Minnesota
Health Care Financing Task Force

HEALTH CARE DELIVERY DESIGN & SUSTAINABILITY

OCTOBER 23, 2015

MINNESOTA
HEALTH CARE
FINANCING
TASK FORCE

Health Care Delivery Design & Sustainability

October 23rd, 2015

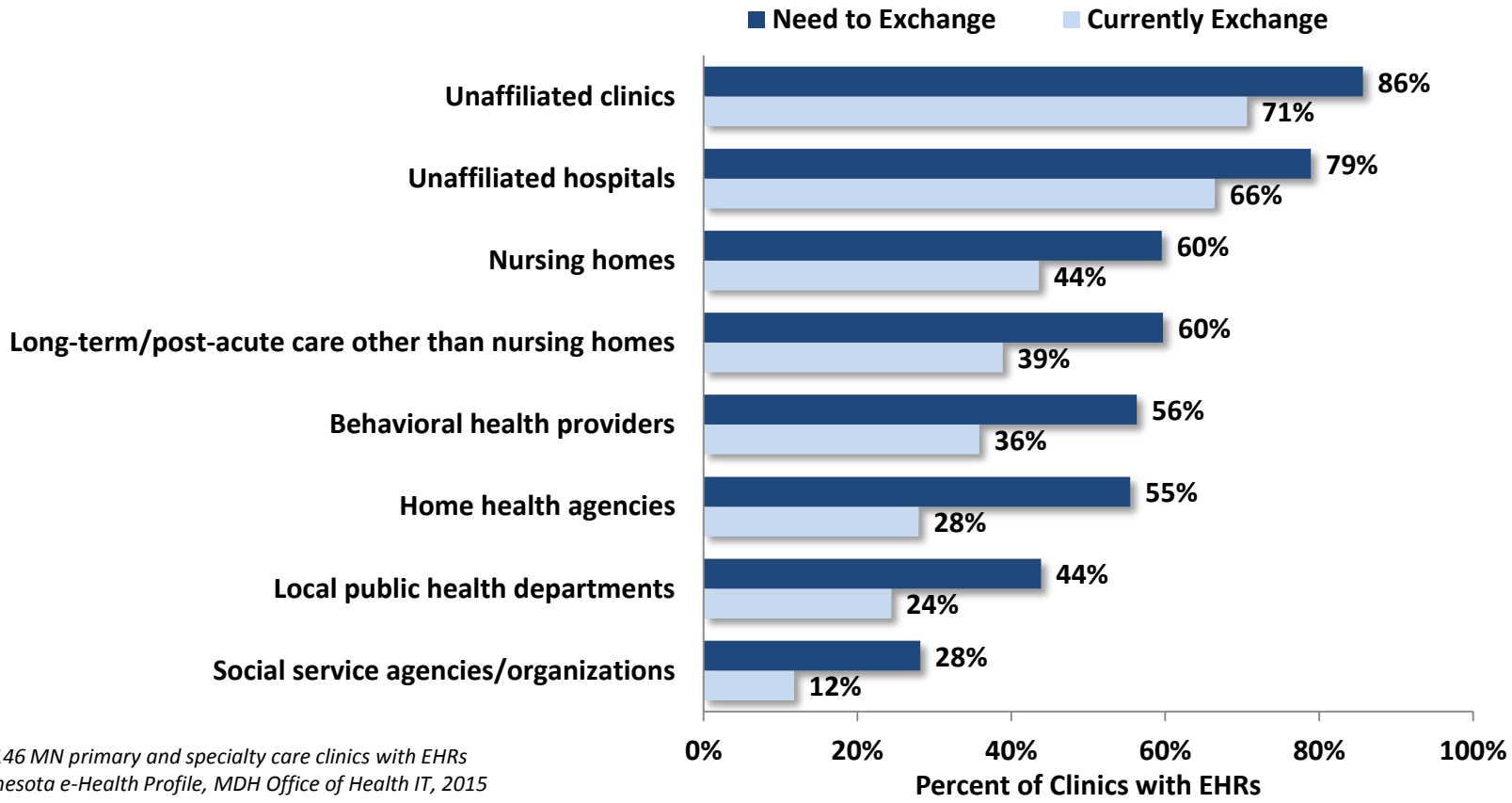
Agenda

- Welcome, Roll Call, and Meeting Purpose
- Interconnections Between Workgroups, and Workgroup Priorities
- Barriers to Health Data Sharing
  - Presentation
  - Patient Stories
  - Identification and Discussion of Options
- Next Steps
- Public Comment
- Wrap Up

Health Information Exchange (HIE): Status

- Need for exchange (across continuum of care) outstrips current capabilities
- Exchange within existing systems is robust; drops off sharply for different EHRs, unaffiliated providers
- When exchange does happen, it is often still not "consumable" in EHRs: Fax/PDF and non-standard data are common.

