

care spark

AHIC Privacy and Security Workgroup
9-28-06

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CareSpark Facts



- **Multi-State Region**
- **710,000 Patients**
 - (2/3 in TN, 1/3 in VA)
- **16 Hospitals**
 - 2 Large Community-Based Health Systems
- **1,200 Physicians**
 - Many Rural and Smaller Practices
- **No single payor dominance**
 - 25% Medicare
 - 18% Medicaid
 - 2-20% Other
 - 15-18% Uninsured
- **Few Large Employers**
 - Eastman Chemical – 8,000



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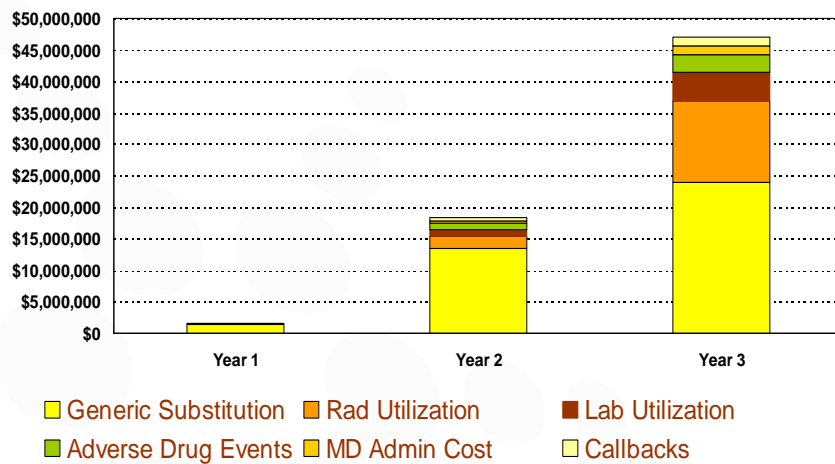
To improve the health of people in Northeast Tennessee and Southwest Virginia through the collaborative use of health information

Reduce High Regional Disparities and Worsening Trends for:

- Diabetes
- Cardiovascular Disease
- Hypertension
- Lung Disease
- Cancer

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Medication and Diagnostic Services Improvement Savings Model Projections*



* Data sources: BlueCross BlueShield and John Deere Health, 2004

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What Will CareSpark Do?



Improve health through the collaborative use of health information

Decision Support Capabilities at the Point of Care

- Patient-specific information
- Compliance with evidence-based guidelines
- Coordination of care among patient, provider, payor

Cost-efficient Use of Resources

- Reduced administrative cost / workflow improvement
- Reduced duplication
- Increased use of generics and centers of excellence
- Preventive care and disease management to reduce acute care

Outcomes Improvement

- Feedback on individual health outcomes
- Monitor and address population health issues

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Tactics – Parallel Pathways



- 1. Interoperable EHR Adoption** – Encourage and support increased use of EHRs (with e-prescribing and decision support tools) among providers
- 2. Regional HIE Platform** – Implement infrastructure and connectivity for sharing of information among providers, payors, public health
 - Align with state-led initiatives in TN and VA
 - Align with AHIC national standards and Nationwide Health Information Network infrastructure
- 3. Public Health Improvement** – Biosurveillance, community-wide aggregation and study, improved disease reporting, prevention services and chronic disease identification, management and outcomes
- 4. Financial Incentives** – For patients (reduced co-pays to encourage compliance); for providers (for acquisition, use of IT, increased compliance with guidelines, improved outcomes)

