eHealth Initiative Interoperability Work Group

March 15, 2016

2:00 p.m. ET

Reminder

Please mute your line when not speaking

(* 6 to mute, *7 to unmute)

This call is being recorded

Agenda

Topic	Timeframe
Welcome and Overview	2:00 p.m.
How Can We Improve Behavioral Health Data Exchange? The Challenges & The Opportunities Of HIE	2:05 p.m.
Updates	2:50 p.m.
Next Steps	2:55 p.m.

How Can We Improve Behavioral Health Data Exchange? The Challenges & The Opportunities Of HIE

Kansas Health Information Network, Inc.

KHIN
Kansas Health Information Network

Agenda

- KHIN Background
- State Legislation & Patient Consent
- 42 CFR Part 2
- Mental Health Center and Integrating with HIOs
- Questions

KHIN Key Statistics

KHIN
Kansas Health Information Network

- **Over 2 Million + Unique Patients in KHIN Exchange**

- **Over 5 million available for query**
- **1,230+ KHIN Members**
- **600 +Health Care Organizations in Production**

KHIN HIE Products 2015

- **Secure Clinical Messaging/DIRECT**
- **Query Based Exchange**
  - **Full HIE–Query functionality**
  - **Web based access**
- **Image Exchange**
- **Personal Health Record**
- **State level interfaces**
  - **Immunizations**
  - **Syndromic Surveillance**
  - **Reportable Diseases**
  - **Cancer Registry**
  - **Infectious Disease Registry**
- **Alerts and Data Extracts**

Kansas Key HIE Achievements

- **2011 Passage of KHITE Legislation normalizing all patient consent requirements with HIPAA**
- **2012 Legislature reconfirmed KHITE**
- **KDHE authorized to provide oversight**
- **KDHE technology functionality requirement for security override**
  - **Patient consent**
  - **Life threatening emergency**
- 2013 KHIN Policy and Procedure

KHIN Security Override Policies

- Kansas is an opt-out State
  - Obtaining health information from other Participants for care and treatment of patients that (1) have opted-out of including their health information in KHIN, and/or (2) have records and information accessible through KHIN that are protected under 42 C.F.R. Part 2
  - KHIN does not disclose “opt-out” patient’s health information and/or a health information protected under Part 2, unless (1) a medical emergency exits, or (2) Patient consent is obtained pursuant to a Part 2-compliant consent form at the point-of-care.

42 CFR Part 2

Blocking Substance Abuse Patient Data – Who Must Comply

Providers and Medical Facilities that are BOTH:

- “federally assisted” and meet the definition of a program under 42 CFR Part 2.11

-and-

- “hold themselves out as providing and provides alcohol or drug abuse diagnosis, treatment or referral for treatment” (42 CFR Part 2.11)

42 CFR Part 2
What does “Federally Assisted” Mean?

- authorized, licensed, certified, or registered by the federal government
- receives federal funds of any kind
- assisted by IRS through a grant of tax exempt status or allowance of tax deductions for contributions
- authorized to conduct business by the federal government (e.g., Medicare provider, conduct methadone maintenance treatment, or registered with the Drug Enforcement Agency to dispense a controlled substance used in the treatment of substance abuse)
- is conducted directly by the federal government.

42 CFR Part 2
Patient Consent Considerations for Data Sharing

Two Options

1. Block Data at the EHR level.
   - Concerns:
     - Data is NOT available in an emergency
     - Data is NOT available when a patient gives consent

2. Block Data at the HIE level.
   - Concerns:
     - On going communication between provider and HIE
     - Notification of security override without patient consent

Identifying Substance Abuse Patients to be Blocked

Who is Blocked:

- Primary diagnosis
  Secondary diagnosis
- Patients enrolled in substance abuse programs

When are they blocked:

- At intake
- At billing

Mental Health Centers

Who is Using HIE?

- 15 Mental Health Centers are KHIN members and have QSOAs
- Health Care Home Staff
- Hospital Diversion Staff
- Management
- Medical Records
- Emergency Services

Mental Health Centers

Why Are They Using HIE?

