Pennsylvania eHealth Partnership Advisory Board Meeting

August 4, 2023

P3N PA PATIENT & PROVIDER NETWORK
PRIVATE & PROTECTED

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DEPARTMENT OF HUMAN SERVICES

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Consent to Recording

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Agenda

10 a.m. Welcome and Introductions
10:05 Minutes of May 5, 2023, Advisory Board Meeting
10:10 Health Information Exchange Trust Community Committee Updates
10:25 PA eHealth Partnership Program Initiatives
11:00 Chesapeake Regional Information Service for Patients (CRISP) Overview
11:30 PA Navigate Project Implementation
12 p.m. Networking Luncheon
12:30 TEFCA Impact on HIE
12:50 PA eHealth SFY 2022-2023 Strategic Plan Accomplishments
1:40 Vice Chair Nominations
12:45 New Business
1:50 Public Comment
2 p.m. Adjournment

Welcome and Introductions

Paul McGuire

Post-Acute Care Representative

and

PA eHealth Advisory Board Chair

PA eHealth Advisory Board

Mr. MARTIN CICCOCIOPPO, Director, PA eHealth Partnership Program
Pennsylvania Department of Human Services (Secretary of DHS Designee)

Ms. PAMELA E. CLARKE, Senior Director, Quality, Health Promotion Council
(House Appointed HIO Representative)

Mr. JOSEPH FISNE, Associate Chief Information Officer
Geisinger Health System (Senate Appointed HIO Representative)

Mr. SCOTT FRANK, Chief Information Officer
Capital Blue Cross (Insurer Representative)

Dr. BRIAN HANNAH, formerly Vice President, Chief Medical Information Officer
Mercy Health (Hospital Representative)

Dr. TIMOTHY HEILMANN, Chief Medical Information Officer
UPMC Susquehanna (Physician or Nurse Representative)

Ms. TERI L. HENNING, AVP Government Affairs
Aveanna Healthcare (Home Care or Hospice Representative)

PA eHealth Advisory Board continued

Ms. MUNEEZA IQBAL, Deputy Secretary for Health Resources and Services
Pennsylvania Department of Health (Secretary of Health Designee)

Ms. JULIE KORICK, Director of Finance & Business Development
Pennsylvania Association of Community Health Centers (Underserved Representative)

Ms. MINTA LIVENGOOD, Vice Chair, Consumer Subcommittee of the MAAC
(Consumer Representative)

Mr. PAUL MCGUIRE (Vice Chair), Chief Operating Officer, Quality Life Services
(Post-Acute Care Facility Representative)

Ms. KATIE MERRITT, Policy Director, Pennsylvania Insurance Department
(Insurance Commissioner Designee)

Dr. MICHAEL A. SHEINBERG, Chief Medical Information Officer
Penn Medicine Lancaster General Health (House Appointed HIO Representative)

Dr. MARGARETE ZALON, Professor Emeritus, Department of Nursing
The University of Scranton (Consumer Representative)

Ex Officio Members

Ms. PHYLLIS SZYMANSKI, President
ClinicalConnect HIE (Nominated as Senate HIO Appointee)

Mr. DON REED, Chief Operating Officer
HealthShare Exchange (Nominated as House HIO Appointee)

HIE Trust Community CommitteeUpdates

Phyllis Szymanski

President

ClinicalConnect HIE

HIE Trust Community Committee

Chairperson:

- Phyllis Szymanski, President, ClinicalConnect HIE

HIE Trust Community Committee Meeting Summaries:

- HIETCC Meeting Agenda, July 12, 2023
- HIETCC Meeting Minutes, June 7, 2023
- HIETCC Meeting Minutes, May 10, 2023
- HIETCC Meeting Minutes, April 5, 2023

HIE Trust Community Committee

Topics covered/discussions w/continued focus on:

- PA NAVIGATE (formerly RISE-PA) – Grant Program for HIOs to Select Statewide RRT Vendor (RFA 03-22)
- Adding OB Needs Assessment Forms and AAA Care Plans to P3N Care Plan Registry
- Providing encounter notification services for P3N-HIO(s)
- Full P3N Disaster Recovery Exercise
- Trusted Exchange Framework and Common Agreement (TEFCA)
- Cognosante P3N/PHG Implementation/Transition
- P3N Operations and Transparency
- CMS Streamlined Modular Certification
- Interstate Data Sharing – CRISP Onboarding to P3N ADT Service (MD, WV, CT, DC, and AK)
- Leveraging Hospital Quality Incentive Programs to help close “white space”
- Proposed new MA Enterprise Funded ADT Grant Program for P3N-HIOs
- Began annual review of P3N Certification Package
- P3N Re-Procurement

PA eHealth Partnership Program Initiatives

Martin Ciccocioppo, MBA MHA

Director

Pennsylvania eHealth Partnership Program

Office of Medical Assistance Programs

Pennsylvania Department of Human Services

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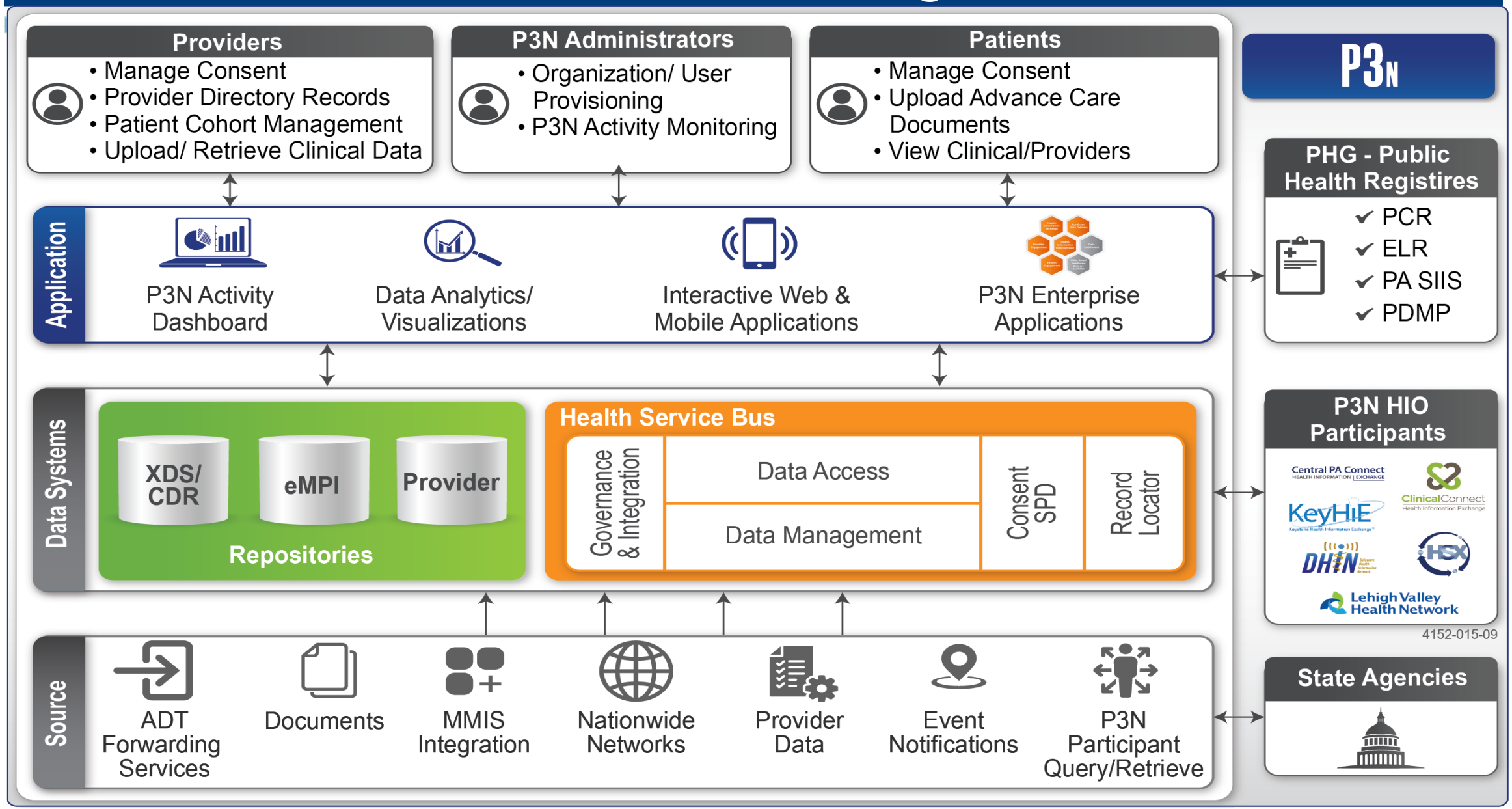
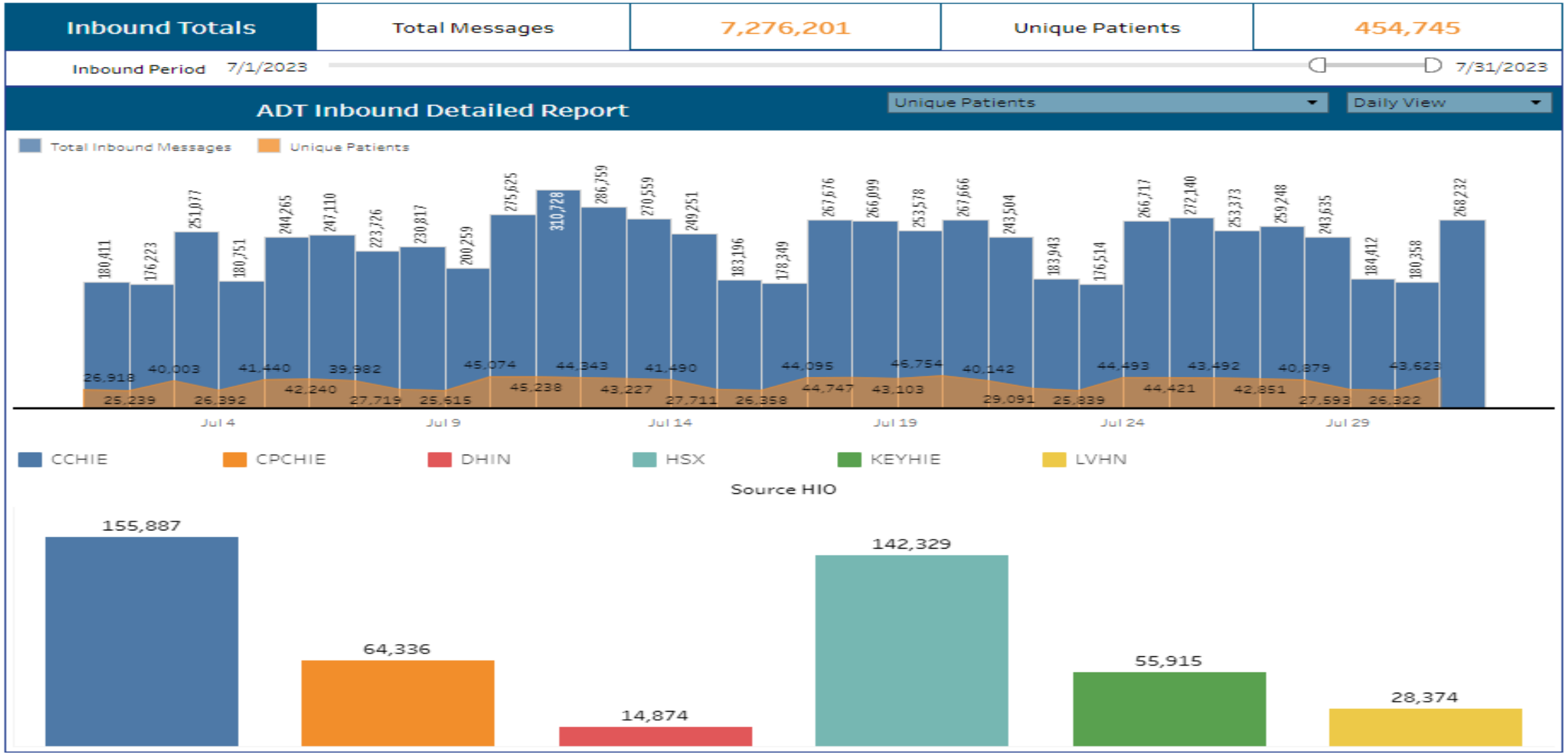
P3N Functional Diagram



