Delaware Health Information Network
Town Hall
Wednesday, November 11, 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

As you are aware, the software/data base conversion is in its second month and is not going well. During the first 30/45 days we experienced a series of issues with results delivery but have thankfully been resolved; however, we continue to experience slow performance issues. Organizations are struggling to load patient charts in a timely manner compatible with their clinical work flow. There has been a 17% drop in the number of unique users since August; none have dis-enrolled and we are encouraged that providers/organizations are clearly waiting for issues to get better and have not given up.

As mentioned in past meetings, this software upgrade/data base conversion involves re-indexing data which goes back eight years. When we began, we knew the conversion would take time and occur in three different pathways. The re-indexing of data occurs in three separate streams of activity:

1. New results hit the system and are indexed accordingly.

2. When an end user searches for a patient, the patient's data must be converted in order to be displayed, and this is done "on demand" to display in a new environment. Pulling/converting patients with eight years of data has created a drain on both the system and performance.

3. Data conversion occurs in the background one data stage at a time. Each data sending organization has a separate data stage where the data rests in a hosting environment and each is converted one by one. This process was anticipated to take several months, but we did not anticipate the huge drain on performance it would cause. DHIN did not have a testing environment that would enable us to test at load; and a vast majority of the performance issues that we experienced were due to the load on the system. DHIN requested that Medicity provide a parallel production environment that will allow testing at volumes and loads that simulate what is currently in production. Moving forward, we will have the ability to test under conditions at a much greater degree and simulate what we are experiencing in the actual production environment.

DHIN has twenty-two data senders and all but three have been completely converted. The remaining three are Lab Corp, Bayhealth and CCHS which represent the other half of the data. LabCorp is just over 80% completed; Bayhealth is 35% percent completed and CCHS is 13% complete.

One of the strategies we are strongly considering is converting the last two years of clinical data for the remaining data stages and come out of conversion mode. Meanwhile, the background conversion will continue to occur; but on demand conversion would not continue if we shut off conversion mode. When the end user goes to search a patient and load the chart, the only data that will display is data that has been converted to the new indexing system. This would give us at least two years of clinical data from all data senders; and as the background conversion continues the older data would increasingly become more available. We are still contemplating this strategy and are having daily calls with representatives from our data sending organizations and collaboratively making decisions on how to proceed.

The parallel production environment is ready for DHIN to take possession, simultaneously Medicity will be working on a performance patch and we are currently going through QA. We are hopeful that at the time we gain access to the parallel environment, we will also have access to the performance patch. Once we begin testing, we will address any/all performance issues; however, until we start testing, we will not know if it stabilizes the system.

In addition, moving forward we need to ensure the ability for data senders to have visibility end-to-end in the status of delivery for each message sent across the system; and with three different channels by which results can be delivered: Inbox, Auto Print and EHR integrations. Practices may elect to receive results by one or more of these delivery channels and delivery to more than one provider in a successful way. Data senders need to have the ability to track and verify that they are seeing their results and that those results are being delivered to the intended recipient.

Medicity recognizes the need to address performance in an aggressive way. They have stopped all other research and development and have placed everything on hold to address the underlying issues that led to the performance issues. In addition, they have brought in outside consultants who are reviewing codes from beginning to end.

Public Health

CCHS and Beebe continue having issues with Syndromic Surveillance Reporting. Cerner's HealthSentry system has been sending multiple messages to Public Health which clutters their ability for tracking and analytics. HealthSentury is working on a fix and will be validating before engaging Public Health.

We have received notice from Public Health that effective January 1, 2016, a daily fine will be instituted for all data senders for non-compliance with the HL7 2.5.1 format of Syndromic Surveillance and Electronic Lab Reporting.

Union Hospital has gone into production with Syndromic Surveillance Reporting to Public Health twenty-six days ahead of schedule; our first out of state hospital reporting Syndromic Surveillance to Delaware.

