Welcome to the Civitas Networks for Health Annual Conference: Bridging Data and Doing!

Hosted in Partnership with our Upper Midwest Region members

Thursday, October 17, 2024

Networked FHIR Exchange: Maximizing the Value of Standardized Data Exchange

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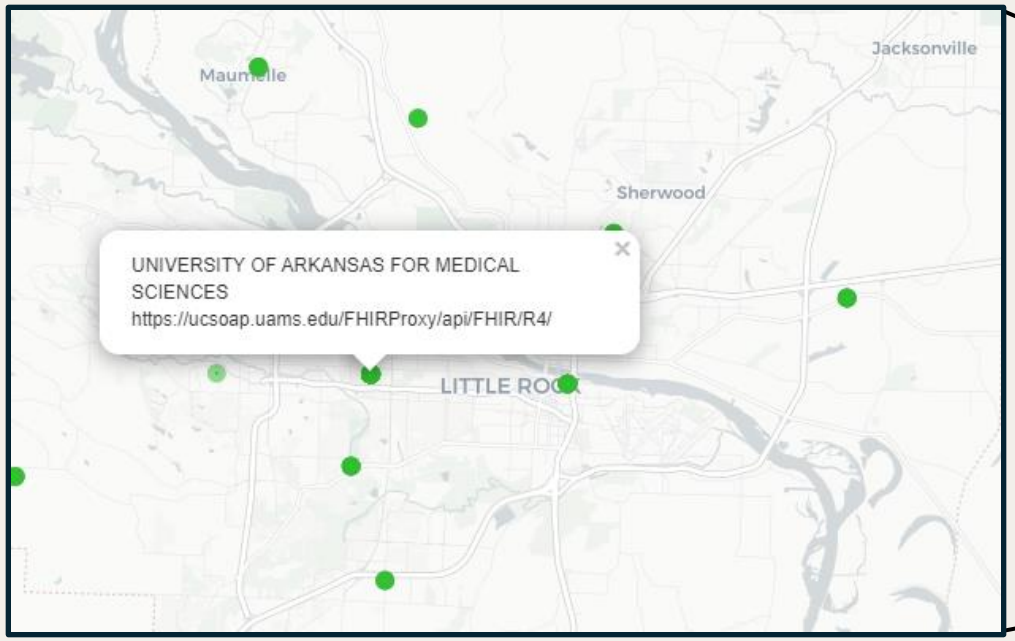
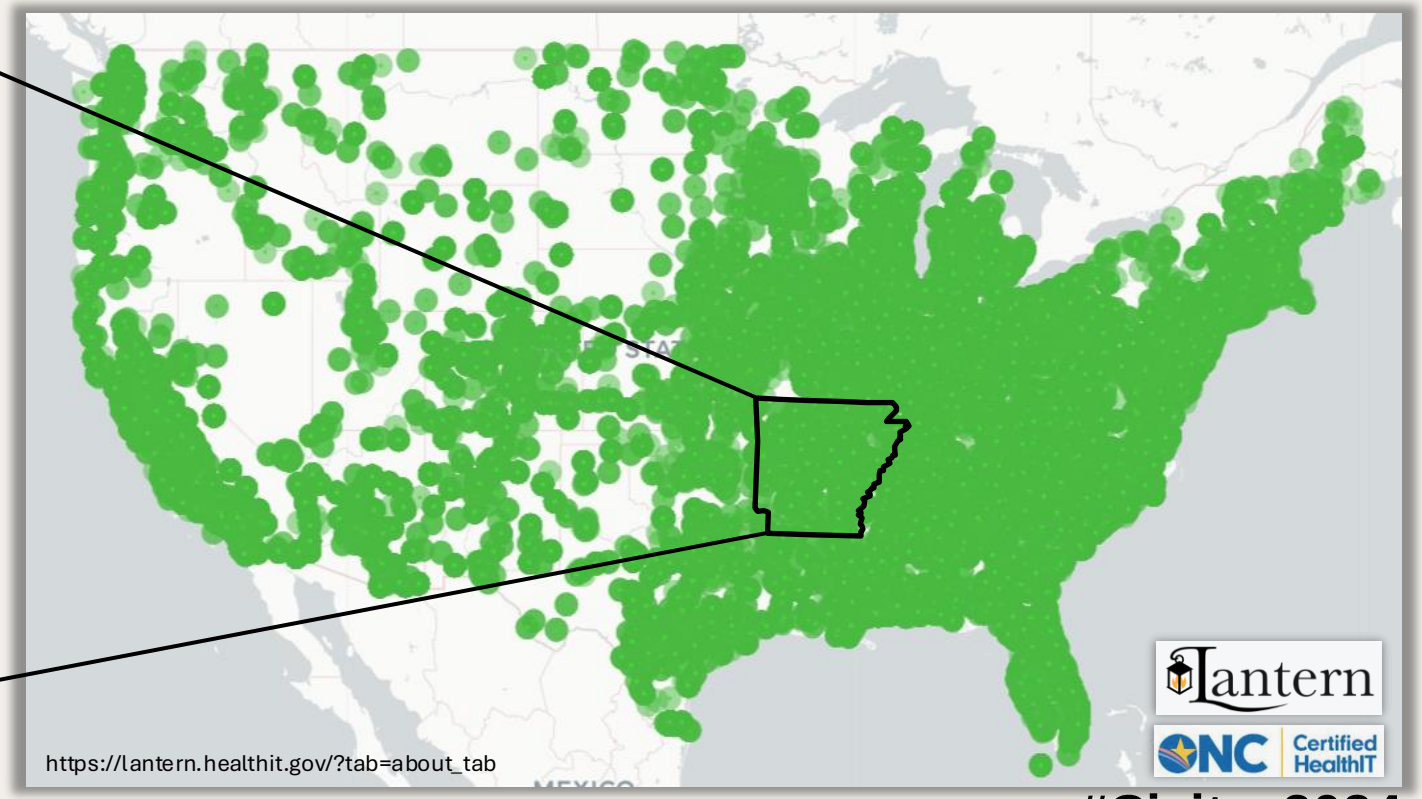
Current State: Interoperability (and FHIR APIs)