P3N Inbound ADTs and Unique Patients by HIO in July 2023



P3N ADT Service Unique Patients Sent by HIO in July 2023

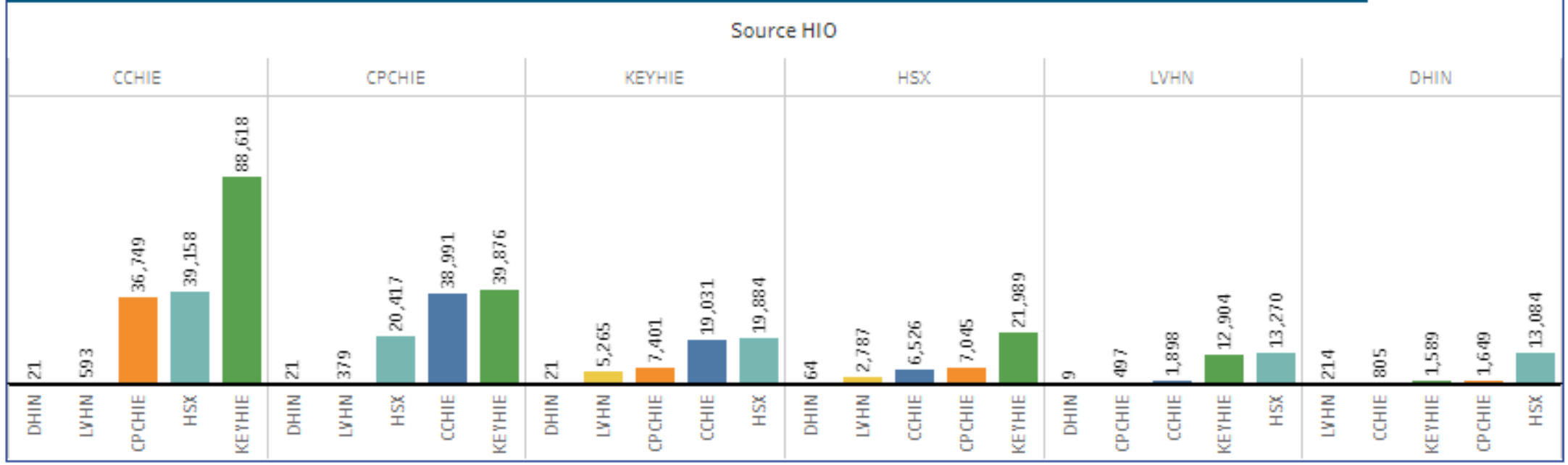
ADT Type (All) Unique Patients

Outbound Totals	Unique Patients Outbound Messages by Source HIO	253,061

Outbound Period 7/1/2023 — 7/31/2023

Total Outbound Messages by Source HIO

(All)



Note: Messages sent to DHIN are undercounted.

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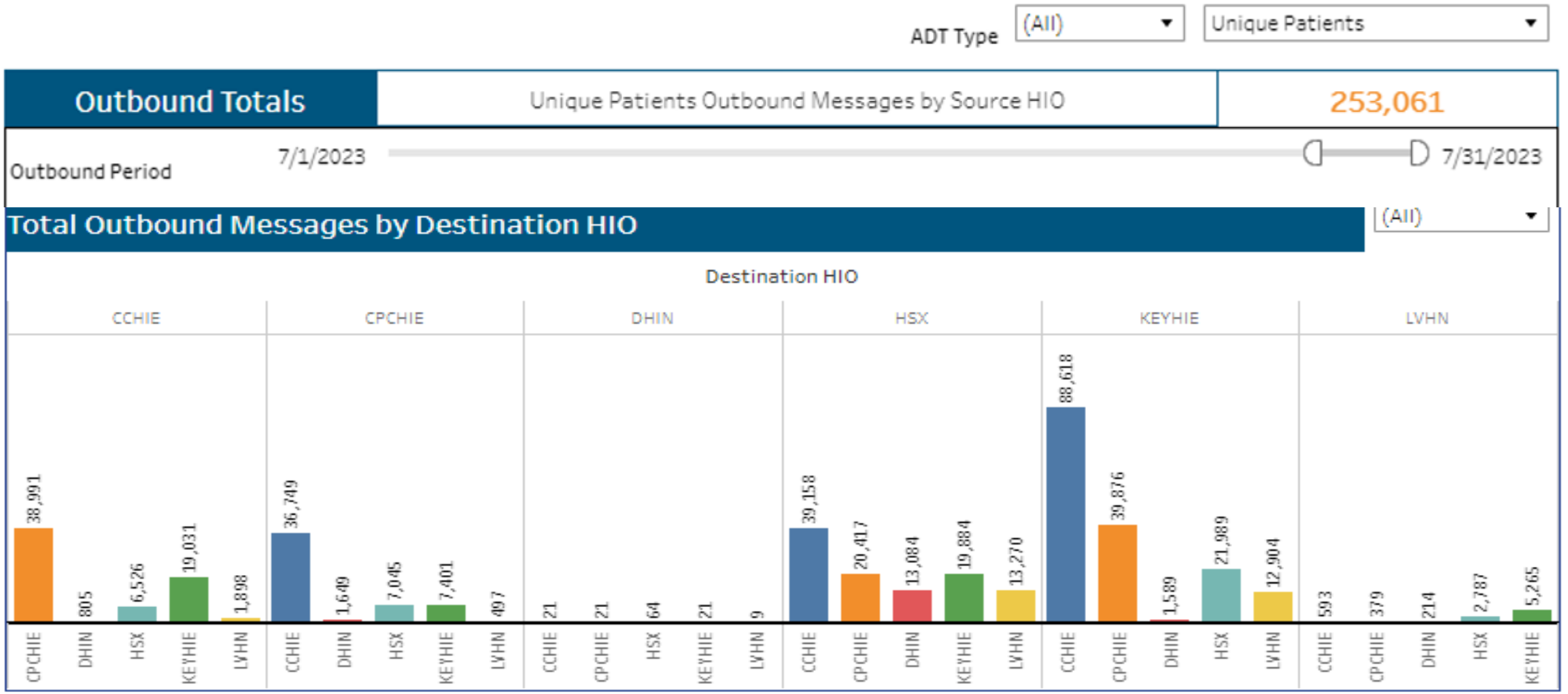
P3N ADT Unique Patients by Destination HIO in July 2023



Note: Messages sent to DHIN are undercounted.

P3N ADT Service Unique Patients by Sending Facility

ADT Type (All) | Unique Patients

Outbound Totals | Unique Patients Outbound Messages by Source HIO | 253,061

Outbound Period 7/1/2023 — 7/31/2023

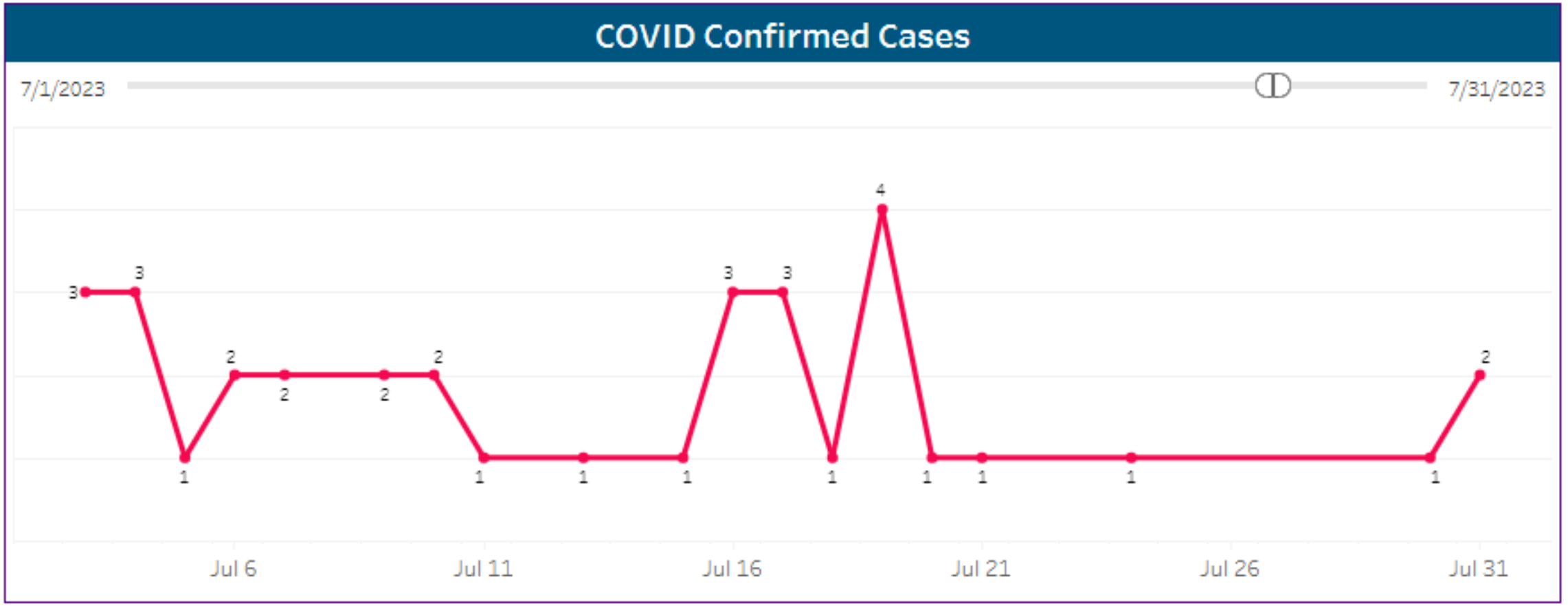
Total Outbound Messages by Sending Facility

1 — 10,032

Sending Facility	Destination: CCHIE	CPCHIE	DHIN	HSX	KEYHIE	LVHN
CCHS	232	1,043		8,162	662	42
PSHHERSHEY	10,032	6,129	10	6,379		313
LVHN_CC	633	193	2	5,173	3,227	
LGH	3,945		15	5,133	5,463	121
NEM	150	258		3,891	416	56
PSHSTJOE	411	707	2	3,327		422
EMPI		3,676		2,715	7,076	33
YH	4,356		1	2,635	3,684	55
PINNACLE_HH		957	5	2,589	5,441	109
LVHN_MH	253	50		2,109	1,327	
MEDIPAC-L		2,472		2,042	4,421	14
CH	1,767			1,849	2,093	28
GHS-GMC	2,012	126	3	1,799		431

Note: Messages sent to DHIN are undercounted.

P3N ADT COVID Confirmed Cases in July 2023



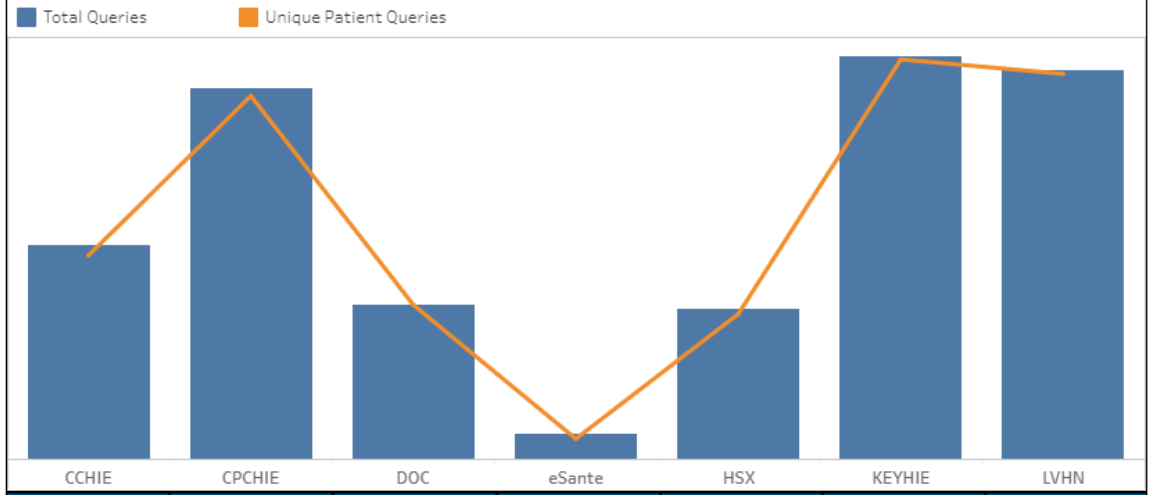
Note: Messages sent to DHIN are undercounted.

