

RI HIT STEERING COMMITTEE

AGENDA

MARCH 10, 2021

5:30 PM

Welcome and Introductions

Review of the Minutes

Reports:

Interoperability Work Group

Planning Sub-Committee Recruitment

Presentations and Discussion:

Opt-Out Legislation (Senate Bill 495)

Aligning with Comprehensive Primary Care Plus (CPC+) - Multipayer Data Strategy Needs

Next Steps and Next Meeting – Wednesday, April 14, 2021 at 5:30 pm

Public Comment

Members:

Co-Chair: Cedric Priebe, MD

Co-Chair: Assistant Secretary Ana Novias

Stacey Aguiar

Director Nicole Alexander-Scott, MD

Dennis Bailer

Marcela Betancur

Garry Bliss

Jay Buechner

Mice Chen

Shamus Durac

Craig Elice, DDS

Carrie Bridges Feliz

Andrea Galgay

Commissioner Patrick Tighe

Zachary Gerson-Neider

Amar Gurivireddygari

David Hemendinger

Affiliation:

Lifespan

Rhode Island Executive Office of Health & Human Services

UnitedHealthcare

Rhode Island Department of Health

Project Weber Renew

Latino Policy Institute

Prospect Health Services RI

Neighborhood Health Plan of RI

Coastal Medical

Rhode Island Parent Information Network

Pediatric Dentistry Ltd.

Lifespan Community Health Services

Rhode Island Primary Care Physicians Corporation

Office of Health Insurance Commissioner

Rhode Island Foundation

Blue Cross & Blue Shield of Rhode Island

Brown Physician's Group



Members:

Joseph Imbimbo
Ben Isaiah
John Keimig
Phil Kahn
Jonathan Leviss, MD
Gary Ligouri
Mike Oliver
Rebecca Plonsky
Director Kathryn Power

Megan Ranney, MD
Neil Sarkar
Director Ben Shaffer
Scott Soucy
Brian Tardiff
Larry Warner
Kyle Wohlrab, MD
Pano Yeracaris, MD

Affiliation:

Tufts Health Plan
The Providence Center
Healthcentric Advisors
Care New England
Providence Community Health Centers
College of Health Sciences, University of Rhode Island
The Claflin Company
Integrated Healthcare Partners
Rhode Island Department of Behavioral Healthcare, Developmental
Disabilities, and Hospitals
Brown Emergency Medicine
Rhode Island Quality Institute
Rhode Island Medicaid
Genesis Healthcare
Rhode Island Division of Information Technology
United Way of Rhode Island
Women & Infants Hospital
Care Transformation Collaborative Rhode Island

INTEROPERABILITY WORKGROUP UPDATE

First CMS Requirement to be addressed by the workgroup: Admission, Discharge, and Transfer Event Notifications (*applicable April 30, 2021*):

Requires hospitals, including psychiatric hospitals need to send electronic patient event notifications of a patient's admission or discharge and/or transfer to another healthcare facility or to another community provider or practitioner

Short-term Goals:

- Standardize ADT event notification messages content and format: define data elements to include and work to hospitals to use data set
- Determine how to educate community providers regarding:
 - Receiving event notifications and the decisions they need to make (who will receive notifications and how)
 - Requirement to update CMS's National Plan and Provider Enumeration System (NEPPS)

Long-term Goal:

- Establish a streamlined approach to align event notifications processes in order to eliminate sending duplicate notifications to providers, e.g., sent from both RIQI and the hospitals



SENATE BILL 495 - PROPOSED CHANGES TO THE HEALTH INFORMATION EXCHANGE ACT OF 2008



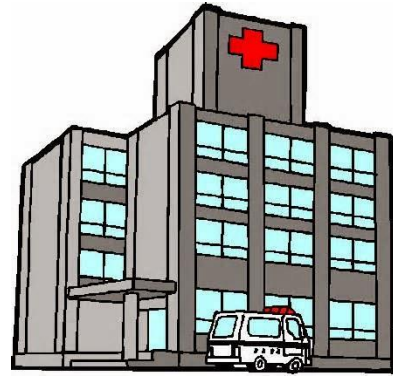
2021 LEGISLATION

- [Senate Bill 495](#) (sponsored by Senator Josh Miller) amends the Health Information Exchange Act of 2008 in the 2021 Legislative Session to transition from an **opt-in** model to an **opt-out** model

Healthcare is delivered in variety of settings, and your health information resides in numerous locations today



Your primary care provider...



