Iowa Department of Public Health

The Current State of Health Information Technology in Iowa

State Innovation Model Grant

December, 2017

Introduction

The move to adoption of health information technology began in 2004, when then President George W. Bush called for every American to have an electronic health record by 2014. This aim was reaffirmed by President Barack Obama in 2009 upon the signing of the American Recovery and Reinvestment Act (ARRA).

In Iowa, the Commission on Affordable Health Care Plans for Small Businesses and Families (The Commission) was formed by the Iowa Legislature in 2007. Membership consisted of 10 legislators, eight members of the public representing various health care interests appointed by the Legislative Council, five consumers appointed by the governor, and three state agency directors. The Commission was charged to review, analyze and make recommendations on a broad spectrum of issues relating to the affordability of health care for Iowans, including HIT. At the recommendation of The Commission, House File 2539 established eleven advisory councils. One of these councils was the Electronic Health Information Executive Committee administered by the Iowa Department of Public Health (IDPH).

The first meeting of the Electronic Health Information Executive Committee was in January of 2009 and the first strategic plan for HIT in Iowa was published in July of 2009.

Adoption of Health Information Technology at the Provider Level

The focused assessment and tracking of the implementation of HIT across health care providers in Iowa has been consistent and ongoing since the implementation of the first Iowa HIT plan in 2009, the 2010 Cooperative Agreement between the state and the Office of the National Coordinator as well as the start of the EHR Incentive Program.

The following reports provide current information regarding the adoption of HIT at the provider level throughout the State of Iowa. While Eligible Providers have mostly transitioned to utilization of electronic health record systems, these reports indicate that most have not advanced to a point where exchange between disparate systems is a regular occurrence and much of this is still done via paper.Care coordination and quality improvement activities are still very manual operations without automation. There is little happening outside of larger health systems related to analytics or the collection of clinical quality measures. Non-Eligible Providers have been much slower to adopt electronic health record systems.

Iowa Medicaid Enterprise Provider Enrollment Survey Results

In February of 2017, the Iowa Medicaid Enterprise (IME) published a report presenting the results of the HIT survey that must be completed by providers as part of enrollment or re-enrollment in the Meaningful Use EHR Incentive Program. This report includes provider use of EHR, intention to purchase an EHR, version of CEHRT in use, participation in the EHR incentive program, interest in submitting clinical quality measures (CQMs) to the IME and participation in a health information exchange.

Iowa Health Information Technology and Meaningful Use Landscape in 2015

In 2016, the University of Iowa Public Policy Center published a report on the result of a 2015 environmental scan of the landscape of health information technology to assess the impact of the CMS Meaningful Use program on the implementation and utilization of health information technology across eligible provider types.

Health Information Technology Survey of Select Iowa Health Care Providers

In the fall of 2017, the Iowa Health Information Network (IHIN) completed an environmental scan to assess the existing capabilities of HIT infrastructure in provider facilities. The scan targeted Home Health Agencies, Long Term and Post-Acute Providers (skilled nursing facilities and intermediate care facilities), Hospices, Rural Health Clinics and Federally Qualified Health Centers and Assisted Living Facilities. The survey assessed ability to collect patient information, access to data files and

aggregation of information; current and planned use of data reports or analytics; care coordination, data exchange and patient portal and; payment reform programs and clinical quality measures reporting.

Qualitative Data Report – Environmental Scan

In addition to the technology survey, the IHIN also completed a number of key informant interviews and observations. The report provides an in-depth look at the technical infrastructure of different provider types, how the technology is being utilized, and challenges faced and future plans. This report identifies that, in regards to analytics and reporting, a large number of organizations are still utilizing manual methods to accomplish tasks. Many organizations identified that they are either participating in, or are interested in participating in, an alternative payment model (APM) but few have the technical capacity or knowledge to fully implement and benefit from an APM.

Data Reporting, Aggregation, and Analytics Ability –Statewide

The following table provides an overview of the Health Information Technology systems operating in the state at this time. The table identifies the health IT function and purpose of the system such as data collection, data aggregation, analytics or reporting services. Federal and state policy levers and regulations are also identified.

