Overview of Provider and EHR Requirements

Interoperability Webinar 2

March 4, 2021

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Interoperability Webinar Series

- Provide a knowledge foundation for county behavioral health about recent federal requirements for sharing electronic health information
- Inform county interoperability planning

Webinar 1: Overview of Interoperability and County Behavioral Health Plan Requirements
March 4, 2021

Webinar 2: Overview of Provider and EHR Requirements
March 24, 2021 12noon-1:30pm

Special Thank You and Acknowledgement

This Interoperability Webinar Series is supported by a grant from the California Health Care Foundation.

California Health Care Foundation

Webinar 2 Agenda and Topics for Discussion

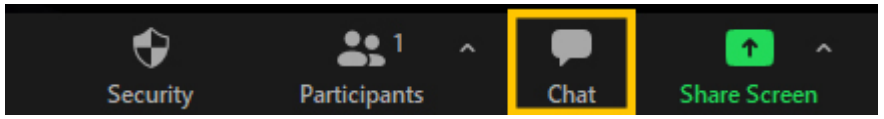
1. Webinar 1 follow up and DHCS updates
2. Provider Requirements
3. EHR Requirements
4. Pathway Forward

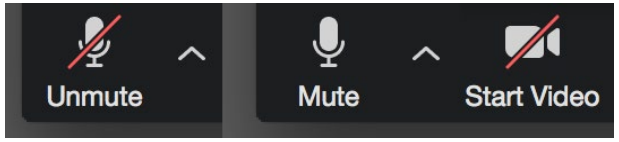
3 opportunities for audience Q&A and panelist discussion

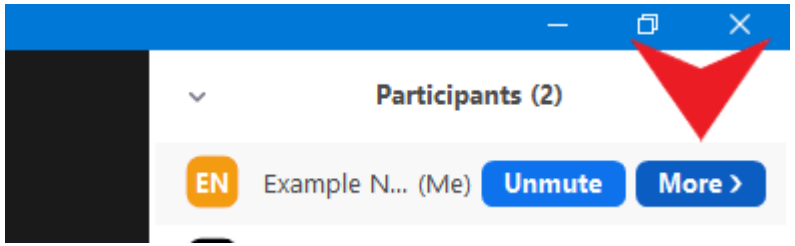
- Please Submit Evaluation and Feedback: https://forms.gle/H9a8x8WY1tuZXsWZ7
- Presentation slides, recording and chat discussion will be shared after the webinar

Zoom Logistics

- Everyone will be muted to start
- Submit questions/comments in chat
- Unmute – through Zoom or phone (*6)
- Zoom name display
  - Name, county/ organization
  - Jane Doe, San Mateo County







Webinar materials will be shared with all participants following the webinar

- Presentation slides, video recording and chat questions and responses

Panelist

Mirian Avalos

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Speakers

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1. Webinar 1 Follow Up and DHCS Updates
2. Provider Requirements
3. EHR Requirements and Information Blocking
4. Pathway Forward

Webinar 1: Introduction to Interoperability and County Behavioral Health Plan Requirements

March 4, 2021

- Presentation slides
- Zoom Recording
- Chat questions and responses
- Responses to Poll Questions
  - Where are you in the planning process
  - Confidence to meet “Plan” requirements

After Webinar 1 - Interoperability Introduction and Plan Requirements

Common Questions and Concerns

- So many new requirements, no budget allocation and not enough time
- Do I have to make clinical/ USCDI data that I don’t have or is not currently in our EHR system?
- What about clinical notes – program notes, group notes, psychotherapy notes, OpenNotes?

DHCS Updates and Q&A Session

Webinar 2 Agenda and Topics for Discussion

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Who Enforces?

Who is Impacted?

Payers/ Plans

Providers

States

ONC-Certified EHRs

CMS Patient Access and Interoperability Final Rule (CMS-9115-F)

County Plan Requirements

1. Patient Access API
2. Provider Directory APIs
3. Payer-to-Payer Data Exchange

Provider Requirements

1. Hospital Admission, Discharge Transfer (ADT) Event Notification
2. Public Reporting – Prevention of Info Blocking
3. Public Reporting - Digital Contact Information

CMS Patient Access and Interoperability Final Rule (CMS-9115-F)

County Plan Requirements

1. Patient Access API
2. Provider Directory APIs

Care Transitions

3. Payer-to-Payer Data Exchange

1. Hospital Admission, Discharge Transfer (ADT) Event Notification

Provider Requirements

2. Public Reporting – Prevention of Info Blocking
3. Public Reporting – Digital Contact Information

Hospital ADT Event Notification

Who is Impacted

All Hospitals participating in Medicare, Medicaid

- Including psychiatric hospitals
- Have EHRs capable of generating electronic event notification

New Medicare Condition of Participation

What

Send electronic event notification for patient's admission (ER and inpatient), discharge and transfer