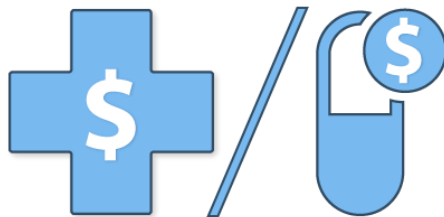
Your hospital...



Your lab...



Your radiology center...



Your health insurance...

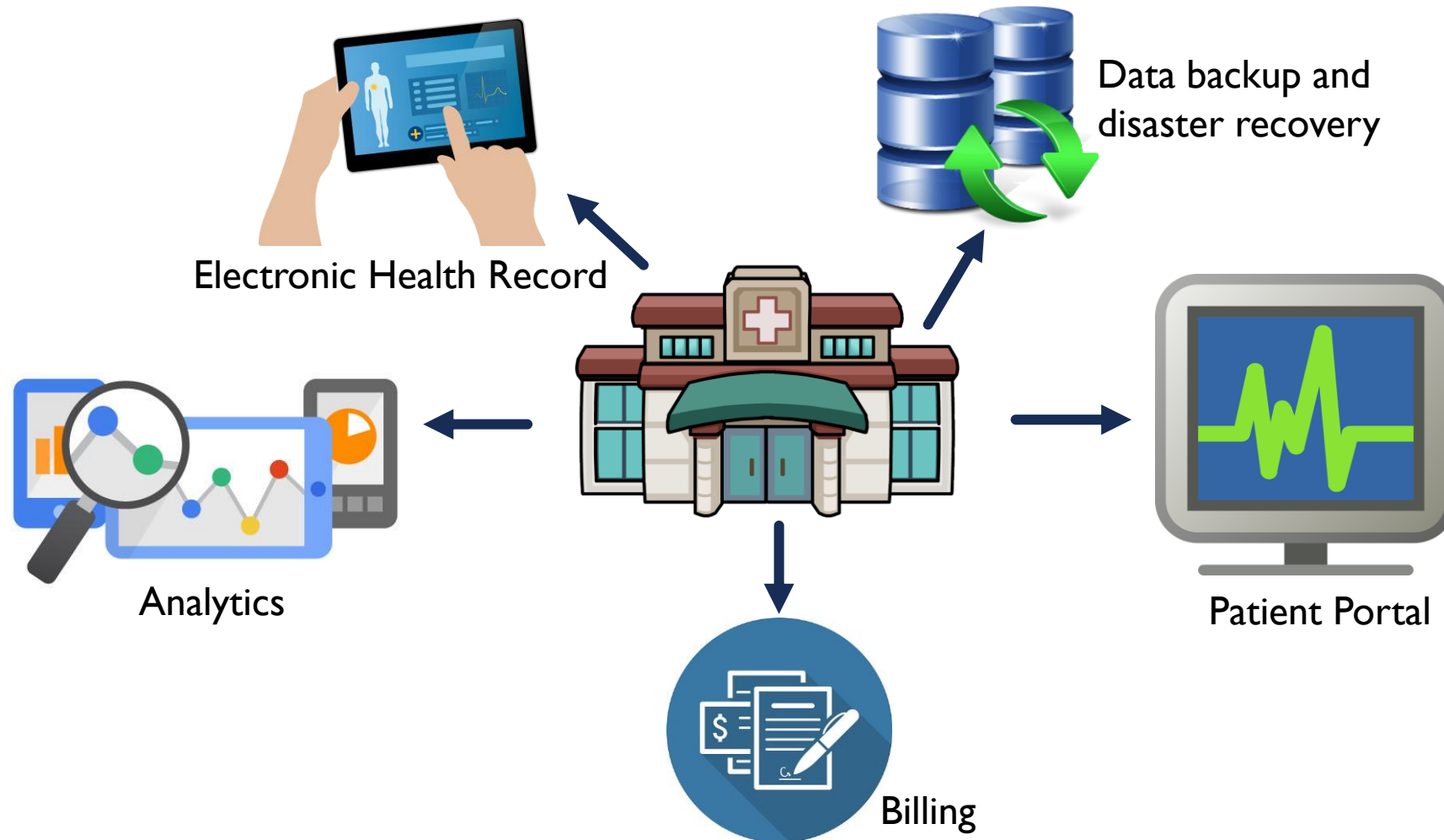


Your Department of Health...

