Delaware Health Information Network
Town Hall
Wednesday, December 9, 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

DHIN continues working on issues with the software/data base conversion. We are currently in stable condition with results delivery occurring in real time by all channels, and no time outs; however, performance continues to be unacceptably slow. DHINs November Management Report shows a 20% drop in the number of unique users compared to August; which sets us back a full year in terms of end user adoption and utilization.

The conversion/re-indexing of the data is moving along. In October, there were three data senders remaining to be converted; Bayhealth, CCHS, and LabCorp. In November, all but CCHS had been completed; at the current rate of progress we should be out of conversion mode by the end of December. In addition, there is a software patch that will address a number of performance issues, including the slowness of a patient load. This patch will be treated and tested just like an upgrade. We currently expect completion of this patch by early January.

There are a number of items that are still required of Medicity from this upgrade that are intermediate to long term fixes. One of the items we are quite insistent on is that Medicity give us the ability to trace all results from end-to-end to every designated delivery point. We need to have the ability to see at any moment in time, where every single result that a data sender may have sent is in the process of being delivered to the intended recipient/recipients by each of the available methods of delivering results.

DHIN has a scheduled call with Medicity today to discuss strategies for how these long term issues are going to be implemented.

Public Health

CCHS and Beebe have been approved for production of Syndromic Surveillance and went into production on December 4th. Public Health is currently working with CCHS on Reportable Labs; and Bayhealth and St. Francis are waiting on new systems in order to comply.

Immunization Reporting

An additional four practices have moved into production. We are now up to eighty practices in production which is 17% percent of all practices across the state sending immunization updates electronically into the state registry along with 62% of pharmacies and 67% of hospitals.

Newborn Screening

Nanticoke is now in full production and sending early hearing screening data to Public Health. NBS is the combination of the early hearing detection and metabolic screening for testing of genetic conditions; combining both into a single report and deliver to both the birthing hospitals and ordering providers. We ran into an issue with the legal framework allowing genetic testing results to be stored in the EHR of both the originating institution and DHIN. 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 EHR.

Phase 1 of NBS was getting all the birthing hospitals to send early hearing studies to Public Health electronically. Phase II will be combiningg the hearing testing and metabolic screening into one report and sending it back to DHIN for delivery to the birthing hospitals and ordering provider, as well as storage in the Community Health Record.

DHIN has identified one beta practice and is looking for others to provine 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, that is with EHR deliveries, clinical inbox, and auto-print.

Out of State

Peninsula Regional is currently on course to go live in January 2016.

II. PLANNED Activities Update

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.

DHINS Grant: Federal grants are being scrutinized more closely than ever before to ensure that recipients of different grants are collaborating and not using federal funds to procure the same capabilities over and over. The Delaware Health Care Commission is the grantee for the State Innovation Models grant. The work that DHIN will be doing with our grant is a subset of the shared technology components of the State Health Innovation Plan. Therefore, we are collaborating closely with the Health Care Commission and the Delaware Center for Health Innovation to ensure that we are aligning our efforts.

We have four target groups under DHINs ONC Grant: Long Term and Post-Acute Care Community; Behavioral Health Community, Consumers and Eligible Professionals.

Long Term and Post-Acute Care/Behavioral Health Communities: DHIN intends to offer Direct secure messaging as a tool for secure communication of protected health information from point to point. Data that is transmitted via Direct secure messaging is **not** incorporated into the community health record. Data is sent from point A to point B and no one outside of the two end points has the ability to see the contents of the message.

The sensitivity of behavioral health issues including substance abuse and mental health issues make it imperative that there is more nuance in the handling of the data. It is part of the State Health Innovation Plan to improve the integration between behavioral health and primary care. At a minimum giving behavioral health access to Direct secure messaging will provide a tool that will allow for electronic secure communication between members of the patients care team; and with the patient's consent, information can be provided to anyone the patient gives consent to see it.

Our first behavioral health beta practice is ready to work with DHIN on implementing Direct secure messaging. DHIN also has a verbal commitment from our first skilled nursing facility to implement Direct secure messaging. Part of what we have been working on is a provider directory, which continues to be a work in progress. We have received a huge amount of help from Quality Insights and we would like to publicly thank them for all their help in collecting Direct addresses from a large number of healthcare entities in our geographic area and across borders in Maryland, New Jersey and Pennsylvania. The provider directory will allow newcomers to the digital community to find their exchange partners and enable them to send/receive Direct secure messages to/from their intended recipients.

In addition, we are working on an initiative to extend the digital ecosystem to include the long term and post-acute care community. The KeyHIE Transform Tool will allow LTPAC to contribute care summaries into the community health record; the Transform tool extracts critical data elements and generates a care summary in the standard CCDA format that will allow us to incorporate the data into the community health record. Our first beta organization has given us a verbal commitment and we are fortunate that they are affiliated with an organization that already implements this

in Pennsylvania. We are in the process of getting the technical components ready to implement; we look forward to having care summaries from nursing homes come into our documents repository and then into the community health record.

