange systems to state-based systems for Medicaid enrollment and administration.

Health IT supports bi-directional communication between behavioral and physical health providers through the use of electronic information systems that store, retrieve, share and enable users to analyze health information and streamline healthcare delivery. Health IT tools such as electronic health records (EHRs) and health information exchange (HIE) systems enable behavioral health providers to share and receive information during a referral which in turn saves time otherwise spent looking for information about the Medicaid beneficiary's medical history. To learn more about other applicable health IT tools available for facilitating care coordination between providers and beneficiaries, refer to the Using Technology to Manage Your Health Care Factsheet and the Digitally Driven Integrated Primary Care and Behavioral Health Report.

To learn more about the benefits of health IT, visit the Benefits of Health IT webpage.

What is the Health IT Infrastructure needed to enable Integration?

To better support state Medicaid agencies in implementing state-level reforms to integrate care delivery and promote coverage and financial accountability for behavioral and physical health services, the Office of the National Coordinator for Health Information Technology (ONC) developed the Behavioral Health IT Integration Framework. The Framework consists of four key components that states should consider when establishing their data and health IT infrastructure: Policy, Technical, Business Operations, and Finance.

To learn more, visit www.healthit.gov

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Describe priority components of a robust health IT data infrastructure for Medicaid payment and delivery reform.

5 Medicaid focused Fact Sheets:

- Attribution
- Identity Management
- Provider Directory
- Medicaid Financing Options for Health IT
- Health IT Considerations for Medicaid Behavioral and Physical Health Integration

Exemplar ONC IAP Targeted Assistance (TA)

State	TA Activities
KY	• Provided training on how the state can leverage their existing data infrastructure to reduce provider burden associated with quality reporting
NJ	• Presented Health IT Infrastructure Framework to help NJ frame what health IT assets they need for payment reform • Shared lessons learned from other states who are using their existing health IT assets for Asthma Bundled Payments program
ID	• Evaluated state of ID's data sources, core measures, and reporting capabilities to support care delivery and ongoing performance improvement • Connected Medicaid and State Innovation Model (SIM) teams to support alignment of two programs

Lessons Learned from ONC IAP Engagements

- Each IAP state is at different stage in the design and implementation of their payment and delivery system reform efforts
  - » TA needs to be customized and remain flexible
- States have variable data infrastructure available to support the automation of needed health IT capabilities
  - » Important to clarify what their current state is before designing future state
- Economies of scale can be achieved integrating one or more payment reform programs within the state
  - » E.g. IAP and SIM Program Integration

Understanding Health IT Opportunities within Medicaid Programs

CMS Guidance for Medicaid Value-Based Payment Model Design: SMD#12-001

State Medicaid Agencies have **four** focus areas when creating new delivery models: reform, modernization, stewardship, and collaboration

- **Modernization:** implement electronic health systems that will guide HIE and provide the "necessary infrastructure for automated quality measurement, reporting, and continuous quality improvement"
- **Stewardship:** establish a strong quality measurement infrastructure that enables states to standardize and validate quality metrics reported by providers and states and allow for rapid evaluation

https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-001.pdf

Health IT Frameworks for VBP Model Design

ONC developed two frameworks states can use to guide the design and implementation of their Medicaid VBP models:

- **Health IT Infrastructure for Alternative Payment Models (APMs)**
  - Builds from HCP-LAN APM Framework Four APM Categories
  - Helps states identify what health IT capabilities or functions they need to automate and integrate within their VBP model design as they transition from FFS to VBP
- **Health IT Modular Infrastructure**
  - Presents core modular components for building an optimized health IT ecosystem
  - Modules can be added to a system or replaced, as needed, to implement a required functionality

Health IT Infrastructure Framework: Key Capabilities or Functions

Clinical Data Capture

- Electronic health records and/or health IT systems used to record patient/beneficiary encounter data

Care Management and Care Coordination

- Event notifications (e.g. Admission, Discharge, Transfer alerts)
- Query for clinical data from another organization
- Send Referrals electronically
- Shared Care planning
- Patient-generated health data (PGHD) access and integration