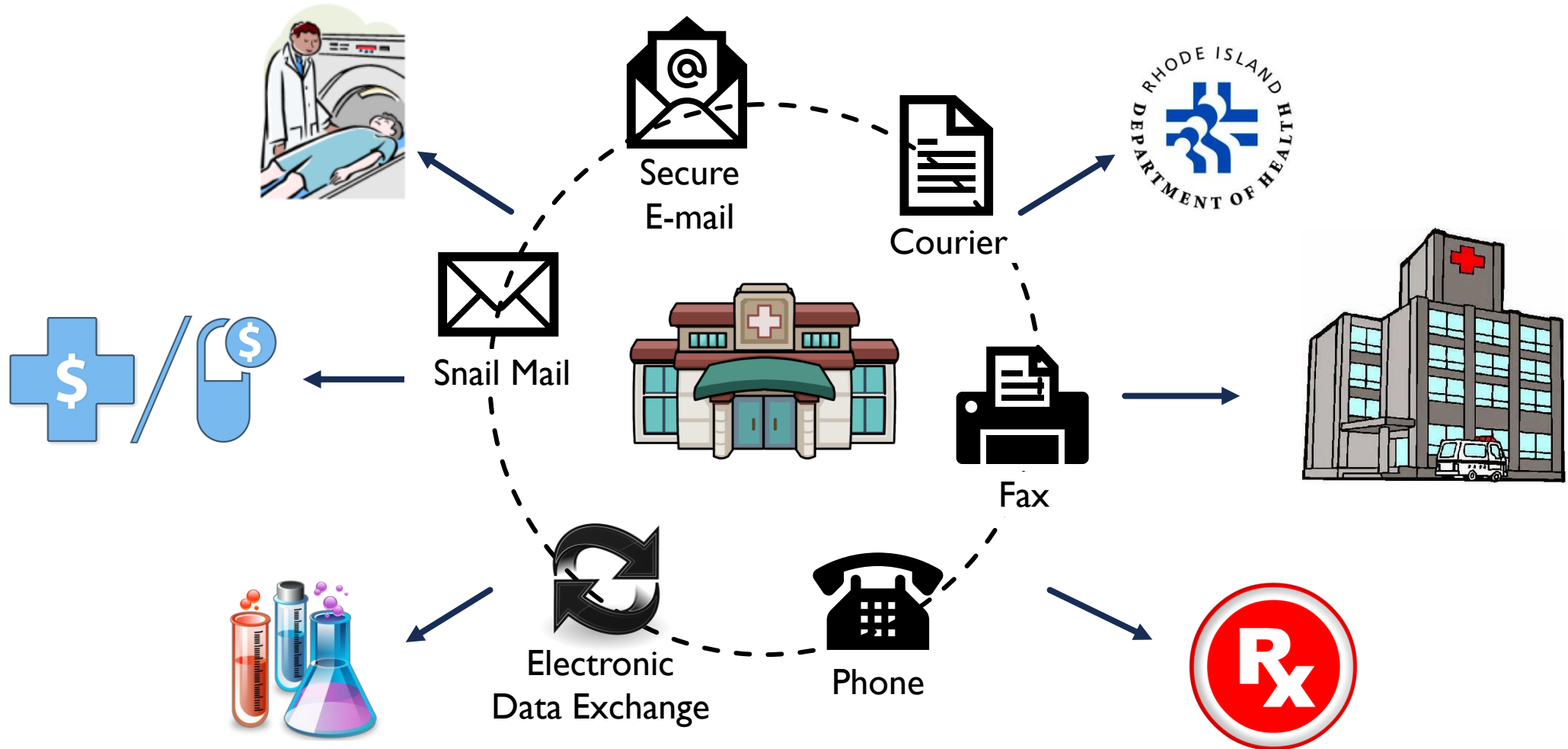


Your pharmacy...

Each one of these healthcare organizations protects the health information they have about you. Your protected health information may be stored in different systems using several vendors



All of these healthcare organizations are allowed to securely share your health information as part of standard healthcare delivery for payment, treatment, operations, and public health



**Health Insurance Portability
and Accountability Act
(HIPAA)**

42 CFR Part 2

Existing State and Federal privacy laws allow providers to share a patient's personal health information to support treatment (including care coordination), payment, and operations within an opt-out model*.