P3N Interoperability Report in July 2023

Total Patient Queries/Unique Patients

7/1/2023 — 7/31/2023

Total Patient Queries	Unique Patients
1,431,097	1,296,497



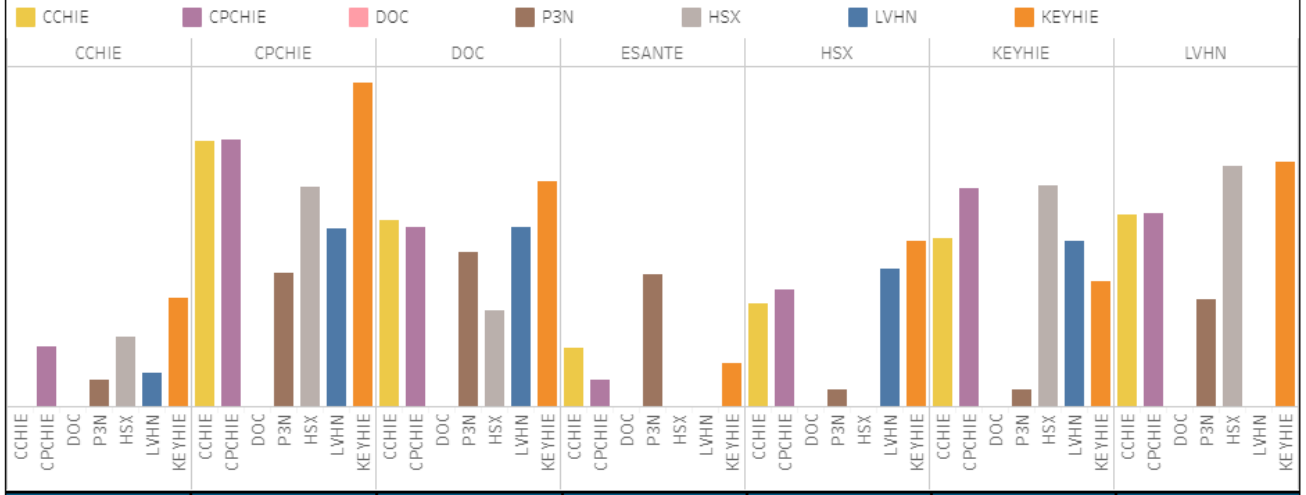
Total Queries: CCHIE	Total Queries: CPCHIE	Total Queries: DOC	Total Queries: eSante	Total Queries: HSX	Total Queries: KEYHIE	Total Queries: LVHN
7,607	301,907	1,874	90	1,723	654,309	463,587

Unique Patients: CCHIE	Unique Patients: CPCHIE	Unique Patients: DOC	Unique Patients: eSante	Unique Patients: HSX	Unique Patients: KEYHIE	Unique Patients: LVHN
5,973	255,364	1,868	80	1,511	602,739	428,962

Total Document Queries/Retrieves

7/1/2023 — 7/31/2023

Total Document Queries	Total Document Retrieves
954,969	889,450



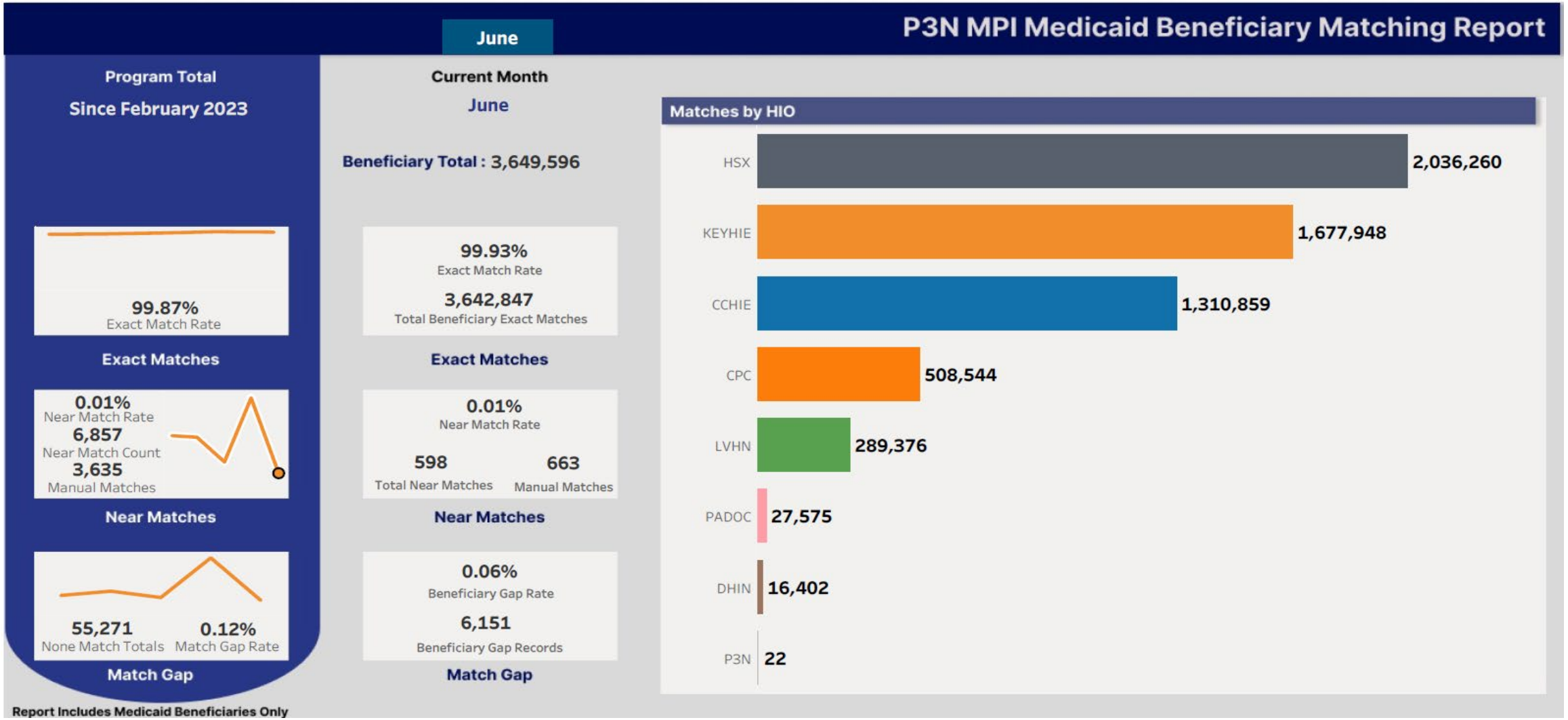
Document Queries: CCHIE	Document Queries: CPCHIE	Document Queries: DOC	Document Queries: eSante	Document Queries: HSX	Document Queries: KEYHIE	Document Queries: LVHN
152	860,278	19,524	254	1,519	20,068	53,174

Document Retrieves: CCHIE	Document Retrieves: CPCHIE	Document Retrieves: DOC	Document Retrieves: eSante	Document Retrieves: HSX	Document Retrieves: KEYHIE	Document Retrieves: LVHN
127	800,195	17,440	252	1,445	19,535	50,456

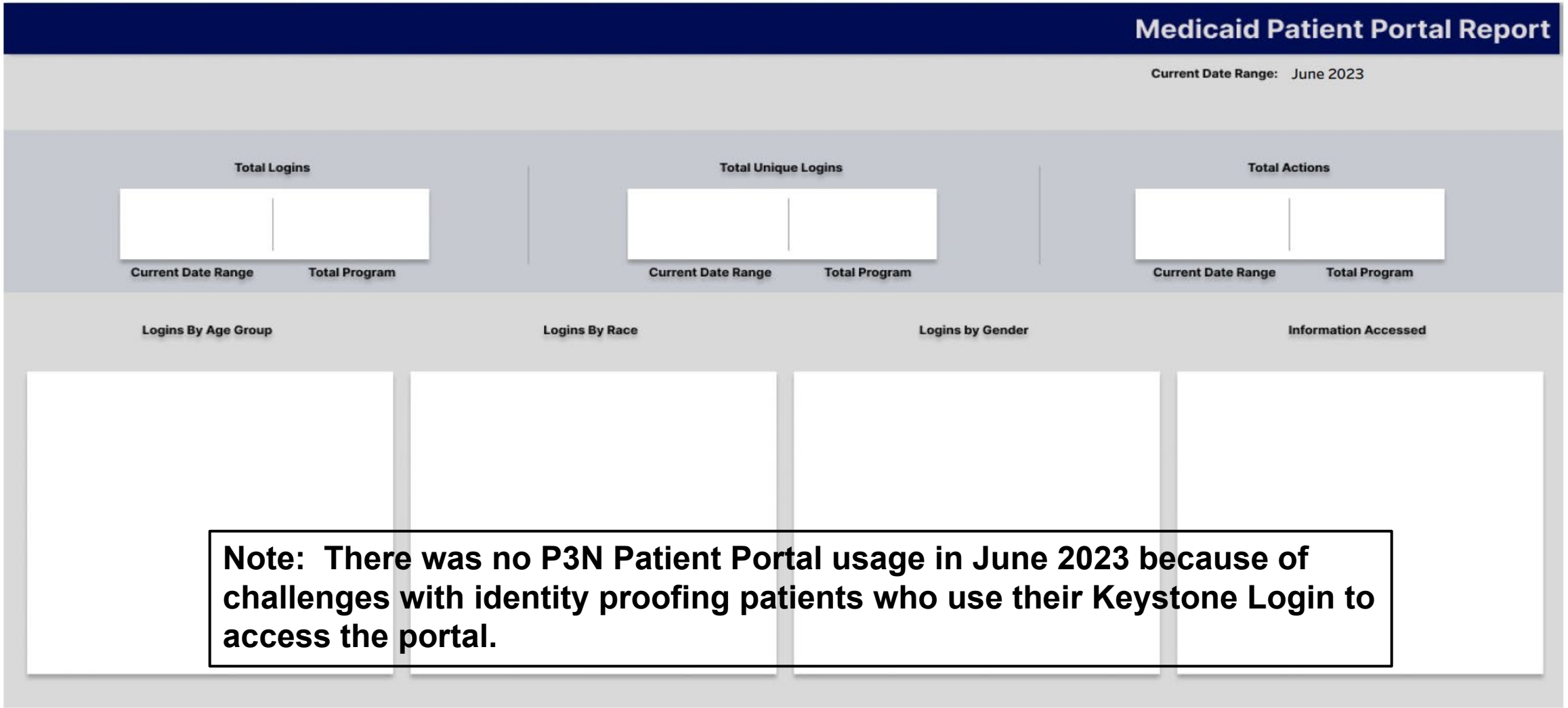
CMS Approved P3N SMC Metrics

1. Increasing numbers of **matching** and linking rates, over time, as additional patient demographic sources and data such as previous address, phone number, and email address are introduced to the **EMPI**.
2. Increasing Medicaid Beneficiary usage over time as the **Patient Portal** is implemented and matures.
3. Increasing both Medicaid Provider and Beneficiary usage over time as the **Provider Directory** is implemented and matures.
4. Increasing Medicaid Provider usage over time as the **Provider Portal** capability is implemented and matures.
5. Over time, the **Clinical Data Registry and Repository** will increase in the number of structured clinical data and documents while decreasing the number unstructured clinical data and documents in support of a more rich, tailored experience for both Medicaid Beneficiaries and Providers.
6. Increasing, over time, the number of Medicaid Providers that can receive **super protected data (SPD)** after patient authorization, and decreasing over time, the number (percentage) of patients that have elected to not share their clinical data.
7. Identifying, over time, the number of Medicaid Providers that send messages to the P3N **Encounter Notification Service** and the number of affected Medicaid Beneficiaries participating with an MCO, as this capability is implemented and matures.
8. Increasing both Medicaid Provider utilization of the **Clinical Data Push Service** and the number of Medicaid Beneficiaries affected over time as this capability is implemented and matures.
9. Increasing both Medicaid Provider utilization of the **Public Health Gateway (PHG)** Service by showing increasing number of messages to Pennsylvania's public health reporting registries of Medicaid Beneficiaries over time as this capability is implemented and matures.

