

Pulling it all Together for Secure Health Information Exchange: From the Enterprise to Nationwide

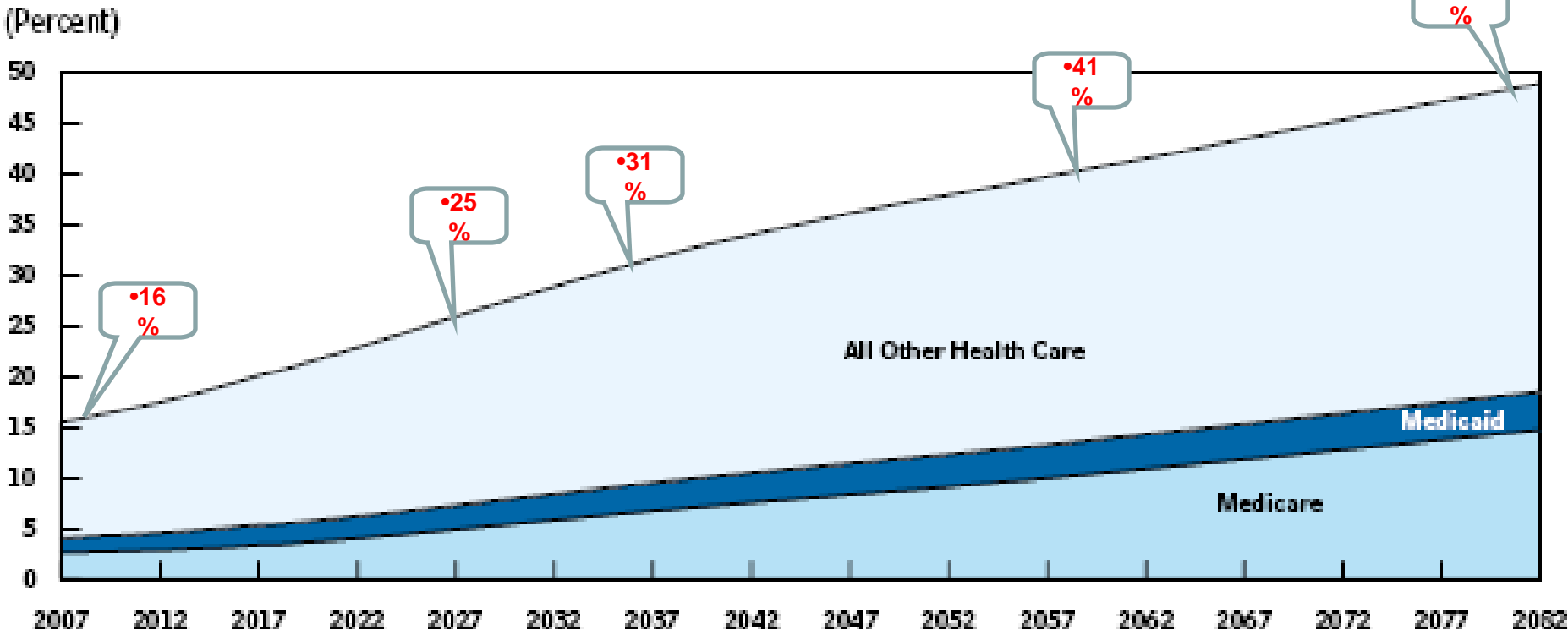
Holt Anderson, Executive Director
NCHICA

The 16th HIPAA Summit
Boston, MA
August 20, 2008

**Will HIE efforts continue with
change of Administrations?**

If so, why?

Projected Spending on Health Care as a Percentage of Gross Domestic Product, 2007 to 2082



Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

•"TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING," CBO, January 31, 2009

