Delaware Health Information Network
Town Hall
Wednesday, February 10, 2016
11:00 a.m. – 12:00 p.m.

Conference Room
107 Wolf Creek Boulevard
Suite 2
Dover, DE 19901

Meeting Minutes

Purpose
To keep our public informed.

Agenda
What we are doing
What we will be doing
What should we be doing (public feedback)

I. CURRENT Activities Update

DHIN continues working on issues with the software/data base conversion. The system is currently stable but the level of system performance is not yet acceptable. The software patch is currently being tested and if all goes well, we will go into production this weekend.

An additional patch in early spring will give us the ability to configure the system and the ability to retrieve sections of patient charts. Medicity has also pledged to develop a tracking tool allowing data sending organizations to trace all results from end-to-end to every designated delivery point. Giving us the ability to see at any moment in time, where every result that a data sender may have sent is in the process of being delivered to the intended recipient(s) by each of the available methods of delivering results.

Public Health

CCHS and Beebe have both moved into production with sending Syndromic Surveillance into Public Health. November to December showed an 82% jump in both Syndromic Surveillance and electronic lab messages being sent from hospitals through DHIN to Public Health. St. Francis and Bayhealth are in the process of changing their EHR vendor and the remaining work to send their data into Public Health will be completed after their software upgrade.

Immunization Reporting

DHIN currently has eighty-five practices in production which represents 18% of all organizations across the state that are sending immunization updates electronically into the state registry.

Newborn Screening

NBS is the combination of the early hearing detection and metabolic screening for testing of genetic conditions combined into a single report. The goal is to electronically deliver the NBS results to both the birthing hospitals and ordering providers. Work paused for a period of time; and at the last legislative session, a statute was passed specifically addressing storage and access of NBS information along with a separate statute addressing genetic information, more broadly acknowledging storage in the EMR.

DHIN has identified several beta practices to prove out the ability to store the data into the community health record and deliver to the ordering providers. We required at least one practice for each possible delivery channel; EMR deliveries, clinical inbox and auto-print. We are working with Public Health on how to operationalize the statute; once approved we are ready to move forward.

Data Senders

Peninsula Regional moved into production on January 12th with ADTs. This is our third out of state hospital as a full data sender.

In addition, MedExpress, our first walk-in clinic has gone into production and is submitting ADTs.

DHINs kick-off with CNMRI took place earlier in the week, representing another imaging group sending reports into DHIN.

II. Planned Activities Update

Grants

Two of the major activities we continue working on are: the ONC Grant that DHIN has received; and DHINs role in the State Health Innovation Plan which went to the Delaware Health Care Commission. Though they are two different grants and recipients, both support the State Health Innovation Plan.

DHINs Grant: The grant that DHIN received from ONC will allow us to advance shared technical components of the State Health Innovation Plan. DHIN is working with four target groups:

Behavioral Health and Long Term Post-Acute Care communities were not included in the EHR Incentive Program (Meaningful Use); therefore, not eligible for the incentive funds. DHIN is working with both communities on the adoption of health information technology and technology standards which are being promoted to address interoperability across settings of care.

At a minimum, the lowest common denominator would be offering Direct Secure Messaging and would be covered under the DHIN grant to secure point to point exchange of protected health information.

DHIN is also standing up a Provider Directory which will allow newcomers to the digital community to find their exchange partner and enable them to send/receive Direct Secure messages to/from their intended recipients.

In addition, we are offering to the Post-Acute Community a transform tool which will take data that is already being electronically submitted to CMS and extract critical elements to generate a care summary in the standard CCDA format allowing DHIN to incorporate the data into the community health record accompanied by an ADT.

Consumers: This initiative will use grant funds to implement a state wide patient portal that connects with data in DHIN. The goal is for patients to have the ability to access their health data from one log-in.

1. For organizations that currently have a patient portal, DHIN wants to integrate the community health record on the back-end of the hospital or practices portal and feed data from all data senders when a patient does a query from the hospital or practices portal. Patients will be able to access all of their data from one place. Reporting will be provided back to the provider stating access from an individual patient who was searched and the provider will receive credit under the Meaningful Use Program.