When

Beginning May 1, 2021
(delayed from November 2020)

Hospital ADT Data Sharing Requirements

Required

- Patient name
- Treating practitioner name
- Sending institution name

- Additional data elements if sending C-CDA into provider EHR workflows

Optional

- Optional data can include diagnosis when permitted by law

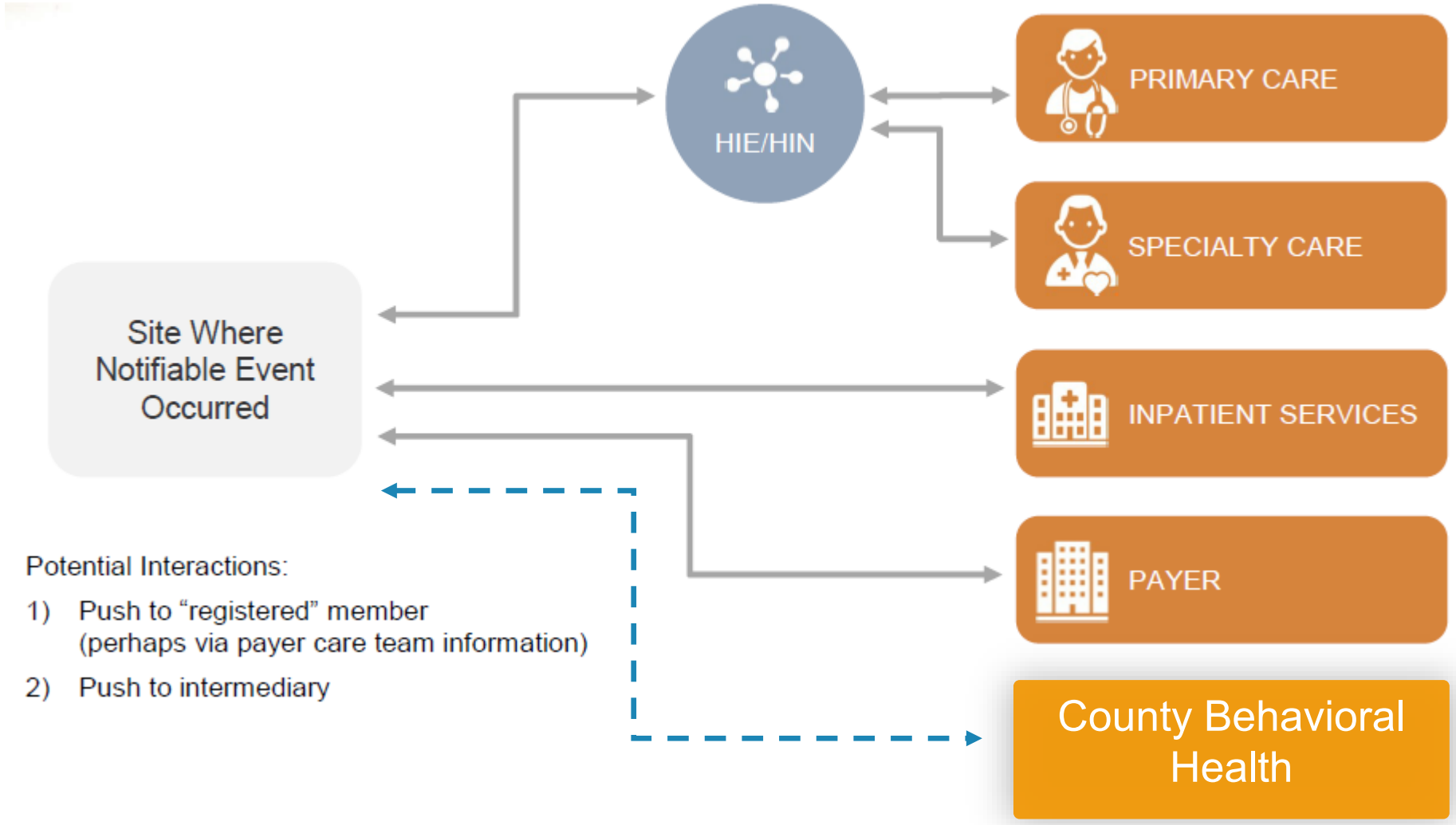
Hospital ADT Notifications Must be sent to:

- Patient's established primary care practitioner, primary care practice group or entity – responsible for his/ her care
- Including post-acute care services providers and suppliers

- Must demonstrate “reasonable effort”
- But don’t have to send notification if hospital cannot identify a primary care practitioner or a post-acute provider for a patient

FHIR-based Alerts/Notifications (Da Vinci Project)

Admit/Discharge Notifications, Clinical & Administrative Events



Old Way

- one-off point integrations
- Faxes…
- Certain parts of care continuum outside hospitals not available

Public Reporting: Provider Digital Contact Information

Who is Impacted

All providers with a National Provider Identifier (NPI)