Quality and Performance Measurement

- EHR-based clinical quality measures (CQMs)
- Chart and claims based CQMs
- CQM submission to payers

Data Aggregation and Attribution

- Provider directory
- Claims submission from payer to provider
- Organization level data warehouse for claims and clinical data

Risk Scoring

- Risk scores shared between payers and participants

Financial Management

- Aggregated utilization and cost data

Health IT Modular Infrastructure

Data Sources

- Health Care Provider Systems
- Other Provider Systems
- EHR
- Registries
- Non-Provider Systems
- Patients

Clinical Data

Non Clinical Data

Information

Reporting Services

Analytics Services | Consumer Tools

Notification Services | Provider Tools

Exchange Services | Patient Attribution

Data Extraction | Data Transformation | Data Aggregation

Data Quality & Provenance

Identity Management | Provider Directories

Security Mechanisms | Consent Management

Accountable Oversight & Rules of Engagement | Policy/Legal

Financing | Business Operations

Formatted Information

Data Users

- Private Purchasers
- CMS & Other Federal Agencies
- Medicaid & Other State Agencies
- ACOs – MCOs - APMs
- Public Health
- Providers
- Others

Four Pillars for Advancing Health IT in Medicaid Program

Through SPA and Waiver program design, CMCS has the opportunity to require or incentivize the use of HIE/health IT infrastructure that Medicaid has already paid for.

Medicaid can use four key levers to promote the use of health IT:

1. **Provider Qualifications**
2. **Service Definitions**
3. **Quality Plans**
4. **Reimbursement Rates & Methodologies**

Pillar 1: Provider Qualifications

Provider qualifications can be established that mandate or encourage the participation of targeted providers in health IT capabilities that Medicaid has funded.

EXAMPLES:

» New York's DSRIP requires providers who are part of the program to actively participate in state funded HIEs, including support for specific data exchange use cases.

» Rhode Island's Accountable Entities, their Medicaid ACOs, must send data to CurrentCare, a Medicaid funded HIE, and have the ability to receive data from the HIE. They must also demonstrate a certain percentage of their patients are enrolled in the HIE or document a plan to increase their patient's enrollment.

Pillar 2: Service Definitions

Programs can establish different services definitions that have varying expectations for care coordination and other services. For example, a state could establish an enhanced service definition for mental health and behavioral health services that requires the use of certain previously-funded Medicaid health IT services.

EXAMPLE:

- Minnesota has established Integrated Health Partnership (IHPs) providers, Medicaid ACO like entities which have enhanced care coordination requirements. The state has encouraged IHPs to use Medicaid funded health IT system that provides notifications when a IHP's attributed patient is admitted or discharged from a hospital.

Pillar 3: Quality Plans

When Programs are establishing clinical quality measurement requirements, they should look to leverage existing standardized electronic clinical quality measures (eCQMs). Leveraging existing eCQMs used in other CMS programs such as meaningful use, MIPS, and CPC+ can help reduce provider burden as health IT systems are often already capable of capturing the necessary information to calculate these measures.

EXAMPLE:

» Oregon's, Coordinated Care Organization (CCO), the state's Medicaid ACOs, must report on four eCQM as part of their overall quality reporting requirements. CCOs can receive an incentive payment for good performance and electronic submission of the eCQMs. Three of the four measures are nationally specified and used in other CMS programs. The fourth measure is state specified.

Pillar 4: Reimbursement Rates & Methodologies

Reimbursement rates and methodologies can be designed to reinforce or require the use of certain previously-funded Medicaid health IT services. States can create higher reimbursement rates for providers that use health IT tools to complete a task. States can make the use of health IT a requirement to receive payment for certain activities.

EXAMPLE:

» Hospitals that wish to receive low-income pool (LIP) funding in Florida must participate in the Florida HIE's hospital discharge and admission notification program.

What are Additional Examples of Health IT Opportunities?

