

**Delaware Health Information Network**  
**Town Hall**  
**Wednesday, June 12, 2019**  
**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 two major projects, both the technology refresh and the implementation and on-going operations Health Care Claims Data Base.

Community Health Record (CHR) Transition:

DHIN is in the third of four waves of go-live. The first two waves began small with organizations/practices that do not get results from DHIN; therefore, do not need the clinical inbox, only the CHR search and lookups. DHIN now has approximately 3100 users from 200 practices that have been deactivated from the Medicity CHR and have completely switched over to the new CHR.

Several of our hospitals are in the current wave of go-live: Beebe, St. Francis, Nemours, Bayhealth, Peninsula Regional and Public Health. The final wave will take place next week and will include: CCHS, Union Hospital, Atlantic General, Nanticoke and all their affiliated practices. In addition, there will be a cluster of smaller practices also going-live.

Approximately 100 users per day having been logging into the new CHR which includes between 7,000 and 10,000 actions being performed; normally our Service Desk would see 400 to 500 users per hour. We have successfully load tested up to 500 users simultaneously, meeting our required service levels. In addition, we have received feedback from a few users stating that the system seems be much faster than before. A few issues have been reported; however, our largest number of tickets/calls have been password resets and logging into the new environment.

There have been several issues with Internet Explorer (IE) 11 which is concerning due to the fact that IE is used by all hospitals and a majority of the state agencies; we are aware of the issues and are currently working on the fixes.

The clinical in-box and the CHR are two different applications. The user interface is designed so that they work together. Not all users use the clinical inbox as their primary delivery channel. Over half of DHINs practices have an EHR integration. We have had significant issues with filtering in the clinical in-box and expect the next build, scheduled for Monday to correct these issues; a day or two for internal testing and in production by Wednesday. Through

DHIN has the last week of June set aside for any issue resolutions before shutting down the Medicity environment. Our contract with Medicity ends on June 30, 2019; as of July 1<sup>st</sup> all users will be logging into the new CHR. Through next Thursday, June 27, 2019 vendors will be on-site for quick responses on any issues reported.

Medication History was tightly tied to Medicity. We are now using Sure Scripts which is live with several hundred users accessing medication history. We also have a small number of subscribers to direct secure messaging. DHIN was previously using Medicity as our HISP and we have since switched to MedicaSoft as our provider.

Single Sign-On (SSO) is a functionality that is extremely important to our hospitals. DHIN has Cerner for a SSO and hoping to get EPIC at a later date for Bayhealth and Nemours users.

#### **Healthcare Claims Data Base:**

DHIN has been working on the implementation and operation of the HCCD. The HCCD has gone live and we currently have 495,000 unique Delaware residents in the HCCD, some of which may be under more than one carrier. We have received data from 2013 for all of the original set of mandatory reporting entities which include Highmark, AETNA, United, Medicaid MCOs, State Employee Health Benefits and the qualified plans on the Marketplace.

We have also been in testing with DMMA to send us Medicaid Fee for Service Data for Medicaid. At the last legislative session, the expanded reporting requirements now include all carriers of insurance for residents of Delaware residents.

The commercial plans have all submitted test data to us and we expect them to submit their monthly data submission in July 2019. The commercial plans will be sending us data from back in 2015, which will give us data on the majority of all Delaware residents; in addition, we will receive data from 2013 for over half of all Delaware residents. As for the data quality, all payers have had multiple resubmissions as we go through the validation process.

Uses and Access to Data: We have executed an Interagency Agreement with the State Employee Benefits Committee and are in the process of negotiating an agreement with Public Health and DMMA.

In May, DHIN fulfilled the first data request from the State Employee Benefits Committee. We provide a data extract that they are using to evaluate possible networks of excellence for high cost elective procedures.

We have four additional applications pending; three of which will not be paying customers and the fourth is from CDC which will be our first customer for data or reports coming out of the Healthcare Claims Data Base.

We have a handful of Tableau interactive reports that we have developed and our intent for FY20 is to develop high level aggregated reports that will be publicly available.

Paying for the HCCD: The initial work to fund implementation for the HCCD came through grants. DHIN also received a grant from ONC which helped acquire a consulting firm to help us through the initial process. The SIM Grant which was received by the State assisted in helping procure technology and begin implementation. However, grants do come to an end and we need to bridge the gap. The State of Delaware appropriated \$2M for the implementation, development and operation of the HCCD.

DHIN has been working with DMMA and Freedman on a proposal enhanced by federal financial participation. We have received an approved application to secure federal participation through 2021. The first year will be 90/10. After the first year, we will have a mix; anything on-going, design, development and implementation will be 90/10; and all sustaining and operational costs will be 75/25.