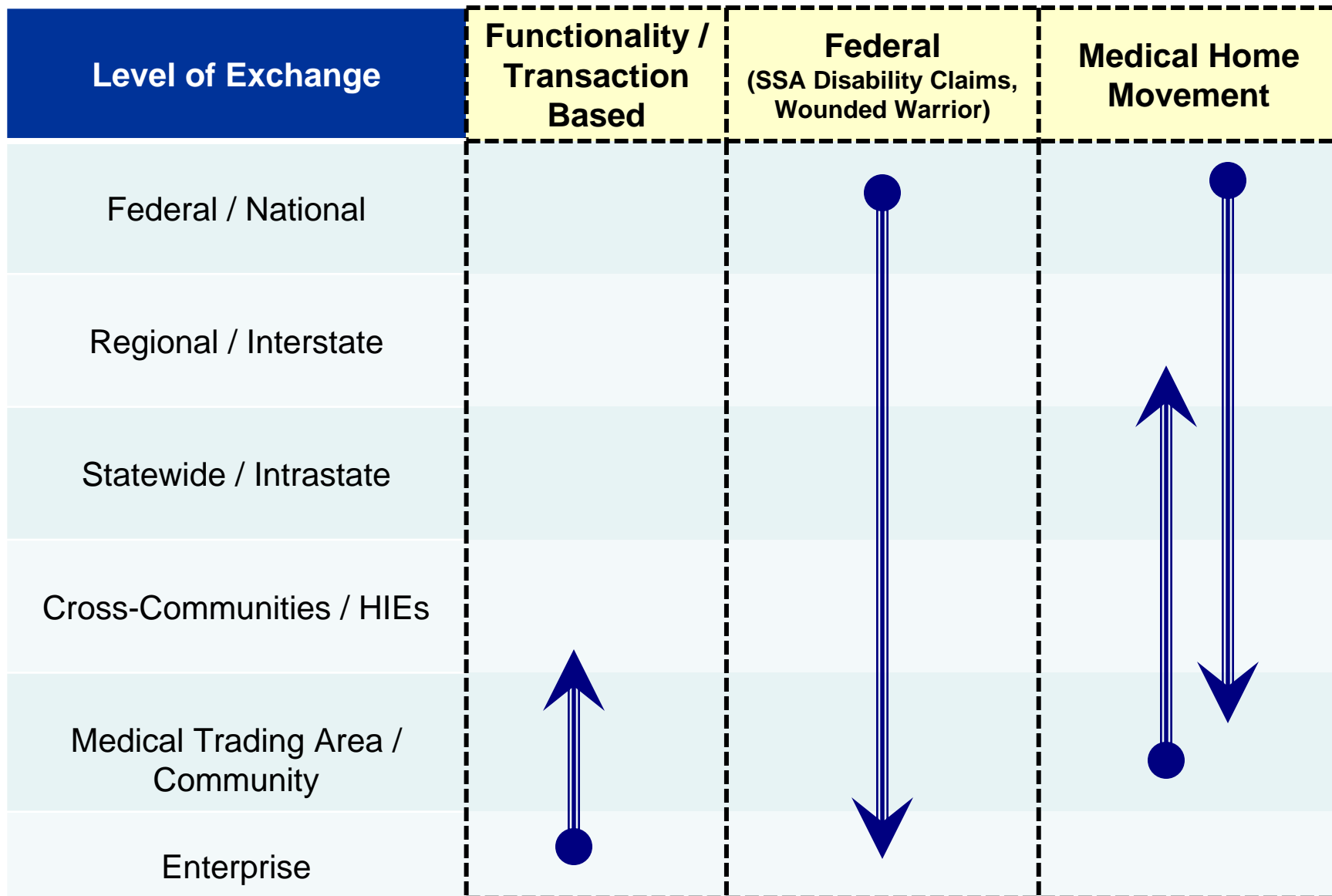
Pulling it Together to Build a Nationwide Health Information Network

**Is there a business case from
the enterprise to nationwide?**

Business Case for Nationwide HIE Investment

Level of Exchange	Primary Interest	Support for NHIE
Federal / National	Clinical & Administrative Referrals, Results, Pop. Health events (Medicare, MHS/VA/IHS/SSA etc.)	Strong interest in NHIE and Mandatory Use of National Standards
Regional / Interstate	Referrals, Results, Pop. Health events (Nat'l Payers & Self-funded Plans, etc.)	Strong Interest in National Standards; Interest in NHIE
Statewide / Intrastate	Clinical & Administrative (Medicaid, State Health Plan, State BCBS, Pop. Health awareness)	Strong Interest in National Standards; Mild interest in NHIE
Cross-Communities / HIEs	Referrals, Results, Pop. Health events (Health Systems, Regional Payers, PH)	Interest in National Standards; Mild interest in Intrastate or NHIE
Medical Trading Area / Community	Referrals, Results Delivery, Administrative (eRx, Lab, HIPAA claims/pmts)	Interest in Standards Avoid technical isolation; Mild interest in Intrastate / NHIE
Enterprise	Internal Network (Internal to Practice, PH, Hospital, etc.)	Low Interest in <u>N</u> HIE