What

Publicly report providers who do not list or update their **digital contact information in NPPES**

- Facilitate sharing of eHI and care coordination between providers
- Examples: Direct Messaging (secure email), FHIR endpoint
- Not required to receive an NPI

When

End of 2020 (delayed)

At this time, no penalty for not updating digital contact information

Public Reporting on Prevention of Info Blocking

Who is Impacted

Physicians and hospitals participating in Medicare FFS

- Physicians → Physician Compare
- Hospitals → Hospital Compare

What

Publicly report whether providers attest to 3 attestation statements about prevention of information of blocking

Public Shaming

When

Report late 2020 (delayed)

- based on 2019 attestations

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ONC Cures Act Final Rule

Final Rule went into effect June 30, 2020

GOAL

Make it easier for patients and their providers to access patients' health information *especially* via mobile devices and apps.

OBJECTIVES

- Standardize **how** health information is shared electronically.
- Standardize **what** health information at a *minimum* is shared electronically.
- Address *behaviors* that could **interfere** with electronic sharing of health information.

https://www.healthit.gov/curesrule/

How Did We Get Here?

Evolution of federal government's efforts to give patients more control over their health information and improve interoperability.

2010

CMS & VA release Blue Button 1.0

2011

HL7 begins looking at interoperability "redo" using modern technologies

2015

ONC requires EHRs to support an API & Common Clinical Data Set

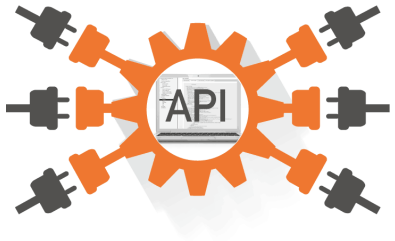
ONC issues report on Information Blocking

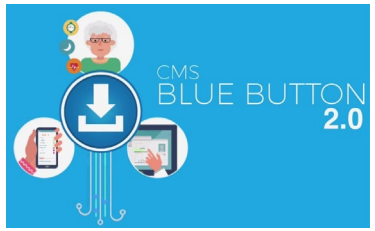
2018

CMS releases Blue Button 2.0

2020

- *CMS Patient Access & Interoperability Rule*
- *ONC Cures Act Final Rule*





New EHR Requirements

ONC-certified vendors will need to add **new** functionality to make it easier for patients and providers to access electronic health information (EHI).

By Dec. 31, 2022

- Standardized API:
  - FHIR v4.0.1
  - FHIR US Core Implementation Guide v3.1.0
  - SMART Launch Application Framework Implementation Guide 1.0
  - FHIR Bulk Data Access v1.0
  - OpenID v1.0
- USCDI v1.0

By Dec. 31, 2023

- EHI Export*:
  - Single patient
  - Patient population

* File(s) must be electronic and computer-readable; however, format not specified - vendor must provide a link to its specifications.

Additional Vendor Requirements

ONC-certified vendors must also do additional things to maintain their certification.

Update their EHR to support revised technical standards and requirements, including:

- Electronic prescribing
- Quality reporting
- Data segmentation
- Security

Not engage in information blocking.

Attest to its compliance with Conditions of Certification on a regular basis.

Permit customers to communicate about certain aspects of a vendor's EHR, including:

- Usability
- Interoperability
- Security
- Users' experiences
- Vendor's business practices related to exchange of EHI

Conduct real world testing of its EHR and report test results.

FHIR and USCDI

FHIR

- Focuses on **how** health information should be shared electronically, including:
  - Communication between IT systems
  - Authentication & authorization
  - Structure and organization of data
- Based on technologies modern information systems are built on.

USCDI

- Defines **what** health information *at a minimum* must be shared (if available):
  - Identifies specific data classes and data elements (e.g., demographics, problems, medications, etc.)
  - Requires use of specific terminologies and ontologies to standardize data and make it computer-readable; for example, RxNorm for medications

https://www.hl7.org/fhir/
https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi

USCDI US Core Data For Interoperability

The Office of the National Coordinator for Health Information Technology

Allergies and Intolerances *NEW

- Substance (Medication)
- Substance (Drug Class) *NEW
- Reaction *NEW

Assessment and Plan of Treatment

Care Team Members

For more info:

HealthIT.gov/USCDI

Clinical Notes *NEW

- Consultation Note
- Discharge Summary Note
- History & Physical
- Imaging Narrative
- Laboratory Report Narrative
- Pathology Report Narrative
- Procedure Note
- Progress Note

Goals

Health Concerns

Immunizations

Laboratory

- Tests
- Values/Results

Medications

Patient Demographics

- First Name
- Last Name
- Previous Name
- Middle Name (incl. middle initial)
- Suffix
- Birth Sex
- Date of Birth
- Race
- Ethnicity
- Preferred Language
- Current Address *NEW
- Previous Address *NEW
- Phone Number *NEW
- Phone Number Type *NEW
- Email Address *NEW

