

New York eHealth Collaborative Policy Committee Meeting
January 29, 2019
12 p.m. – 4 p.m.
Meeting Notes

A meeting of the NYeC Policy Committee was held on January 29, 2019. Present either in person or via telephone were:

Art Levin, Center for Medical Consumers, Co-Chair Policy Committee
Nance Shatzkin, Bronx RHIO
Steve Allen, HealtheLink
Tom Check, Healthix RHIO
Amy Warner, Rochester RHIO
Karen Romano, HealtheConnections
Deirdre Depew, NYS DOH
James Kirkwood, NYS DOH
Lynn Dicerbo, NYS OMH
David Nardolillo, NYS OPWDD
Dr. Virginia Scott-Adams, NYS OPWDD
Sarah Lesser, NYS OPWDD
Dr. John-Paul Mead, Cayuga Medical Associates
Dr. Tom Mahoney, Common Ground Health
Dr. David Cohen, Maimonides Medical Center
Dr. Glenn Martin, Queens Health Network
Linda Adamson, NYSTEC
Laura Alfredo, GNYHA
Zeynep Sumer King, GNYHA
Evan Brooksby, HANYS
Tom Hallisey, HANYS
Courtney Skivington-Wolf, Care Design New York
Courtney Ortiz, Care Design New York
Val Grey, NYeC
Eric Boateng, NYeC
Cindy Sutliff, NYeC
Nathan Donnelly, NYeC
Alison Birzon, NYeC
Alexandra Fitz Blais, NYeC
Tijuana Summers, NYeC
Bob Belfort, Manatt
Alex Dworkowitz, Manatt

The meeting was called to order by Mr. Levin at 12 p.m.

I. Welcome and Introductions

Mr. Levin welcomed the Committee members and described the meeting agenda. He asked Committee members to provide any comments on the meeting summary notes to Ms. Sutliff. Mr. Levin introduced Mr. Kirkwood to provide an update.

II. DOH Update

Mr. Kirkwood said the last round of policy changes were going through approval at DOH. He explained that DOH had made one change to the proposed language of Section 1.2.2(d), regarding disclosure of HIV information for purposes of care coordination; the revision requires such activities to be undertaken in coordination with DOH so that the AIDS Institute is kept in the loop. Dr. Mead asked whether Performing Provider Systems (PPSs) would be able to access information for the entire PPS, or whether they would need to get patient-by-patient approval. Mr. Kirkwood responded that it was the former. Ms. Sutliff said NYeC would address this issue in guidance.

III. Executive Director Update

Mr. Levin introduced Ms. Grey to provide an executive director update.

Ms. Grey said that due to the government shutdown, there has not been many developments at the federal level. She said NYeC is anxiously awaiting quite a few policies, including those related to the revised TEFCA proposal and the information blocking proposed rule. She said there was still interest in revising the Part 2 rules.

Ms. Grey said there were more developments at the state level. The governor's budget proposed funding for the overall system at last year's levels, and budget negotiations would be ongoing.

Ms. Grey said that in 2019, the SHIN-NY enterprise would continue to focus on executing the 2020 Roadmap, by taking actions such as expanding the data available in the SHIN-NY. She said they would focus on functionality as well, such as the wire once policy. This year, NYeC will also focus on the development of a long-term sustainability plan, with the goal of having a draft plan by the end of the year.

Mr. Kirkwood said wire once is becoming more important, as agencies such as OPWDD and OMH are interested in making just one connection to the SHIN-NY. Ms. Grey said they heard the same message from health plans.

Mr. Allen asked about actions regarding I-STOP, the state's prescription drug monitoring program, and medication fills. Ms. Grey said they were working on the SHIN-NY obtaining medication fill data, and that Rochester RHIO was piloting integration with I-STOP. Ms. Sumer King noted that I-STOP was interoperable with 25 other states prescription drug monitoring programs, and asked if there was a way to leverage this. Mr. Kirkwood said he was not sure the same hub would be used, but there is federal funding to obtain connections to contiguous states such as Pennsylvania and Vermont.