Scenario Driven Business Case for HIE





FEDERAL HEALTH ARCHITECTURE PROGRAM

Using the NHIN Infrastructure for the Needs of Federal Providers of Care

Accelerating The Momentum

•December 12, 2007



•U.S. Department of Health and Human Services

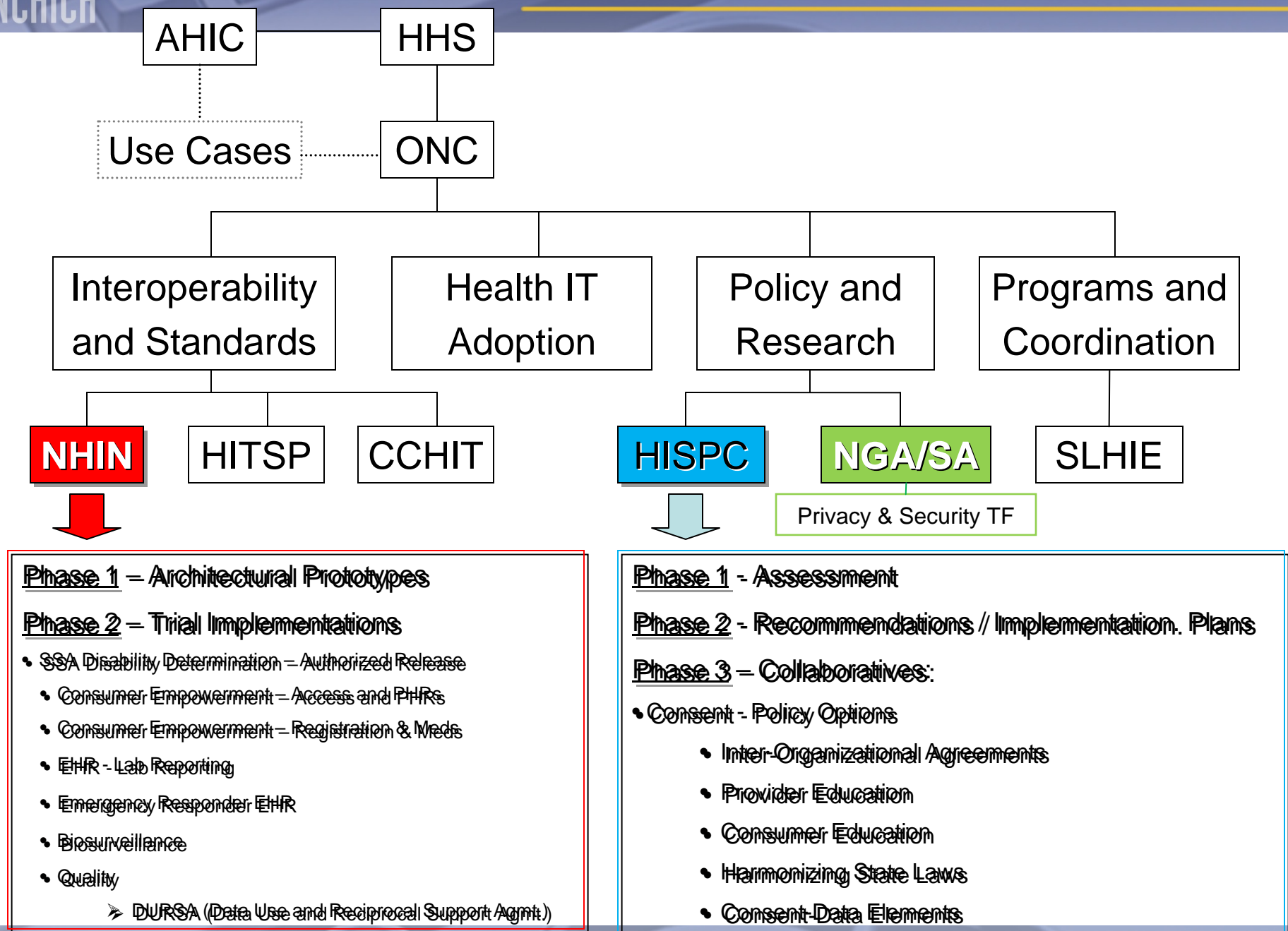


Federal Interests in Health

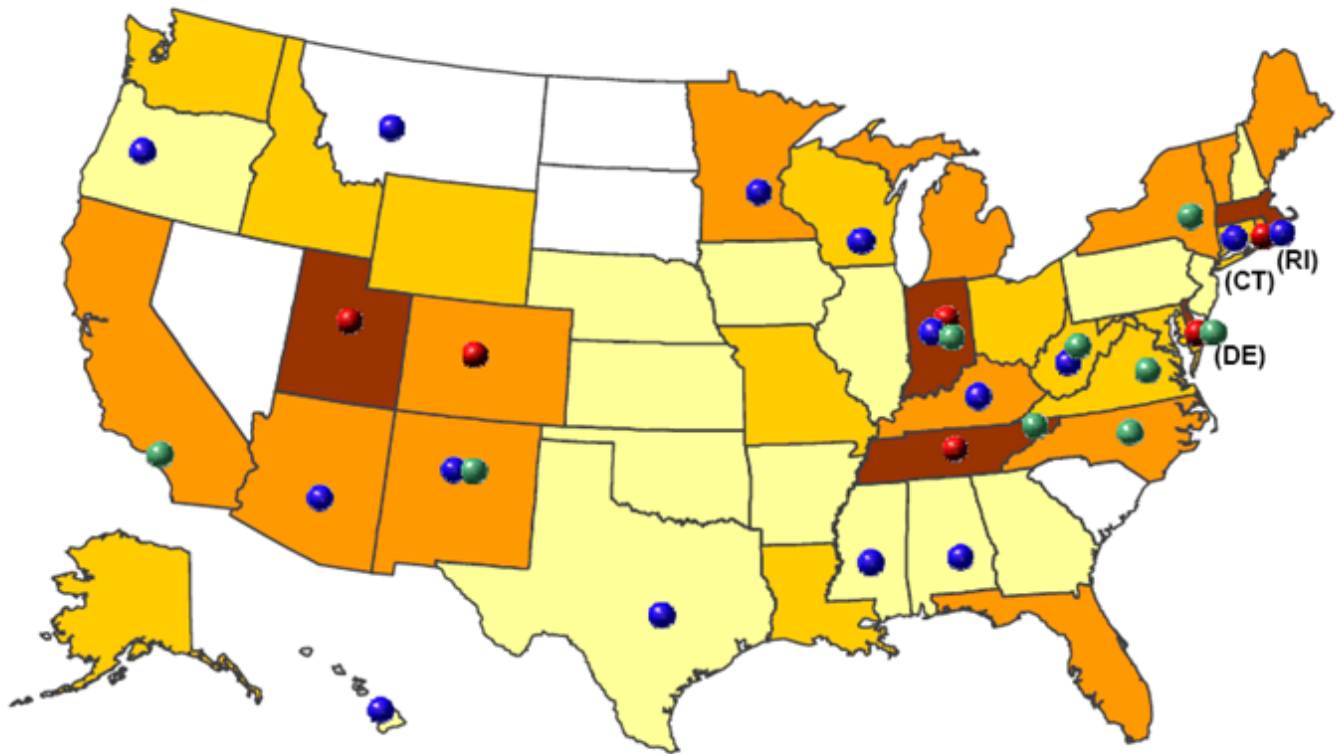
- Major provider of care (DoD, VA, IHS, others)
- Federal Government pays for 40% of health care
- Public health and biosurveillance
- Research
- Policy
- Quality and transparency

Pulling it together for Secure Health Information Exchange: Is there Coordination?

**Various efforts sponsored by
Federal Agencies**



State Level HIE - An Evolving Landscape



● State/Regional Contracts (6)	■ 1. Early Planning
● Medicaid Transformation Grants – HIE/EHR focus (15)	■ 2. Foundational
● NHIN Trial Implementation (9)	■ 4. Operating
	■ 3. Early Implementation

Pulling it Together for Secure Health Information Exchange

Building effective policies to inform and enable technology solutions.