Problems

Procedures

Provenance *NEW

- Author Time Stamp
- Author Organization

Smoking Status

Unique Device Identifier(s) for a Patient's Implantable Device(s)

Vital Signs

- Diastolic Blood Pressure
- Systolic Blood Pressure
- Body Height
- Body Weight
- Heart Rate
- Respiratory Rate
- Body Temperature
- Pulse Oximetry
- Inhaled Oxygen Concentration
- BMI Percentile (2-20 Years) *NEW
- Weight-for-length Percentile (Birth - 36 Months) *NEW
- Occipital-frontal Head Circumference Percentile (Birth - 36 Months) *NEW

Comparison of API Requirements

CMS Patient Access and Interoperability Rule (Payers)	Technical Requirement	ONC Cures Act Final Rule (EHR Vendors/Providers)
✓	FHIR v4.01	✓
✓	FHIR US Core Impl. Guide v3.1.0	✓
✓	SMART Launch Application Framework Impl. Guide 1.0 (OAuth 2.0)	✓
✗*	FHIR Bulk Data Access v1.0	✓
✓	OpenID v1.0	✓
✓	USCDI v1.0	✓

* Proposed under new CMS Reducing Provider and Patient Burden Proposed Rule (Dec. 2020); see fact sheet.

Vendor and Provider Responsibilities

Functionality	ONC-certified EHR Vendors	Providers
FHIR-based Standard API *USCDI*	Provide by Dec. 31, 2022	• Make sure your vendor will be ready by deadline • Understand what additional resources may be needed and who will provide them • Understand what you will need to do - both 1X and ongoing
EHI Export	Provide by Dec. 31, 2023	None

What is Information Blocking?

DEFINITION

"Practice that except as required by law or covered by an exception is likely to interfere with access, exchange, or use of electronic health information."

Information Blocking rules go into effect April 5, 2021

- **Access** is the ability or means necessary to make electronic health information available for exchange or use.
- **Exchange** is the ability for electronic health information to be transmitted between and among different technologies, systems, platforms, or networks.
- **Use** is the ability for electronic health information, once accessed or exchanged, to be understood or acted upon.

https://www.healthit.gov/curesrule/final-rule-policy/information-blocking

Need for Information Blocking Rules?

- Standardizing how and what health information is exchanged *necessary* to enable electronic sharing, but **not sufficient**.
- Must also address **behavior** by providers, hospitals, payers, vendors, and other parts of the healthcare system that could interfere with electronic sharing of health information.
- Due to numerous complaints received from patients and their caregivers, providers, and others on how hard it is to get health information.


REPORT TO CONGRESS

APRIL 2015

Report on Health Information Blocking

Prepared by:

The Office of the National Coordinator for Health Information Technology (ONC)

Department of Health and Human Services

200 Independence Avenue SW

Washington, DC 20201

ONC April 2015 Report to Congress on Health Information Blocking

Whom Does Information Blocking Apply To?

Final Rule identifies three types of “actors” subject to the provisions.

PROVIDERS includes physicians, practitioners (including clinical psychologists), hospitals, health clinics, community mental health centers, skilled nursing facilities, federally qualified health centers, and long term care facilities.

For full list, see: https://www.healthit.gov/cures/sites/default/files/cures/2020-08/Health_Care_Provider_Definitions_v3.pdf

HEALTH IT DEVELOPERS are entities that develop or offer health information technology and have one or more products certified under the ONC’s Health IT Certification Program.

HEALTH INFORMATION NETWORKS or **EXCHANGES** are entities which control the use and exchange of EHI between unaffiliated organizations.

https://www.healthit.gov/sites/default/files/cures/2020-03/InformationBlockingActors.pdf

What Does Information Blocking Look Like?

- Definition is purposely broad as information blocking could take many forms.
- Practice that by itself interferes with access, exchange, or use of EHI is not information blocking.
- Keys:
  - Actor *knows* or *should know* that the practice is interfering
  - No *reasonable justification* for the interference