1. Increasing numbers of matching and linking rates…

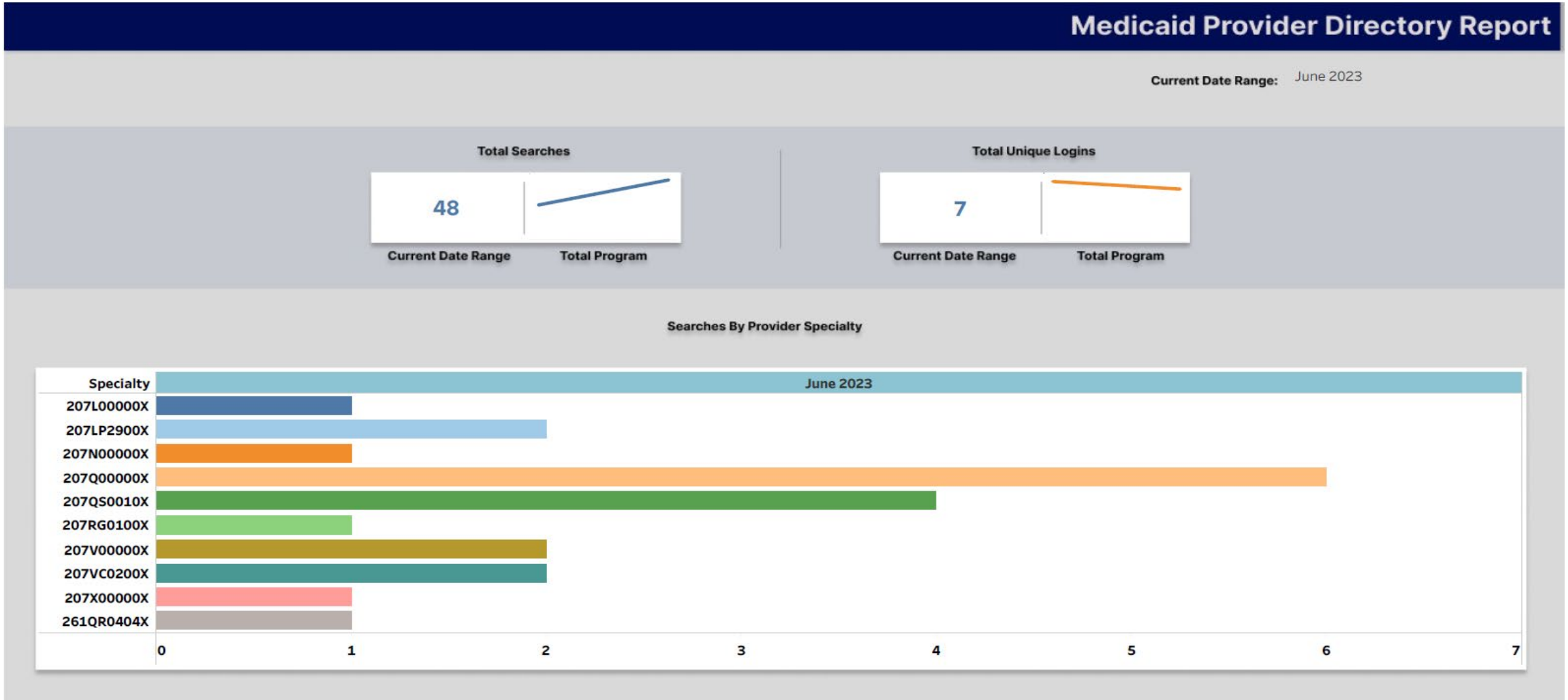


2. Increase Patient Portal usage over time as the …

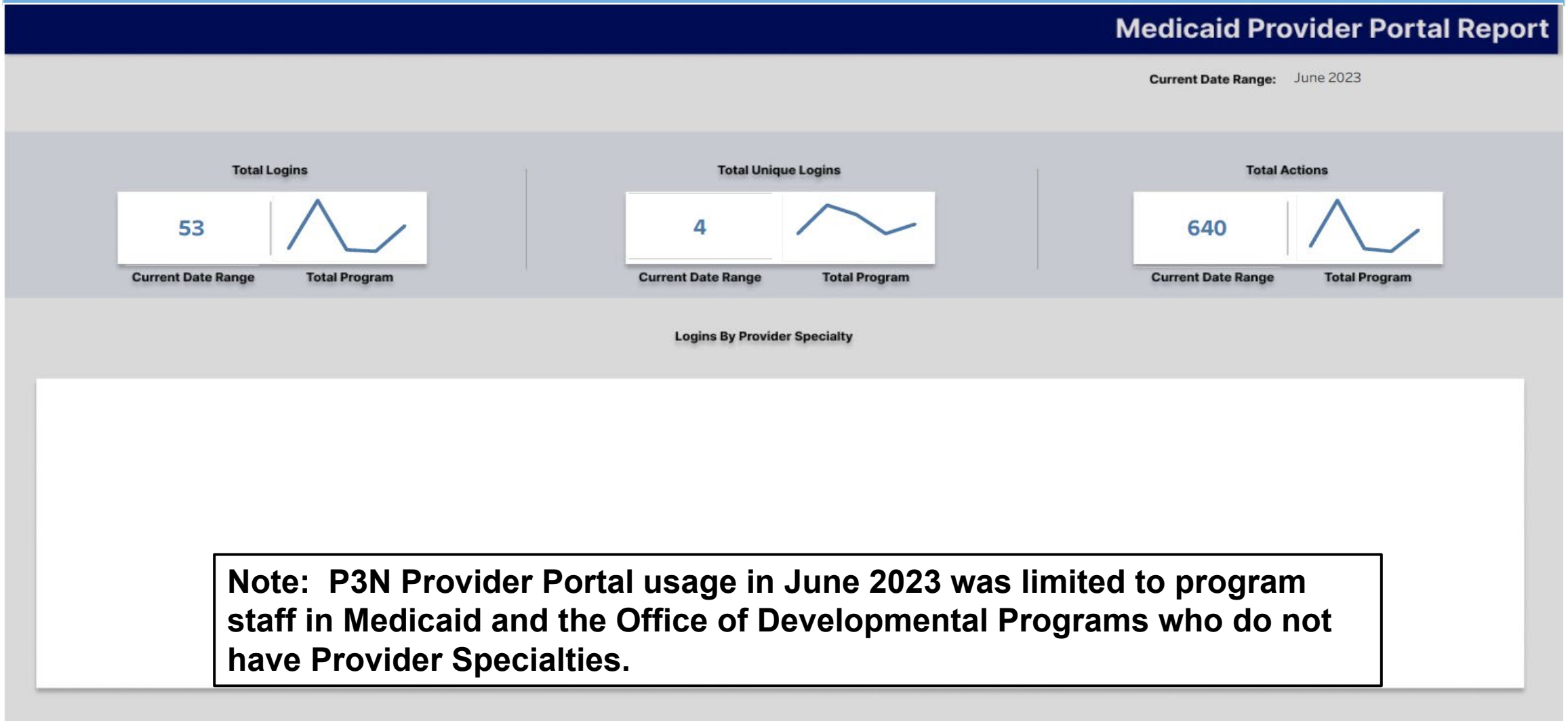


Note: There was no P3N Patient Portal usage in June 2023 because of challenges with identity proofing patients who use their Keystone Login to access the portal.

3. Increase Provider Directory usage over time…

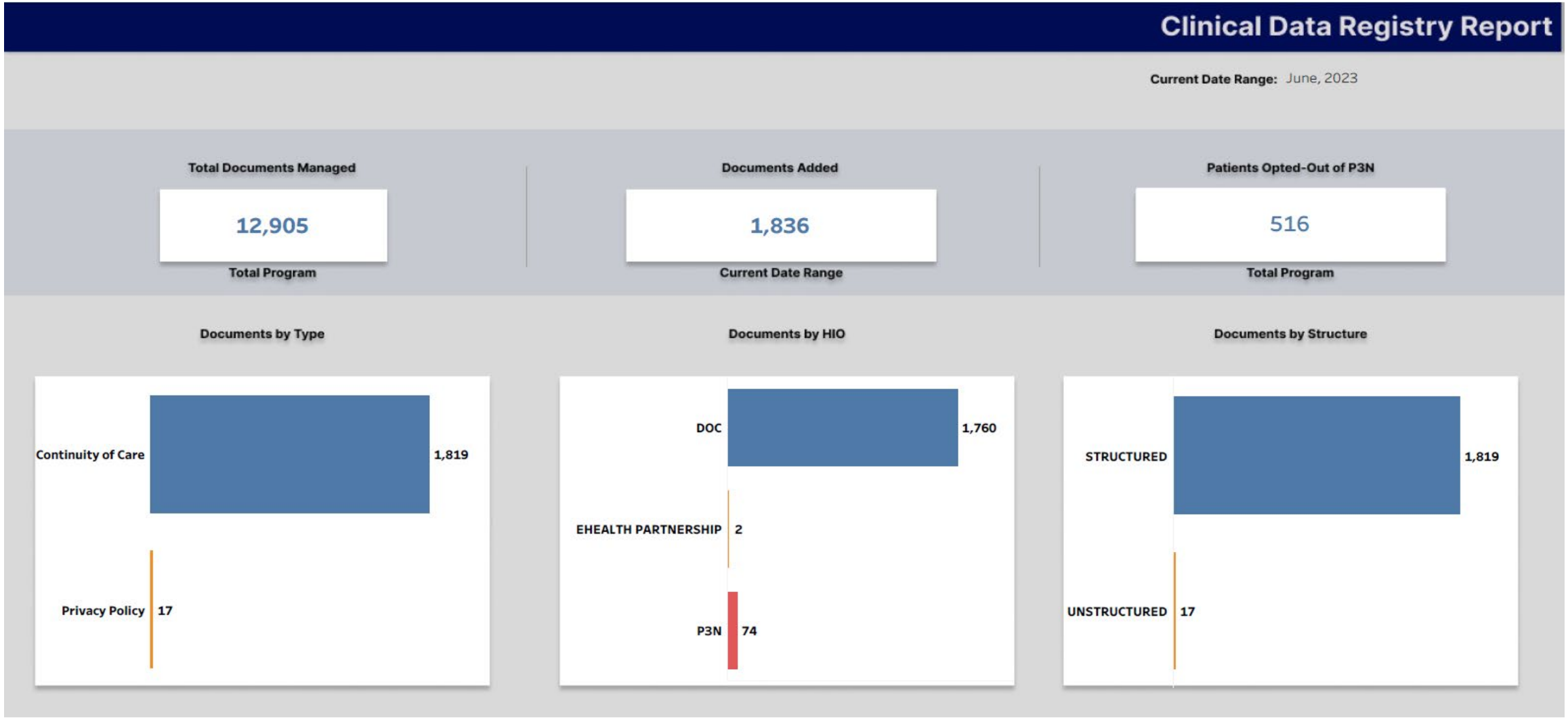


4. Increase Provider Portal usage over time…

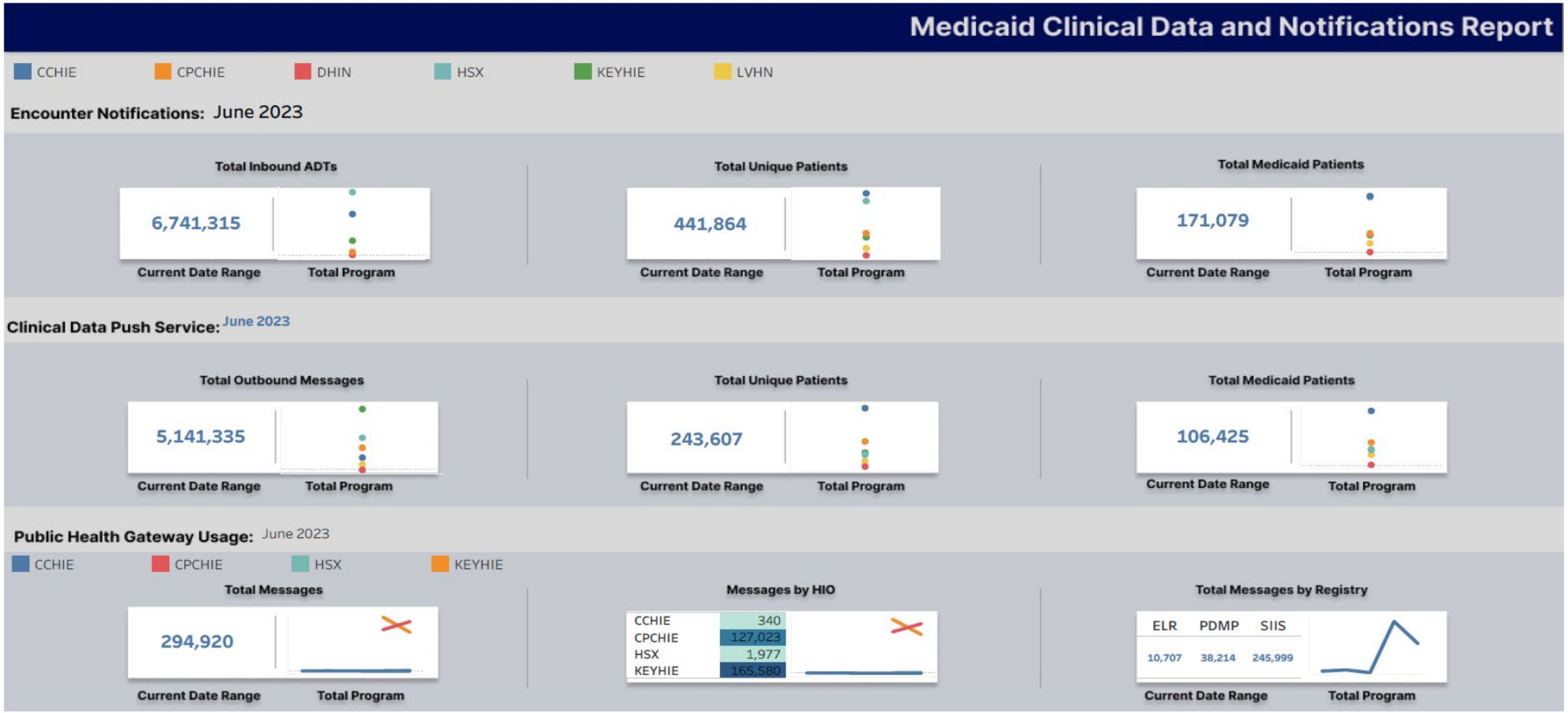


Note: P3N Provider Portal usage in June 2023 was limited to program staff in Medicaid and the Office of Developmental Programs who do not have Provider Specialties.