RI Mental Health Law

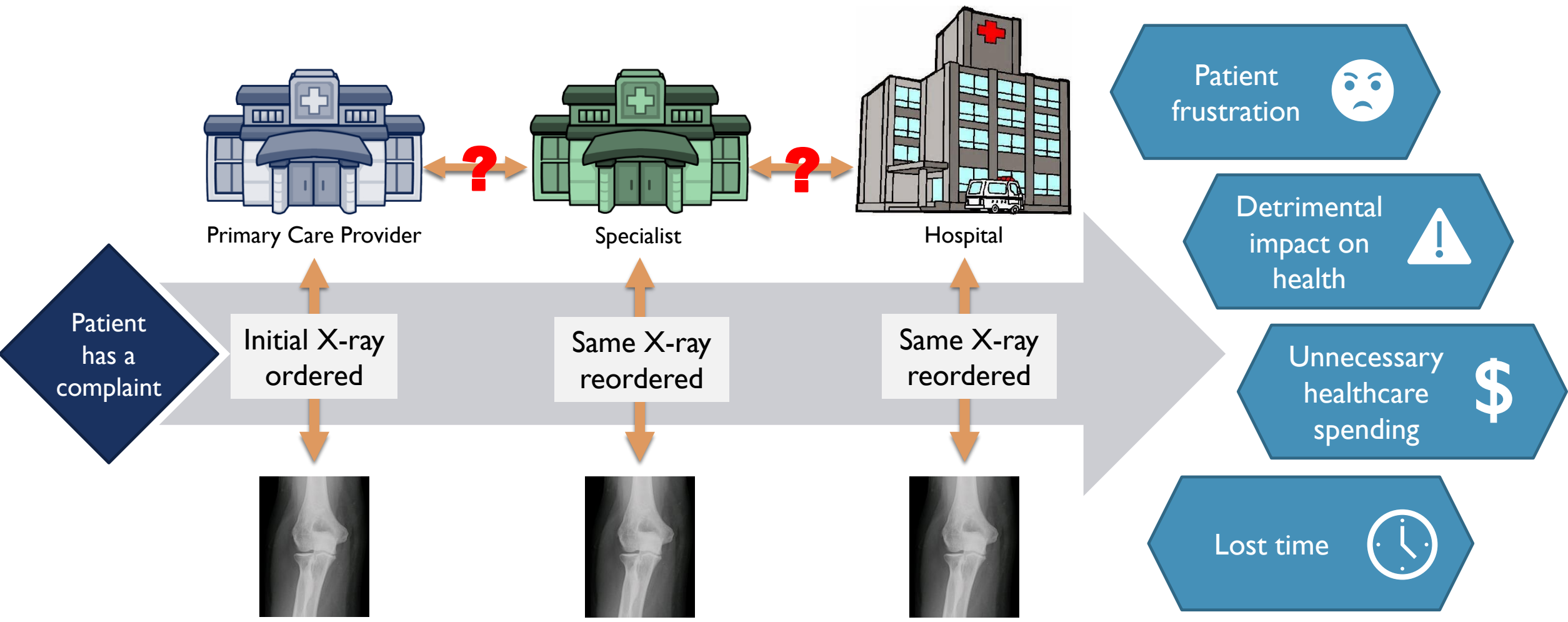
**RI Confidentiality of Health Care
Communications and Information Act**

**Note: There are certain programs or uses that may require consent; for example, under 42 CFR Part 2, participating programs must get consent to disclose substance use treatment data.*

