Delaware Health Information Network
Town Hall
Wednesday, January 13, 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 our software/data base conversion. The software patch, which is actively being tested, will address a number of performance issues, including the slowness of a patient load. DHIN has had numerous conversations with Medicity and they have presented us with a roadmap of work to help address the systemic problems that were unmasked in the upgrade. An additional patch will be tested in early spring which will address accelerating patient search and chart load times.

Also expected in the early spring is Intelligent Retrieval of Large Records. DHINs patient load goes back to 2007 and several patient charts in the community health record are very large. When searching for patients it can take several minutes for the patient chart to return, which is inexcusable in a clinical workflow. The next patch will give us the ability to configure the system to retrieve sections of patient charts that are required immediately and the remainder of the chart at a later time. This will enable patient chart loads to go faster. The additional work Medicity is doing will not be seen by the end user; however, it is instrumental in detecting any issues that arise before they get out of hand. There will be hardware changes to strengthen the system and add stability as well.

In addition, one of the items that we are quite insistent on is the ability to trace all results from end-to-end to every designated delivery point. This will give us the ability to see at any moment in time, where every single result that a data sender may have sent is in the delivery process.

Public Health

In early December, CCHS and Beebe moved into production with Syndromic Surveillance showing a huge jump in the volume of messages being sent to Public Health. Public Health continues working with CCHS on Reportable Labs; and Bayhealth and St. Francis are currently waiting on new systems in order to comply.

Immunization

An additional five practices have moved into production. We are up to eighty-five practices in production which represents 18% percent of all practices 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 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 one beta practice and we are looking for others to prove out the ability to store the data into the community health record and deliver to the ordering providers. We need at least one practice for each possible delivery channel; EMR deliveries, clinical inbox and auto-print.

Data Senders

DHIN continues working with new data senders; MedExpress is our first walk-in clinic to send reports of encounters to DHIN. We expect to begin receiving ADT feeds by the third week in January; however, they have run into issues with their vendor and there will be additional delays in getting the clinical data which represents the full report of the encounter.

In addition, DHIN has signed an agreement with CNMRI radiology imaging as a new DHIN data sender.

Out of State

Peninsula Regional Medical Center is currently on course to go live in January 2016 with ADTs, and will be our third out of state hospital as a full data sender. ADTs went live the first week in January and the remainder of the clinical data will be sent later in the month due to minor issues related to their vendor and the ability to format and transport files in the necessary manner.

II. PLANNED Activities Update

Grants

Two of the major activities we continue working on are the ONC Grant that DHIN 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.

DHIN's Grant: DHIN continues working with Behavioral Health and Long Term Post-Acute Care organizations on Direct Secure Messaging as an easy entry into the digital eco system. We have a small number of organizations that have executed agreements and are in the process of on-boarding and implementing this functionality.

DHIN is also working with the Long Term Post-Acute Care Community to implement the KeyHIE Transform Tool; the ability to take data that is already being electronically submitted to CMS and extract critical data elements to generate a care summary in the standard CCDA format. LTPACs sending in CCDs, will allow DHIN to incorporate the data into the community health record for access by other healthcare professionals in the Community Health Record. An ADT will accompany each of the LTPAC CCD files.

Admission Discharge Transfer (ADT) is a foundational file that allows us to match clinical data with a specific clinical encounter from the point of arrival at a hospital until departure by transfer or discharge.

When we receive a clinical result, (lab, image or hospital document) it comes with an ADT that allows us to say it goes with this patient, this event, and/or this encounter. The Event Notification function that we offer to providers/payers is driven by ADTs. If we know a group of patients that a practice is interested in following; DHIN can send an alert whenever a patient in the group has an encounter or event at the hospital. When an ADT hits our system about one of those patients, an alert will be triggered back to the practice stating that one of their patients has been admitted/discharged from the hospital or emergency room.

A number of practices that have been using ENS are also interested in other transitions in care for their patients. When their patients are seen by a specialist or admitted/discharged from a hospital or nursing home, practices want to know that the encounter occurred and want the ability to track all transitions in care for each of their patients.