5-6. Increase Clinical Data and Patient Authorization…



7-8-9. Increase Alerts, Data Pushed, and PHG usage…



CRISP Overview

Sheena Patel, MD, CMPE

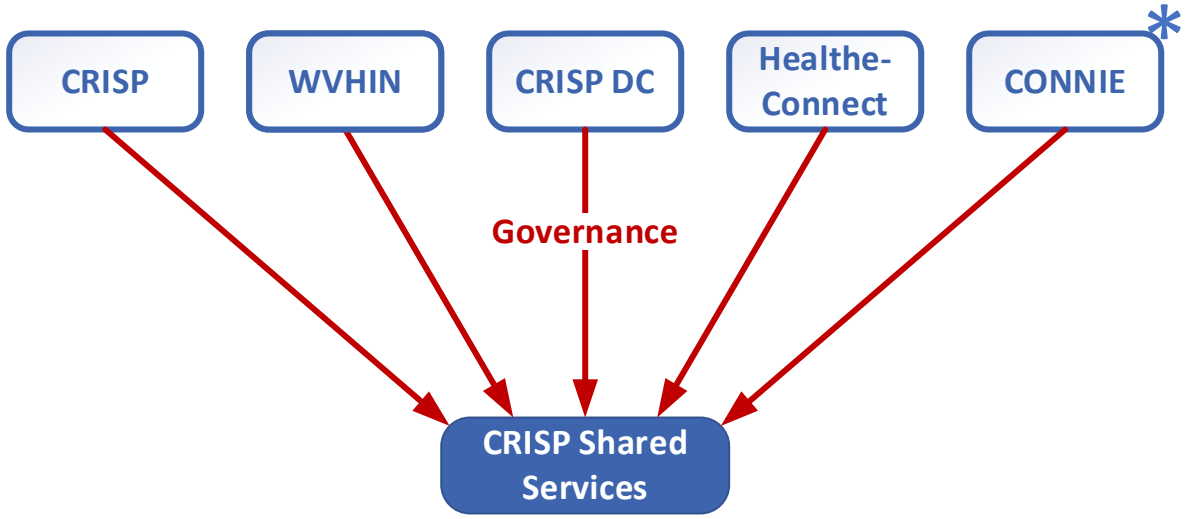
Senior Director

CRISP Maryland

sheena.patel@crisphealth.org

Structure

- *The mission of CRISP's shared services is to:* ***assist member organizations in achieving economies of scale, pooling innovation efforts, and implementing best practices.***



CRISP Shared Services is a non-profit support organization, with each HIE participating in governance efforts.

Affiliation Principles

1. **Preserve the independence of the HIEs in each jurisdiction**, such that all regions can prioritize and fund their own initiatives, leveraging the shared infrastructure.

2. **Improve HIE technologies** available to serve all patients, providers, public health officials, and other stakeholders.

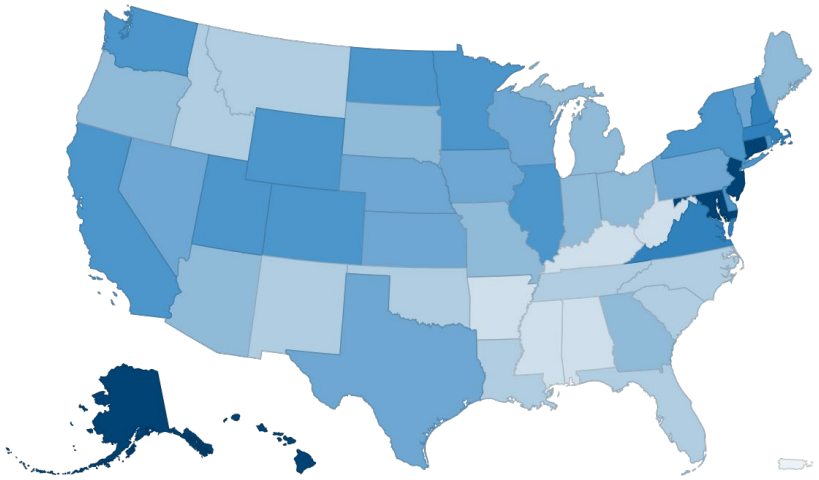
3. Take advantage of the favorable economics of sharing HIE infrastructure technologies, to **reduce costs for all regions**

There is another … collective advocacy

Empower the Local Jurisdiction

- The primary motivation of CRISP Shared Services is to **enable and support the local jurisdiction's Healthcare community so that it can improve health outcomes** for its patients. We've done this in Maryland, D.C., and West Virginia through affiliation. Connecticut and Alaska have recently joined for the same purpose. We've also deployed select components of our stack to other jurisdictions.

- CRISP Shared Services **works with local HIE leadership** to implement solutions which best serve the needs of the community even if those solutions are deployed or built by external vendors.



Public Health Data Utility

What does a PHDU Do?

1. A PHDU combines data to enhance data

- Public health practice **uses registries and reportable events** to gather the information on which assessments and decisions are based. The registries themselves have limitations, relying on submitting organizations for accuracy and patient context. **By combining the registries with existing clinical information and claims data**, the information available to public health can be significantly enhanced.
- Combining data can only be done by an organization trusted to hold patient identified records.

2. A PHDU delivers data back to clinicians in the field

- Public health may possess important information about a patient through the reporting process, but clinicians who make diagnosis and treatment choices are frequently unaware of those facts. The **public health record can be made part of the medical history available to a treating clinician** and can enhance public health interventions.
- When public health data is made available to clinicians, a PHDU does so in consistent and workflow friendly ways, in contrast to stand-alone examples of information sharing that clinicians rarely use.

3. A PHDU supports public health interoperability projects

- **Examples**: facilitating mandatory reporting, calculating quality measures, hosting selected registry data, interfacing with Advanced Directive registries, compiling resource directories, publishing public health charts and graphs, aggregating EMS and police reports for overdose events.
- Such projects may be considered tactical support – a PHDU brings technical expertise to the public health team, working under the direction of public health leaders.

What characteristics make a PHDU work?

PHDUs should be:

- Statewide, or matching the jurisdiction of the public health agency
- Officially designated through a method of the state's choosing
- Non-profit company or independent state commission, broadly governed by a mix of public sector and private sector health leaders
- Connected to all important healthcare providers, especially hospitals
- Receiving some data by mandate or from the department of health
- Held to a high level of security and patient privacy protections

Public Health Use Cases in Production

Maryland

- Integration with Maryland PDMP System
  - Provides access to scheduled II-V prescription drugs, alerts providers when patients have had previous overdose events.
- Cancer Registry Enhancement
  - Provide Cancer Registry team with patients who have cancer dx to alleviate 1000s of manual searches for clinical documentation.
- Public Health Investigations
  - Provides access to public health investigators who are seeking additional health information about overdose fatalities, patients with infectious diseases, and other reasons as deemed necessary by the Medical Examiner.

Washington, DC

- Integration with Lead Registry system
  - Alerts providers when their patients have elevated blood lead levels. Links them to appropriate guidance.
- Colorectal Cancer Screening Compliance
  - Partnered with DC Health to increase awareness and compliance with colorectal cancer screening initiatives. Working with providers to submit screenings to the HIE.
- HIV/AIDS Lost to Care and PREP Medication Reporting/Analytics
  - Supporting DC Health by providing hospital notifications to the health department for certain “lost to care” HIV patients.
  - Supporting District-wide HIV initiatives through aggregate level reporting on PREP use

West Virginia

- Neo-Natal Abstinence Syndrome
  - Work with community partners to provide an alert on the patient’s record when an infant is born with Neo-Natal Abstinence Syndrome. Allows providers to make appropriate adjustments to treatment course throughout childhood.
- Point-of-Care COVID-19 Test Reporting
  - Created an infrastructure that allowed sites performing point-of-care COVID-19 testing to report the results of those tests through the HIE to Public Health. Additionally made that information available to providers as an alert.
- End of Life Registry Reporting
  - The HIE is integrated with the West Virginia End of Life Registry which allows a patient’s end of life choices to be shared broadly to all participating providers.

Examples of what a PHDU can do

- ✓ Enhance the race and ethnicity data on reportable COVID cases, from low accuracy to over 90% accuracy
- ✓ Deliver school absentee data to a student's treating pediatrician
- ✓ Improve situational awareness of respiratory infection trends in a region, with ambulatory encounter data and not just hospitalizations
- ✓ Notify emergency department clinicians of a patient's prior diagnosis of a drug resistant infection
- ✓ Analyze COVID breakthrough infections, matching chronic conditions flags to reported cases among those previously vaccinated
- ✓ Inform prescribing clinicians when a patient has previously experienced an overdose

By combining existing data sets, these real-world examples are achieved without adding any new reporting burdens to healthcare providers.

More examples of what a PHDU can do

- ✓ Calculate changes in rates of preventative healthcare services during a pandemic, by neighborhood and by demographic
- ✓ Alert EMS personnel regarding an infectious disease diagnosis for a recently served patient
- ✓ Maintain an up-to-date directory of organizations registered to provide certain services
- ✓ Operate a behavioral health bed registry which publishes real time bed availability to referring clinicians
- ✓ Provide immunization reports to individual practices, showing patient-by-patient immunization status in the state's immunization registry to support outreach
- ✓ Rapidly stand-up clinician referral and scheduling tools for state managed services such as COVID testing, immunization, or infusion centers

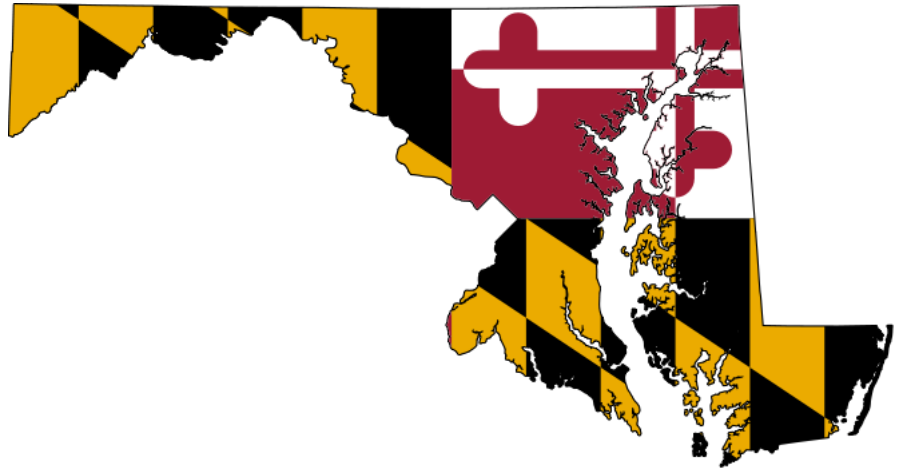
Even for tactical projects which might be done otherwise, a state's partnership with a PHDU can bring technical knowhow to bear more quickly.