*Treatment Exchange (Providers querying Providers (for CDA's)) is **very common** (driven by Meaningful Use / P.I. programs)*

*Payers have FHIR Patient Access APIs (Patients querying Payers), but the **usage is modest**.*

*Payer Exchange (Payers querying Providers) is **less common** (causing manual (and costly) approaches for exchanging data)*





“Facilitated” vs. “Networked” FHIR

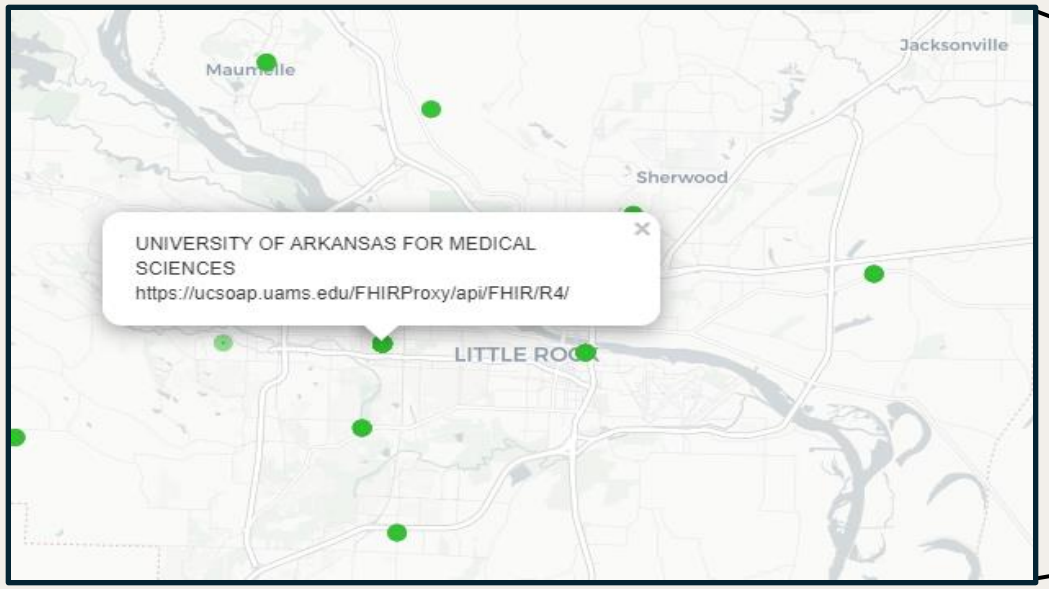
Market Need:

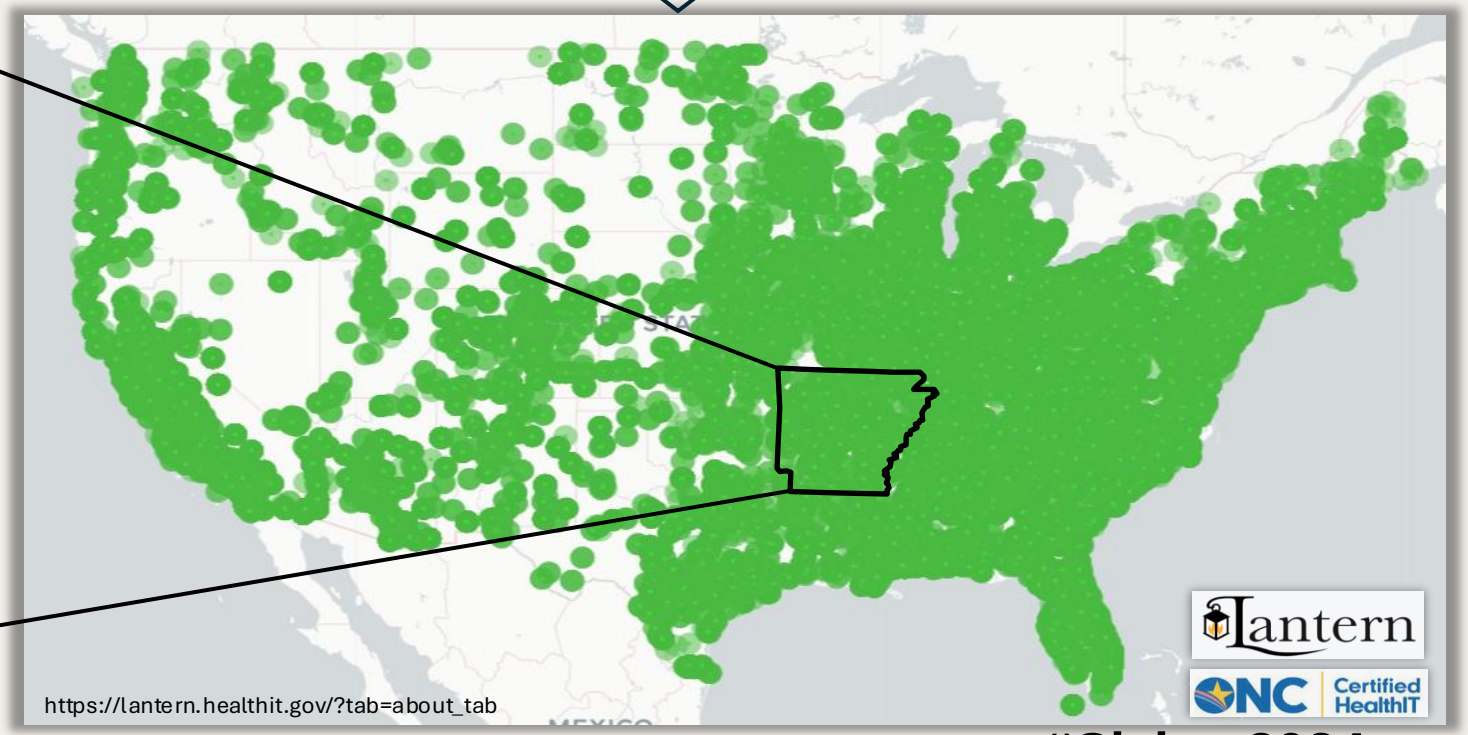
- For Treatment: healthcare is *mostly* local (so ~90% coverage can be obtained with ~10-20 trading partners)
- For Payers: members are *not* only local (so ~90% coverage requires 100’s or 1000’s of trading partners)