Program Areas	Health IT Opportunities
Provider Qualifications	• Require use of health IT (i.e. certified electronic health records) • Require participation in an HIE • Require submission of electronic data to the HIE and/or Medicaid
Service Definitions	• Require providers participating in a care coordination programs to develop, use, and exchange electronic care plans • Require use of health IT (i.e. certified electronic health records) • Require use of standardized electronic functional assessment tool

Quality Plans	• Leverage existing nationally adopted electronic clinical quality measures for monitoring and quality improvement programs. Examples of other programs/sources of electronic clinical quality measures include:
	  • Adult / Child Medicaid Core Measure Sets
	  • CPC+
	  • MIPS
	  • Promoting Interoperability

Reimbursement Rates & Methodologies	• Use performance on electronic clinical quality measures for the basis of payment in value-based payment programs

What are Ways States Can Encourage Health IT Adoption?

Use Special Terms and Conditions (STCs) and other approval documentation to spur states to advance necessary health IT capabilities to support desired reforms.

THREE APPROACHES

ENCOURAGE	INCENT	REQUIRE
Ask questions about level of health IT currently in place or will be leveraged to support Medicaid program.	Provide additional funding to states that plan to implement health IT or facilitate HIE	Mandate that states use health IT to support Medicaid initiatives

42 CFR Part 2 and HIPAA

Policy Levers: 42 CFR Part 2 Fact Sheets

ONC and SAMHSA released two fact sheets to assist with the application of Part 2 provisions across different environments, including health information exchange (HIE) mechanisms and in provider settings.

- Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me? This fact sheet explains a 42 CFR Part 2 Program and how healthcare providers can determine how Part 2 applies to them using exemplar scenarios:
  - Opioid Treatment Program
  - Mixed-Use Facility
  - Accountable Care Organization
  - Integrated Care Setting
- Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data? This fact sheet describes how 42 CFR Part 2 applies to the electronic exchange (directed or query–based) of healthcare records with a Part 2 Program.

Policy Levers: 42 CFR Part 2 FAQs and HIPAA Blogs

ONC and SAMHSA FAQs assist with application of Part 2 provisions across different environments:

- Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange. Lists 37 FAQs specific to the electronic capture and exchange of health data.
- Applying the Substance Abuse Confidentiality Regulations. Lists 17 FAQs specific to the applicability of 42 CFR Part 2 across various scenarios (not HIT specific).

Privacy and Data Sharing Guidance from ONC details how HIPAA supports the permissible sharing of electronic patient data in support of care coordination, care planning, and case management, quality assurance and population-based activities.

- Blog Post 1: The Real HIPAA Supports Interoperability
- Blog Post 2: Permitted Uses and Disclosures
- Blog Post 3: Care coordination, Care Planning and Case Management Examples
- Blog Post 4: Quality Assessment/Quality Improvement and Population-Based Activities Example

Questions?

For questions, technical assistance or suggestions, contact ONC at:

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BACK-UP

Health IT Infrastructure Framework

	Category 1 Fee for Service - No Link to Quality & Value	Category 2 Fee for Service - Link to Quality & Value	Category 3 APMs Built on Fee-for-Service Architecture	Category 4 Population-Based Payment
		A Foundational Payments for Infrastructure & Operations **B** (Pay for Reporting) **C** (Rewards for Performance) **D** (Rewards and Penalties for Performance)	**A** APMs with Upside Gainsharing **B** APMs with Upside Gainsharing/Downside Risk	**A** Condition-Specific Population-Based Payment **B** Comprehensive Population-Based Payment

Current Health IT Capabilities

Health IT capability (key number)	Categories covered
1 Organizational EHR	Category 1 – Category 2
1 Organizational EHR with interoperable summary clinical data	Category 3 – Category 4
2 Event notifications (i.e., ADT; fax; spreadsheet; Direct)	Category 2A – Category 4
2 Query for clinical data from another organization or system	Category 2A – Category 4
2 Separate care coordination system with manual data entry to create care plans	Category 2A – Category 4
3 EHR CQMs	Category 2B – Category 3A
3 Near real-time, provider-based eCQMs	Category 3B – Category 4
3 Manual chart review & claims based CQMs	Category 2B – Category 3A
5 Risk scores from payers to participants based on claims data	Category 3B – Category 4
3 Manual submission of CQMs to payers	Category 2B–D
4 Basic provider directory for patient attribution (i.e., spreadsheet)	Category 3 – Category 4
4 Limited historical claims data sent from payer to provider/organization	Category 3 – Category 4
4 Linking of organizations' patient data to limited payer data	Category 3 – Category 4
4 Organization level data warehouse for claims & clinical data	Category 3 – Category 4
2 ETL methods for pulling clinical data from EHRs	Category 3 – Category 4
6 Aggregated utilization and cost data for entire panel	Category 3 – Category 4
6 Payer data for total cost of care for Payer contracted APMs	Category 3 – Category 4
4 Preadjudicated claims from the organizations in the APM	Category 3B – Category 4
2 General benefit & eligibility information available to establish referral networks along with estimated cost data	Category 3B – Category 4