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Notification Services	**Statewide Alert Notification System (SWAN)**	Current marketplace for using ADT data is Immature. Practice model for use in a rural setting has not yet been developed Funding beyond SIM – Pricing Model / Return on Investment	SIM (funding provided for alerts on the Medicaid population only)	Same day notifications of inpatient hospital stays is a requirement outlined in the RFP for the MCOs	SWAN has been operational since December 2015
	Wellmark Notifications to ACO providers Weekly report to ACO providers listing inpatient hospitalizations.	Wellmark Proprietary Inpatient Reporting Process Requires compliance with Wellmark reporting requirements for each hospital.	Wellmark		Wellmark implemented this process in 2012

Exchange Services	**Iowa Health Information Network (Direct Secure Messaging, Query)**	Existing Federated HIE model does not support analytic reporting. In process of platform change to support analytic reporting. Independent financial sustainability.	Payer (Medicaid) Provider	Participation is not mandatory but meeting some Meaningful Use core measures can only be achieved as an IHIN Participant.	Services of the IHIN became functional in 2012.In March 2017 the IHIN transitioned from a state-run entity to private non-profit. The platform change is currently in progress.
Health IT functionality	**Information Purpose & Location**	**Long Term Barriers**	**Funding**	**Policy Levers Utilized**	**Implementation Date**
Consumer Tools	**Health Risk Assessment (HRA)**	The lack of a standardized tool for direct service providers has resulted in inconsistent connections between patient and providers. And inadequate collection of information related to social needs in individual and aggregated form.	SIM (Assess My Health)	MCOs are required as part of their contract with the state to complete HRAs on all newly enrolled members within 90 days of enrollment. Requirement of the Healthy Behaviors Program for the expansion population requires the completion of an annual HRA.	The IME began using the Assess My Health HRA in 2014. Since the implementation of Managed Care additional HRAs are being used specific to each MCO.
	Member/Patient Portals	No integration of disparate patient portals throughout the state. Patient information is only unique to claims submitted to a particular payer or services rendered through a particular health system	Varied (not SIM)	Unknown for payers but for Eligible Providers a patient portal was required in order to meet the Core Measures for Meaningful Use Stage 2.	varied

	Wellmark Public Provider Star rating Members are able to see VIS calculated quality score (1- 5) of a provider on the Wellmark website		Wellmark		Wellmark began publishing the Star rating in January 2017
Health IT functionality	**Information Purpose & Location**	**Long Term Barriers**	**Funding**	**Policy Levers Utilized**	**Implementation Date**
Provider Tools	**3M Value Index Score (VIS) – Quality Metrics Dashboard** A quality improvement score is available to providers / organizations through an online dashboard that is derived from claims based quality measures. Wellmark also uses the VIS to track quality improvement scores for participating providers in the Wellmark ACO program	3M provides a quality improvement score that is derived from claims based measures Providers struggle with linking their quality score to clinical quality improvement activities.	SIM for Medicaid Wellmark for Wellmark	Medicaid contract with the Managed Care Organizations requires the use of 3M Analytics as a tool to inform VBP Contracting in Iowa. Iowa's other largest payer Wellmark also uses 3M for analytics with their ACO contract. Payer alignment reduces undue burden on providers.	The IME began using the VIS as a Metric reporting tool in 2014 with the Iowa Medicaid Expansion population "Iowa Health & Wellness". Wellmark began using the VIS as a Metric reporting tool in 2012 with their ACO Participating Providers.
	Provider Incentive Payment Portal (PIPP) – Meaningful Use Reporting System	This tool was solely designed as an attestation portal for the EHR Incentive Program; it was not developed with the intention of being a	HITECH	Iowa Administrative Code requires that providers attesting for the Medicaid EHR Incentive Program use PIPP and abide by all terms and conditions	The Provider Incentive Payment Portal (PIPP) became operational in April 2012. EHR attestations prior to this date were collected through another mechanism.

	PIPP is the State Level Repository (SLR) developed to allow Medicaid Providers to log into a secure web based system to attest to Meaningful Use including manual reporting of aggregate clinical quality measures as required by the EHR Incentive Meaningful Use Program	reporting mechanism and lacks the capability to report data that would be useful in VBP.		associated with the incentive program.	