Services

Available Services

1. **POINT OF CARE: Clinical Portal & In-Context Information**
   - Search for your patients' prior hospital records (e.g. labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine other members of your patient's care team
   - Be alerted to important conditions or treatment information

2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED



3. **POPULATION HEALTH REPORTS: CRISP Reporting Services (CRS)**
   - Use Case Mix, Medicaid, and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers

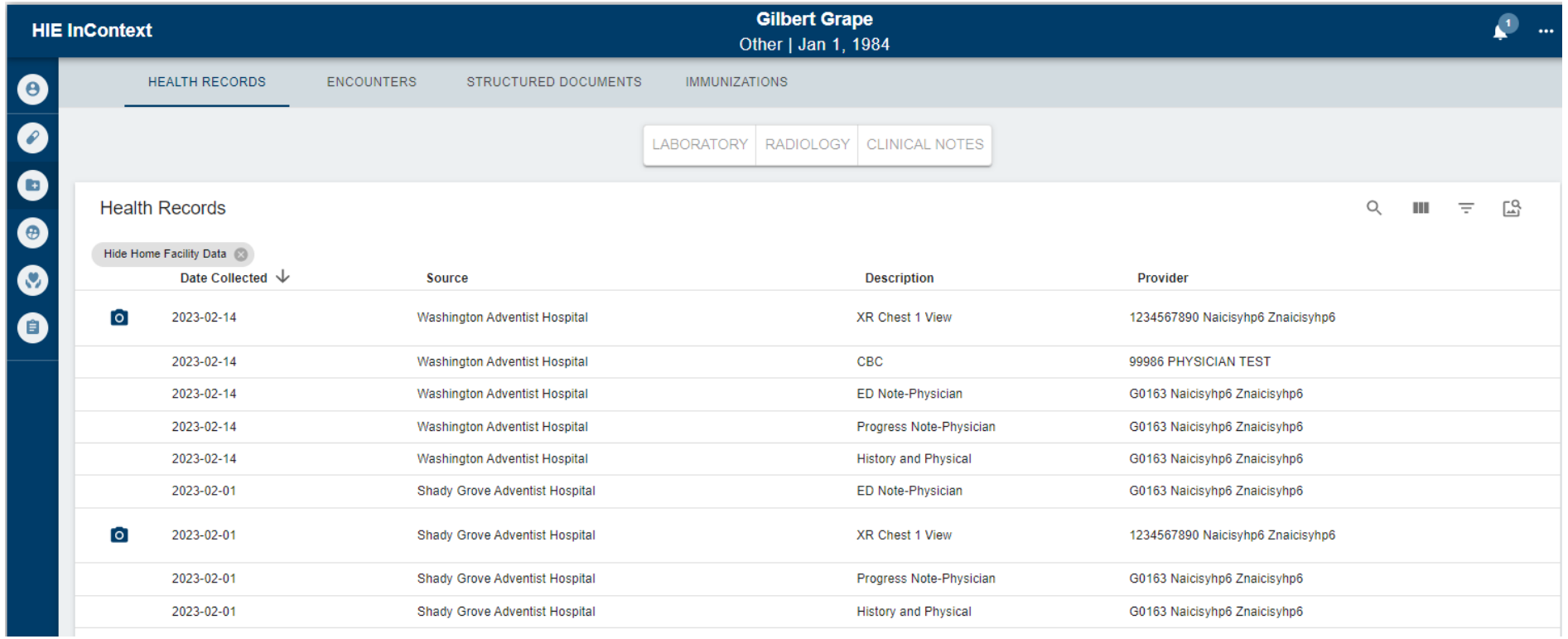
4. **PUBLIC HEALTH SUPPORT:**
   - Deploying services in partnership with Maryland Department of Health, DC Department of health, and West Virginia Bureau of Public health
   - Enabling researchers to appropriately access aggregated data and manage cohort studies
   - Housing the Prescription Drug Monitoring Program (PDMP) for Maryland

5. **PROGRAM ADMINISTRATION:**
   - Making policy discussions more transparent and informed
   - Supporting Care Redesign Programs

Affiliate Services

	MD	DC	WV	CT	AK	VA
Point of Care	X	X	X	X	X	
Care Coordination	X	X	X	X	X	
CRS	X	X				
Public Health	X	X	X			X
Program Admin	X					

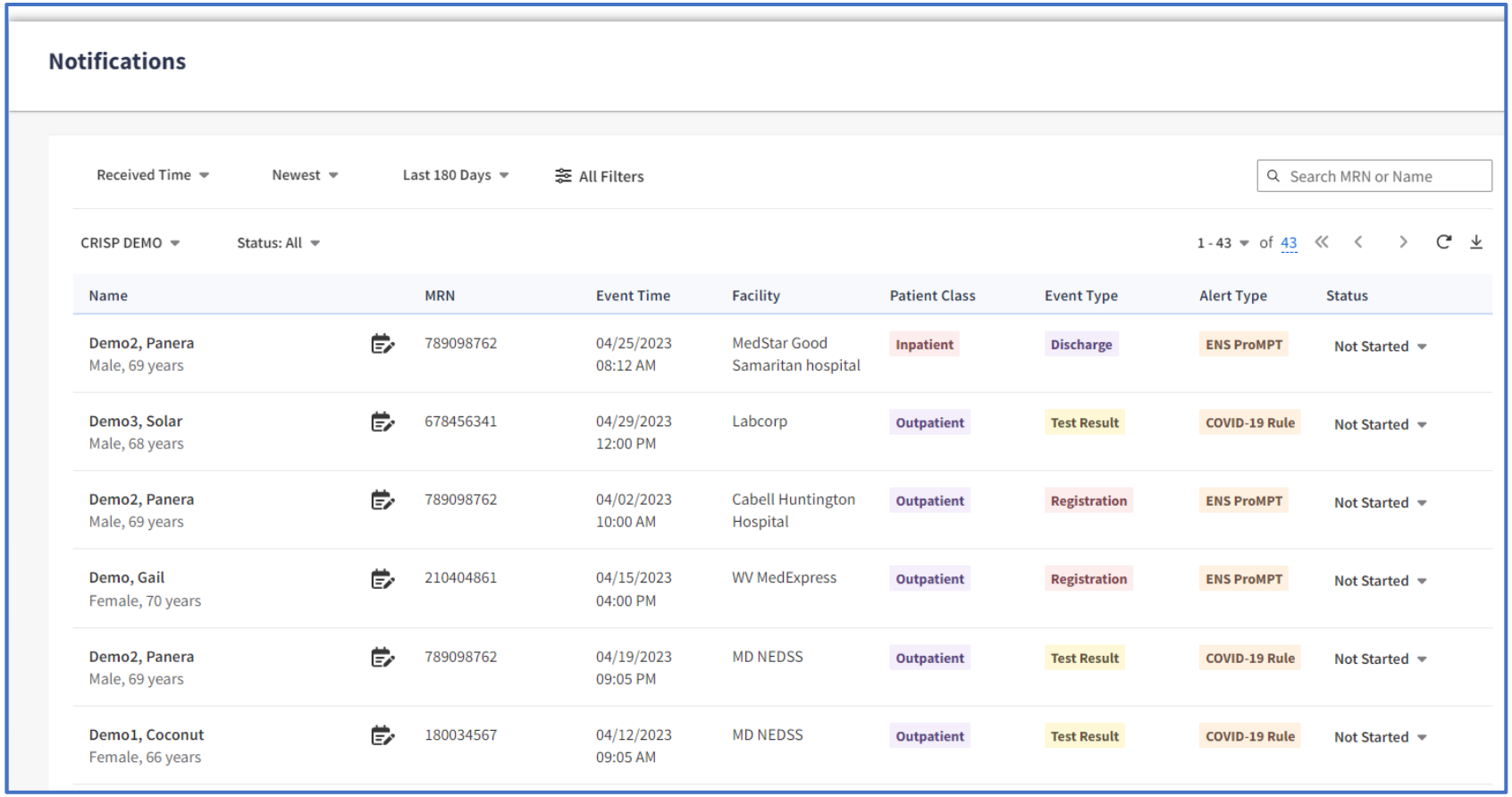
Clinical Information



- In MD, 100% of acute care hospitals, 75% SNFs, 1000+ ambulatory sites contribute data
- Encounters, Labs, Rads, Clinical Notes, SDOH data, and more

Care Coordination (ENS)

- Real-time or batch alerts to appropriate providers based on treatment and care management relationships
- Interactive user interface within CRISP Portal or messages delivered into EHRs
- ENS subscription information (a patient's Care Team) is displayed at the point of care through Portal or In-Context



CRISP Maryland – Public Health Support

MDH Support:

- ✓ Enhance COVID and Mpox testing data with demographics, R/E to facilitate effective contact tracing efforts – increased R/E capture to 90%
- ✓ Cancer Screening Efforts
- ✓ Health Equity Data Set – support statewide efforts to perform health equity analyses
- ✓ Medicaid support – MCO transition alerts
- ✓ Immunet support – serve as pass through for mandatory vax reporting, alleviating system performance issues

End User Support:

- ✓ Deliver bulk immunization files to K-12 schools, allowing for significant reduction of administrative burden
- ✓ Notify emergency department clinicians of a patient's prior diagnosis of a drug resistant infection
- ✓ Analyze COVID/Flu/Pneumonia/RSV breakthrough infections, matching chronic conditions flags to reported cases among those previously vaccinated
- ✓ Inform prescribing clinicians when a patient has previously experienced an overdose

Important Services for the Future

1. Consistently capturing patient relationships*
2. Delivering public health data to the point of care
3. Facilitating data aggregation for public health analysis and for research, both state and federal
4. Enhance existing healthcare data sets with non-healthcare data – Housing, WIC, SNAP – that impact overall health outcomes
5. Serving as a utility for the interoperability activities of others
    a. Encounter data hub
    b. Consent clearinghouse
    c. Social Determinants of Health

PA NAVIGATE Project Implementation

Phyllis Szymanski

President

ClinicalConnect HIE

and

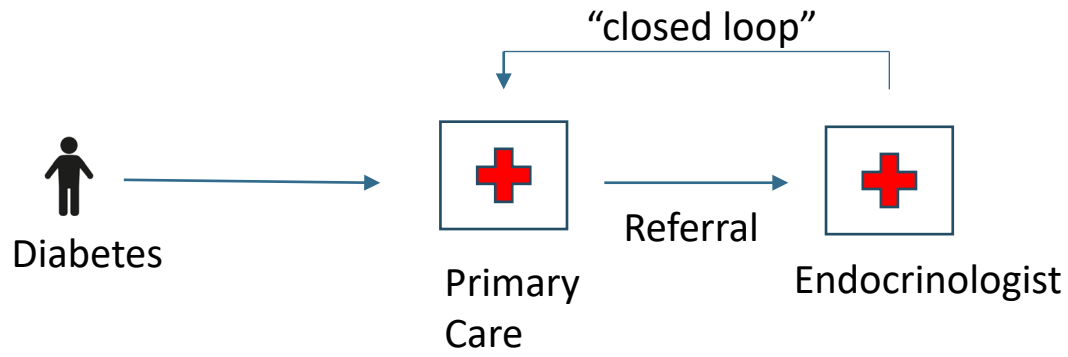
Kim Chaundy

Associate Vice President Applications and Interoperability

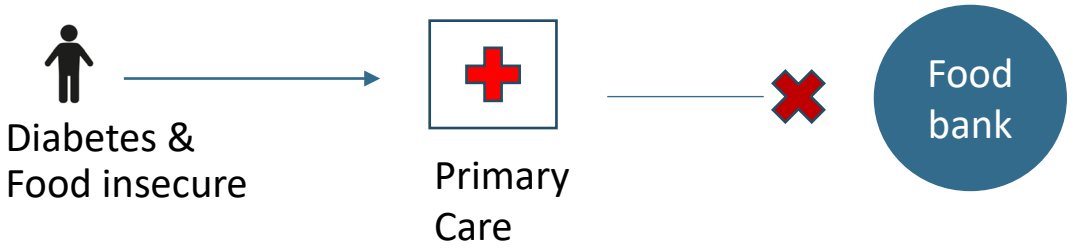
Geisinger

What is the problem with our systems today?