IV. 2019 Goals and Agenda

Ms. Sutliff explained that at the end of 2018, an internal leadership team came together to undertake some planning for 2019. She said that the work of the Policy Committee would continue to align with the SHIN-NY 2020 Roadmap. She described key policy areas of focus as including HIPAA alignment, supporting Medicaid initiatives, health plan participation, and exploring what policies might benefit the SHIN-NY as a whole if required as opposed to optional for implementation. Ms. Sutliff said NYeC is working on filling the Committee's open membership spots.

Ms. Sutliff asked if there were any other subjects that the Policy Committee thought should be addressed in 2019. Dr. Mead asked how the QEs could help with value-based purchasing (VBP) initiatives under Medicaid. Mr. Kirkwood responded that the goal of DOH is to have 80% of Medicaid spending to be made under VBP arrangements by 2020, but there is a question as to whether people are ready to take on that level of risk.

Mr. Levin asked if anyone has any responses to the possible imposition of mandates (policy requirements) on QEs. Mr. Allen urged caution, saying that the Policy Committee should mandate what they are trying to accomplish, not how it should be accomplished. Ms. Sumer King said she viewed it not so much as mandates but as standardization aiming for uniformity, and that hospitals are supportive of such an idea, as differences in implementation among QEs have been challenging to navigate for hospitals. Ms. Grey said she heard similar comments in discussions with multi-sector association groups.

Mr. Kirkwood asked how much of the variation was due to differences in policies versus a difference in technical implementation. Dr. Mead said he participated in a PPS that is part of three QEs, and some QEs allow them to do community-wide consent while others would not. Dr. Mead said he would like to see uniformity on this type of issue. Dr. Martin said there were firm beliefs on community-wide consent and it was a difficult issue to tackle, but he questioned why there was a reticence to implement alerts. Mr. Check said in the case of alerts, different QEs had different priorities on their tasks lists, and he was not sure if it was so much as a philosophical difference as it is a reflection of different QEs being able to implement sooner than others. Ms. Sumer King said if that was the case she would push harder for mandating. Ms. Shatzkin said she was not opposed to mandates, but they had to be rooted in reality. She noted that not all impediments are at the QE level, and her difficulty in implementing alerts was getting information, for example, on who the OMH licensed facilities are. Dr. Mead agreed, saying it was the state that needs to force these things to occur. Ms. Warner said her QE represented its communities and hospital systems, and that they needed to take into account patient privacy.

Ms. Grey noted they do not live in a static environment. Ms. Grey said that from a long-term sustainability perspective, the SHIN-NY needs to be nimble and have the ability to shift given the ever evolving technology space and the movement towards use of more data and patient access. If we do not pay attention to these developments, there may not be a SHIN-NY or Policy Committee to worry about in the future. Mr. Levin said that the point was well taken.

Ms. Sutliff said they have done studies on alerts, but these are the types of things they need to do more of. Dr. Martin said this needs to be built into an implementation plan, because a policy may end up doing more harm than good, as has occurred with the Medicare readmissions penalty. Dr. Mead agreed, saying they could design into policy a study of the effect of a change of policy.

Mr. Dworkowitz asked if there were barriers to prisons participating in QEs. Mr. Check said there are correctional facilities that participate in Healthix. Mr. Donnelly said they are working with the criminal justice workgroup and there may be another pilot to have prisons participate in a QE.

Ms. Sumer King said it would be helpful if a matrix could be provided with information on how each QE was implementing new policy changes, as there is a lot of confusion about what policies are being adopted by different QEs. Ms. Grey said it was important to strike the right balance, and just because something is hard to figure out doesn't mean it is not the right policy. Dr. Martin agreed, saying they initially had security policies that were too lax by giving too much deference to the difficulty of implementing certain security requirements.

V. OPWDD/Healthix Initiative

After a break, Ms. Sutliff introduced Dr. Scott-Adams to discuss OPWDD's efforts to connect to the SHIN-NY. Dr. Scott-Adams said they were looking to leverage the SHIN-NY for the population that OPWDD serves. She said that in the current state OPWDD clients will sometimes bring a binder of papers to appointments with providers, and OPWDD is hoping to create efficiencies via use of the SHIN-NY that would expand patient choice since an individual would not be limited to seeing providers who are willing to go through a binder of information.