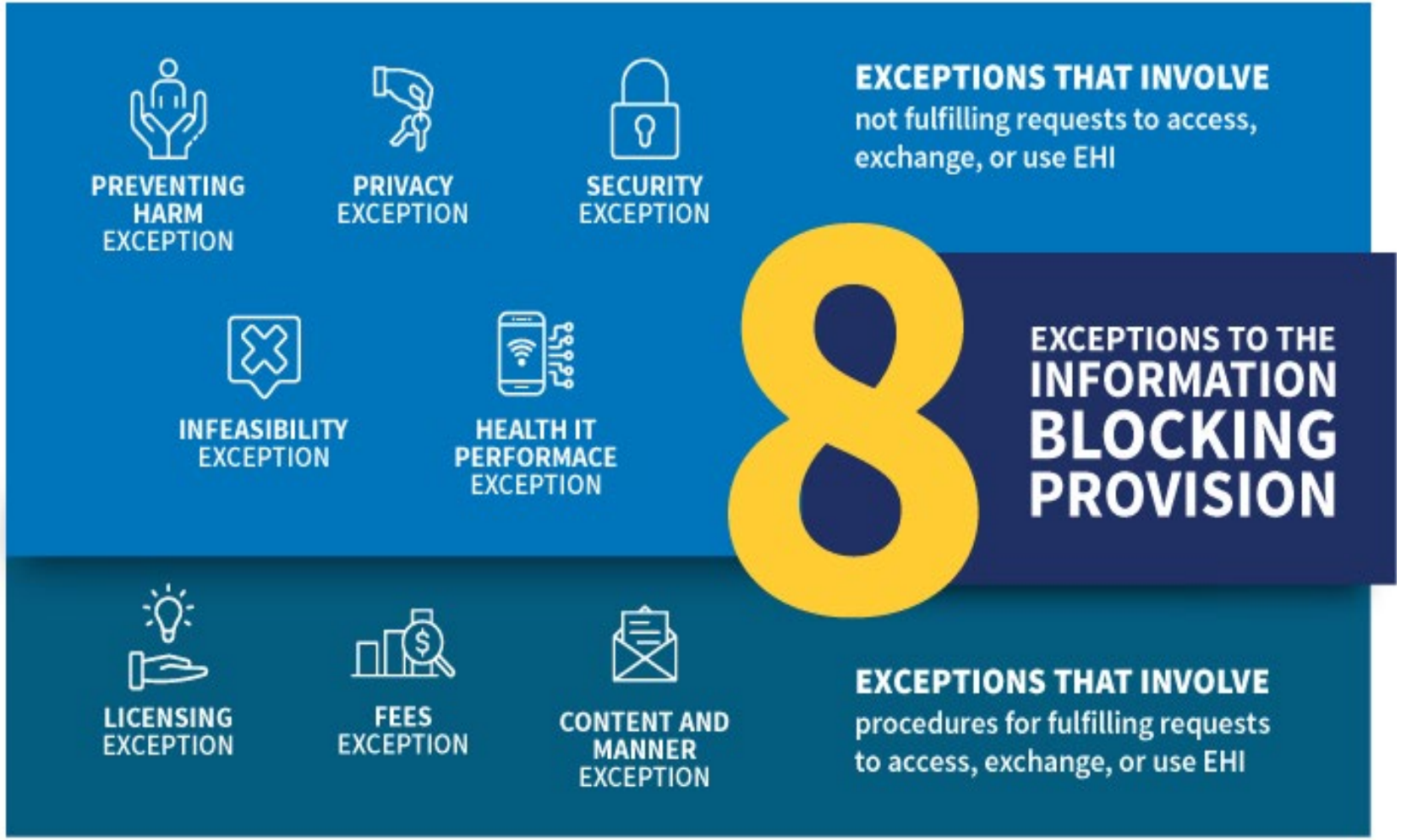
EXAMPLES

- Not giving patient her information or charging a fee for electronic access
- Not giving treating provider access to patient's information when requested or requiring patient to provide separate written consent
- Discriminatorily deciding which provider organizations to share or not share data with
- Providing EHI in proprietary or non-computer readable format

https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf

Information Blocking Exceptions

- Providers **must** provide EHI when requested by an appropriate third-party unless there is *reasonable* justification not to do so (i.e., exception).
- For each exception, key conditions must be met.



https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf

Provider Responsibilities

- Ensure policies and procedures clearly identify situations when EHI would **not** be provided - conditions cannot be *too stringent* or *overly broad*.
- Provide EHI when requested unless there is *reasonable* justification not to do so.
  - Before Oct. 6, 2022: Only USCDI data elements (if you have them)
  - On or after Oct. 6, 2022: All electronic PHI

WHAT ARE THE PENALTIES?

- For Providers:
  - "Appropriate disincentives" - additional rulemaking forthcoming
  - Like HIPAA, will evolve over time

* For HIT Developers and HINs/HIEs, civil monetary penalties could be up to $1M per violation and removal from ONC Health IT Certification Program.