Ideal Health IT Capabilities

Health IT capability (key number)	Categories covered
1 Organizational EHR with interoperable summary clinical data	Category 1 – Category 2
1 Organizational EHR with all clinical data interoperable	Category 3 – Category 4A
1 EHR & Community-based/ social service systems with all clinical data interoperable	Category 4B
2 Closed referral loop	Category 2A – Category 4
2 Shared care plan integrated with EHR and available to entire clinical care team, patient, & their caregivers	Category 2A – Category 3
2 Shared care plan integrated with any system & available to entire care team (clinical, community-based/social services, patient, & caregivers)	Category 4
2 Event notifications integrated into workflow	Category 2A – Category 3
2 Event, care gap, change in risk score, PGHD-based notifications integrated into workflow	Category 4
4 Limited claims data sent from payer to provider/organization	Category 2B–D
5 Real-time risk scores from claims & clinical data	Category 3
5 Real-time, disease specific risk scores from claims & clinical data	Category 4A
5 Real-time risk scores from claims, clinical, & socio-economic data	Category 4B
4 Organization data warehouse to combine clinical & claims data	Category 2B–D
4 Aggregate multi-payer (commercial, Medicaid, & Medicare) adjudicated claims data & multi-organization clinical data that's available to all participants in APMs	Category 3 – Category 4
4 Linking of organizations' patient data to limited data set from payers	Category 2B–D
4 Interoperable provider directory – hierarchical & relational	Category 3 – Category 4
3 Near real-time, provider-based eCQMs	Category 2B–D
4 Near 100% accurate linking of claims and clinical data from multiple organizations	Category 3 – Category 4
3 Majority of CQMs are eCQMs & can be reported to multiple payers	Category 2B–D
3 Real-time patient-centric eCQMs calculated across systems or contracts	Category 3
3 Real-time patient-centric eCQMs calculated across a set population	Category 4
6 Calculate total cost of care from adjudicated claims & clinical data	Category 3 – Category 4
2 Near-real-time benefit/eligibility information & evidence-based CDS available at time of order	Category 3 – Category 4
2 Provider value score (cost & quality) available at the time of order	Category 3 – Category 4

Key

1. Clinical Data Capture at Point of Care
2. Care Coordination/Management
3. Quality Measurement
4. Data Aggregation & Attribution
5. Risk Scoring
6. Financial Management

New Jersey
Substance Use Disorder 1115 Waiver
HIT Plan

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Division of Medical Assistance and Health Services

NJ Department of Human Services

November 29, 2018

Purpose of the 1115 SUD Waiver

- To expand Medicaid coverage to residential treatment in Detox, Short Term and Long Term Residential rehabilitation services.
- Increase the Medicaid benefit package to include peer services and case management services for individuals with a Substance Use Disorder (SUD)
- Provide and monitor evidenced based services for individuals with a SUD
- Closely monitor the effectiveness and efficiencies of services expanded and covered in the waiver

1115 SUD Waiver Authority

- Effective 10/31/17, NJ FamilyCare has received Waiver authority to claim expenditures for services provided in residential facilities that meet the requirements of an Institution for Mental Disease (IMD) for individuals 18 and over.
  - **Non-hospital based Withdrawal Management, ASAM 3.7WM**
  - **Short term Residential Treatment, ASAM 3.7**
  - **Long Term Residential Treatment, ASAM 3.5**

- NJ FamilyCare must maintain a combined average length of stay of 30 days or less for these services.