HISPC

Health Information Security and Privacy Collaboration

HISPC Phase 3

Collaborative	Participating States and Territories	
		Abbreviations
Consent 1 – Data Elements		IN, ME, MA, MN, NH, NY, OK, RI, UT, VT, WI
Consent 2 – Policy Options		CA, IL, NC, OH
Harmonizing Privacy Law		FL, KY, KS, MI, MO, NM, TX
Consumer Education and Engagement		CO, GA, KS, MA, NY, OR, WA, WV
Provider Education		FL, KY, LA, MI, MO, MS, TN, WY
Adoption of Standard Policies		AZ, CO, CT, MD, NE, OH, OK, UT, VA, WA
Interorganizational Agreements		AK, GU, IA, NJ, NC, PR, SD

Collaborative Deliverables

- Systematic process or roadmap for states to use in addressing intrastate and interstate consent issues
- Central Library of Consent Documents/Forms
- Matrix of international and national consent approaches
- Summary of risks and benefits associated with mandatory and voluntary consent approaches for each intrastate HIE scenario evaluated
- Recommended best legal mechanism to address conflicting state consent laws to facilitate interstate HIE

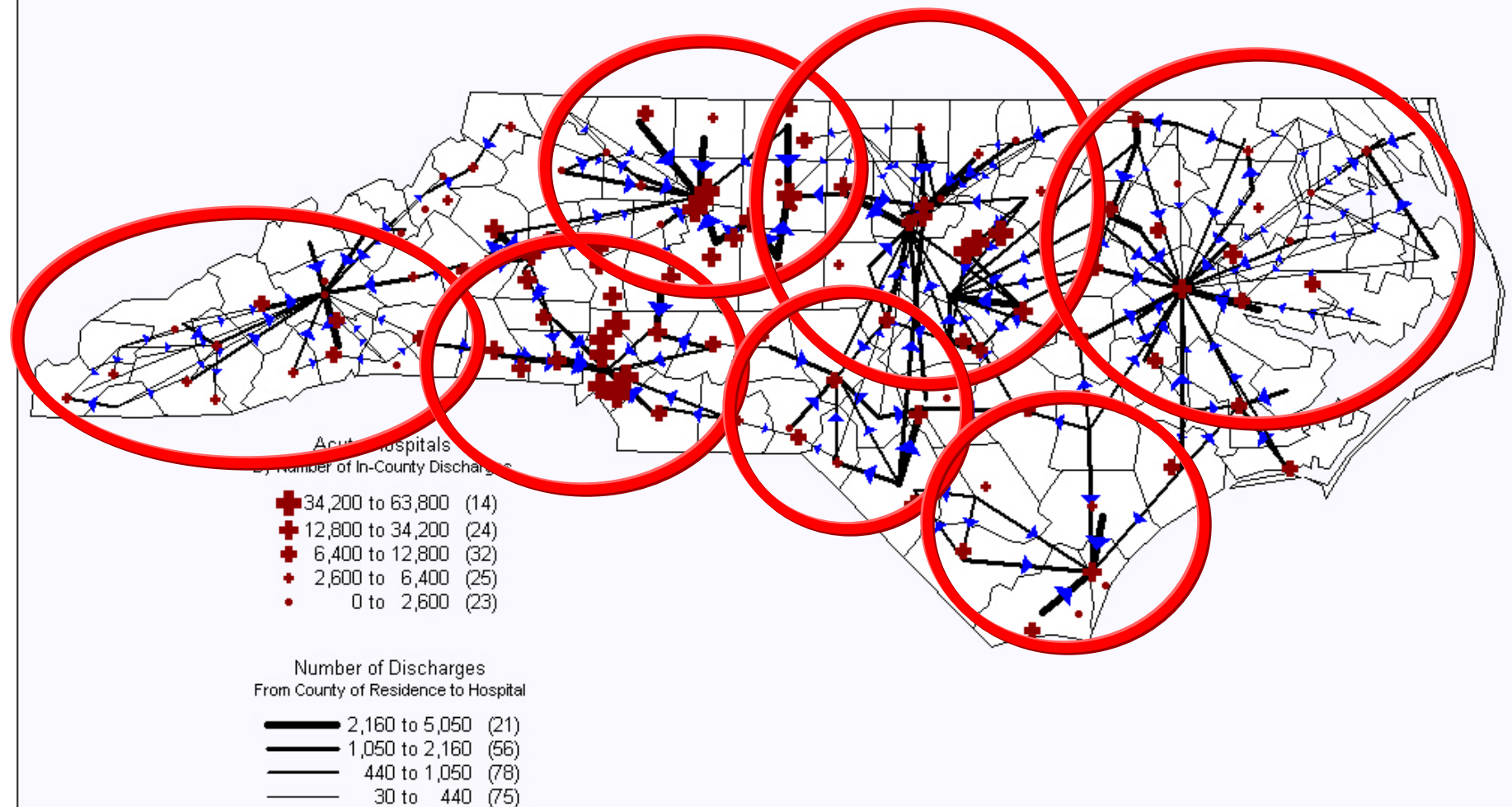
•HISPC Consent Policy Options
Collaborative

Pulling it together for Secure Health Information Exchange

North Carolina's Approach through NCHICA

Map 1.