Key Takeaways

- Counties are ultimately responsible for ensuring that patients can easily access their EHI

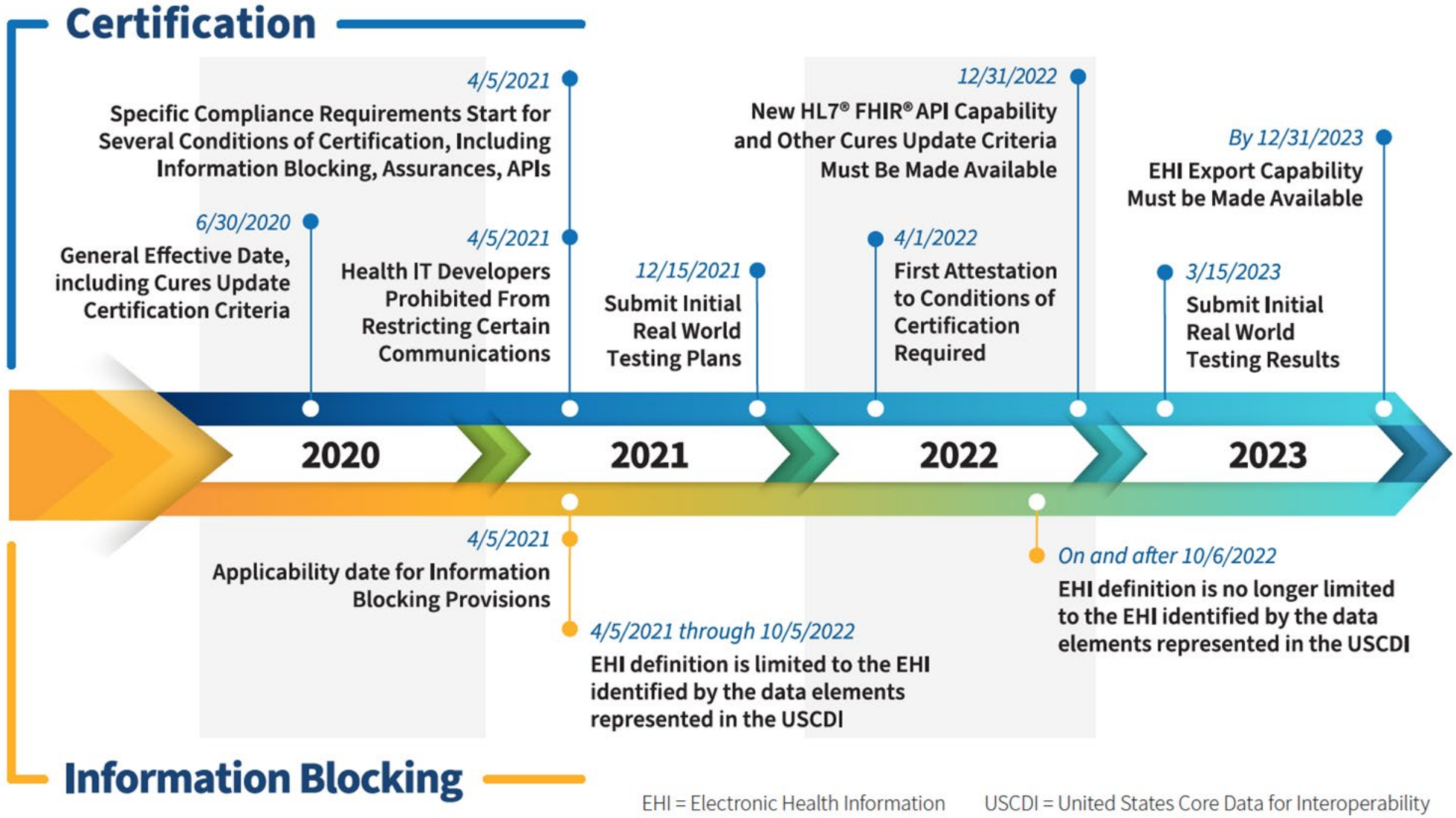
- Information Blocking rules go into effect April 5, 2021:
  - Must provide EHI when requested unless an exception applies
  - Until Oct. 6, 2022, need to provide only USCDI-specified data elements; afterwards, all EHI
  - Only need to provide data you have

- ONC-certified EHR systems must have FHIR-based API ready by Dec. 31, 2022

ONC Cures Act Final Rule Timelines

For ONC-certified Vendors

For Providers



EHI = Electronic Health Information USCDI = United States Core Data for Interoperability

https://www.healthit.gov/cures/sites/default/files/cures/2020-10/Highlighted_Regulatory_Dates_All.pdf

Helpful Resources

- ONC Cures Act Final Rule
  https://www.healthit.gov/curesrule/

- Information Blocking FAQs https://www.healthit.gov/curesrule/resources/information-blocking-faqs

- CMS Rules and Guidance
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

Questions from the Audience

1. Who is responsible for what?
    - Is it the county's responsibility to provide electronic access to patient medical files?
    - Or is this a requirement of certified EHR platforms to provide an API and then the county's responsibility to interface with this system via another user interface?