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Key Strategic Decisions



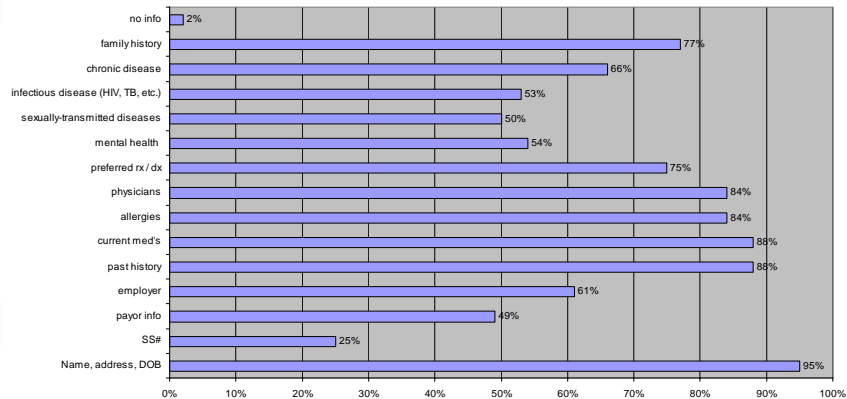
1. **Scaled to allow participation by all patients and providers in region**
2. **Default Passive Enrollment (“opt-out”) and Active Enrollment (“opt-in”)**
enabled by Master Patient Option Preference (MPOP) and Local Patient Option Preference (LPOP)
3. **Clinical Data Repository**
to enable decision support, public health monitoring and centralized services
4. **Data Access and Uses**
patient: view content of records, view access log
provider: view information related payment, treatment, operations
public health: required reporting and authorized queries
research: IRB-approved studies
payers: de-identified aggregate data
5. **Fee-Based Revenue Model**
contracts with insurers and employers (PMPM)
transaction fees for data providers (labs, hospitals, large practices)

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Community Feedback on Privacy



Patient Would Give Permission to Share:



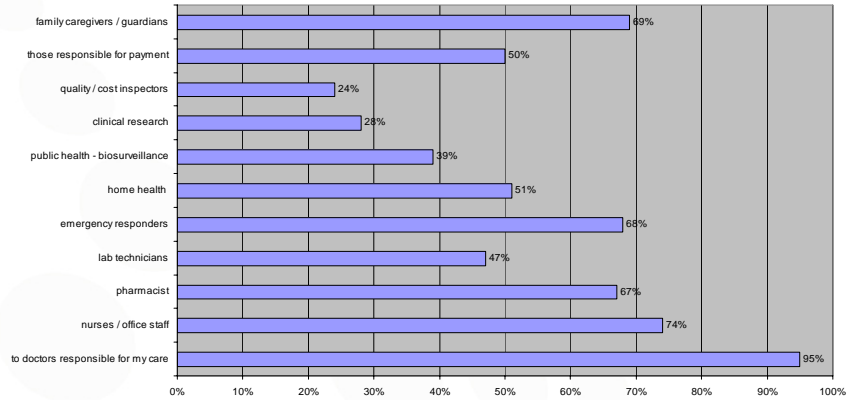
Source: general community survey of 169 people in CareSpark region, March – May 2006

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Community Feedback on Privacy



To Whom would Patients Give Access?



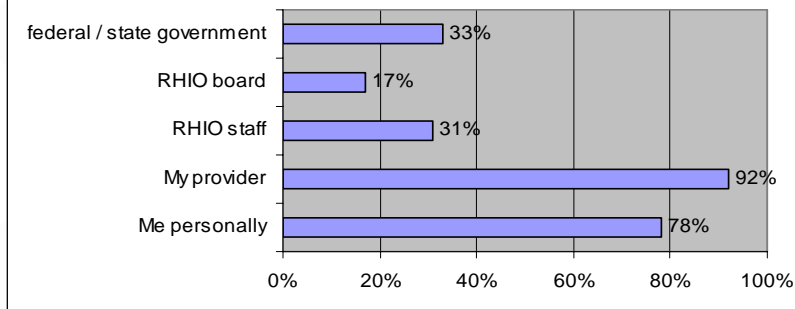
Source: general community survey of 169 people in CareSpark region, March – May 2006

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Community Feedback on Security



Who is Responsible for Security of Information?



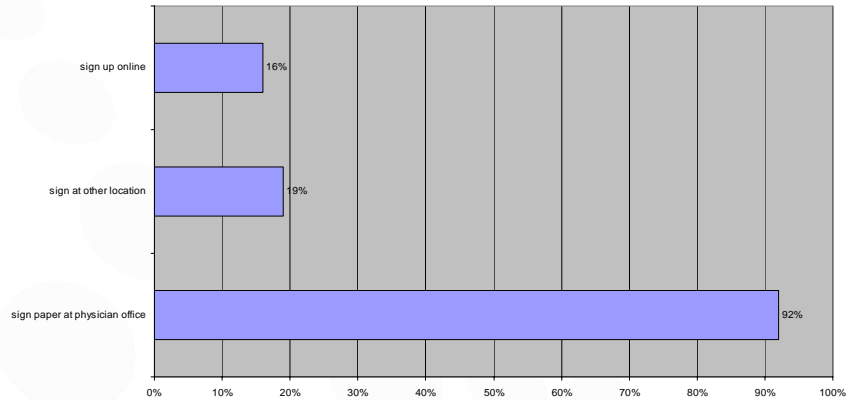
Source: general community survey of 169 people in CareSpark region, March – May 2006