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Provider Tools cont…..	**In Patient Out Patient (IPOP)** Statewide Inpatient Database that contains patient-level discharge data for all acute discharges including newborns from Iowa community hospitals	Dependent on consistent hospital reporting	IHC; CMS (HIIN)	641-177.3(76GA,ch1212) Iowa Administrative Code	The IHA Statewide Outpatient Database contains all hospital outpatient visits beginning in 2004 and a subset of hospital and outpatient procedures from Iowa hospitals from prior years back to 1995. Data is submitted from Iowa hospitals quarterly and readmissions aggregated by hospitals by month is provided to IHC and used in the SIM Portal to develop community scorecards.
	Electronic Lab Reporting (ELR) Reportable lab results are transmitted from a connected providers EHR to the SmartLab	SmartLab is an expensive product that may be cost prohibitive long-term.	HITECH and Provider	Iowa Code Section 139A.3(1) Chapter 139A Communicable and Infectious Diseases and Poisonings	Labs began connecting to the SmartLab in 2012.

	as a service offering of the IHIN.				
	Immunization Registry (IRIS) Iowa's Immunization Registry Information System (IRIS) provides computerized tracking of immunizations for children, adolescents and adults throughout the state.	Currently not integrated as an IHIN service and is its own connection.	HITECH and Provider	Iowa Code Section 139A.8(6) Chapter 139A Communicable and Infectious Diseases and Poisonings	First immunization registry began in 1995. Current web based system implemented in 2012.
Health IT functionality	**Information Purpose & Location**	**Long Term Barriers**	**Funding**	**Policy Levers Utilized**	**Implementation Date**
Provider Tools cont.….	**Iowa HealthCare Collaborative (IHC) Community Scorecard** Developed to drive quality improvement at the community (C3) level. Data is collected through the IHC SIM Portal and IDPH. Clinic NQF measures; SIM Community process and outcome measures; HIIN Hospital Data; IDPH SDH, measures are aggregated by community and displayed on the scorecard.	Manual collection of NQF Measure The Scorecard is only for SIM (C3) participants.	SIM	SIM Contract	Scorecards will be distributed quarterly to C3s, starting March 2017.

	Cancer Registry Population-based cancer registry that has served the State of Iowa since 1973.		National Cancer Institute, National Institute of Health, DHS(F)(S), University of Iowa	641 IAC 1.14 (139A) Iowa Administrative Code Meaningful Use Stage 3	Implemented in 1973, Electronic reporting capability with CEHRT as a service offering of the IHIN.

Health IT functionality	Information Purpose & Location	Long Term Barriers	Funding	Policy Levers Utilized	Implementation Date
Provider Tools cont…..	**Electronic Health Records (EHR)**	EHR systems are limited by the functionality that the provider/ organization purchased. New certification requirements will enhance the functionality of EHRs but the requirement on the provider to utilize/update their system is not until 2018	Providers Purchase their own EHR	The HITECH Act and ONC have set specific certification standards to ensure that EHRs will have the capability to be used Meaningfully to inform HealthCare Quality and performance improvement.	Providers began using EHRs at various times throughout the state. Iowa has a high EHR adoption and use rate with over 4000 unique payments going to providers and hospitals who attested to AIU since 2011. And over 3500 unique payments going to providers and hospitals who have attested to years 2-5 for Meaningful Use.
Patient Attribution	**3M – PCP Assignment or Plurality of Visits** Methodology is updated monthly on a rolling basis. Members are attributed to Medicaid enrolled PCPs.The methodology allows the member to choose or be assigned a PCP (through a process defined by their assigned MCO).If a member does not have an assigned PCP, then the member is attributed using a methodology based on counting unique E/M visits In this case the member is assigned to the provider with the highest number of unique visits.		SIM	Medicaid requires the MCOs assign members to PCPs upon enrollment to their plan.	The IME adopted this methodology with the implementation of VBP in 2014 with the Iowa Medicaid Expansion population “Iowa Health & Wellness”. Wellmark began using this methodology in 2012 with their ACO Participating Providers.

Financing

Multiple sources have been utilized to finance the health IT landscape in Iowa. While providers are responsible to invest in their own IT infrastructure, Meaningful Use payments have assisted in this investment for Eligible Providers.

In regards to the health information exchange and other systems to facilitate interoperability and reporting, multiple sources facilitated the development. The initial funding sources included ARRA and HITECH 90/10 funding. The State of Iowa received $7,074,312 from the ONC in ARRA funding and $7,450,000 in HITECH 90/10 funding in a contract with the Iowa Medicaid Enterprise. State funds were initially allocated to fund the Office of Health IT at IDPH. Fees were also assessed to Participants of the IHIN.