2. Will there be funding for EHR upgrades needed to meet the requirements?

3. Will this impact how clinicians document?
    - Progress notes may be confusing to patients since so much of the documentation process involves billing

Panelist

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Framework for Pathway

1. As You Will Note – This is Complex
2. Know That You Have Options
    - In Addition to Your EHR Vendor
    - CalMHSA and CBHDA as Advocates
3. An Effective Strategy Requires An Architecture “Above” the EHR
4. Coordination and Consolidation of Efforts Will Breed Best:
    - Results
    - Cost
    - Compliance
5. Timelines For These Requirements Overlap CalAIM
    - Resource Wisely

Framework for Pathway – Core Considerations and Analysis

There are several levels of focus that need to be evaluated:

1. The Data:
    - There are essentially three types of data that need to be included in CMS Requirements
        - Provider Directory – May be stored in different systems in different Counties
        - Patient Data – Most likely all in EHR (Clinical Data, Claims and Encounters)
        - Payer to Payer – Client Clinical Data (Most likely all in EHR)
2. Access to the Systems/Data:
    - Cloud Hosted vs. Self Hosted
3. Access Management
4. County Resources – CMS/ONC Requirements vs. CalAIM

Access Management Requirement Example

- For Patient Access API

Patient/ Member

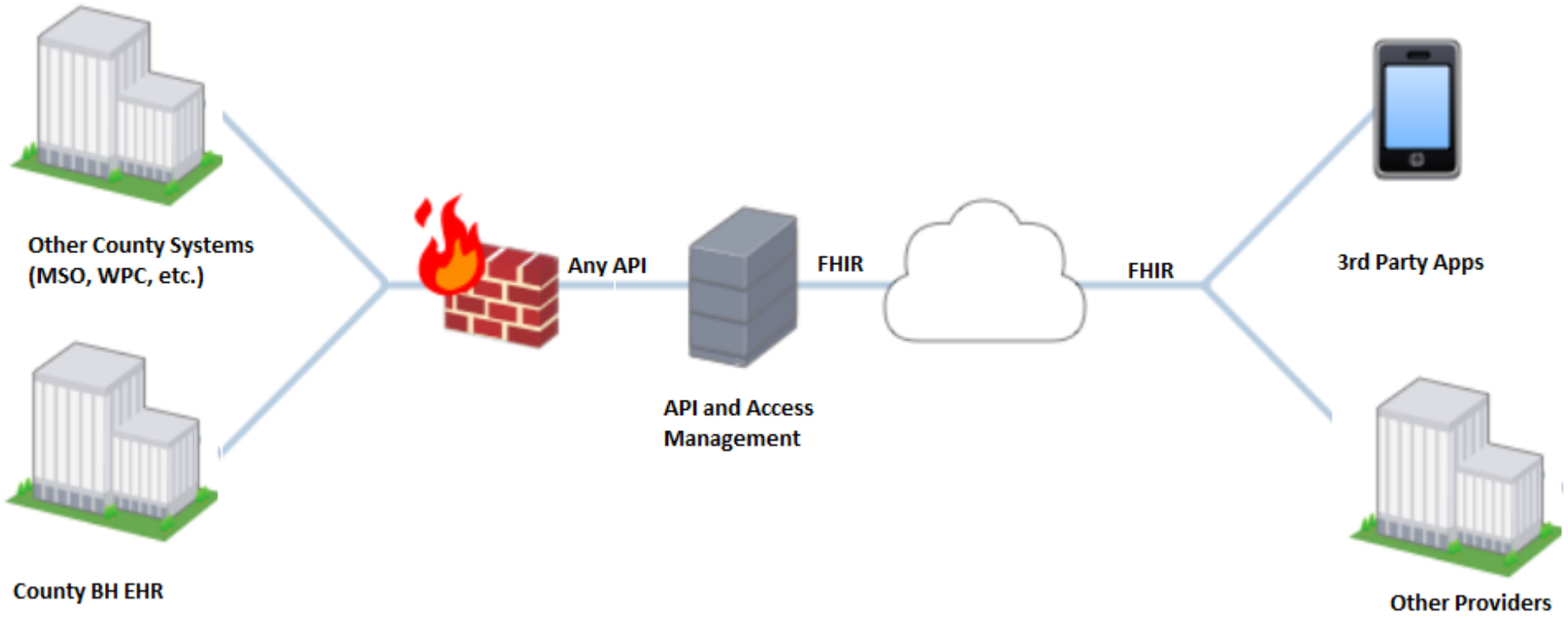
1. Member education
2. Consent management
3. Identity management
   - Verification (initial set up)
   - Authentication (ongoing)

3rd-party Apps

1. Documentation for onboarding and API connectivity
2. 3rd-party authorization
3. Privacy attestation (optional)
4. Security risk assessment (optional)

Framework for Pathway – Anticipated Architecture

The initial impression is that all data would reside in one system (EHR), and thus, the APIs be built there. But given Access Management, Future Integration Requirements, etc. the more likely architecture will be:



Framework for Pathway – Consolidating Efforts

Here is how CalMHSA and CBHDA Propose to Help:

- Solicit Interested Counties in Collaborative Effort
- Evaluate/Categorize Participating County
  - Data Systems
  - Hosting Scenarios
- Define Compliance Standards With DHCS
- Produce RPF for Participating County Categories
- Manage Selection and Implementations

Value Proposition

- Frees Resources to Address Other County Operational Needs
- Establishes Foundation for Future Interoperability Requirements
- Efficiency and Cost Savings Through Collaboration

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Wrap-up

Evaluation and Feedback

Survey link: https://forms.gle/H9a8x8WY1tuZXsWZ7

Special Thank You and Acknowledgement

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Speakers and Panelist Bios

Khoa Nguyen

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Mr. Nguyen helps health care companies with strategy and planning to support the new federal interoperability and data sharing requirements. He started his consulting firm in 2018 to lead a special initiative with California Medi-Cal safety net health plans and identify opportunities to build group purchasing and shared services.

Prior to his consulting firm, Mr. Nguyen was the Chief Strategy Officer for the Health Plan of San Mateo, a local, nonprofit Medi-Cal managed care plan serving approximately 150,000 residents of San Mateo County. He served as an executive leader responsible for organizational strategic planning, policy and advocacy with the State and CMS on issues impacting Medi-Cal and Medicare programs, leading strategic initiatives and new partnership developments, and operational oversight of Informatics and Marketing and Communications departments. Mr. Nguyen earned his master’s degree in public health policy from the University of Michigan at Ann Arbor.

Glen Moy

Consultant
glenmmoy@gmail.com

Mr. Moy has over twenty years of health IT experience including health information exchange, interoperability, data analytics, and electronic health record systems. He has held leadership positions in a variety of healthcare settings, including ambulatory, corrections, and payer. Most recently, he was director of health informatics for a Medicare Advantage health plan, where he led the organization's clinical data acquisition strategy and managed the implementation of several health IT infrastructure projects. Glen also previously served as a senior program officer at the California Health Care Foundation, where he led the Foundation's health IT project portfolio.

Amie Miller

Executive Director, CalMHSA
amie.miller@calmhsa.org

Amie Miller is the executive director of CalMHSA a Joint Powers Authority serving the public behavioral health system. Prior to joining CalMHSA, Amie was the director of Behavioral Health in Monterey County. She is a licensed marriage and family therapist and has a doctorate in Psychology.

Mirian Avalos

Chief Information Officer, LA County Department of Mental Health
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Ms. Avalos has utilized technology successfully to innovate government throughout her 18 years in IT. Her personal mission is to create government that is transparent and efficient. Prior to DMH, she served as Chief Technology Officer of the Office of the District Attorney in San Bernardino, transforming the DA's office into a government organization that was leading Southern California counterparts in government innovation and transparency. She served on the Customer Advisory Board for Taser International advising them on the use of Body Worn Cameras and Evidence.com. She also Co-Chaired the Southern California District Attorney IT Directors. Ms. Avalos also held technology positions with the Los Angeles Unified School District and the Southern California Associations of Governments. She completed Clinical Informatics coursework from the University of Chicago, is a graduate of the Carnegie Mellon University CIO Institute, holds a Masters in City Planning from the Massachusetts Institute of Technology, and completed her undergraduate degree from UC Berkeley.

Chris Esguerra, MD, MBA

Chief Medical Officer at DME Consulting Group
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Dr. Esguerra is currently the CMO at DME Consulting Group, which provides in-home assessments for optimal equipment, home modifications, and rehabilitation services. He also serves as an Advisor to health tech startups including interoperability, telehealth, eConsults, and patient engagement. His experience encompasses health care provider and systems leadership, managed care operations, novel payment models, public-private partnerships, and health care transformation. He has led significant efforts around integration of care and services for a variety of populations, holistically addressing social determinants of health in healthcare delivery, and helping people remain and age in the community with appropriate long-term services and supports. He most recently served on a National Academy of Science, Engineering, and Medicine committee that published Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health.

John Fitzgerald

CalMHSA Healthcare IT Consultant
jfitz0660@gmail.com

Mr. Fitzgerald specializes in Behavioral Health EMR/EHR engagements, having worked for 20+ years for several EMR/EHR vendors serving the unique needs of California County BH organizations. He has participated in 25+ County Behavioral Health EHR procurement processes, was primary business analyst and architect for development efforts associated with MH and SUD/AOD Cost Reporting, and had managerial responsibility for 30+ EHR implementations in California (both County as well as Contract agencies). As a Consultant, Mr. Fitzgerald has expanded his knowledgebase by working with several technology “start-ups” designing specialized applications for the MH/SUD and Public Health specialties, as well as managing EHR implementations for Value-Based Care organizations outside of California.

Mr. Fitzgerald has established a partnership with CalMHSA to identify, evaluate, and implement common strategies and solutions focused on addressing mutual challenges and delivering measurable value to its constituent Counties.