- Patient seen recently at hospital and why
- Alerts
- Lab values
- Medications
- Emergency situations
- Find diagnosis to qualify for certain programs
- Find diagnosis to update diagnoses for ICD10/DSM5 (for clients that don’t see a doctor at the MHC)
- Patient referrals
- Verify patient home addresses and insurance

Contact Information

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Pilot Test Data Collection Tool

- Review updates
- Suggestions for outreach

2:50 -- 2:55

Profile Element	Description		
Responsible Entity	Organization responsible for the implementation of the practice or data exchange		
Legal Authority	Laws or regulations that govern the data exchange and consent to share data		
Are you in an Opt-in or Opt-out state or other?			
Entities Involved in Data Exchange	Mental Health	Substance Abuse	Other
Problem Addressed	What problem does your consent model or procedures address?		
Description	What consent or privacy practice have you implemented?		
Current status of 42 CFR Part 2 data	Does your organization manage data that falls under the 42 CFR Part 2 regulations		
Data Included in Exchange	Categories of data that are exchanged		
Data Excluded from Exchange – describe circumstances	Categories of data that are not exchanged and the reason that the data is excluded		
Standards Implemented	What interoperability standards were implemented/adopted to support privacy and consent management?		

2:50 -- 2:55

Profile Element	Description
Policies Adopted	Describe policies that were adopted among the data exchange participants
Legal Agreements	Describe any legal agreements that data exchange participants enter into
Clinical Workflow Impacts	How is the data exchange incorporated into clinical workflows?
Technical Overview	Data flows between organizations, applications, data storage, data transport
Documented Improvements that the practice enables	What improvements or benefits have resulted from the data exchange? Where available, provide quantitative findings.
Challenges	Challenges and how they were addressed
References	Links or attached documents
Contacts	Point of contact for further information

2:50 -- 2:55

Suggestions for Outreach

2:50 -- 2:55

Data Sharing Practices Repository – Timelines

Task	Jan	Feb	Mar	Apr	May	Jun
Project Planning	🟩					
Consult with Related Initiatives		🟩				
Solicit Examples			🟩	🟩		
Review Examples				🟩	🟩	
Develop Repository					🟩	🟩

2:50 -- 2:55

Next Steps for Interoperability Work Group

- Next call
- Agenda
  - Feedback from related projects

2:55 – 3:00

Questions?

eHI

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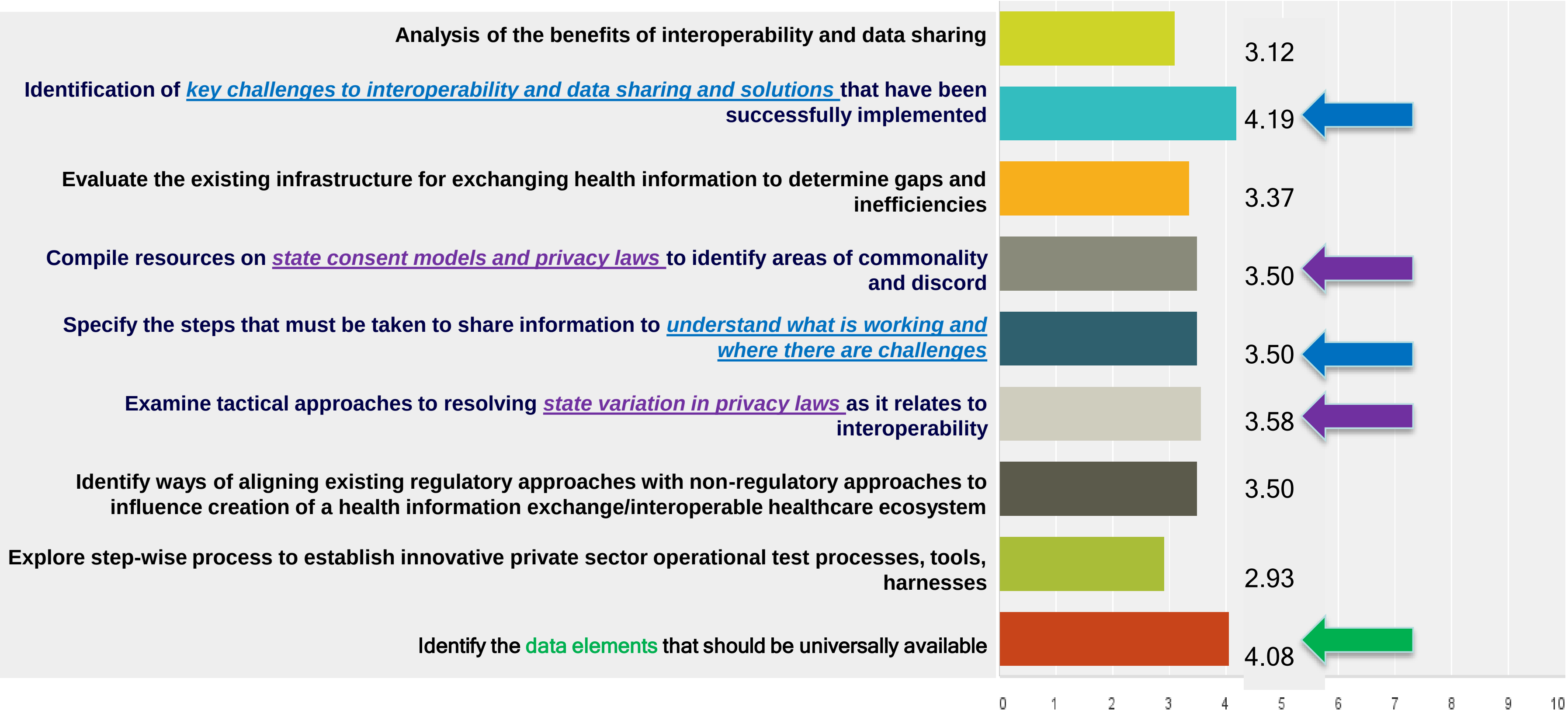
Thank you!