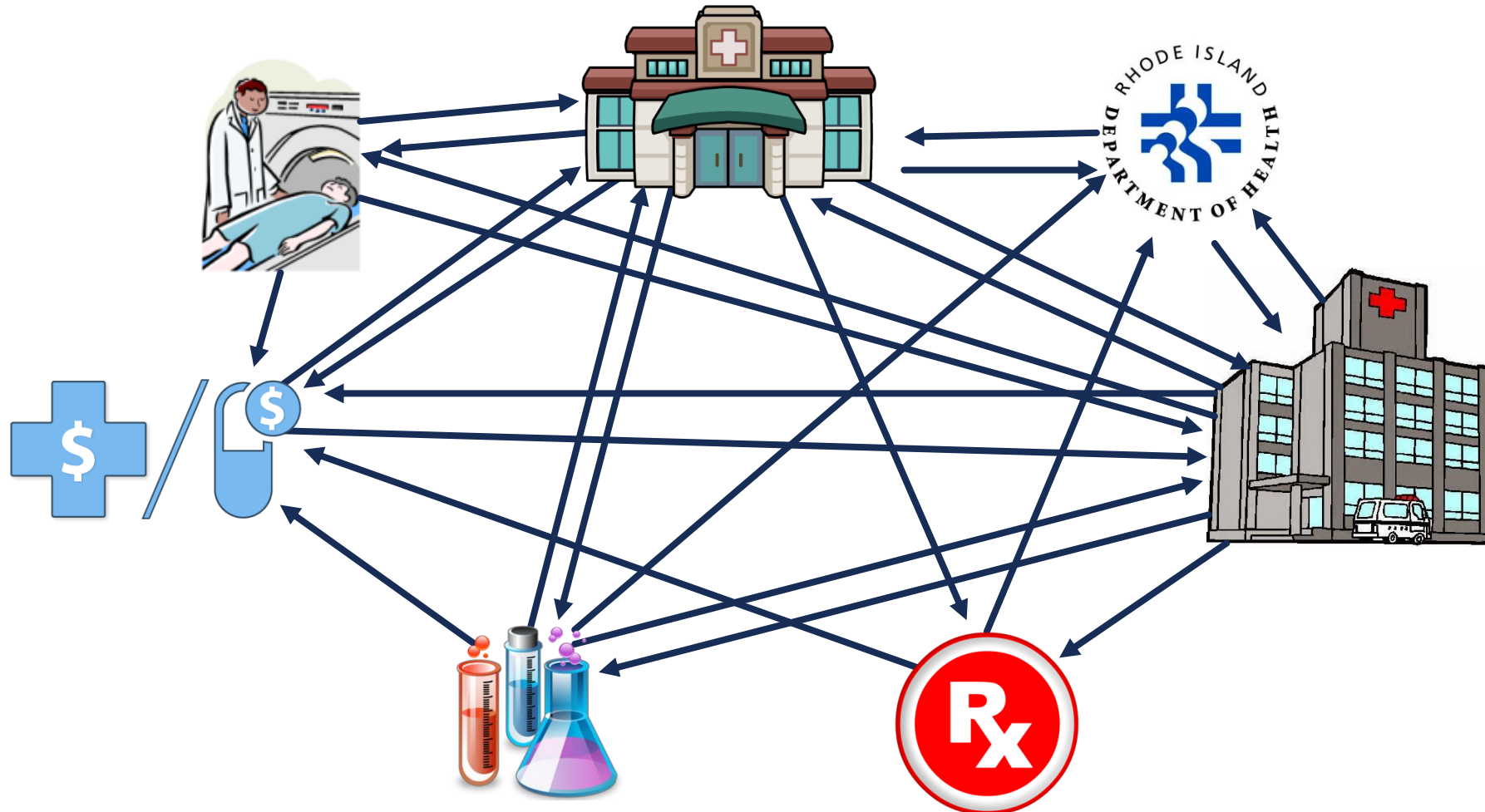
Healthcare organizations are required to share how they will keep your personal health information private and secure.

They do this by having you sign that you received their privacy policies, which is referred to as the **HIPAA Notice of Privacy Practices.**