UAMS University of Arkansas for Medical Sciences ↔ **“Facilitated FHIR”** (point-to-point) → Arkansas BlueCross BlueShield

Example: *Walmart employees are in 50 states, not just Arkansas*

“Networked FHIR” (many-to-many)





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Market Needs

Access to National Data

- To achieve a complete clinical data profile for all members, payers currently need to source data from each regional and national vendor (e.g. health information exchanges, data aggregators, electronic health records).
- Variability in mechanisms for member matching, connectivity, verification of data feeds for quality reporting (e.g. primary source verification) and pricing arrangements needs to be tracked for each integration, creating unnecessary administration costs.
- Inconsistent data quality presents complexities that result in excessive data ingestion costs.

Scalable Trust Frameworks

- Payers face complexities with negotiating and managing data use agreements, security protocols and endpoint management across numerous vendors through point-to-point connections.
- Negotiating individual contracts is a lengthy process for each data partner and is a significant barrier to entry to operate at scale.
- Payers require assurance in liabilities and indemnification through proven data exchange trust framework models given compliance requirements and severe consequences from breaches and violations of the law related to the exchange of sensitive data.

Where are we today?

Trebuchet

… a Catapult design optimized by Da Vinci
… a Collaboration to launch HL7 Da Vinci IG's into Production

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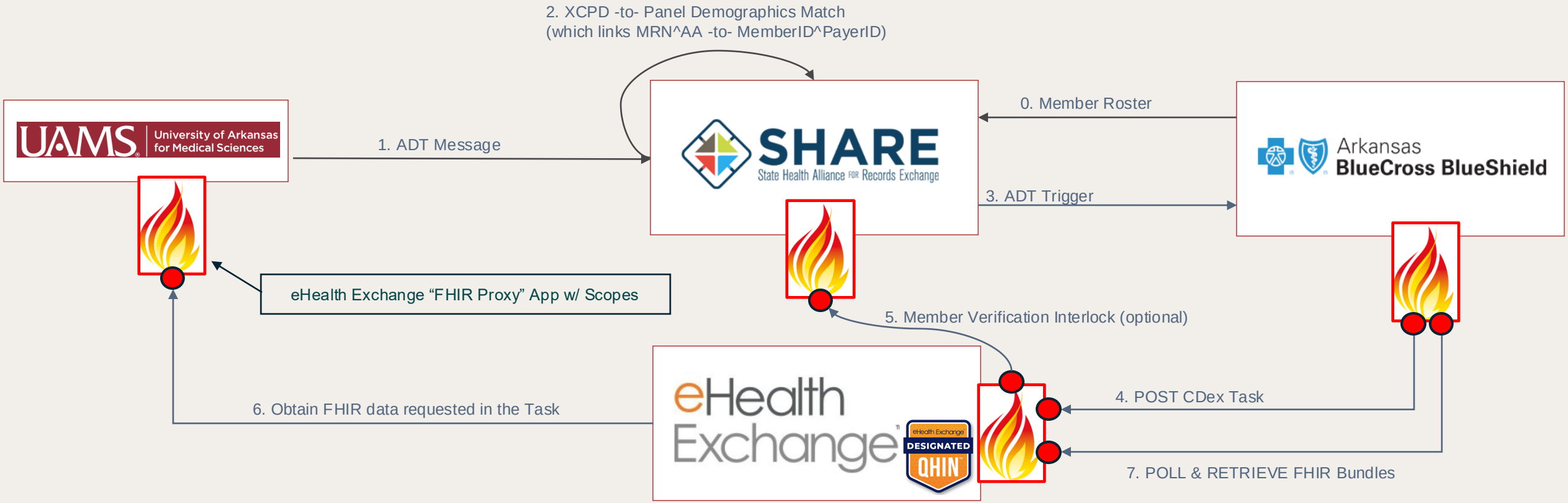
Where are we today?