Focus Area Priorities

- Challenges and Solutions
- Privacy and Consent
- Data Elements

Q1 Please indicate the importance you would assign to each focus area listed below.

Answered: 27 Skipped: 0



Focus Area Comments

With respect to patient information safety and security and to ensure ongoing monitoring of compliance with HIPAA and other privacy measures, **are there any current discussions/efforts to incorporate HIE standards into accrediting bodies such as JCAHO, ACHC**, etc?

Identifying successful solutions that **focus on patient and provider engagement** will improve interoperability by better understanding those factors that motivate patients and providers to share information with each other despite the current barriers that exist. The stream of sharing that needs to be better understood involves **provider to provider, provider to patient, and patient to provider information sharing.**

Data standardization is one of our highest priorities. We have a monthly meeting with our major payers and two PPS's, as well as regular contact with our data sources. Jointly, we are discussing out to reach out to practices to educate them too.

continued collection of examples of interoperability successes costs of ensuring interoperability capabilities IT requirements additional documented (and anecdotal) examples

I think the **benefits are being covered in the Clinical Motivators workgroup.** The key challenges/solutions is very similar to what we just did in this recent report. Perhaps we could **clarify where/how the different exchange standards/approaches being worked on should be used (CCDA, FHIR, Commonwell, eHealth Exchange, Epic CareEverywhere, etc)**. No one of them is sufficient on its own to solve the interoperability problem even though each may promote itself that it is. We could help clarify the **strengths/weaknesses and appropriate/inappropriate use cases for each** to help the industry get past the hype and understand how to use them.

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Focus Area Comments

We are currently working to compare the ambulatory CCDs and CCDAs that our HIE is receiving for gaps in data; if the data is not on the document due to 1) not captured during the encounter, 2) workflow at practice or 3) how the vendor set up the rules around data pulled to the document. We have multiple practices on eCWorks, Allscripts, and Athena, we will complete an analysis across unaffiliated practices. We also have two eCW HUBS that support multiple affiliated practices, we can look at the variance that may be due to practice workflow and data capture. What we have found so far is that the "table of contents" on the front of the document is in no standard order. It may prove helpful to the clinician if the list had a standard order - ie. problems list, then medications, then allergies, etc. The table of contents only includes data elements found on the document, but it's difficult to confirm at a quick glance what is in the document which can be 3 pages or 42 pages. We will share findings of our gap analysis with eHealth, HIMSS and other interested organizations.

I ranked every option "very low" save for one above because **the wording of each reveals a mindset that accepts the status quo and proposes, in one way or another, to study it.** To my mind the best thing this group could do is **take a sober and honest look at the real-world impediments to interoperability in healthcare, shine a bright light on those, and give some publicity to successful efforts to circumvent those impediments**. That has the potential to move the needle in a meaningful way.

Over the past several years the nation has battled to achieve National Interoperability, are the efforts currently underway and being spoken about demonstrate that a **focus on Regional Interoperability** is more in line with current Healthcare needs. Could the focus on National Interoperability be distracting us from the immediate needs (the highest patient care requirements - are select segment of the population) - with patients at the center of the care-circle - solutions need to **focus on Regional Interoperability, Care Teams ability to coordinate (which may lay outside a single organization) workflow, Access Consent (controlled sharing of clinical information) across the care continuum.** The challenge here is no-one vendors can provide a solution, the industry must work together with regulators, and standards bodies. We need to see the larger mission of patient first, patient focus initiatives - Interoperability at the patient level does matter - Until then, we will keep getting lost with National initiatives (such as the ones like ONC publishes), but which many Regional initiatives don't bother with and are not focused on. Who is doing Interoperability it right?