Patient Origin for North Carolina Residents and Acute Hospitals Inpatient Discharges by County of Residence and Hospital, Fiscal Year 2000

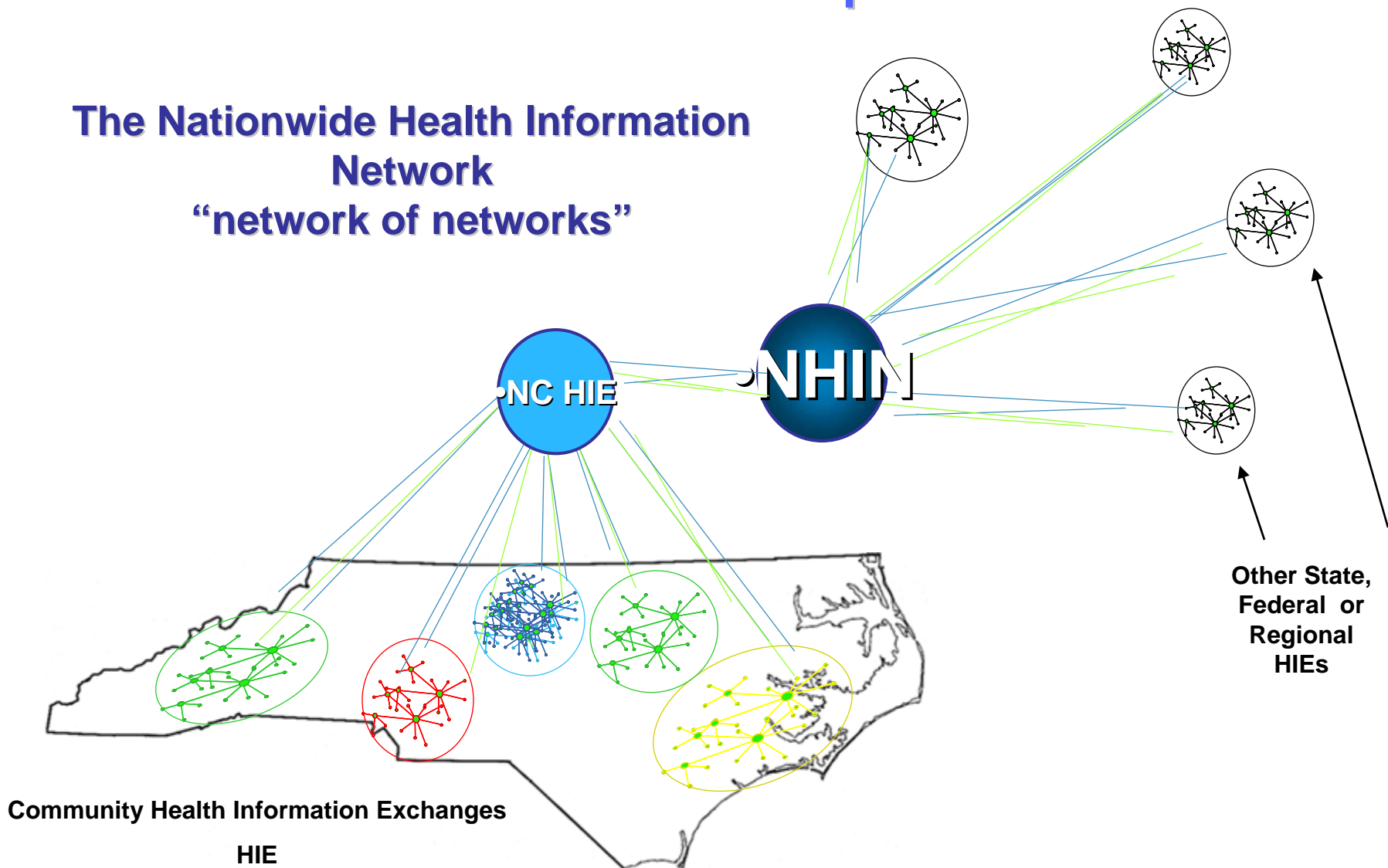


Source: Solucient, Fiscal Year 2000 (Oct. 1, 1999 - Sept. 30, 2000).
Produced by: North Carolina Rural Health Research Program, Cecil G. Sheps
Center for Health Services Research, University of North Carolina at Chapel Hill.

