Delaware Health Information Network
Town Hall
Wednesday, March 4, 2015
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

Public Health
DHIN continues working with hospitals in upgrading to HL7 version 2.5.1 for Public Health reporting, which is also a requirement for Meaningful Use Stage 2. Nemours has gone into production with Electronic Lab Reporting and the CCHS upgrade has moved from technical testing to content testing and is sending files daily for Syndromic Surveillance. We continue working on Electronic Lab Reporting with CCHS.

Immunization Reporting
Currently 124 organizations are in production and sending their immunization data updates electronically to Public Health; 83 pharmacies, 2 hospitals and 39 practices.

Newborn Screening:
DHIN continues working with Public Health on Newborn Screening to work out the details for combining both hearing screening and metabolic screening into one report. However we are still experiencing issues on storing the genetic data into the community health record and until legislations is passed establishing statutory authority to store the data, it is a pass through only and information will not be retained. The bill has been drafted for the general assembly and we are hopeful the statue will be amended to allow storage of data.

Currently, we have two hospitals that are ready to move ahead with the work on the interfaces back to the birthing hospitals, Nanticoke Hospital and St. Francis.

Delaware Center for Maternal Fetal Medicine has been interested in becoming a data sender into DHIN; however a large portion of their work deals with pre-natal genetic testing. Not only are there issues in storing their data in DHIN, but also their own internal EMR does not have the capability to selectively make that data available only to providers that have a direct relationship with that patient.

In addition, we will not be sending messages through CCHS or their own practices. We will reconvene with DCMFM next week to see if the messages can be delivered.

CCDA (Consolidated Clinical Document Architecture)

DHIN continues working with ambulatory practices to incorporate care summary into our environment. Currently, five practices are automatically sending care summaries at the conclusion of each encounter. DHIN currently has over 13,000 care summaries in the repository; and we are working with our vendor Medicity to establish a connection to make this data accessible in the community health record. DHIN is trying to leverage all sources of funding to minimize the cost to practices.

One of the groups we are working with is physician led ACOs; when the work is done there will be an additional eleven practices that we will receive care summaries from. In addition, technical work is done for all the Athena/Cerner practices and once the practices sign the agreements with DHIN they will be ready to activate.

Software Upgrade

DHIN continues working with Medicity on the software upgrade/data base conversion. We have moved into the testing environment and have experienced a few setbacks; all but one will be addressed in the next software patch. We are working with Medicity on timing and the implication of delays. Once we are in the cert environment and ready for testing, it will be still be several months away from production. Depending on timing, it is possible we could encounter additional delays when our participating data senders have to switch over from ICD-9 to ICD-10. They may not be able to devote testing resources to the DHIN software upgrade until they are past that transition. We hope that our upgrade can be completed before that becomes a problem.

Out of State Hospitals

DHIN anticipated Union Hospital to be in production by late February; however due to a few setbacks we are now looking at mid-March.

We are very happy to announce that we have executed an agreement with Peninsula Regional and they are committed to onboard as a data sender for all five data types; lab reports, pathology reports, radiology reports and transcribed reports for all Delaware residents that are seen at their hospital. Currently, 15% of Peninsula Regionals emergency department visits are Delaware residents which will give our

community health record significantly more value. Work has begun and it will be several months before we go into production.

DHIN is also in discussion with HealthShare Exchange of southeastern Pennsylvania. Their legal department is in the process of reviewing a draft MOA and we are awaiting their position/decision. As we do with CRISP, DHIN will exchange ADTs based on the state of residence of the patient; a Delaware resident crosses over to the bordering state to receive care from a southeastern Pennsylvania hospital and DHIN will receive the ADTs populated to our system and vice versa.

Direct/Secure Messaging

DHIN continues working with Medicity on implementing a state wide Health Information Service Provider (HISP) for Direct Secure Messaging, which will enable all practices in Delaware to have Direct Secure Messaging. We are currently working to onboard four practices and our intent is to make the HISP available to all practices participating in DHIN.

The intent is not to replace what hospitals and providers are currently using, but to make available an option for users that currently do not have Direct secure messaging capabilities.

By implementing a single HISP and making it available to the health community, we can all communicate with each other and be certain that messages are received timely and securely.