Funding through Medicaid channels also comes with conditions and working with DMMA will benefit all users of the HCCD.

## II. ON-GOING Activities Update:

DHIN has on-boarded Avera Diagnostics as our newest data sender; Avera is used by several St. Francis OBYGN practices.

Westside will begin sending encounter level CCDs documents to us however, they are not yet viewable in the CHR.

DHIN is also working on the expansion agreements with CRISP. DHIN has been exchanging data with CRISP for several years; data sharing is based on geography and zip code of the patients addresses whether they are a Delaware or Maryland resident. DHIN has been sending ADTs to CRISP for all patients with a Maryland address and CRISP has done the same for Delaware residents.

CRISP provides the infrastructure for Maryland, District of Columbia and West Virginia; along with our participants from Southern New Jersey and Philadelphia we are receiving ADT data from over 200 hospitals/emergency rooms on Delaware residents.

CareLink is providing care coordination services to practices and patients that do not live in Delaware. We are working with CRISP on expanding our data exchange agreement in two ways:

1. Receiving not just ADTs, but other clinical data that accompanies that specific ADT
2. Roster based exchange: CareLink will provide DHIN with a roster of patients they provide services for - even if the patient that lives in Maryland, CRISP will send us the data on those patients.

### Sunset Review:

Delaware's Legislative Oversight and Sunset Law, provides for the periodic legislative review of state agencies, boards, and commissions. The purpose of review is to determine if there is a public need for an entity and, if so, to determine if it is effectively performing to meet that need. Sunset recommendations: **DHIN is meeting the publics need efficiently!**

- Continue to pursue MOUs with various state agencies regarding their access to the HCCD
- Explore partnership and MOUs with state agencies other than those mandated. DHIN has met with representatives from the Division of Substance Abuse and Mental Health and the Department of Corrections.
- The \$2M appropriation would normally expire if not used at the end of the year. The appropriate funding will not expire and will be used as a state match with for our work with Medicaid.
- DHIN is required to submit an annual status report to the Governor and the General Assembly beginning January 1, 2020. The report should include an analysis of strengths and weaknesses, detailed budget, any new grant applications, vendor contracts and detail on any receiving revenue
- The Sunset Committee will sponsor a bill to make technical recommendations to DHINs governing statute.
- The Sunset Committee will create and chair a task force to draft bills to accomplish the following: Maximize the number and type of claims submitted to the HCCD; permit more detailed reporting of claims related to sensitive diagnosis; maximize the number of entities that submit clinical information.
- Continue to update the DHIN web-site

Since there are Action Items, DHIN will be held over with the Committee through January 2020.

FY20:

DHIN has also begun our cycle of Strategic Planning for FY20 for our goals, our work plan and our budget for the upcoming year.

Working with DSAMH on our readiness to receive and manage Part 22 data, which is the code of federal regulation that deals with privacy of information related to Substance Use Disorder and Opioid Use Disorder.

DHIN will be joining a National Network in FY20. We have not yet made a decision as to which one; there are several options and we are looking at the cost, technology, uses of data shared, expectations and restrictions.

**III. Public Comment:**

**Q: Terry Steinberg, CCHS:** What happens if an issue is found after June 30<sup>th</sup>?

**A: Dr. Lee:** I truly do not believe that we will find anything that cannot be fixed. We have done an unbelievable amount of testing and extending with Medicity is not an option.

**Q: Terri Steinberg, CCHS:** What are you currently doing in regards to substance abuse and the federal regulations?

**A: Dr. Lee:** We are getting claims data from submitters, but all personal information will be redacted and not identifiable. There is some level of aggregation and reporting but not at the granulated level we would like to see. Utah has applied to become an IRB allowing them to get the data. Utah is currently receiving fully identifiable claims from their participants. On the clinical side, for admissions and discharges we receive what the hospital sends us. Specifically, substance use disorder, diagnosis, treatment or referral – but only if the entity holds themselves providers of those services. In order for us to get identifiable data you must have the patients consent to share the data. There is a provision

that is similar which serves the same purpose as a Business Associate Agreement. If data is sent to DHIN, we will identify and apply filters NOT to expose Part 2 data unless patient consent is given.

Why send to DHIN if we don't want to share? There are exceptions to federal requirements: In the case of a life threatening emergency; another exception would be data to be used for research without patient consent, but with the consent of the sending organization.

Next Town Hall is scheduled for July 10<sup>th</sup> at 11:00 am