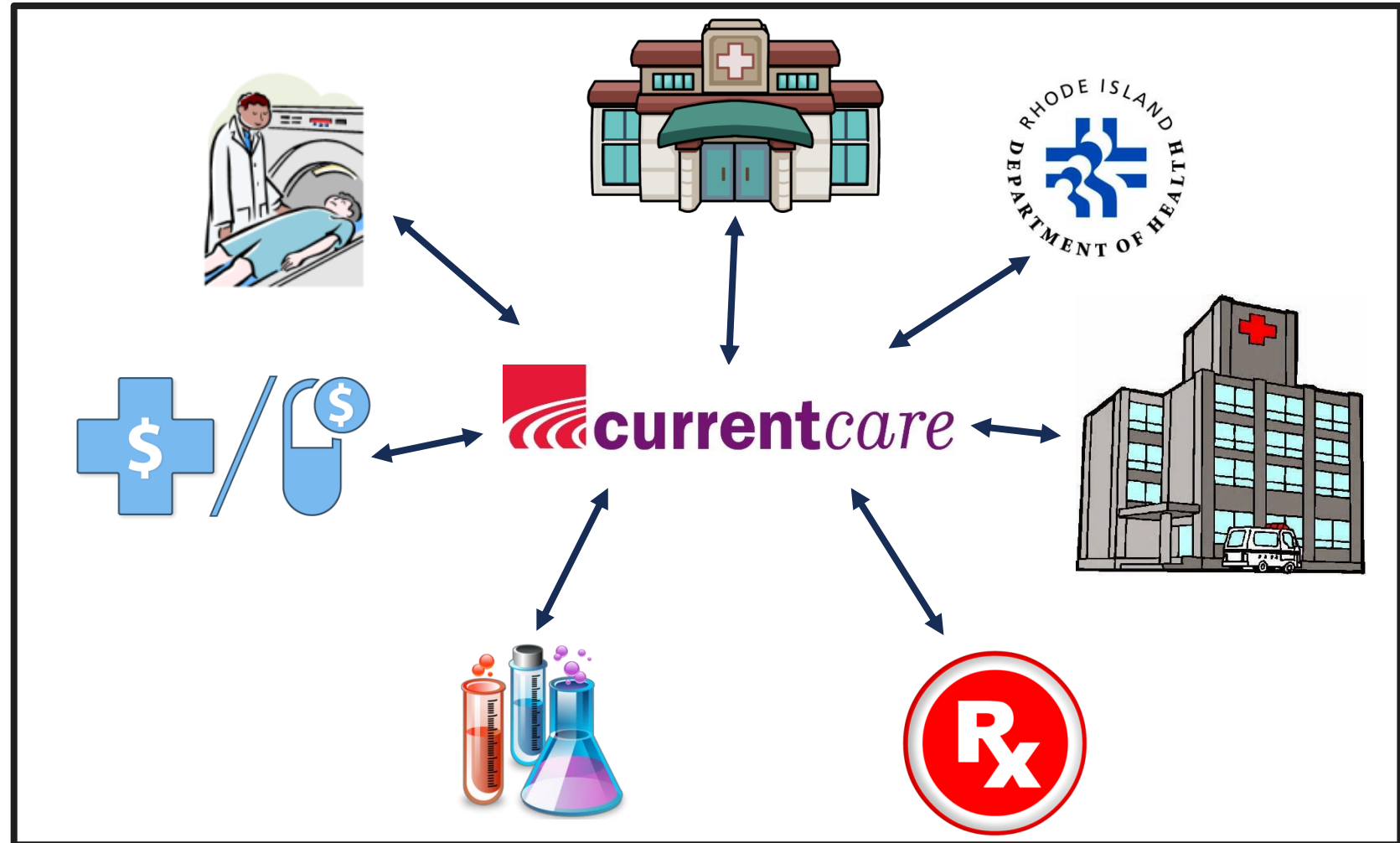
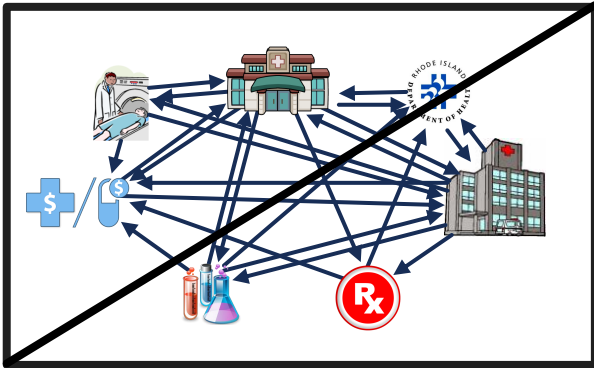
Although data is shared among health care organizations many times every day, sometimes the information does not get shared. This can put patients at risk for medical errors, duplicate diagnostic tests, or unnecessary treatment



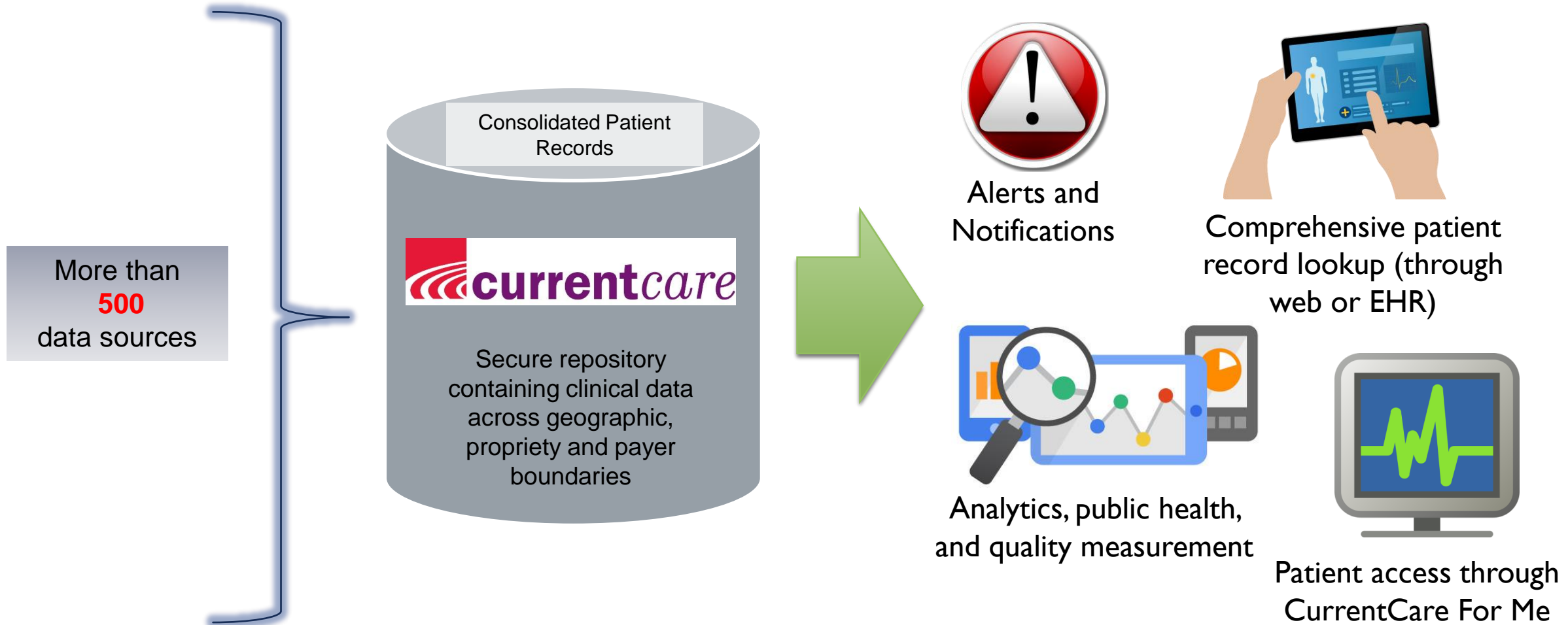
The web of healthcare communications is complex. Technology aims to simplify it, to make it easier and less expensive to ensure the right information is at the right place at the right time to benefit patients