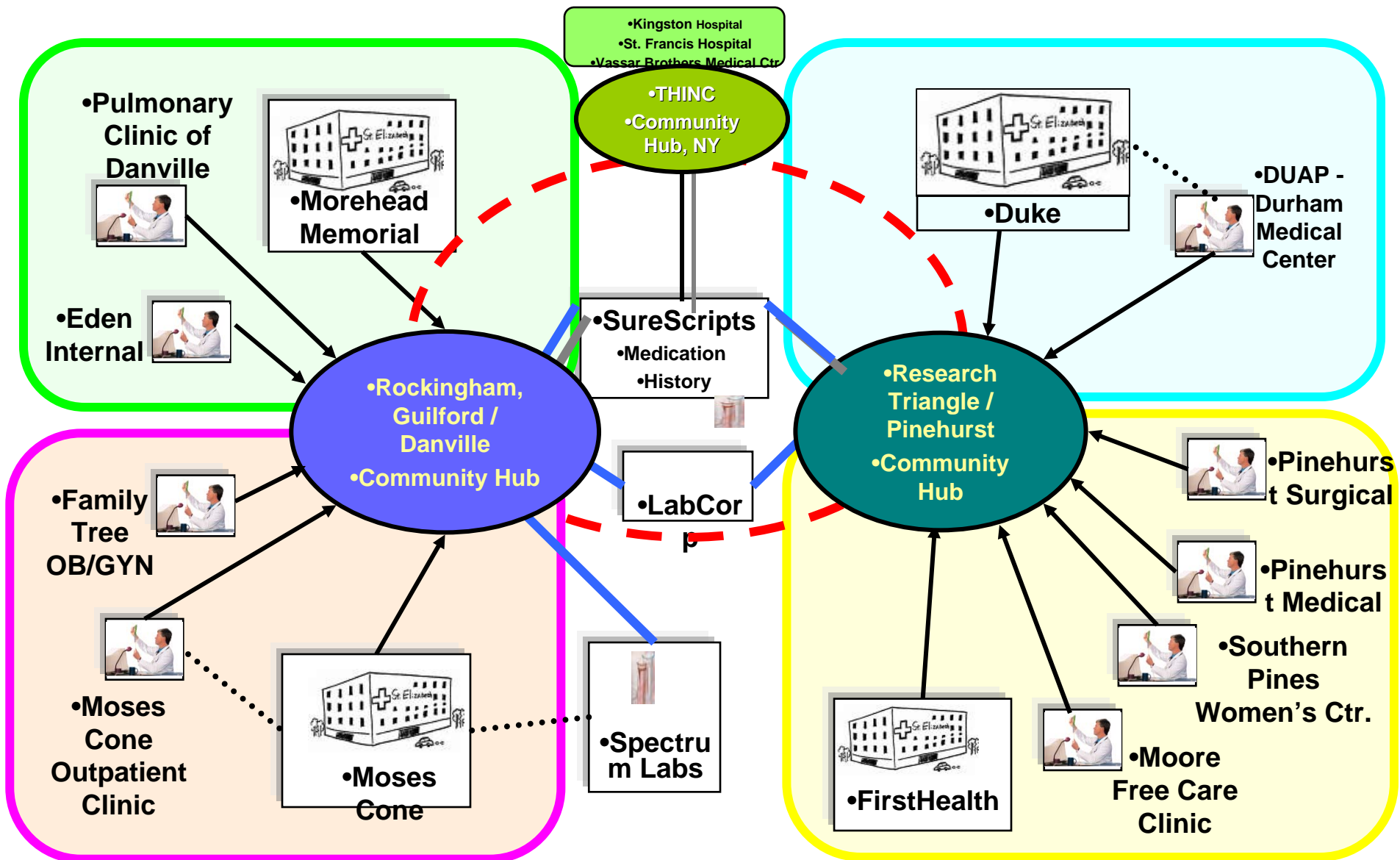
Notes: For any county, vectors are drawn only for hospitals receiving at least five percent of the county's admissions and counties with at least ten admissions. Admissions to psychiatric, rehabilitation and substance abuse facilities have been removed. Normal newborn admissions have also been removed.

•NHIN Phase 2 – Trial Implementations

The Nationwide Health Information Network
“network of networks”



NHIN Phase 1 - Architecture Prototype



NCHICA NHIN Trial Implementations

Key Participating Providers



NHIN Phase 2 Use Cases

Consumer Empowerment: Access to Clinical Information

Personal Health Records (PHRs)