For DHIN to provide the notification it is required that we have ADTs corresponding with each transition in care. Even if we don't have all the clinical data from MedExpress, we have the ADT which will provide us with an opportunity to notify a practice that one of their patients had a visit at a walk in clinic and/or admitted to a skilled nursing facility, emergency room or hospital. As we get more walk-in clinics and skilled nursing facilities enrolled and using the transform tool, it will not only helps those organizations and increase the value of the community health record by adding important patient data; but it also expands DHIN's ability to trigger the notifications of important events. As we move towards value based payment and accountable care, it is important that practices are able to track patients and their care through the entire care continuum.

Consumers: This initiative also overlaps with the State Health Innovation Plan. DHIN is using ONC Grant funds to implement a state wide patient portal. We have been gathering requirements and evaluating vendors and anticipate an RFP will be out for bid in the first quarter of 2016.

The goal is for patients to access their health data from one log-in. There are three scenarios:

1. DHIN does not want to interrupt or compete with the hospitals, practices and health plans that currently have a patient portal. However, DHIN does want 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. Patients will be able to access all of their data from one place. Reporting will be provided back to the providers 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.

We will also be specifying in the RFP requirements that the solution must be capable of producing reports that would help support the attestation requirements of the practices or hospitals in meeting their Meaningful Use reporting obligations.

A final rule has been published for a modified Stage 2 and Stage 3 for Meaningful Use, with the expectation of additional public comment that would inform the final rule for implementation of MACRA. Today's headlines show that CMS is moving to focus not on use of technology by providers but by the outcomes that should be driven by the use of technology. For now, we are going with the expectation that we

will need to provide reports that the practices can use in attesting to how many of their patients have viewed data that has been provided.

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

1. Event Notification System, also a part of the State Health Innovation Plan. DHINs goal is to expand the number of practices that subscribe to ENS and the amount of notifications we can provide. This is an ADT based alerting, if we get an ADT or are able to generate an ADT from the information we receive, then we can use it to populate ENS. Funding is available through our grant to roll out broadly throughout the state.

2. CCDA Exchange is the ability to send documents to the community health record from a practice EHR and query the data from within a practice 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. We currently have twenty-four practices in production and sending CCDAs to DHIN; an additional fifteen practices are expected to go live by the end of this week; a total of seventy one practices have signed agreements and another fifteen have verbally committed.

3. Analytic capabilities also overlap with the SIM grant and we continue working with the Health Care Commission and Delaware Center for Health Innovation on piloting a common provider scorecard. Payers agree that on a significant portion of their value based contracts with the provider will be based on performance against a common set of measures that will be used across the state by all providers.

Version 1 Release 1of the scorecard was released to 21 beta practices; Version 1 Release 2 is expected to pilot with the initial group in the next two weeks. Release 2 is working with the payers to nail down the process for submitting the files in a timely manner.

Version 2 of the scorecard is expected to be released to the original pilot group in the first quarter of 2016 and will roll out state wide by the second quarter of 2016. Version 2 will have an expanded set of clinical quality measures and will include practice transformation metrics, benchmarking data and averaging across the state; and if we are able to get the necessary legal agreements with the payers, it will also include attribution data that allows the providers to see who the payer is attributing to them and to each of the measures both numerator and denominator.

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 fundamental issue of the ability 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 with the analytics tools that we have licensed, organizations can write their own queries. Resources are available for training at practices.

SIM Grant

The SIM Grant has also contemplated a multi-payers claim base. We have engaged in preliminary conversation and are at the beginning of a long road; legal issues need to be addressed regarding agreements, data sharing and file formats; many unanswered questions that need to be addressed. It is a part of a vision and several years down road before becoming a reality.

III. Comments

C: Last month, Dr. Steinberg raised a concern regarding documents being sent in a PDF format and cannot be ingested in readable form by every EHR. DHIN is currently evaluating options on how to address this issue.

The issue has been fixed with slightly over half of the EMRs that are used in Delaware that we have integrations to; however, we are still left with a significant number that are not receiving the information in a readable format. DHIN has been in conversations with representatives from CCHS to evaluate several options identified. We recognize the urgency and are working diligently to find a solution.

Q: Stefanie Brumberg, CCHS: With the Intelligent Retrieval of Large Records, will the provider always need to make a choice on how far to go back? Would there possibly be a default to request enough data which would only take seconds; and later ask for additional data?

A: At this time, we have not seen any design details. The data sender representatives who have been very intimately involved with the upgrade/data base conversion have specifically asked for this as a feature to help reduce the load time for large charts.

The next Town Hall is scheduled for February 10th @ 11:00 a.m.

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