In Rhode Island, the Health Information Exchange (CurrentCare) was designated in 2008 to simplify and modernize these activities



CurrentCare consolidates data from multiple healthcare sources to make it easier to share patient information and to provide valuable services



The Health Information Exchange Act of 2008 originated from questions about data from different healthcare organizations being transmitted through one place. There was a general consensus that the HIE needed **special protections** and **public oversight**.

As an early adopter of HIE, it was decided that Rhode Islanders should opt-in in order for their health information to become part of CurrentCare.

Under the current model CurrentCare can only support patients who have enrolled by signing an authorization form (i.e. opted-in).

51%

About 51% of Rhode Islanders are enrolled, most likely because they were offered enrollment at their doctor's office.

49%

Most of the remaining 49% of Rhode Islanders are likely not enrolled because they were either never offered enrollment, didn't understand the value of the service, or may have chosen not to enroll

Vermont Experience

Vermont has had similar experiences with opting into the VT HIE, and found that about 95% of people who were asked to enroll in Vermont's HIE did enroll.

They attribute their low enrollment rate to a low number of Vermonters being asked given the cumbersome nature of enrolling.

There have been many changes in Rhode Island's healthcare system that has changed since CurrentCare was launched.

The [Statewide HIT Roadmap Gap Analysis](#) documented the following about CurrentCare (Page 8):

Current State: There is strong interest in building on CurrentCare's existing foundation and expanding/ improving core services and usability.

Gaps: The HIE consent law is a significant barrier to the growth and effective use of CurrentCare, and there is strong stakeholder support to change to an opt-out consent model.

And the following slides document other key changes since 2008.

The national and state policy landscape has changed since the law was originally passed

In 2008

There were concerns about the data being used to exclude consumers from insurance coverage

The ability to secure data was not as advanced and the concept of cybersecurity was just beginning to emerge

Now

RI's own law, *RIGL 27-18-71 Prohibition on preexisting condition exclusion* and the Affordable Care Act protect consumers

Federal cybersecurity standards are issued routinely since 2010, which have helped to keep data secure

Healthcare delivery has changed since the law was originally passed

In 2008

Patients often had to determine how to coordinate their own care, including transporting their own health records among their treating providers

Healthcare delivery was very individual provider-focused, with many providers working in silos

Now

To improve outcomes, healthcare organizations provide more care coordination, which relies on sharing a patient's health information across treating providers

Healthcare delivery is much more comprehensive and team-based, in an effort to provide better outcomes, e.g. integrating physical and behavioral healthcare

Electronic Health Record (EHR) use and interoperability has changed since the law was originally passed, with [new CMS Interoperability Rules](#) being implemented now in 2021

In 2008

Adoption of rudimentary EHRs was about 67% among physicians and much less among other health professionals

The process for sharing health information was mostly done on paper and by fax (such as required public health reporting)

Now

Adoption of EHRs that are certified to perform advanced functions is now 91% among physicians and growing steadily among other health professionals

EHRs and healthcare systems, including public health, can now send and receive health information electronically.