Immunization Reporting

There is a 3% increase for immunization reporting from last month, 16% of all practices are sending immunization updates electronically into the state registry along with 62% of pharmacies and 67% of hospitals.

Newborn Screening

Nanticoke continues experiencing issues with one of their two early hearing detection machines and are currently working with vendors to determine the cause; however, they are sending reports through on one machine. Work has been underway to hire a new interface specialist and is expected to take place this month.

The second phase of the NBS project will be delivering a combined report of both early hearing detection and metabolic screening, storing the data, and making it available through the community health record to deliver to both the ordering provider and the birthing hospital. In addition, we continue working with Public Health to refine the details of the Project Statement for the second phase and identifying beta practices to work with us in proving out the ability to store data in the community health record and delivering to the ordering providers.

Out of State

DHIN continues working to onboard Peninsula Regional and have come across unexpected issues with file formatting; however, we do anticipate an early January 2016 production date.

II. PLANNED Activities Update

DHIN has received a federal grant from ONC to expand Health IT functionality across the state of Delaware. We are targeting through this grant four populations to include Long Term Post-Acute Care; Behavioral Health; Consumer; and Ambulatory Providers/Eligible Healthcare Professionals.

Long Term Post-Acute Care: We have been working to collate and publish a provider directory to include direct email address of practices, hospitals and emergency room departments. Our first approach is providing all skilled nursing facilities with direct secure messaging so they can receive messages point to point. Information will be sent electronically to the emergency department when the patient arrives and then be able to forward to the appropriate place of the next visit/admission.

DHIN is ready to begin recruiting organizations to test; however, there are some concerns that this will represent a workflow change at both the skilled nursing facilities and receiving hospitals. DHIN will provide support to assist with the workflow changes that are necessary to implement this new functionality.

DHINs staff is currently approaching the long term, skilled nursing and home health facilities. There is also interest from several hospitals and we will be reaching out for further discussions.

DHIN is working on an initiative to extend the digital ecosystem to include the long term and post-acute care community. We are working with VorroHealth on laying the technology foundation that will allow us to receive electronic care summaries from both the skilled nursing facilities and home health organizations. The Key High Transform Tool was developed through grant funding; data is extracted from information that the nursing homes/home health organizations are already submitting to CMS. The Key High Transform Tool extracts critical data elements from those messages and generates a care summary in the CCDA format that will allow us to ingest the data into the community health record. When a skilled nursing facility admits a patient, they are required to generate a MDS Form that will go directly to CMS and then quarterly thereafter; in addition, this tool will extract data from the MDS Form and create a care summary which will be in the community health record. Anyone, including emergency departments and hospitals who receive patient's forms, the skilled nursing facilities will be able to obtain the data from the community health record and see the summary of information that was submitted. However, if the last time the patients information was submitted was two months ago and they are now being sent to the emergency department and something has changed, part of the workflow will be to see how easy, difficult, or time consuming it will be for the skilled nursing facility to generate another current care summary to submit to DHIN verses using direct secure messaging with interim changes since last time the summary was submitted into DHIN. Other states that have implemented this tool are very

excited about it and DHIN is first in line to work with VorroHealth and is currently looking for beta practices to begin.

Behavioral Health: DHIN is also working with Behavioral Health organizations in providing direct secure email accounts. The Delaware Healthcare Commission received an Innovation Grant (SIM) which allotted funding to assist Behavioral Health organizations to acquire and implement an EMR. DHIN will work with these organizations to provide direct secure messaging accounts and ensure they communicate privileged information back to the primary care provider, **but will not be included in the community health record nor be searchable through the community health record.** DHIN will assist in providing tools to enable a smoother exchange of information point-to-point between the patient's primary provider and their medical team.