Today, Participant fees remain an integral piece of the financing of the IHIN. Private payers have not yet contributed to the financing of the IHIN. Going forward, private payers are targeted for inclusion. Additionally, the IHIN is planning to leverage additional HITECH 90/10 funding to change the architecture of the HIE to expand functionality and increase service offerings. Other grant opportunities are also being explored through the Iowa Legislature and the Office of the Chief Information Officer.

Governance

Organizational Governance:

In 2015, House File 381 directed the transition of the Iowa Health Information Network (IHIN) from the Iowa Department of Public Health to a private non-profit model of governance. Upon transition, Iowa Code 135D.6 was instituted to, among other things, provide the legal authority and framework for the IHIN Board of Directors. This Code section requires that the Board not be disproportionately represented by industry or provider type, that the Board have at least one consumer member and that the Directors of the Department of Public Health and Iowa Medicaid or their designee be members of the Board. It also requires the inclusion of a consumer member. This Code section obligates the Board to “develop, implement and enforce standards, requirements, policies and procedures for access to, use, secondary use, privacy and security of health information exchanged through the IHIN.” These standards and policies are to be consistent with existing federal and state standards.

As of this writing the Code of Iowa has not been updated to reflect the transition. It will be available when the Supplement is published in the winter of 2018. HF 381 provides the prior as well as current code language for review. Elements of the legislation apply to all categories of governance.

House File 381

The Articles of Incorporation and the by-laws of the IHIN are available through the Office of the Iowa Secretary of State.

As has been the case over the last eight to ten years of progress in health information exchange in Iowa, the IHIN is utilizing work groups to inform the Board regarding infrastructure needs, policy needs, service offerings etc. These work groups consist of members of the provider community from throughout the state.

Legal/Functional Governance:

The IHIN, which has operated as the state designated health information exchange, was transitioned to a private non-profit model of governance on April 1, 2017.HF 381, linked above, directed the Iowa Department of Public Health to undergo a competitive bid process to select a Designated Entity to serve as the IHIN going forward. Per legislation, the IHIN is subject to all HIPAA regulations and may be used for treatment, payment and healthcare operations activities. Iowa is an opt-out state in regards to patient choice to participate in health information exchange. IHIN and Participant obligations

regarding data use and reuse can be found in the Participation Agreement. More details can be found in the Privacy and Security Policies.

IHIN Participation Agreement

IHIN Privacy and Security Policies

The following list provides links to the legal requirements for providers in Iowa to submit health data to the Iowa Department of Public Health as well as the Meaningful Use letter directing providers in Iowa of how to meet public health reporting requirements to attest for Meaningful Use. The reporting requirement links are not all inclusive, but a snapshot of reporting requirements. These links include references to disease reporting, birth and death certificates, immunization reporting, congenital and inherited disease reporting, cancer reporting, trauma registry, etc. These are areas of priority for the Department going forward.

IDPH Meaningful Use Letter

Chapter 139A Communicable and Infectious Diseases and Poisonings

Chapter 144 Vital Statistics

Chapter 147A Emergency Medical Care - Trauma Care

Technical Governance:

The current landscape in Iowa does not include technical governance as it relates to use cases for a value based payment system and the use of health IT across provider and payer systems. The leadership group of the State Innovation Model grant intends to convene a Round Table of business leaders, payers, providers and other state leaders to begin identifying and coming to consensus on a direction in this regard. It is anticipated that a number of workgroups will emerge from this Round Table. It is likely a discussion identifying a core list of eCQMs for reporting will emerge.

Sustainability

Based on the current information collected from the provider community across Iowa, the question isn't whether or not the current state of health information technology is sustainable. Use of electronic health record systems is here to stay and those who are not yet utilizing this technology likely will sometime in the future. The question is whether or not providers will utilize these systems to their full potential and whether or not they develop into an integrated, global record of patient care, providing benefit to not only the provider, but the payer and patient as well.

HF 381, which led to the transfer of the IHIN to a private non-profit model of governance, also dropped the provision that the IHIN be a Federated HIE, unable to collect and store data. This provides a real opportunity to build a health information exchange that provides services well beyond basic Direct Secure Messaging and query for a Continuity of Care Document.

Long term sustainability of health information technology and health information exchange will be made possible if ALL provider systems participate, if additional provider types (behavioral health, long-term care, pharmacy, etc.) connect to participate in exchange of information and if additional use cases can be identified to the benefit of the patient, provider and payer.