EHR: Lab Results Reporting

SSA Authorized Release of Information to a Trusted Entity

Consumer Empowerment: Registration and Medication History

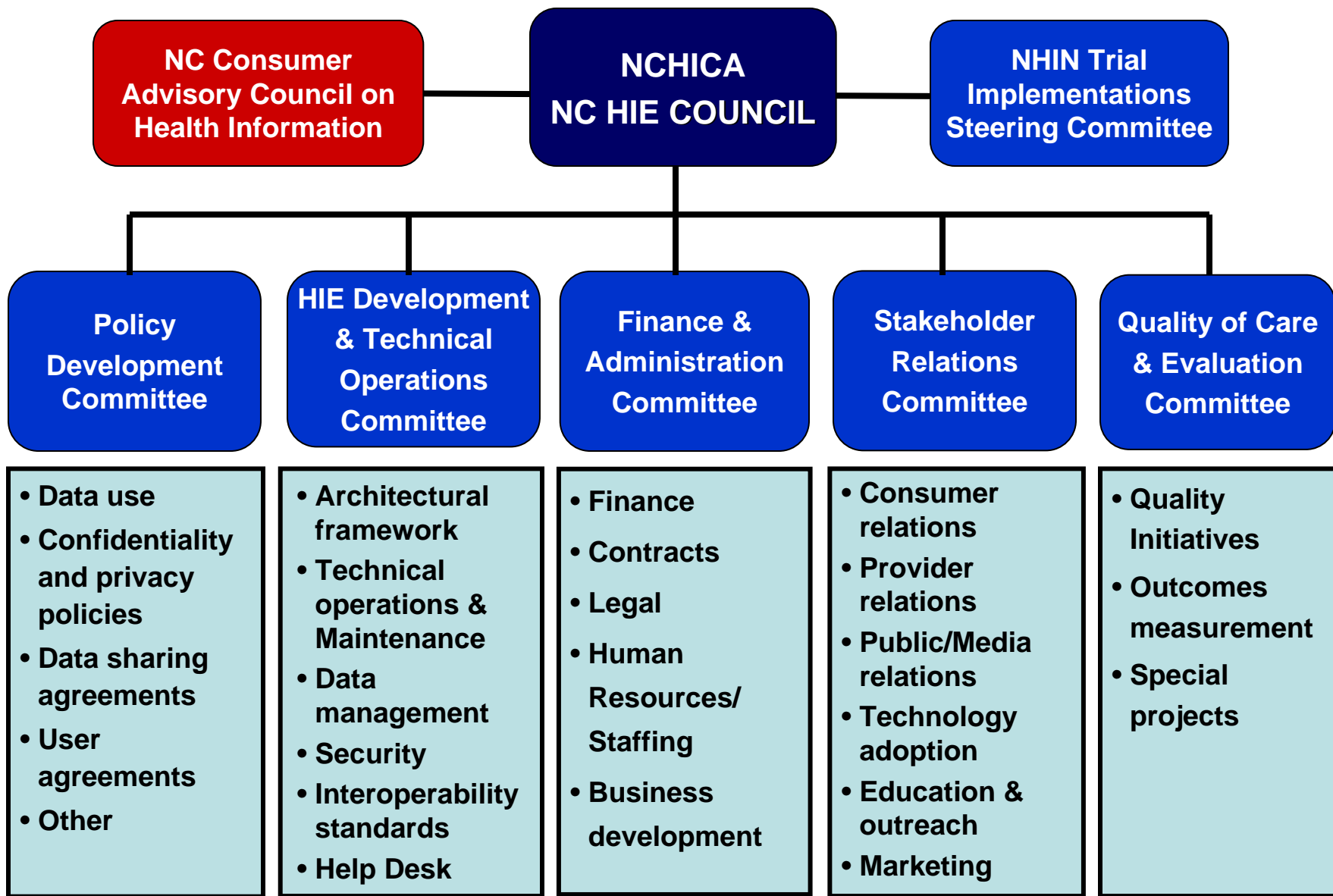
Emergency Responder EHR

Medication Management

Biosurveillance

Quality

NC Health Information Exchange Council (NC HIE Council)



NC HIE Council Membership

- Representative of the North Carolina Consumer Advisory Council on Health Information
- Representative of the North Carolina Medical Society
- Representative of NCHA (the North Carolina Hospital Association)
- Representative of the North Carolina Nurses Association
- Representative of the North Carolina Health Information Management Association
- Representative of the North Carolina Institute of Medicine
- Representative of the North Carolina Association of Pharmacists
- The North Carolina State Health Director or his/her designee
- The North Carolina State Chief Information Officer or his/her designee
- Representative of Local Health Depts appointed by the NC Assn. of Local Health Directors
- Representative of NC Office of Emergency Medical Services
- Representative of the NC Association of Free Clinics
- Representative of NC Division of Medical Assistance (Medicaid)
- Representative of NC Division of Mental Health/Developmental Disabilities/ Substance Abuse Services
- Representative of NC Association of Health Plans
- Representative of private-sector behavioral health
- Representative of long-term care / nursing homes
- Representative of laboratory services
- Representative of radiology services
- Representative of the NCHICA CIO Roundtable who also is a member of NC HIE
- Two (2) at-large members appointed by the Board of Directors of NCHICA
- Representative of a Healthcare Information Service Provider that could operate an exchange network

NC HIE Council – Policy Committee

Focus:

Build consensus approaches and model agreements to enable health information exchange in North Carolina with surrounding areas consistent with emerging national policy standards.

- Data use
- Confidentiality and privacy policies
- Data sharing agreements
- User agreements
- Other

HISPC

Health Information Security and Privacy Collaboration

Consent Policy Options Collaborative
(CA, IL, NC, OH)

Consent Policy Options Collaborative

Purpose:

To analyze the consumer role in permitting use and disclosure of their health information: currently, what is this role, and what should it be?

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Collaborative

Consent Policy Issues that will be Explored

- How much flexibility should consumers have in permitting the sharing of their health information by entities that hold their information?
 - What level of specificity or “granularity” should be permitted? Should consumers be allowed to authorize release of lab results to one physician but not another, or some labs to one physician but all to another?
 - What about highly sensitive information?

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Collaborative

Consent Policy Issues that will be Explored

- Should providers be allowed to place an individual's health information into an eHIO without the individual's knowledge or permission, where doing so will enable the patient to receive improved and necessary care?
 - How might this affect consumers' trust of health care providers?
 - What if sharing such information without the patient's consent violates state or federal law?

Privacy Principles to Guide our Evaluation of Intrastate Consent Issues:

1. Openness
2. Health Information Quality
3. Individual Participation
4. Collection Limitation
5. Use Limitation
6. Purpose Limitation
7. Security Safeguards
8. Accountability

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Intrastate Consent Policy Options: NC's Work Plan

- Define the continuum of consent approaches for sharing health information in an intrastate HIE:
 - No permission (consent is mandatory)
 - Opt In (assumes refusal of consent; consumer has choice to consent)
 - Opt In w/Restrictions (assumes refusal of consent; consumer has choice to consent for some but not all exchanges)
 - Opt Out (assumes consent; consumer has choice to refuse consent)
 - Opt Out w/Exceptions (assumes consent; consumer has choice refuse consent for some but not all exchanges)

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Intrastate Consent Policy Options: NC's Work Plan, cont.