- NJ FamilyCare will provide a full continuum of SUD services that includes **case management** and **peer recovery support services**.

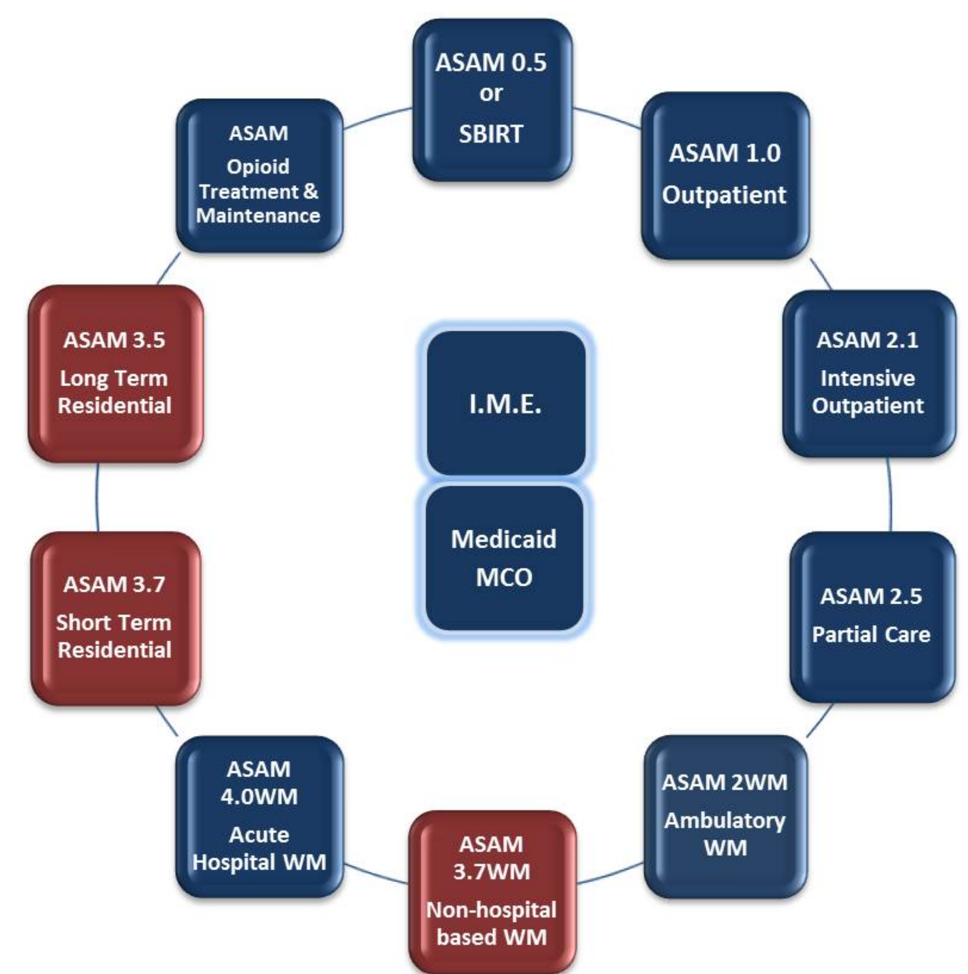
A Full Continuum of Benefits for SUD Treatment

Peer Support Services

Case Management

Support and Enhance existing M.A.T.

BH and Physical Health Integration



Special Terms and Conditions

CMS Deliverables

- SUD Program Implementation Plan
- SUD Program Health IT Plan
- SUD Program Evaluation Design
- SUD Program Monitoring Protocol
- Budget Neutrality

Special Terms and Conditions

Milestone 1
- Access to Critical Levels of Care
- ASAM 3.7 WM
  ASAM 3.7 STR
- ASAM 3.5 LTR

Milestone 2
- Evidence Based Placement Criteria
  ASAM
- LOCI-3
  for UM Review

Milestone 3
- State process to review providers for ASAM compliance
- Ensure residential services offer use of MAT on site or via affiliation