2. For practices that do not have a portal, we can use grant funding to help set up a patient portal and brand it for each practice. Again, it will provide the patient with access to data sent by ALL data senders with a single login.

3. Patients visiting paper based practices still have data in the DHIN repository. A DHIN branded portal would be made available for those patients to access their health records from anyone that has contributed data.

DHIN has been working on writing an RFP; and as we near completion, we will be soliciting review from key stakeholders to ensure all requirements are being met.

Eligible Professionals: Three main interventions that DHIN will be offering to eligible professionals through our grant:

1. Event Notification System: Based on ADTs, DHINs goal is to expand the number of practices that subscribe to ENS and the amount of notifications we can provide allowing real time notifications back to the primary provider. There are currently 286 providers actively receiving notifications on a daily basis; an additional 100 plus have signed agreements and are ready to proceed with the next steps.

2. CCDA Exchange: The ability to send documents to the community health record and query the data from within the organizations EHR. One of our goals is to increase the number of eligible professionals that are able to ingest and parse CCDAs received from external sources. At this time, 134 eligible professionals are actively sending care summaries at the conclusion of each encounter. The encounter summary is triggered when an encounter is finalized in the organizations EHR and automatically goes into the DHIN document repository.

DHIN is working with Medicity to allow CCDAs to be visible in the community health record and be queried using IHE XDS.b query and retrieve profile; which is the technology standard for query of data from external systems.

3. Analytic Capabilities: Payers agree that a significant portion of their value based contracts (with the provider) will be based on the performance against a common set of clinical quality measures that will be used across the state by all providers.

The providers recognize and accept that measuring clinical quality will happen and that there must be objective measures of quality of care provided. However, contracts with multiple health plans and trying to report measures in different formats and different transports has been a challenge.

We have piloted with a group of 21 practices in the two releases of Version 1; and the requirements for Version 2 have been defined. Feedback from the original pilot has led to refinement in both measures and functionality of the scorecard. We have been working with the payers to execute the legal agreements that will permit them to send us the attribution level data. We are looking to roll out Version 2 of the scorecard no later than the second quarter of 2016.

The scorecard is a first pass at making analytical tools accessible to the eligible professionals. We are looking at a continuum of services that address the fundamental issue of the need to do population level analytics. DHIN is looking at three services around analytics::

Data as a service: An organization with access to analytic tools would need DHIN to provide any data on their patients that they may not already have and deliver the data requested in volume.

Reporting as a service: DHIN has both the data and the IMAT analytics tools for practices and other organizations that can define for us either a standard set of reports to be run at standard intervals or ad hoc reports; DHIN can offer this on a subscription basis.

Analytics as a service: Organizations that have or will invest in training a resource in their own organization (in the Python query tools). DHIN can provide the organization with a “walled garden” inside the IMAT analytics platform so the data is

accessible and organizations can write their own queries using the analytics tools DHIN has licensed. Resources are available for training at practices.

Strategic Planning

DHINs five year strategic plan which was submitted in 2011 has been fully executed and we are required to submit another five year plan. We have contracted with a facilitator for a deep-dive strategic planning exercise and will be reaching out to request interviews with stakeholders for input on what they would like DHIN to do for them. What can DHIN do better/differently to add more value for both the providers and consumers?

III. Comments

Q: Mary Marinari, DMMA: Regarding the care summaries that eligible professionals send after each encounter; is this something that there might be a special registry for and can be used for individual point of information?

A: Our goal is to increase the number of eligible professionals that are able to ingest and parse CCDAs received from external sources. Working with EHR vendors for implementation helps if we can do a group of practices that use the same vendor since the technical work will be similar for each practice. At this time, we have a significant number of practices using Athena, Amazing Charts, STI and Cerner. In addition, we are beginning work with a group of St. Francis practices that are using Allscripts and have had a number of contract discussions with other EHR vendors. Funded by the ONC Grant, CCDA documents whole intent is for clinical quality measure reporting, population level, or use of the data for any analytic information we may want to utilize.

The next Town Hall is scheduled for March 9th @ 11:00 a.m.
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