Task-based Exchange (Da Vinci CDex): Pilot Example



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Challenges/What's Next?

1. **Governance / Trusted Relationships**
   - HIE's know the local business needs and players
2. **Legal Agreements and Policies**
   - HIE's have existing agreements which can be leveraged to accelerate time to value
   - This can also be more responsive to local needs than national initiatives (which serve only as the "floor")
3. **MPI**
   - HIE's have patient matching services with governance / stewardship and populated by many sources
4. **Attribution**
   - HIE's have Patient-to-Provider-to-Payer attribution
   - This can also be used to verify "Trusted Relationships" (e.g. a neutral entity confirming valid relationships)
5. **Consent**
   - HIE's are best positioned to manage consent and preferences (given the combination of #1, 2, 3, 4)
   - Consent is part of CMS-0057 (opt-in for Payer-to-Payer, opt-out for Payer-to-Provider)
6. **Alerts/Trigger events**
   - HIE's have ADT feeds and neither TEFCA nor national networks nor FHIR have an alternative to key triggers
7. **Directories**
   - HIE's have Provider/Org/Practitioner directories (given 1, 2, 3, 4)

Da Vinci Resources

- Da Vinci has publicly available Confluence resources!
- Da Vinci Welcome – Confluence page to learn about Da Vinci project and signup for Listserv
- Da Vinci Implementation Guide Dashboard – Confluence summary view of information and links per use case
- New to Da Vinci? Check out the Implementer Resource Page
- Da Vinci Use Cases – Confluence parent page to each use case containing meeting meetings and use case materials
- Da Vinci Video Presentations – Confluence page to view past slides, recordings from Community Roundtable and more!

- Request an Account – HL7 Jira/Confluence accounts are free and available to anyone (including non-members)
- Quick Links have presentation slides for community to leverage

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Q&A Expected (~15-20 minutes) (assuming 0:45 minus 0:03 intro, 0:06 Doug, 0:06 BillH, 0:06 Anne)

1. **Q: Is this live today?**

   A: barely … several pilots in CA, UT, AR, WA are early production … most hurdles can be streamlined as discussed on the previous slide, where everyone needs to do what they do best (Payers, Providers, HIEs, National Networks) to get this to work at scale. Nobody wants to go first. Also, need local relationships (and risks of key people leaving).

2. **Q: What about where there are regions without HIE's?**

   A: alternatives exist, but they are not optimal, for patient matching, relationships, alerts, etc..

3. **Q: What about reciprocity policies? Provider duty-to-response to Payers?**

   A: Today, no mandatory responses for Payment and Operations. TEFCA may allow fees for non-Treatment. Payers have been mandated to offer Patient Access API (at no cost), and Provider Access API (assumed at no cost).

4. **Q: What about Payer Platforms (Epic, athena, etc.), or Clearinghouses (e.g. Change, Availity, etc.)?**

   A: yes, these are the exact competitive options … having done the pilots, there's plenty of opportunity to fill the void (competitive alternatives can provide solutions). This comes down to cost, trust, and time to market (and federal regulations are excellent forcing functions, like CMS-0057). Also, concrete example where AR-SHARE has ~75 EHRs (no market is 100% Epic).

5. **Q: How do I get involved?**

   A: pilot solutions and partner with forward-leaning payers and providers.

NETWORKING BREAK WITH SPONSORS

Ontario Exhibit Hall
11:00am-11:30am

CHECK OUT OUR AGENDA!

SCAN