Consumers: The third group DHIN will be working with under this grant is the consumer. A public meeting was held by the State Innovation Model Cross Committee to provide an update and the progress of key committees and key activities under the State Innovation Grant. As part of that meeting, we sought feedback from the public and stakeholders on the plans to implement a state wide patient portal as well as plans to implement a multi-payer claims data base and enhance CCD reporting from the practices back to DHIN. The multi-payers initiative is under the SIM Grant, not DHINs. However, DHIN will have an active role which is yet to be defined. Under our grant we do have the funding to support the implementation for a state wide patient portal. DHIN is in the process of gathering requirements and evaluating potential vendors ensuring the right one is chosen.

For the state-wide portal, DHIN does not want to interrupt the process for hospitals, practices and health plans that currently have a patient portal. However, DHIN does want to integrate information from the back-end and feed data on all their patients. Patients will be able to go to one place to access all their health data from the practice, the hospitals EHR and DHIN. Reporting can be provided back to the provider stating access from an individual patient who was searched and the provider will get still receive credit under the Meaningful Use Program for the patient having viewed data from the provider's portal.

For practices that have not set up a patient portal, DHIN can set up a portal and brand it for each practice. The patient will again be able to access their data that the practice/hospitals/DHIN has fed in from the back-end.

Patients that visit practices that are paper-based would still have data in the DHIN repository due to lab work, ER visits and hospitalization. A DHIN branded portal would be made available for those patients to access their health records from anyone that has contributed data.

Ambulatory Providers/Eligible Healthcare Professionals: There are three major services we will offer to ambulatory providers and eligible healthcare professionals:

1. Event Notification Service (ENS) will allow us to take information we have received from hospitals in real-time and provide notification to the provider that one of their patients has been discharged from the hospital/emergency room department. This will allow providers to proactively reach out to his/her patient and ensure they are scheduled for out-patient follow up and understand their care and medication and/or treatment plan for good care coordination. In addition to ensuring consistency in the data that is provided from hospitals when an ADT is sent for both admissions and discharge. As we onboard the skilled nursing facilities, we will look closely to ensure we have the ability to use data they send to us to feed alerts through ENS.

2. Expand the ability to send CCDA documents into the community health record and to query from within their EHR for any care summaries provided by others. This will add value to the community health record and widen the continuum of care across which data is available; and also assist eligible professionals in meeting their Meaningful Use requirements.

We have successfully tested one practice with STI and we continue working with several others. Approximately fifteen practices that use STI have executed agreements with DHIN to send care summaries. In addition, we are exploring an agreement with Allscripts and continue to actively work on additional options with other EHR vendors. If anyone is interested in participating, please contact the DHIN office; support through grant funding is available through 2017.

3. Analytics Capabilities, a form of the common provider scorecard. The state of Delaware received a separate grant to work with the care delivery and payment to accelerate the move toward value based payment rather than volume based payment. Version 1 of the common provider scorecard was released to 21 beta practices and was exclusively based off of the claims data that was reported by payers. DHIN is working with the payers on the necessary legal agreements that need to be in place in order for them to send us patient level data in the attribution files that can be included in the second release of Version 1 of the scorecard.

DHIN is looking ahead to roll out Version 2 of the scorecard to the initial pilot group in February 2016; and will include new measures in addition to setting goals and thresholds for each measure. The DCHI Clinical Committee, in collaboration with the payers has selected the actual measures for the scorecard.

The pilot group will assist in refining the goals in the first quarter of FY16 and by May 2016 we should be able to roll out across the state. The Platform we are using for the provider scorecard is a larger range of analytic services, and through our grant with ONC, we hope to offer analytic services to some of the smaller independent practices that would not be able to access these tools.

III. Public Comment

C: Cathy CCHS: The explanation on what is occurring with the provider directory has been appreciated. CCHS had a request for direct addresses for emergency department physicians. Understanding the process is helpful and we are looking for information to be incorporated into the medical records so everyone has access. I believe working with the HIM Committee members in the hospitals would be the best source to reach out to. The information needs to get into the medical record and also the community health record.

The next Town Hall is scheduled for December 9th @ 11:00 a.m.
1-408-792-6300 Access Code: 573 296 990