Other states and HIEs have been successful with many activities that are difficult or impossible under our current model in RI

Care Coordination Services

- Electronic referrals to move away from fax
- Electronic consults to avoid unnecessary referrals
- Universal alerts and notifications to make sure all of a patient's providers know about important medical events
- Referrals to community and social services to address social and environmental determinants of health

Reporting/Analytic Services

- Clinical Quality Measurement to measure and pay for healthcare quality
- Public Health Reporting (i.e. immunizations, diseases, etc.)

Workflow Simplification Services

- Identifying information of the most importance in a patient's record
- Simplify or eliminate intake forms for patients

Rhode Island's model was not as helpful as it could have been for addressing COVID-19

For RIDOH

- Required a number of workarounds to get critical or mandatory data to fuel public health operations (faxes, call centers, CSV files, data entry portals, etc.)
 - Lab results
 - Case report data
 - Supplemental data sets (ex. race/ethnicity to ensure understanding of disparate impacts of COVID-19)
- Required development of new technology to meet critical use cases
 - New lab interfaces (directly with RIDOH), batch file upload tools, data entry portals
 - Test result look-up tool (rather than CurrentCare for Me)

For Providers

- Limited providers' access to COVID-19 test results for their patients; they could only get results on enrolled patients
 - The majority of testing has been taking place external to the PCP relationship, making this more challenging
- Limited ability to support provider clinical information needs for telehealth
- Limited providers' access to medical history for patients hospitalized due to COVID-19



The state recognizes CurrentCare's significant benefit to our healthcare system.

The Opt-Out legislation was introduced to update the law that was groundbreaking when passed, but now can be seen as lagging the rest of the country as technology has advanced and the healthcare system has changed.

What would the opt-out consent model mean?

- **All healthcare data would be shared with CurrentCare** and could be disclosed for allowable uses as defined by HIPAA and other State or Federal law.
- **Patients will still have choice to participate** and will be notified that they may opt-out of having their data shared (disclosed) from CurrentCare
- There would be **some exceptions** to the opt-out which would allow for the universal use of CurrentCare for certain activities (i.e. emergencies like COVID-19, public health reporting, provider-to-provider communication, etc.)
- Some data would still require a consent to be signed before it could be shared, such as substance use treatment information for 42 CFR Part 2 covered programs

The implementation of opt-out demands a careful transition plan

If passed, the law's implementation plan would need to be developed with care and should:

- Ensure that patients understand their choices, providing plenty of opportunity to opt-out before any change is made and regularly reminding them
- Educate the community, including providers and other important touchpoints in the healthcare system, about the changes and patients' choice and process to opt-out
- Make the opt-out process as simple and understandable as possible
- Ensure any exceptions to an opt-out have a meaningful and compelling reason, i.e. for public health

Security would not change:

- Existing security features of CurrentCare are robust and meet or exceed all applicable requirements
- Changing the model of consent would have no effect on the security practices of CurrentCare

ALIGNING WITH COMPREHENSIVE PRIMARY CARE PLUS (CPC+) – MULTI-PAYER DATA STRATEGY NEEDS – PROJECT DESCRIPTION

- Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based **multi-payer payment reform** and **care delivery transformation**.
- CMS has contracted with Deloitte Consulting to provide **facilitation, convening and technical assistance for payers participating in CPC+**. The Care Transformation Collaborative RI provides payor convenor support for CPC+ in Rhode Island.
- RI's CPC+ payers have expressed interest in developing a **statewide strategy to better leverage data, support data use, and align to the CPC+** (and potential future) models, to further primary care transformation.

ALIGNING WITH COMPREHENSIVE PRIMARY CARE PLUS (CPC+) – MULTI-PAYER DATA STRATEGY NEEDS

Examples of Potential Shared Work, to be determined by CPC+ with input and comment from the RI HIT Steering Committee:

- Work with payers to improve data collection with regard to race, ethnicity, sexual orientation and gender identity. This involves systematically capturing the data and doing so in standardized manner – and is required in order to eliminate health disparities, to support population health, and to address Social Determinants of Health.
- Work with payers to develop a sustainability plan for the Quality Reporting System (QRS), which was developed originally with SIM Funds and is now supported by federal 90/10 funds from HITECH. With HITECH sunseting, the state as a whole must answer questions about a sustainable funding model.

Next Steps

Next Meeting: Wednesday, April 14, 2021

PUBLIC COMMENT