Consumers: This initiative also overlaps with the State Health Innovation Plan, using DHINs ONC Grant funds to implement a state wide patient portal. We continue gathering requirements and evaluating vendors and anticipate selection 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 into the community health record on the back-end and feed data from all data senders when a patient queries the hospital or practices portal. Patients will be able to access 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 is also evaluating requirements to ensure that we are helping hospitals and providers in meeting their Meaningful Use requirements. For patients to view, download and transmit their data along with secure messaging between provider and patient; context sensitive patient education materials; ability to incorporate patient generated data; and reporting back to the provider/hospital that they can use as audit proofing their Meaningful Use attestation.

We have received feedback from a number of different public sessions to gather requirements for vendor selection; and we are still soliciting input for additional considerations that we should take into account before putting out an RFP.

Eligible Professionals: There are three major interventions that we plan on using with grant funds for eligible professionals.

1. Event Notification Services: DHINs goal is to expand the number of practices that subscribe to ENS and the amount of notifications we can provide. Feedback through the State Health Innovation process is that users of ENS want additional notification if their patient has been admitted/discharged as an in-patient, but also want to know if their patients have had a nursing home visit/home health care encounter or a visit to a specialist. This is an ADT based alerting, if we get an

ADT or are able to generate an ADT from the information we receive, we can use it to populate the ENS. As we implement the Transform Tool for LTPAC it will give us the ability to provide these additional notifications back to the primary care provider if they have subscribed to receive it; and for the period of our grant, we can offer this service at no cost.

2. CCDA Exchange: Expand the ability to send documents into the community health record and to query from within their EHR. One of our goals is to increase the number of eligible providers that are able to ingest and parse CCDAs received from external sources.

DHIN has implemented and is actively working with several different EHRs; Amazing Charts and Athena are in production; in addition to nine practices, 43,000 CCDAs are currently in our document repository.

DHIN continues working with STI and have found a few technical glitches that still need to be worked out. We are also in active conversation with Allscripts and contracts are being evaluated by our legal counsel. The contract with Allscripts will allow us to use grant funds to defray the cost of implementation.

We are reviewing a proposal with Practice Fusion and have reached out to eClinical Works and Epic. If anyone is an Epic customer, it would be helpful to facilitate an engagement with them and DHIN to discuss CCDAs coming into the community health record.

3. Analytics Capabilities: The state of Delaware received a separate grant to work with care delivery and payment reform to accelerate the move toward value based payment rather than volume based. The common provider scorecard Version 1 Release 1was released to 21 beta practices.

After the first release, there were questions on the accuracy of the data; therefore, it was determined that the addition of attribution data would be beneficial. However, since attribution data would introduce PHI into the scorecard, specific legal documentation regarding the sharing of the data between DHIN and the payers needs to be finalized. The decision was made that Release 2 of Version 1 will not contain attribution but will incorporate design changes that flowed out of the initial test group, with the goal of adding the attribution data to the next release. Our hope is to pilot with the initial group in the first quarter of 2016; and roll out state wide by the second quarter of 2016.

The scorecard is a first pass at making analytical services available to eligible professionals. DHIN selected the technology partner and platform because it is capable of much more: We are looking at a continuum of services that address fundamental issues of needing to be able to do population level analytics.

Data as a Service: If an organization already has access to analytic tools, they just need us to provide any data on their patients that they may not already have, and deliver it in bulk. CCHS has implemented this service. They have provided DHIN with a watch list of patients of interest, and as data hits the community health record for these patients from any source, it is sent to CCHS and they have their own analytic tools to manipulate the data they are specifically interested in.

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), we can provide the organization with a "walled garden" inside the IMAT analytics platform so the data is accessible and the analytics tools we have licensed, organizations can write their own query. There are three levels of analytics services DHIN is prepared to offer.

State Innovation Plan

The SIM grant has also contemplated a multi-payer claims data base. DHIN has started preliminary work with Medicaid and the State Employee Benefits Program on potentially incorporating claims data from these two state programs into the DHIN environment. This is new territory for DHIN and there are a lot of questions to be explored in a discovery process. Specifically which data elements of a claim we are interested in and all of the legal/data sharing agreements. At the December 3rd Delaware Heath Care Commission Meeting, the standards for all Market Place qualified health plans for 2017 were formally adopted. Among those standards is a requirement for the qualified health plans to send claims data to DHIN.

The goal is to provide the community health record with additional data. Of interest is Medication History; we have not found a cost effective way to incorporate medication data systemically on all patients with data coming into the community health record. The second goals would be to expand analytics and population health capabilities not just for practices and health care organizations but to inform public policy.

III. Comments:

Q: Terri Steinberg: CCHS: Has there ever been a time in DHINs history that the percentage of customers has decreased? Could the numbers of unique users be affected by the season?

A: DHIN does not measure unique user log-ins every month. Medicity has gone back to pull metrics from last year to compare the number of users; but only from August to November.

C: Terri Steinberg, CCHS: I would like to publicly mention an issue that involves practitioners around the state. Increasingly EMRs are able to send PDFs to DHIN and then DHIN takes them and delivers them to an EMR interface. There are some EMRs that cannot open PDF documents. This is my opportunity to publicly request that DHIN develop capabilities to address the EMR interface delivery of PDF documents.
A: We are currently looking at a vendor and anticipate further discussions in January to address this issue.

The next Town Hall is scheduled for January 13th @ 11:00 a.m.
1-408-792-6300 Access Code: 573 296 990