State Innovation Model Testing Grant

DHIN has been working with IMAT on developing the Common Provider Scorecard. The intent is that all payers will agree that a portion of provider compensation under their pay-per-value contract with the providers will be based on a common set of measures that specifically address areas known to be important in Delaware.

The Clinical Committee of the Delaware Center for Health Innovation has been a primary driver in defining requirements. They have selected the measures and are currently working on refining both the definitions and the data sets. Version 1 of the Scorecard is expected to be in beta testing by the end of March and we expect to have a small number of volunteer practices who will be the early users look for any issues that may arise. We anticipate that by July 2015 we will begin enrolling practices in the new models of care delivery and payment.

The Scorecard will be based on claims, and the clinical portion will be based on CTP II codes on claims. Entering CTP II codes will be an extra step and will create additional work for the providers. However, the faster we receive ambulatory data electronically (in the form of CCDs or QDRAs), the faster we can start using clinical data sources rather than claims to back-up the clinical measures. The real goal is that clinical quality measurement becomes a by-product of normal clinical work and providers can focus on doing their clinical work. This becomes another important

reason for practices to send CCDs to DHIN, in addition to supporting the MU2 transitions of care measures.

PLANNED Activities Update

DHIN has been in discussion with Medicaid of getting funding from CMS via Medicaid for additional tech work that we both wanted.
After conversations with CMS, we concluded unfortunately that the level of funding provided will not be enough to justify ongoing interests.
One area both DMMA and DHIN have an interest in is the continuation of exploring support for eClinical quality measure reporting.

RSNA (Radiological Society of North America)

DHIN is in discussion for a potential grant with RSNA to enable consumers to view their own images through their own personal health records. We currently have links to images for Nanticoke Hospital, St. Francis Hospital and Mid Del Imaging and are looking to implement image viewing with 8 other radiological data senders.

ONC Grant Opportunity

ONC has recently announced a $28M grant opportunity to advance HIEs; which are already successful in enabling them to leverage structure to go further and faster. We have a short time period to pull everything together; the letter of intent went out on Monday, March 2nd and the final application is due April 6th. There will be 10 to 12 states awarded between $1M and $3M each. DHIN is excited about this opportunity and feel we are well positioned to be a possible candidate for the grant award. The awards will be announced in mid-June.

Public Comment:

C: (Marcy Parykaza, DPH): Immunization Reporting is a core objective for Meaningful Use and during recent audits, it was brought to our attention that a few Medicaid practices when attesting for Meaningful Use attempted to opt-out of Immunization Reporting due to Public Health not having the ablility to receive messages. However, Public Health has been receiving messages since 2012; it is the EHRs that were not ready to connect and not sending messages.

C: (Mary Marinari, DMMA): I'd like to make an announcement regarding EHR Incentive Program for Medicaid providers in Delaware. Just completed a test packet for the new version of the state level registry and have implemented the Flexibility Rule which allow the providers and hospitals to attest using an older version of the certified health information technology.

Q: (Joann Hasse, League of Women Voters): Does DHIN expect any opposition in regards to the genetic testing for newborns whether parents opt in or opt out?
A: The big point of this debate is whether the genetic screening program, particularly for newborns, should be an opt-in or opt-out program. Public Health would prefer for

it to be opt-out, meaning unless the parents specifically state they do not want their baby tested, the default is that all babies will get tested. But there are those who oppose that approach, and that could lead to debate and possibly delay in passage of the bill. An opt-in rule (meaning the parent(s) must affirmatively give permission in writing for each and every newborn to be tested) carries the risk that some parents do not give consent for testing, which could results in a certain number NOT getting early detection of metabolic defects and in some cases irreversible harm because treatment was not begun early enough. An opt-in rule would probably have little to no opposition and the bill is expected to pass quickly and easily. An opt-out rule is more consistent with public health goals, but will almost certainly be opposed by a group of people, and could lead to delays or complete defeat of the bill.

Q: (Millie, Delaware Surgery Center): Are there any future plans for image viewing with EKGs?
A: Though it has been discussed, there are currently no plans. Theoretically, it is possible to use the same image viewing technology that we are currently using for X-rays. However, it is not scheduled to take place in the near future.

The next Town Hall is scheduled for April 8th at 11:00 a.m.
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