Health Information Exchange: Status Clinic HIE Gaps



Clinic N = 1,146 MN primary and specialty care clinics with EHRs
Source: Minnesota e-Health Profile, MDH Office of Health IT, 2015

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Minnesota Department of Human Services

Health Care Financing Task Force
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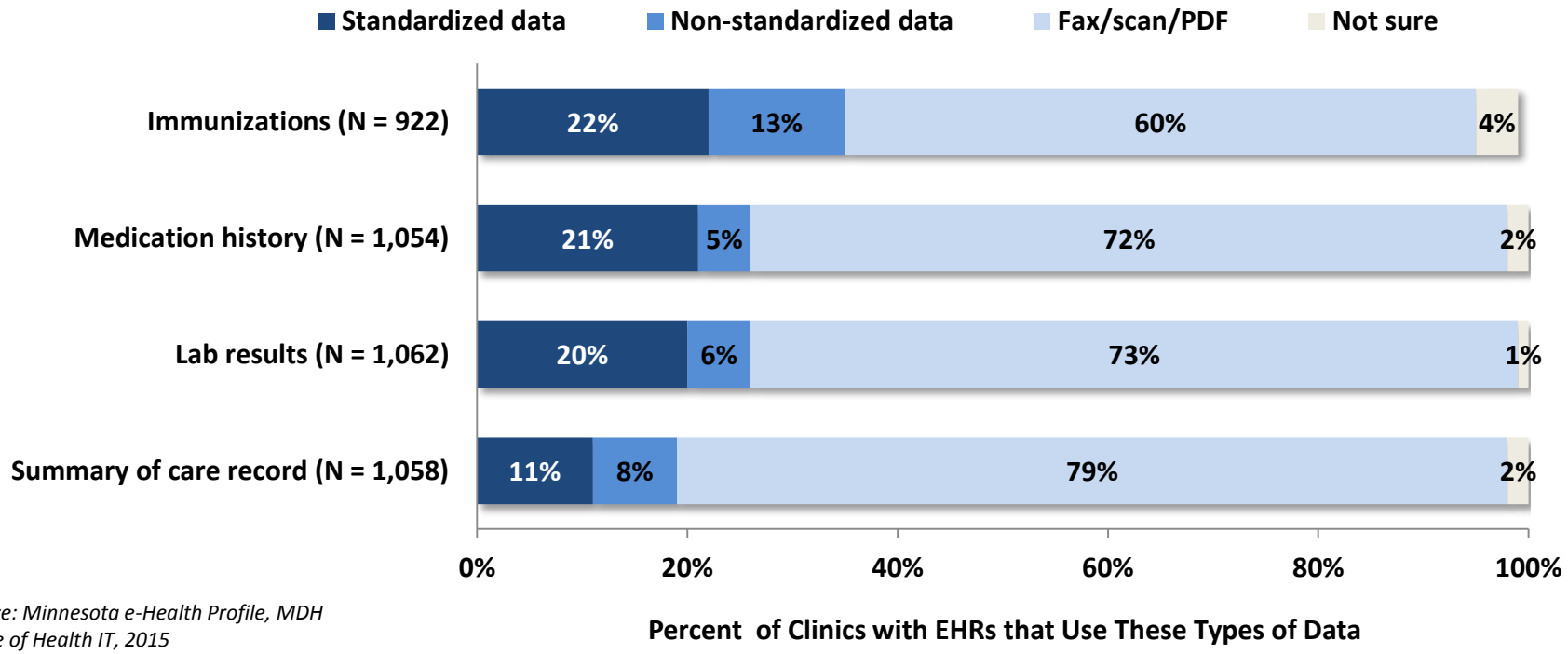
Health Information Exchange: Status
EHR "Consumability"

For each type of clinical information received electronically from providers or sources outside your health system/organization, how do you usually integrate the information into your EHR?



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Barriers to HIE: Key Themes

- Business case/ROI
  - Business case may differ across providers; creates tension
  - Initial investment needs can be high; payoff comes more slowly
  - No statewide approach to funding HIE; creates haves/have nots
- Policy/legal considerations
  - Challenges with implementing MN's consent requirements
  - Challenges understanding MN law and federal interplay
  - HIE governance – different models emerging, resource-intensive
- Competing priorities
  - ICD-10, ACO formation, QI, etc.