Medical needs



Social needs



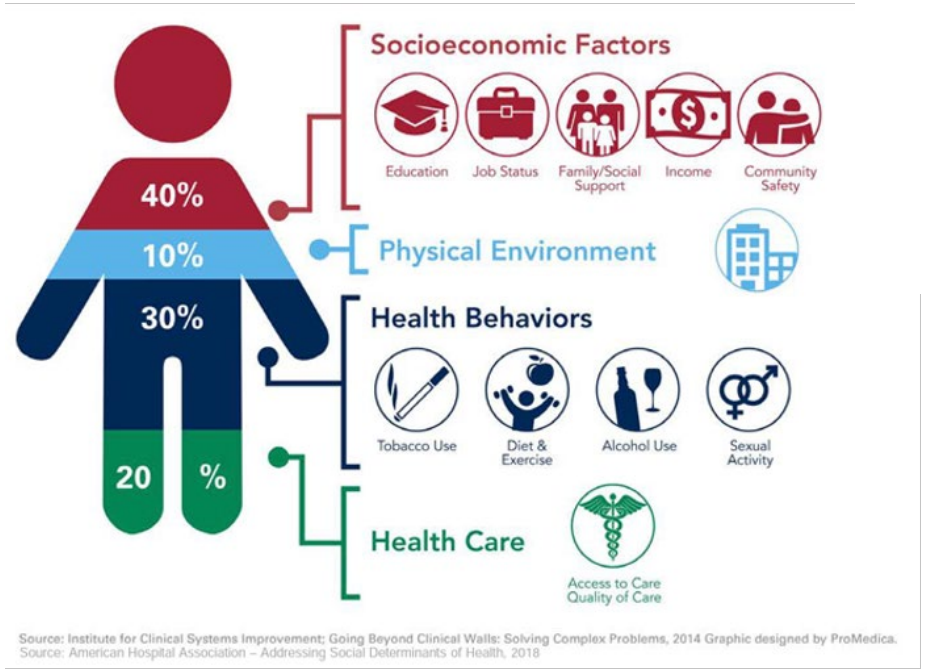
The issues

- Community-based organizations don't know who is referred to them.
- Providers can't directly refer their patients to CBOs to get their social needs addressed.
- Community-based organizations and providers systems do not communicate with one another.
- No common way to screen for social needs.
- Agencies don't have up-to-date information on community-level social needs.

PA NAVIGATE
linking patients to community resources

PA Navigate Goals

- Building a Statewide platform for connecting patients to social services
- Making SDOH data as shareable as clinical data
- Enabling a Population-level view of citizens' needs and CBO capacity to meet them
- Help make Social Care sustainable



PA NAVIGATE
linking patients to community resources

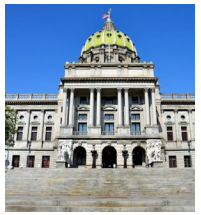
PA Navigate Grant Program (RFA #03-22)

- Four health information organizations (ClinicalConnect, Central PA Connect, HSX and KeyHIE) were awarded $15.5 million in ARPA funds to collectively procure a single, statewide, resource and referral tool with the desired functionality to do closed-loop referrals for Health Related Social Needs.
- HIOs will integrate the tool into the PA Patient and Provider Network (P3N) and health information exchange.
- The selected vendor will onboard community-based organizations (CBOs); no cost to non-profit CBOs.
- Agencies can access the tool through working with the vendor or the HIOs.

PA NAVIGATE
linking patients to community resources

PA Navigate

If you are a clinical provider and have already joined an HIO, the selected vendor would integrate with Health Information Exchange.



DOH

DHS DOC

PA Patient and Provider Network (P3N)

HIO HIO HIO

Provider

Selected PA Navigate vendor

CBO

If you are a CBO, the selected vendor should work to onboard you directly.

Diabetes & Food insecure

PA NAVIGATE
linking patients to community resources

PA Navigate Procurement Process

- Barred from discussion between the HIO's until the final grant agreements from the Commonwealth were awarded & executed
- Held weekly calls throughout the procurement journey
- Spoke to other groups that had gone through a similar selection process to understand their lessons learned
- Settled on one person to "own" the procurement process
  - Singe point of contact with vendors
  - Coordinated the group on meetings
  - Performed basic project management functions

Vendor Selection Process

Identified Key Stakeholders to Participate in Focus Group

- PA211/United Way
- Key Member Organizations – Providers, Health Systems and Payers
- Community Based Organizations

Formulated RFP to Send to Vendors

- Based on State RFP
- Focus Group Feedback
- Special Needs of HIO Community

RFP LOI & Questions

- Received 11 LOI
- Numerous Questions which were responded to by the consortium.

RFP Received and Scored Using Established Algorithm

- 7 Vendors Responded
- Narrowed down to top 3
- *PA211/United Way was part of the RFP response for some vendors so they were removed from Focus Group discussions going forward*

Vendor Demos with Top 3

- 3 hour demo slots for each vendor
- Included Focus Group members
- HIO participants

Narrowed down to Top Vendor

- Updated scoring based on information presented in demos.
- Feedback from Focus Group

findhelp

PA NAVIGATE – Partnering with Findhelp

- Substantial existing PA market share
- Better integration capabilities
- Partnered with United Way of PA
- Financial incentives for CBOs
- #1 SDOH network rating by KLAS

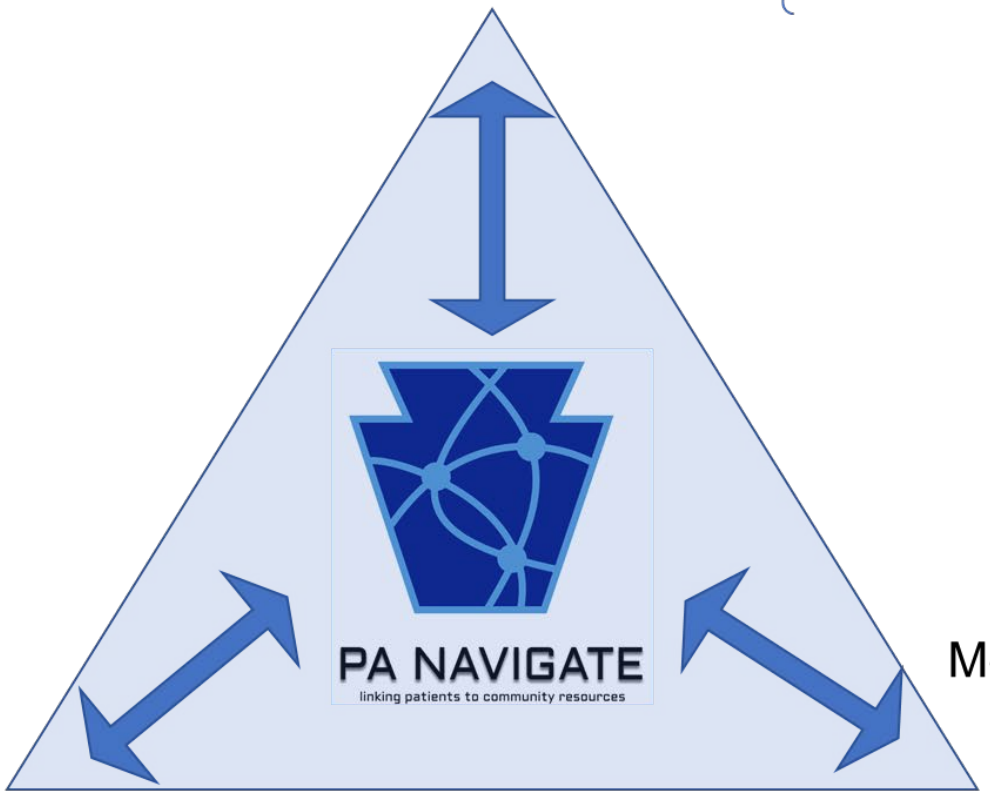
Procurement Lessons Learned

- Partnership with already established networks (211's) is key to avoid duplicative services and "competition."
- Key to engage key stakeholders (CBO's, Providers, Payers, etc) early in the process and keep them engaged; Rely on their expertise in the area!
- The "perfect" vendor does not exist! Focus on the 80% rule.

Multiple Forms of Integration

Coalition Sharing within PA NAVIGATE

For native users via the Web



For non-users

Data sharing through HIEs

EMR/Case Mgmt/Workflow Integrations

For users in other systems of record

Challenges

- New domain: screenings, referrals, follow ups
- Vendors using non-standard data formats
- Undeveloped triggers in EHRs/social need platforms
- National coding standards
- No native data model for this domain in HIEs and EHRs
- New privacy concerns
- Sustainability

Contracting

- Form of partnership
- Clear RFP requirements
- Expected architecture
- Performance standards
- Pro forma agreement with vendor(s)
- Post-procurement governance

Implementation Next Steps

- Execute contracts with findhelp
- Integrating findhelp with HIO technology platforms in 120 days
- Kick-off meeting with United Way PA in mid-August
- Kick-off meeting with PA eHealth and Cognosante in mid-August
-
-
-
-

PA eHealth Advisory Board Discussion/Suggestions

PA NAVIGATE
linking patients to community resources

TEFCA Impact on HIE

Martin Ciccocioppo, MBA MHA

Director

Pennsylvania eHealth Partnership Program

Office of Medical Assistance Programs

Pennsylvania Department of Human Services

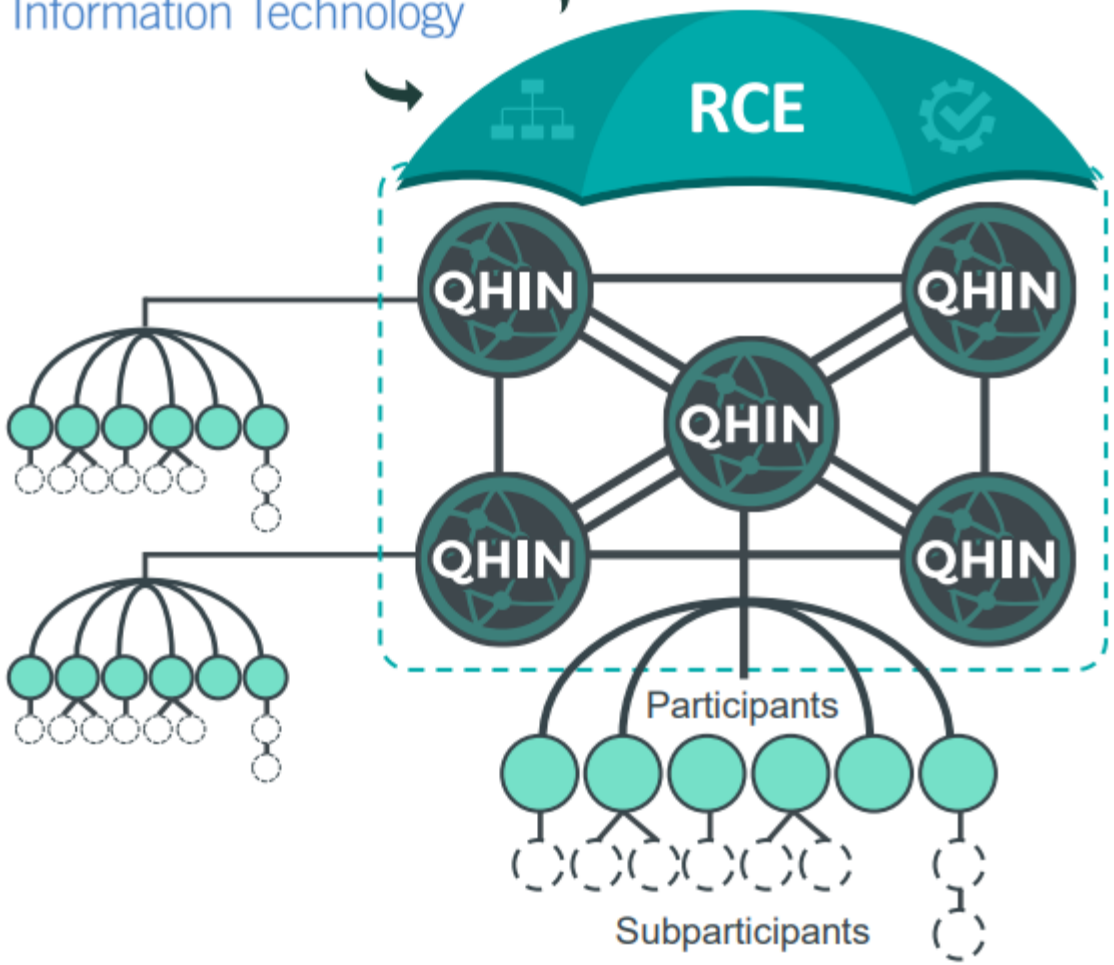
Trusted Exchange Framework and Common Agreement

The 21st Century Cures Act 1 (Cures Act) directs the National Coordinator to “develop or support a trusted exchange framework, including a common agreement among health information networks nationally.”

The Trusted Exchange Framework and Common Agreement, also known as TEFCA, outlines a common set of principles, terms, and conditions to support the development of a Common Agreement that would help enable nationwide exchange of electronic health information (EHI) across disparate health information networks (HINs). The TEFCA is designed to scale EHI exchange nationwide and help ensure that HINs, health care providers, health plans, individuals, and many more stakeholders have secure access to their electronic health information when and where it is needed.

How will exchange work under TEFCA?