Dr. Scott-Adams said they had created an EHR for individuals who receive state operated services from OPWDD, and that 30,000 people have records in that EHR so far. She said that OPWDD is in the process of developing policies and procedures with the goal of making the providers aware that the SHIN-NY can be used as a resource.

Ms. Skivington-Wolf explained that Care Design is one of seven Care Coordination Organizations (CCOs) that act as a specialized health home for the IDD population. She said the state has been building an integrated care manager, and CCOs are responsible for managing the scope of a person's IDD, behavioral health, and other health care needs, not just disability services. She said the population is quite complex, and the goal is to bring this population into managed care.

Dr. Scott-Adams said that these efforts save lives: there are incidents where an individual has multiple medications prescribed and is taken to the emergency room, and these systems allow the emergency room to see the patient's medications to help avoid an adverse event. Dr. Mead asked if the EHR was used only by state operated centers. Dr. Scott-Adams said the EHR was intended to be used only by state facilities, and many of their voluntary agencies use their own

EHR. Dr. Mead asked if eMOLSTs (electronic medical orders for life-sustaining treatment) were available in the EHR, and Dr. Scott-Adams answered that eMOLSTs are available.

Dr. Martin said that with the OPWDD population, patients would either come in knowing nothing or with a book with an overwhelming amount of information that was not useful. He recommended that OPWDD give some thought about how information in the EHR was reported out. Dr. Scott-Adams agreed.

Ms. Sutliff asked about their policies regarding consent and whether the Policy Committee could be helpful in this regard. Dr. Scott-Adams said they have had several conversations about consent, and that in the OPWDD world there is often a question of having the capacity to consent, and therefore consent needs to be obtained from a consent giver such as a guardian. Dr. Mead said consent to share data was a relatively minor issue, and the larger issue was consent for treatment. He said an OPWDD patient recently broke her hip, but because the patient was unable to give consent and they could not locate a consent giver the patient went untreated.

Mr. Nardolillo said if the patient is above 21, the consent giver should be a legal guardian, but there are often disputes between family members as to who should be the guardian and therefore one may not be appointed. He said it would be great if providers could look up the name of the guardian electronically.

Mr. Allen asked if there were statistics on the rate of consent for this population. Mr. Nardolillo said that about 90% of the people eligible for health homes have obtained services through those health homes, and as a condition of obtaining health home services those individuals or their caregivers must sign the 5055 consent form.

Ms. Shatzkin said it would be helpful for an emergency room provider to know that a patient has not been talking for years instead of not just talking that day. Dr. Scott-Adams said they have patients with autism spectrum disorder who are presumed to have schizophrenia who are prescribed the wrong medication, and there is a need to balance the right to privacy with the right to quality care.

VI. Medicaid Use Cases

Ms. Sutliff introduced Mr. Kirkwood to discuss use cases for the Medicaid program. Mr. Kirkwood said the state had spent a lot of money on the SHIN-NY, and they want the SHIN-NY to support Medicaid. The more the SHIN-NY is integrated with Medicaid, the more the state can receive CMS funds to support the SHIN-NY.

Mr. Kirkwood said one use case is managed long-term care (MLTC). He explained that MLTC programs need access to discharge summaries, and they spend a lot of time calling hospitals to get this information.

Mr. Kirkwood said another use case was the assessment of data quality pursuant to medical records review. He said this use case was already accounted for in the SHIN-NY policies, and that based on that process they discovered that the available data was helpful in the assessment of

data quality. For example, they discovered that psychiatric screening was more prevalent than what the QEs expected, and that hemoglobin data was widely available.

Dr. Mead asked if the state had been looking at social determinants of health. Mr. Kirkwood responded that they had been looking at this, but there is the question of what you do with such information. Ms. Shatzkin said there are questions about the quality of data on social determinants of health. Mr. Belfort said the state may want to consider modifying the Medicaid consent form to allow for this type of data sharing. Mr. Kirkwood said DOH was considering this, and that the SHIN-NY consent may be incorporated into the Medicaid application.