Barriers to HIE: Key Themes

- Technical needs
  - Lack of granular standards for specific transactions
  - Need for “shared services” like consent management, provider directories, etc
  - Potential need for core set of HIE transactions, like admission/discharge/transfer alerts
- Market-based HIE infrastructure
  - More complicated for providers
  - Sustainability questions

Barriers to HIE: Key Themes
Difference is MN and Federal Law

Topic	Differences and Policy Considerations
Release of health information / to other providers	MN law is more restrictive in that it is protective of individual privacy rights; MN law does allow sharing within related health care entities; representation of consent is an option but not widely understood or used.
Required or permitted releases without consent	MN law is more restrictive in that it is protective of individual privacy rights
Minimum necessary	No conflict – non-govt. providers comply with HIPAA
De-identified health information and limited data set	No conflict – non-govt. providers comply with HIPAA
Access/copies of health information	No conflict – non-govt. providers comply with HIPAA
Accounting disclosures	Both focus on individual rights of patient to accounting of disclosures
Security safeguards (breaches)	No conflict – non-govt. providers comply with HIPAA

Options for workgroup consideration: Consent/HRA (Option 1)

- Major modifications to MN Health Records Act (HRA)
  - Align HRA with HIPAA
  - Could consider MN-specific requirements for opt-in/opt out of having information exchanged by an HIE service provider.

- Rationale:
  - Patients may be experiencing harm related to lack of coordinated care/secure health information exchange due to more stringent consent requirements
  - Multi-state vendors have to adapt systems to MN-specific laws
  - Current model is challenging to understand and implement

Options for workgroup consideration: Consent/HRA (Option 2)

- Minor technical updates to MN Health Records Act
  - Possible examples:
    - Clarify whether electronic consent meets “written consent” requirements
    - Clarify requirement to “exclude” data from patient information service
    - Clarify consent expiration (e.g. most interpret a 1-year consent expiration in the HRA, but it is not universally understood)
    - Clarify whether care coordination is included in definition of “treatment”

  - Rationale: Keeps existing consent framework in place while updating law to fit with technical capabilities and address some immediate challenges. Could allow time for discussion of broader changes.

Options for workgroup consideration: Study new HIE/consent model

- Study HIE challenges and opportunities, develop recommendations to accelerate and sustain progress. Recommendations could focus on:
  - Potential revisions to HRA/consent model for MN
  - Impact of current model on patient care/harm, costs, HIE progress
  - Market-based vs single HIE entity
  - Finance/sustainability for HIE
  - Governance
  - Business / technical operations of statewide HIE.
- Rationale: Evidence about impact of current model is lacking. HIT/HIE needs and capabilities have evolved; may need to step back and look at other state approaches and develop updated, sustainable model

Options for workgroup consideration: Privacy/Security/Consent Education

- Provide ongoing support/education/TA on privacy, security and consent for providers and patients

- Rationale:
  - Many providers and partners may misunderstand law's requirements;
  - Lack of clarity in consent requirements lead to varying legal interpretations;
  - Providers have to 'reinvent wheel' and may take different stances and/or duplicate effort;
  - Requirements more complex for certain types of data or partners (mental health, CD, education);
  - Resources are needed for implementation and monitoring of best practices regarding privacy, security, and consent (e.g., security risk assessments).

Options for workgroup consideration: Expand/Support Shared HIE Services

- Support establishment of more robust, sustainable "shared services" infrastructure
  - Funding, ability to designate a single entity, sustainability

- Rationale:
  - Certain functions, like consent management, might be more easily handled in one place vs at level of each organization
  - Core HIE functionality, with sustainable financial support, would be available statewide

Options for workgroup consideration: Support Statewide Core HIE Transactions

- Consider funding mechanism for core HIE transactions (e.g. admission/discharge/transfer alerts, care summaries, care plans)
  - Identify minimum data / transactions that should be exchanged statewide
  - Develop specifications, guidance, and TA to support
  - Provide funding to ensure that core services are available at little/no cost

- Rationale:
  - Certain core information, like ADT alerts, is broadly recognized as crucial for care coordination
  - Levels playing field for these core transactions
  - Minimizes duplication/fragmentation of effort across organizations

Options for workgroup consideration: Support Broad HIT/EHR Adoption

- Support expanded HIT capabilities in broad range of settings, as precursor to HIE
  - To be effective, HIE needs to be available across continuum of care
  - HIT adoption relatively low in behavioral health, long term care, home care, social services, chiropractic, etc.
  - Need for funding, TA in new settings