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Community Feedback on Enrollment



Preferred Methods for Enrollment



Source: general community survey of 169 people in CareSpark region, March – May 2006

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Passive vs. Active Enrollment



Passive Enrollment

Providers / Payers – may choose to enroll all patients and notify patients of rights / process to disenroll (“opt-out”)

- Builds on existing patient / provider relationship and trust
- Ease burden of registration for providers
- Achieve “critical mass” necessary for functionality
- Requires assistance for providers to inform patients (incorporate information into notification of patient privacy materials, point of contact for disenrollment)
- Greater issues for data integrity (old records, duplicates, etc.)
- May increase legal liability for provider

Active Enrollment

Providers / Payers – may choose to enroll patients only with express written consent from patient

- Reduces provider concerns about legal liability
- Increased burden of registration process for providers
- Increased need for provider buy-in
- Slower to achieve “critical mass” in securing written permission and adding records to system, limits initial functionality of system
- Greater ability to validate data integrity
- Greater risk for more vulnerable patients not to be enrolled

Either way, patient preference overrules provider / payer decision!

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Managing Patient Option Preferences

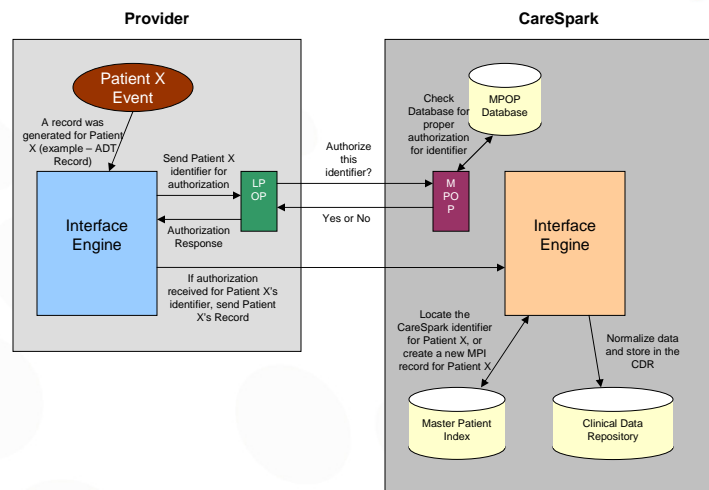


To prevent unauthorized release of patient records to / through RHIO

- Master Patient Option Preference (MPOP) at RHIO-level holds unique patient identifier and yes / no indicator for accepting / releasing records
- Local Patient Option Preference (LPOP) at Provider-level contacts MPOP to verify permission to release records to RHIO
- Indirect provider systems (ie, labs) operate as "slaves" linked to LPOP, releasing records only if LPOP directs release of patient records linked back to provider through order / referral

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MPOP / LPOP design



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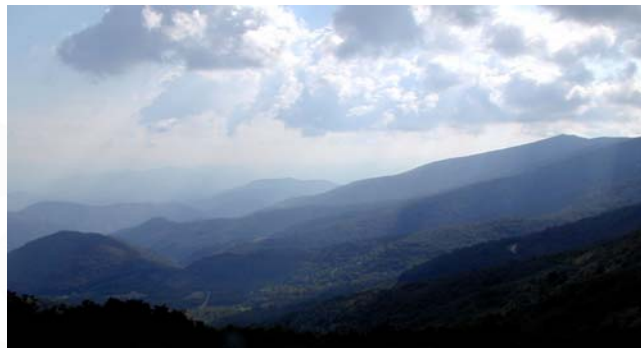
Specific Issues for Lab Data



- **Ordering physician should control sharing of lab data (for reasons of patient consent, sensitivity of results, interpretation of results)**
- **Lab data must be date-time stamped with differentiation between preliminary and final results**
- **If lab data is merged into EMR, data must be normalized to local provider's terminology and standards, with ability to be updated as results are finalized**

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Better Health for Central Appalachia



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