Delaware Health Information Network
Town Hall
Wednesday, June 8, 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

Upgrade
Improvement does appear sustained. Still looking to go faster…less volume on help desk. Remove from topic of discussion

Public Health
Work contingent on EMR replacement with BH/and St. francis – BH go live in hospital
ST – ask lynn
To send required reporting to Public Health.

St. Francis and Bayhealth are in the process of changing EHR vendors and once completed will be sending their data into Public Health.

Immunization Reporting
Incremental im provement # of practices sending immune data into ph
Not updated #

DHIN currently has ninety-two practices in production and are sending immunization updates electronically into the state registry (127 pharmacies and 4 hospitals).

Data Sender
CNMRI

Moving Care summaries from document repository into community health record. May 12…acumulaitng well over a year. Migrate into c ommunity health reacord. On hld due ot upgrade. Intent monthly batches new org into CHR – large number completed in May – another large in June Nanticoke practices, skilled nursing facilities, MedExpress walk in clinics will be in June batch moving to CHR Neighborhood of _____care summaries in chr. – feedback on how going. Expands contiium of care data available hospt lab radiology….now ambulatory space, walkin in clinics skilled nursing facilities.

Second Version – first release of CPS – released to pilot practices, CPS key tech component of Sinnovation Plan. Admini simplification of practices. Different scorecard mesuirng similar things …measure different – admin nightmare focus on ttoo many things. Payers agreed major component of value based paymet contract with providers , common set of metics developed by committee in cooperation payment committee. Selected by not by dhin but clinical payers in state

2nd version contained new meaures, some in first dropped or modified, aslo containted attribution data – ability for providers to know which of their patients represented in numerator denominator – fi

May 25th – five agreed to dep dive in validating measurs using their her and billing data did own calculation to see how compared. Overall agareement was high. Small handful of measures, concern across practices – deep dive for disconnect. Error calculation…error in not understanind measure specificaitons. Five did deep dive pretty positive, believe accurate and reflect atual practices.

2nd release will go out in septemer – and will be offered state wide. Anyone practices choos e to enroll can get scorecard in September – more inititative to get practices

2nd will also include functionality – how does com pare to goal. Goals set by payers. Each payer have a goal for each measure and each provider. State wide goals as state – tryng to move state in directin of wellness. We will be racking. Also showing state level aggregation of data as state how many practices are meetingat least 75 percent of clinical quality measures. State level reporting / benchmarking for practices to compare / hope to bring aetna as additional payer. Willing to to

Release in may hm commercial and united Medicaid. In September highmark Medicaid and aetn commercial. More payers / plans / functionality

Planned activites:

Work on onc grant dhin received as well as _____health commission recei
State wide patient portal: in process of gathering feedback from large amount of sources, h ospitals, DTI, legal review.. hope to select by end of month. Not happen RFP not released. Feedback from gartner (SP) really useful input crafting RFP – longr than h oped for – feedback enable much stronger RFP and selection

Requirements for portal: 3

1. Not trying to rpelacie – if already have – link to their portal when patient queries their data getting all data that dhin has – report back to all who contributed data for credit to MU.
2. Not yet have patient portal
3. Paperbased p ractices:

Strong preference portal branded for hospital or practice affiliated with

Other things under grant: BH/LTPAC into digital eco system – not funded
Many do not have EHRs – at a minimu offer direct secure messaging offering point to point – slower pace than we hoped. Left out of funding – HER incentive program. Not on tdheir radar. Greater level of stupidity than anticipated in understanting data tools which are normal across industry. Blahblahblahblahblah blad

Our grant – include ENS service and care summary to eligible professionals (practices) huge uptake – performance has exceeded expectations uder goal. Nearly ½ of all DE citizens enrolled thorugh provider home health agency or payer. If go to ED somebody gets notified of that. For early follow up for post discharge. Will continue to grow as practices are implemented.

Not another to make claim. State wide small helps. Proud of.

Through grant: analytics tools. Score care is first. More roubst available useful when we get care summariaes in analytic environment. Practices cannot afford high analytics, can come to dhin as long as we have data in system ---rich analytic functions can be used. Capabilities to practices….hosptals looking to use data in different ways. Dhin keep cost of analytic tools affordabvle for small practices to remaind independent. Dhin shared tech platform

Garatner consulting as facilitator five year plan. Very intense and compressed. Excited at recommendations. Still present to board and get ratification before going publich. Subject to foya discoverable. Invite you to take a look once published. Comprehensive…..take dhin to next level keep on cutting edge.

Comments:

laurieAnn Rhodes: Med Society – impressend progress. With common scorecard. First of analytics. Slice and dice…..medicaid and aetna on board in September. Practices multiple payers – why would we need an APCD if we have

Payers are not contirubuint FA data to scorecard. Provide total cost of care for data No way to check or validate. All payers wold FA of claim as well as proxy for information.

Bill before GA – stand up payers claim data base under dhin to leveralge dhins assets no snese in duplicating….it would involve sending claims to include payers actually paide for different services and episode of care. Just like clinical data – sensitive info – restricted to specific use cases – governance process – who to look at – why
Bill is before legislature – time is short…but will see

Allow us to get insights to cost of care that we do not get with current scorecard.

Next town hall ju ly 13th.

II. Planned Activities Update

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

DHINs two year grant is working with Behavioral Health, Long Term Post-Acute Care organizations and Consumers as groups that were not eligible for funding under the EHR Incentive Program. In addition, we are also working with Eligible Professionals who were eligible under the EHR Incentive Program.

DHIN is working with both Behavioral Health and Long Term Post-Acute Care organizations to provide direct secure messaging; the ability to securely exchange protected health information point-to-point with another known and trusted recipient who is allowed to receive information under the HiPAA privacy rules.