VII. HIPAA RFI

Ms. Birzon described the HIPAA Request for Information (RFI) issued by the federal Department of Health and Human Services (HHS), in which HHS asks 54 questions on issues relating to promoting information sharing for treatment and care coordination, accounting of disclosures, and providing information to caregivers of those with substance use disorders. Ms. Birzon outlined NYeC's proposed response to the RFI in several areas, including reducing the timeframe to respond to patient access requests and a mandate to disclose information for purposes of treatment and care coordination.

Mr. Check asked how participants could comply with a mandate to disclose PHI if the SHIN-NY policies typically prohibit disclosure without consent. Ms. Grey said there are different perspectives on this: NYeC's response could be tailored to the current state of the policies, or the response could take into account where the policies need to go. Mr. Check said that if the SHIN-NY could not be used for these mandated disclosures then providers would be forced to make disclosures through other systems. Ms. Shatzkin said the problem is that NYeC was recommending a change that is in direct conflict with the current policies. Mr. Kirkwood said there is a solution, and that is HIPAA alignment. Mr. Belfort said that there is confusion in the marketplace about the need for consent, with more conservative institutions taking a less flexible view but for-profit players more willing to work with uncertainty, and therefore the solution may be to clarify the state law requirement.

Mr. Dworkowitz described proposed comments in which NYeC would support disclosures to community-based programs for care coordination purposes. Mr. Check said they currently have such types of organizations as participants, and they are subject to the same rules as other participants. Mr. Allen asked how the RFI defined social service agencies that could receive PHI. Mr. Belfort said this is one of the challenges, as there is no definition. Dr. Martin said the problem is that the logic has no end to it, and if disclosures are permitted in order to improve a person's health, then PHI could be shared with the DMV since driving fast is bad for a person's health.

Mr. Dworkowitz outlined proposed comments in response to HHS's solicitation regarding substance use disorder disclosures. Ms. Shatzkin questioned whether it made sense to suggest that the same agency should enforce HIPAA and Part 2, given that doing so could lead to more strict enforcement of Part 2. Dr. Martin agreed, saying that OMH, OPWDD and OASAS may be

concerned if their enforcement of confidentiality regulations was handed over to another agency. Mr. Belfort asked if this issue was sufficiently important to raise. Ms. Grey said they should think about it more, since using information to respond to the opioid crisis is an important issue.

Mr. Belfort said another area of possible comment is the RFI's questions regarding the minimum necessary rule. He said that from a health plan's point of view, there is little distinction between care management being performed by a health plan as compared to care management being performed by a provider, but the former is subject to the minimum necessary requirement while the latter is not.

Mr. Birzon described the final area of comments, in which NYeC planned to recommend retaining the notice of privacy practices requirement. Ms. Shatzkin asked if providers get audited regarding notices of privacy practices. Mr. Belfort responded that the government generally does not conduct audits at all, but will investigate if there is a breach or a complaint. Mr. Check said Healthix checks to make sure that its participants have a notice of privacy practices. Mr. Nardolillo said that a notice of privacy practices are very important from the Federal Trade Commission's perspective, since a deviation from such notice can be considered an unfair trade practice. Mr. Belfort said a potential middle ground is to require such notice to be provided to health plan members and to be posted in provider offices.

Ms. Sutliff said they would take the Committee's comments into consideration as a revised response to the RFI is developed.

VIII. Disclosure of Deceased Patient Information

Mr. Levin introduced Mr. Allen to discuss disclosures of deceased patient information. Mr. Allen said that his QE currently receives information on patient deaths in discharge summaries, and such information is valuable to QE participants since they no longer have to coordinate care for those patients. However, some of those patients have not signed a consent. Under current policies consent for disclosure would be required. Mr. Allen called for a revision to the policies to allow for disclosures of a patient's death without consent. Ms. Grey asked if the record would include cause of death. Mr. Allen said it would not.

IX. Closing

Mr. Levin thanked the Committee and wished them safe travels and reminded the Committee members of the next meeting scheduled as a conference call meeting for February 26th from 2-4 pm.