The Office of the National Coordinator for Health Information Technology



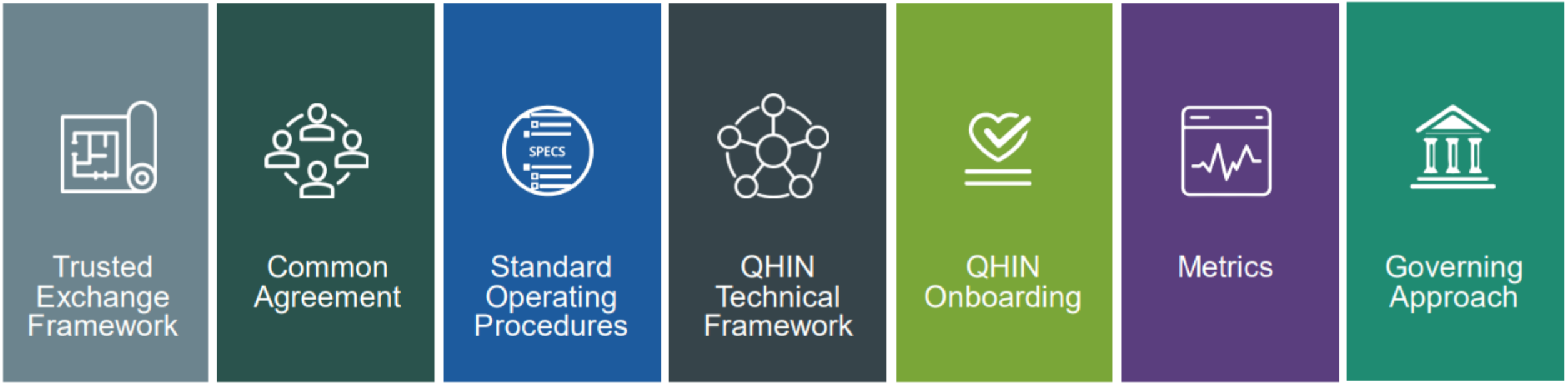
ONC defines overall policy and certain governance requirements.

RCE provides oversight and governing approach for QHINs.

Qualified Health Information Networks (QHINs) connect directly to each other to facilitate nationwide interoperability.

Each QHIN connects Participants, which connect Subparticipants.

TEFCA Components

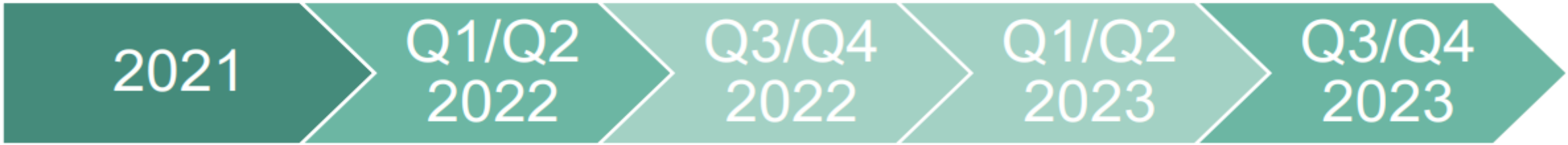


Timeline to Operationalize TEFCA

2021
- Public engagement
- Common Agreement Work Group sessions
- RCE and ONC use feedback to finalize TEFCA

Q3/Q4 2022
- Finalize initial SOPs
- QHIN application review
- Prepare for TEFCA FHIR-based exchange pilot

Q3/Q4 2023
- Additional QHIN applications processed
- Establish Governing Council
- Follow change management process to iterate Common Agreement, SOPs, and QTF, including to support FHIR-based exchange



Q1/Q2 of 2022
- Publish Common Agreement Version 1
- Publish QHIN Technical Framework (QTF) Version 1 and FHIR Roadmap
- Initiate work to enable FHIR-based exchange
- Public education and engagement

Q1/Q2 of 2023
- Onboarding of initial QHINs
- Additional QHIN applications processed
- Establish Transitional Council
- Launch TEFCA FHIR-based exchange pilot

Seven QHIN Applicants Moving to Onboarding

Clarifications:

- Seven QHIN applicants have moved into the next phase of Onboarding
- QHIN application will remain open, and there are others currently going through the process
- Currently, there are no Designated QHINs
  - The approved applicants have remaining processes to successfully complete in order to be Designated
  - There is no guarantee that each will become a QHIN
- There are no cohorts of QHINs
- There will be no first QHIN
- **Health care providers can only be listed once in the TEFCA Provider Directory; therefore, health care providers can only be connected to one QHIN or a downstream participant of a QHIN**
  - **This requirement is likely to have a chilling affect on regional and statewide HIE if a health care provider is connected to their EHR vendor's QHIN**

PA eHealth Strategic Plan Accomplishments

Kay Shaffer

Project Manager

Pennsylvania eHealth Partnership Program

Office of Medical Assistance Programs

Pennsylvania Department of Human Services

PA eHealth Vision and Mission (2021-2024)

VISION

Electronic health information exchange (HIE) enables initiatives striving to improve patient care and experience, population health, and health care cost.

MISSION

To enhance, expand and maintain the statewide interoperable system for participating organizations to electronically move health information in a manner that ensures the secure and authorized exchange of health information to provide and improve care to patients and reduce costs.

Strategic Goals and Objectives (2021-2024)

1. Enable ubiquitous, robust HIE, while maintaining privacy and security
    A. Expand the number and types of stakeholders actively participating in HIE
    B. Educate stakeholders, including patients and their advocates, on the value of participating in HIE
    C. Align health information exchange with Interoperability Rules and the Trusted Exchange Framework and Common Agreement (TEFCA)

2. Increase timely access, accuracy, and availability of clinical information to support diagnosis and treatment of individuals and to improve population health outcomes
    A. Expand HIO access to public health reporting registries
    B. Support newer technology for access to clinical information
    C. Promote health equity

Strategic Goals and Objectives (2021-2024)

3. Improve upon our existing P3N services by leveraging state services and resources
    A. Integrate P3N into the Medicaid Management Information System (MMIS)
    B. Provide P3N access to state program areas

4. Alert patient care teams to relevant patient health care encounters
    A. Expand the number and types of ADT messages contributed to the P3N ADT Service
    B. Capture meaningful information from ADTs for analysis and population health reporting

5. Support care coordination to improve quality and reduce health care costs
    A. Reduce duplicative or unnecessary services
    B. Support value-based purchasing and other initiatives intended to bend the cost curve
    C. Improve HIO access to public health reporting registries by incorporating PHG into the P3N

Strategic Goals and Objectives (2021-2024)

6. Improve patient outcomes and satisfaction
    A. Enable the sharing of care plans and treatment data with a patient's care team
    B. Support telehealth by providing remote access to clinical information
    C. Implement newer technology for access to clinical information

7. Optimize health information exchange stakeholders' experience
    A. Make the data more usable in the stakeholder's workflow
    B. Provide easy access to help when it is needed

1. Enable ubiquitous, robust HIE

Fiscal Year 2022-2023 Accomplishments:

- CRISP Agreement fully executed and began onboarding CRISP to P3N ADT Service for MD, WV, DC, CT, and AK
- LVHN began sending ADTs on behalf of 11 acute campuses
- The P3N ADT Service facility participation increased by more than 30% in the past year; on a weekly basis in June 2023 the P3N ADT Service forwarded ADTs on behalf of more than 80,000 unique patients
- Punxsutawney Hospital joined KeyHIE
- RISE-PA/RRT re-branded as PA Navigate after grants awarded to four HIOs that selected FindHelp as the statewide platform that they will all integrate with to facilitate closed-loop referrals for Health-Related Social Needs (HRSN)
- CPC HIE added Wellspan, October 2022
- KeyHIE added new Penn State Health hospitals
- ClinicalConnect expanded services to payer members
- ClinicalConnect added residential care facilities for people with intellectual disabilities
- National presentations at CDC/ONC Industry Days and State Health IT Connect Summit
- Implemented the Patient portal, Provider Directory, and Care Plan Registry

2. Increase timely access, accuracy, and availability

Fiscal Year 2022-2023 Accomplishments:

- Awarded nearly $15.5 million in American Rescue Plan Act funding for four P3N-HIOs to integrate a single closed-loop referral system for Health-Related Social Needs
- Streamlined PHG by leveraging the new Cognosante P3N
- Onboarded additional facilities to PHG (Evangelical added to eLR by KeyHIE)
- New Snowflake analytics provides accurate near real-time reporting of COVID cases
- Support newer technology for access to clinical information
- New Care Plan Registry, worked on ingesting ONAFs and AAA SAMS care Plans
- eSante Provider and Patient Portals
- Condition-specific surveillance of ADTs
- Developed and deployed Tableau On-line dashboards to monitor P3N service activity and provided HIOs with access to the dashboards

3. Improve upon our existing P3N services

Fiscal Year 2022-2023 Accomplishments:

- Successfully complete MMIS Streamlined Modular Certification Operational Readiness Review and began regular SMC Reporting to CMS in support of full certification
- Enhanced analytics to track services in support of Medicaid patients
- Worked extensively with Labor and Industry to use a P3N-HIO to automate the electronic gathering of P3N clinical information for making disability determinations
- Provided P3N Provider Portal access to OMAP medical directors

4. Alert patient care teams to relevant patient encounters

Fiscal Year 2022-2023 Accomplishments:

- Began sharing full ADTs through new P3N ADT Service
- Standardized ADT submissions
- The P3N received more than 6.7 million ADT messages and sent more than 5.1 million ADT messages in June 2023
- New P3N Portal and Tableau Dashboards are capable of analysis by condition and facility
- New P3N tracks COVID confirmed and exposed cases identified in ADT messages
- Developing capability to identify possible child abuse/neglect for ODP

5. Support care coordination to improve quality

Fiscal Year 2022-2023 Accomplishments:

- Grew P3N, PHG, and ADT Service participation to reduce duplicative or unnecessary services
- Built a care plan registry in the new P3N to support better care coordination between care teams, payers, and patients
- Worked with MA Managed Care Organizations (MCOs) and P3N-HIOs to ensure MCOs are getting valuable access to alerts and quality data
- Built the capability for the P3N to ingest and make available OB Needs Assessment Forms and Area Agencies on Aging care plans
- Public health reporting and access to patient-specific public health data was streamlined through the integration of the PHG into the Cognosante P3N

6. Improve patient outcomes and satisfaction

Fiscal Year 2022-2023 Accomplishments:

- Implemented a completely new robust modernized P3N that uses best of breed technology replacing the antiquated IBM P3N
- Improved record matching in the new P3N by contracting with Verato to use referential data in the master patient index
- The new Cognosante P3N includes a Care Plan Registry to enable the sharing of care plans and treatment data with a patient's care team
- Self-service analytics are now available for P3N community through Tableau dashboards and the eSante portal
- Single Sign On has been enabled for Commonwealth staff access to P3N
- Patient portal is available in the new P3N; we are awaiting improved identity proofing through the Keystone ID to make the patient portal widely available
- Deployed a public-facing P3N provider directory

7. Optimize HIE stakeholders' experience

Fiscal Year 2022-2023 Accomplishments:

- User Experience (UX) optimization is a key component of the new P3N
- Offering 24/7 access to on-demand training in the new P3N
- Provided additional training for existing P3N users in MA FFS, ODP, and L&I
- Provided funding in RRT Grants to customize provider EHRs for deep integration with the statewide RRT vendor through their HIOs
- New P3N Tableau Dashboards and eSante portal
- P3N operations data is available through interactive visualizations rather than Excel worksheets
- Powerful data trending capabilities
- Enhanced help features are built into the new P3N
- Cognosante provides help desk for P3N participants

Advisory Board Vice Chair Nominations

Pennsylvania eHealth Partnership Advisory Board Bylaws

> ***Section 4. Vice Chairperson.***
> *The Advisory Board members shall annually elect, by a majority vote of the members, a vice chairperson from among the appointed members of the Advisory Board, who shall serve as acting Chairperson in the absence of the Chairperson or if there is a vacancy in said Chairpersonship.*

Nominations for Vice Chairperson are open.

Vice Chairperson election to be held during the November 3, 2023 Advisory Board for Calendar Year 2024.

Remaining 2023 Advisory Board Meetings

Friday, November 3, 2023, in-person at 2525 Seventh Street, Harrisburg, 10 a.m. – 2 p.m.

Do first Fridays in February (2nd), May (3rd), August (2nd), and November (1st) work for 2024 Advisory Board Meetings?

Public Comment

- Name of submitter for written comment submission acknowledged by chair
- Verbal comment (3 minutes per commenter)

For further information:
http://dhs.pa.gov/ehealth

PA eHealth Partnership Advisory Board:
https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/eHealth-Advisory-Board.aspx

P3N HIO Certification Package:
https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/HIO-Connection.aspx

P3N Certified Health Information Organizations (HIO) Information:
https://www.dhs.pa.gov/providers/Providers/Documents/Choose%20your%20HIO.pdf