A small handful of organizations have executed agreements and several others have committed verbally. Part of what needed to be in place is a Provider Directory that gives a listing of addresses to send messages securely. DHIN went live with Phase 1 of the Provider Directory within the past month and will become more sophisticated over time; the early version consisted of a spread sheet to access from within the community health record and from inside the DHIN HISP that was offered as part of the Direct Secure Messaging service.

In addition, we are working with LTPAC on a transform tool which will allow us to extract data elements that have already been submitted electronically to CMS and to generate a care summary in standard CCDA format allowing us to populate our document repository and then the community health record.

DHIN has a nursing home and a home health agency currently sending files; however, we have a few technical issues to work out before bringing the files into the community health record.

Consumers: DHINs goal is to stand up a state-wide patient portal that will give patients the ability to access their health data from one log-in.

A draft RFP is being circulated to key stakeholders for legal, technical and requirement review. DHIN does not want this to be in competition with organizations that currently have a successful portal. We would like to connect on the back end to the DHIN data repository so when a patient queries the hospital /practice portal, they will also see any additional data that has been sent to DHIN. In turn, DHIN would be able to provide those organizations with reporting on how many patients have actually downloaded or viewed the information.

We have asked for feedback on the RFP by mid-May with the intent to release it and make a selection by the end of the quarter.

Eligible Professionals: Under DHINs grant, three services are included:

Event Notification Service: ADT based alerting and notifications; the ability to notify a practice/organization that one of their patients has had an encounter in an emergency department, in-patient facility or walk in clinic.

During the month of March, eight percent of all ADT notifications were being sent to providers/organizations from MedExpress and their five walk-in-clinics. As we begin to receive data from nursing homes and home health organizations, the data will become part of the notifications as well; ensuring providers know when their patients have moved anywhere across the continuum of care.

CCDA Exchange: DHIN has surpassed our goal in terms of recruiting practices and eligible professionals to automatically send us a care summary at the conclusion of each encounter. DHIN currently has over 175,000 CCDs in our document repository; we anticipate going into production this week and moving the CCDs into the community health record. We expect to be adding organizations into the community health record in monthly batches; the first will be substantial as we will be adding the practices we have recruited/implemented over the last eighteen months. As additional practices are on-boarded, we will take them in monthly batches into the community health record.

We currently have approximately twenty-seven percent member practices enrolled to automate submission of CCDs to DHIN; and we are interested in receiving feedback from end users as they start to see those in the community health record.

Analytic Platform: 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.

During the SIM planning process, one of the issues we heard from the physician community was a concern that the IT requirements from newer payment models are

capital intense; providers are concerned about the ability to remain independent and still be able to afford the technology that is now a central part of doing business. DHIN will provide a shared platform that will lower the cost of entry for small practices and enable them to remain independent.

The first step is the Common Provider Scorecard which is part of the State Health Innovation Plan. We are approximately two weeks away from the first release of Version 2 of the Scorecard which contains additional functionality and updated/new clinical quality measures. The first release of Version 2 will go out to the twenty-one practices that were part of the original pilot group; and roll out for state wide adoption in September.

In this early stage, the measures are sourced by the payers who are calculating the numerators and denominators and sending data to DHIN along with attribution files: Which patient goes with which provider and practice? Which patients go with each measure? The goal is to get to a place where we are sourcing the clinical quality measures with the clinical data that the practices are sending to DHIN.

In addition, DHIN is gaining traction on a health care claims data base. Draft legislation is in circulation for comment that would stand up a multi-payer claims data base within DHIN; the legal framework and authorization for DHIN to collect claims data in addition to the clinical data that we are receiving from hospitals, labs, imaging groups, ambulatory settings, etc. The statute that is being drafted would amend the statutory authority of DHIN, making us the entity to house the claims data base.

Strategic Planning

DHIN has engaged with Gartner Consulting to facilitate a five-year Strategic Plan. There have been several meetings/interviews scheduled with the DHIN staff, Board Members and stakeholders. Please feel free to contact our office at 302-678-0220 or email us at info@dhin.org. DHIN exists to serve you and we are interested in your comments/suggestions on what we can do for you as consumers/stakeholders moving forward?

II. Comments:

Q: Kathy Westhafer, CCHS: Would you be able to say a few words regarding DHINs involvement in DMOST?

A: DMOST (Delaware Medical Orders for Scope of Treatment) was passed in the last legislative session and has named DHIN (as allowed, but not required) to serve as a repository for medical orders. A committee is in place and currently ironing out the content of the form; as the meetings continue, we will be working on how to get the information into DHIN.

The DMOST form allows EMS personnel and other health care providers both to identify and to honor an individual's wishes to the greatest extent possible and to grant individuals the dignity, humanity, and compassion they deserve.

In order for EMS personnel to honor an individual's request related to end-of-life decisions, the EMS provider must have a medical order. The DMOST form serves both as the summary of the individual's advance health care planning decisions and as the medical order.

Q: John Dodd, Brooks & Dodd Consulting: Some states have a registry for opioid and/or heroin use; does Delaware have a registry.
A: Delaware has a prescription monitoring program; however, it is not connected to DHIN. Over the past several years, there have been several discussions with vendors on both sides.

Q: Marie Ruddy, Nemours: Dr. Lee, you stated that CCDs will be sent in batches on a monthly basis. Will this be for new practices or just in general?
A: Once the interface is upgraded to accept the organization, CCDs will flow in near real time. Going forward, on-boarding new practice groups will be conducted monthly as needed. Once a practice has completed the on-boarding process their CCDs will flow in near real time to the community health record.

The next Town Hall is scheduled for June 8, 2016 @ 11:00 a.m.

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