Milestone 4
- Ensure Provider Capacity

Milestone 5
- Develop opioid prescribing guidelines
- Expand coverage of and access to Naloxone
- Increase utilization and improve function of PDMS

Milestone 6
- Ensure residential and inpatient facilities link beneficiaries with community based services and supports

Implementation Plan-HIT Milestone 5

- The 1115 waiver HIT plan is part of a comprehensive treatment and prevention strategy to address opioid abuse and opioid use disorder;
- Serves to connect state departments and form a shared strategy for integrated data and monitoring;
- Will develop pathways to collect data relevant to the identification of opioid prescribing and trends in the state;
- To integrate systems to support appropriate prescribing, checks for misuse, and improve overall outcomes.

SUD HIT Plan

CMS/ONC Template for SUD HIT Plan
Prescription Drug Monitoring Program - Functionalities - Query Capabilities - Clinician Workflow
Master Patient Index
Overall Objective for Enhancing PDMP Functionality and Interoperability

SUD HIT Plan

Review of State Initiatives
State Medicaid HIT Plan
HIT Environmental Scan
MCO Contract - HIT/HIE Provider Network Data - HIT/HIE Performance Data

Leverage and Reuse HIT Initiatives
Prescription Drug Monitoring Program
Health Information Exchange - ADT Event Notification - Master Patient Index - Opioid Risk Use Case
HITECH Funding Initiatives - EHR Incentive Program - HIE BH Provider Onboarding
Electronic Health Records

SUD HIT Metrics

Key HIT Question Category	Metric Name	Metric Definition	Comments
Slow down Rate of Growth	Medicaid provider on-boarding to the State HIE infrastructure to implement Opioid Use Case	Leveraging HITECH funding, will connect behavioral health providers to the State HIE infrastructure and utilize Opioid Use Case.	Will report the number of providers after the opioid use case is implemented by the NJHIN and NJPMP.
Treat Effectively	CEHRT for SUD providers	Leveraging Statewide initiative, provide ONC certified EHR technology to SUD providers that has the capability to connect to the State HIE infrastructure and the PMP.	Metric will be reported after the RFP is issued and the number of provider participants is determined.
Recovery	ADT Event Notification	Provide Admission, Discharge and Transfer alerts to behavioral health providers, to monitor clients currently in recovery.	Initiative focused on current CCBHC demonstration project providers, will report the number of CCBHC providers that have been connected to the HIE and/or are receiving ADT notices.

Helpful Tools

ONC IT Playbook, Section 4:
www.healthit.gov/playbook/opioid-epidemic-and-health-it/

NJ's 1115 Waiver Renewal:
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-sud-imp-prtclt-appvl-05172018.pdf

NJ 1115 SUD Waiver Implementation Plan:
http://www.state.nj.us/health/njhit/documents/NJ%20HIT%20Environmental%20Scan_Final%20Report_20170923.pdf

NJ Contact Information

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Questions?

Discussion:
Legislative Options for Changing CurrentCare Consent Model

November 2018

Goal of Today's Discussion

Update

- Outcome of last year's regulatory process

Share

- Rationale for considering changes to the CurrentCare consent model (through amending the HIE Act of 2008
- Consent model options (please note these options do not pertain to 42 CFR Part 2 data; the current process will remain the same which includes obtaining consent from Part 2 covered facilities)

Discuss

- Community feedback on which consent model is the best fit for Rhode Island

Questions for Discussion/Feedback

With the goal of using the HIE to improve the health for Rhode Islanders, which model(s) do you think could:

- Improve patients **timely access to their own data from multiple providers?**
- Improve providers ability to **identify and reduce gaps in care** for their patients?
- Reduce the need for patients and/or providers to **fill out duplicate medical forms** (history, screenings, etc.)?
- Support better patient care by **reducing length of time it takes a patient's provider to obtain data from other providers**?
- Help providers **assess the quality of care** they provide to their patients?
- Help **reduce number of costly EHR interfaces** that need to be built?
- Encourage vs discourage providers from **participating in the HIE**?

Which model(s) do you think is best for RI? Which could you support?