The consent approaches will be evaluated
through application to the following use cases:

- Ambulatory Care
- Patient record locator service

Interstate Consent Policy Options: NC Work Plan

- Explore statutory options to resolve conflicts between state privacy laws:
- What law would apply to health information created in state A, stored or accessed electronically by a HIO in state B, and disclosed to an entity in state C?
- Options include: Model Act, Uniform Law, Interstate Compact, Conflict of Law

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Collaborative

HISPC

Health Information Security and Privacy Collaboration

Inter-organizational Agreements Collaborative

(AK, GU, IA, NJ, NC, PR, SD)

IOA Collaborative

- Goals:
 - Develop model cross-state inter-organizational agreements that permit the participating states and providers within those states to conduct interoperable HIEs
 - Once model IOAs are developed, demonstrate their value in pilot HIEs
 - Collaborate in NHIN, including a pilot with the NHIN project in North Carolina

Current List of Barriers and Policy Items

Barriers (from HISPC work)	Policy
1-Misinterpretation and/or Misapplication of Laws or Regulation	1- Data Delivery from Health-Related Enterprises
3-Lack of Policy Standardization across Entities	2- PHI Holder Data Confidence
4-Lack of Security Standardization across Entities	3- Timely Correction of Shared PHI
7-Conflicting or Outdated Federal or State Laws or Regulations	4- Privacy Protection Measures
8a-Lack of Consumer Understanding or Awareness of the Benefits	5- Integration of PHRs and EMRs
8b-Lack of Definition of Consumer Empowerment	6- Encouraging Early Community HIE
	7 - Opt-out impact on persistency of data
	8 - Authorization, Authentication, Access & Auditing

The Core Topics, Encore

- IOA activities focused upon:
 - Recipient Requirements
 - Provider Requirements
 - Privacy
 - Security
 - Liability
 - Indemnification

NHIN

Nationwide Health Information Network

Data Use and Reciprocal Support Agreement (DURSA)

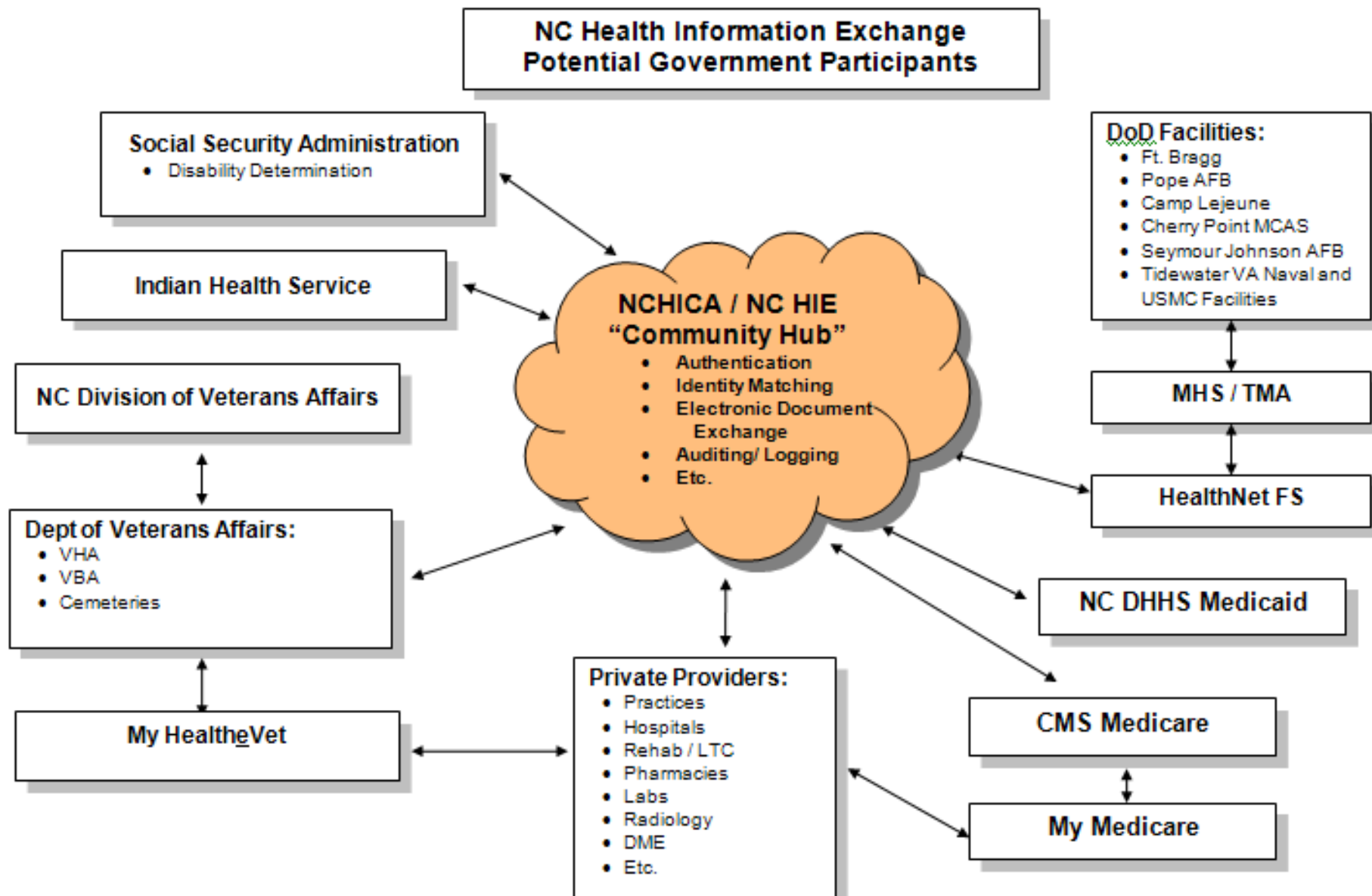
NHIN Specific Policies

DURSA Topics / Issues – Examples Include:

- Allocation of Risk and Liability
- Specific Duties of Requesting /Responding Participants
- Permitted Future Uses
- Consent / Authorization
- Dependency on other Structure / Policy including:
 - Management Entity / Process
 - Technical and Management LOS

Pulling it Together for Secure Health Information Exchange

What could we do with secure health information exchange?



*Improving health and care in North Carolina by
accelerating the adoption of information technology
and enabling policies*

Thank You

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