OKLAHOMA Health Care Authority | Serving Oklahomans through SoonerCare

Health Information Exchange Fact Sheet

Background

SB 574 (2021)

- Created the Oklahoma State Health Information Network Exchange (OKSHINE)

SB 1369 (2022)

- Created the Office of the State Coordinator for Health Information Exchange - OHCA
- Created concept of a State Designated Entity for HIE Operations overseen by the office – OHCA has contracted with MyHealth Access Network as the SDE.
- Requires that "all providers" participate in the statewide HIE by July 1, 2023.
    - Establish a direct secure connection to the SDE and transmit active patient data.
    - Actively utilize HIE services to securely access records during and/or in support of patient care.
- Coordinator may grant exemptions (financial hardship or technological capability).

Health Information Exchange

Health information exchanges (HIEs) are connecting nationwide to seamlessly deliver patient health information across health systems, improving the patient experience by making their health information available whenever and wherever their care occurs.

With the statewide HIE, the state can vastly improve public health, care coordination, records exchange, and address care fragmentation and care gaps for providers.

- 70% of Oklahomans have records in more than one health care delivery system.
- The HIE currently covers more than 1400 locations serving more than 110,000 patients daily.
- MyHealth will charge a one-time connection fee which includes ensuring interoperability.

Patient privacy: All patient data is only accessible in secure, approved ways, compliant with HIPAA, MyHealth Terms & Conditions and Network Policies. The HIE is set up to monitor access of all health care information it receives to ensure patient privacy. More information on patient privacy can be found at https://myhealthaccess.net/who-we-are/faq/ . Psychotherapy notes are excluded from transmission to the HIE as well as any Mental/Behavioral health data covered by 42 CFR part 2.

FAQs

Why do healthcare providers need to share patient information?

If you have ever had to fill out the same form several times, or new forms with the same information, you've experienced the need for information sharing between doctors. Because patients may see several different physicians besides their primary care provider, different sets of medical records for the same patient can be found in different offices. This creates burdensome paperwork for the patient, but also creates a very real risk that the patient could be prescribed a medication they are allergic to, or are already taking, or that the same tests already undergone (and paid for) are re-ordered.

A statewide HIE supports:

- Reduced health care costs associated with redundant testing, hospital readmissions and unnecessary emergency department visits.
- Improving care coordination during transitions between health care settings, reduce adverse drug events and missed preventive care.
- Improved patient experience and provider performance on quality measures

How can a statewide HIE improve health care?

- One prominent study indicates that in 85% of families' visits to the doctor, critical health information is missing that could have changed the treatment plan. An HIE ensures that the relevant information is available for every doctor to consider.
- Eliminates the delays created when a doctor needs more information from other providers involved in a patient's care and would otherwise have to wait on the mail, a fax or a returned phone call.
- Enables your doctors to communicate directly and securely with one another to ensure care is coordinated appropriately.
- Helps to avoid additional costs and health risks created by duplicated medical tests (such as increased radiation), or complications caused by missing information (like medication reactions or missed preventive care).

What health information is stored in the HIE?

Only high priority health information will be included in the HIE. Medical professionals have determined the following information is needed to effectively coordinate your health care:

1. Names of the doctors and other health professionals who provide your care
2. Diagnoses
3. Current medications prescribed to you
4. Lab and x-ray results
5. Past procedures
6. Known allergies
7. Immunization records
8. Hospital discharge records
9. Basic personal information (your name, address, family phone contacts, etc.)

Who will have access to medical records?

Only the health care professionals who are involved in a patient's care is authorized to view their records. These healthcare providers include doctors, nurses, hospital clinicians, diagnostic technicians and pharmacists—the same individuals who maintain health records in separate systems today.

Access to data is guarded closely. MyHealth Access Network will rely on the same authorization procedures doctor's offices uses today to determine which health providers are eligible to have access to a patient's medical records. Access to clinical data elements is restricted to appropriate users such as a patient's doctor and other doctors that are involved in care, and the system keeps track of every person who views medical records so that privacy will be protected through regular auditing of usage logs.

Can an individual restrict the sharing of my medical records?

Any patient may decide to prevent access to their medical records by signing and submitting an "opt out" form available from any participating health professional. Note that providers will continue to use and maintain information in their own systems—but opting out will remove the ability for that information to be shared with other providers.

Can a medical provider see notes from therapy sessions? How is sensitive behavioral health information handled?

Providers cannot see behavioral health records without "breaking the glass" – a process that ensures an audit on why the provider needed the information.

The system conforms to all HIPAA regulations and is regularly audited to ensure compliance. Additionally, any mental/behavioral health providers or clinics covered under 42 CFR Part 2 are excluded from data transmission, as well as psychotherapy notes from any provider are marked as sensitive and excluded from transmission to the HIE. Progress notes may additionally be marked as sensitive and excluded from transmission.

What is the cost?

The one-time connection fee is $5,000 for a typical clinic, which includes ensuring system interoperability. The cost covers the time and effort for the State Designated Entity (MyHealth) to meet with the providers' EMR vendor or IT team, review the standards, setup the secure connection, and test the data flow to ensure data elements are categorized appropriately within the patient's chart.

If a provider finds that they will not be able to meet the mandate due to technological or financial burden, they may request a hardship exemption by submitting a request to the Office of the State Coordinator for HIE through the application describing in detail their situation as to why they are not currently able to meet the mandate.