Update

- An Advance Notice of Proposed Rulemaking (ANPR) pertaining to the regulations for the HIE Act of 2008 was issued a year ago which included proposed changes to the consent model

- There was:
  - Significant support for changes
  - Some concern it exceeded RIDOH's statutory authority

- Decision made to seek changes to the consent model by amending the law; will submit bill this upcoming session

Overview of RI’s HIE: CurrentCare

More than
517
data sources

Consolidated Patient Records

Secure repository containing clinical data across geographic, propriety and payer boundaries

Approximately
512,000
active enrollments

CurrentCare Viewer & Data Exchange

Providers view patient data via secure website & in EMR

CurrentCare Alerts

Providers notified in real-time about patient’s ED & inpatient encounters & risk history

Analytics

Intelligent Alerts, Quality Measures

CurrentCare For Me Patient Portal

Consumers access and manage health data on Portal & Mobile devices & receive notifications

Public Health

De-id and identifiable data for public health purposes

Why is Health Information Exchange Important?

Improves the patient and provider experience and care by:

- Providing a longitudinal record for the patient across health care organizations
- Facilitating sharing of a patient's medical information with their treating providers for care coordination
- Streamlining public health and quality measure reporting
- Stimulating patient empowerment, education, and involvement in their own care
- Reducing the potential of medical errors, redundant tests, and unnecessary ED/hospital admissions
- Sharing data among providers and payers for care management

Defining Consent Models

1. **Opt In to Collect & Disclose (Current RI model):**
   Patients indicate they want to include their data in the HIE and choose with whom their data can be shared

2. **Opt In to Disclose ("Consent to View/Disclose"):**
   Patient data is included in the HIE. Patients choose with whom their data can be shared

3. **Opt Out to Disclose:**
   Patient data is included in the HIE; Patient data is shared with treating providers unless the patient indicates they do not want their data to be shared

4. **Opt Out to Collect:**
   Patient data is included in the HIE unless patient indicates they do not want their data to be included in the HIE.

Defining Consent Models

	Opt In to Collect & Disclose	Opt In to Disclose	Opt Out to Disclose	Opt Out to Collect
Data is collected for all patients	🚫	?	?	🚫
Data is shared only for patients who have enrolled	?	?	N/A	N/A
Data is shared for all patients unless they opt out	N/A	N/A	?	?

National Data, 2016: Consent Policies of State Sponsored HIEs

No Information Available
Opt-In (Collecting & Sharing)
Opt-In (Sharing)
Opt-Out
Opt-In/Opt-Out

Rhode Island is the only state that has a policy restricting the collection of data in the HIE. *'Opt-in' in other states* means the HIE aggregates data but does not disclose it without the consent of the individual

Map is based on a dashboard provided by the Office of the National Coordinator for Health IT

Why Consider Changing the Existing CurrentCare Consent Model ?

Current consent model does not allow for/support :

Patients	• To have their longitudinal health record immediately available to themselves, their designees and their treating providers
Providers, Health Care Organizations & Payers	• To have access to data on all of their patients • To send electronic referrals through CurrentCare • To streamline data connections/interfaces by using CurrentCare to send permitted data to the Rhode Island Department of Health (e.g. reportable diseases, immunizations), or a quality measurement system for calculation
Public Health Officials/ Researchers	• To improve data collection for required RIDOH activities • Support disease management and trending (including outbreaks) • To use aggregate data (deidentified) for total population health analysis in order to make better, data-driven decisions or for clinical research purposes

Consent Model Use Cases

Consent Model is useful for…	Opt In to Collect & Disclose	Opt In to Disclose	Opt Out to Disclose	Opt Out to Collect
Point of Care	? (If the patient opts in, but not immediately; Needs time for data to collect)	? (If the patients opts in)	? (Unless the patient opts out)	? (Unless the patient opts out)
Access in an Emergency		?	?	
Patient access to own health record		?	?	
Public health reporting, emergency preparedness,	🚫	?	?	🚫
Quality Measurement	🚫	?	?	🚫
Referrals	🚫	?	?	🚫
Decreasing health disparities for vulnerable populations (foster care, homeless, low literacy, non-English speaking)	🚫	🚫	?	?

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Questions?

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