Pennsylvania eHealth Partnership Advisory Board Meeting

August 2, 2024

P3N PA PATIENT & PROVIDER NETWORK
PRIVATE & PROTECTED

Pennsylvania
Department of Human Services

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The Wiretap Act

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Consent to Recording

This session is being recorded for record-keeping purposes. By participating in this session, you are consenting to the recording of this session for preparation of meeting minutes. At any time if you have a question or comment, feel free to place that in the chat, and we will respond to you as soon as possible. If you would like to ask your question or to comment verbally – please note that by doing so, you are consenting to the recording of your statements for preparation of meeting minutes.

Please Note: The Commonwealth does not approve having Artificial Intelligence (AI) bots interacting with Commonwealth meetings.

Agenda

10 a.m.	Welcome and Introductions
10:05	Minutes of May 3, 2024, Advisory Board Meeting
10:10	Health Information Exchange Trust Community Committee Updates
10:30	PA eHealth Partnership Program Initiatives
11:00	Engaging Community Based Organizations to Improve Patient Health
11:30	ClinicalConnect Health Information Exchange Overview
12 p.m.	Networking Luncheon
12:30	PA eHealth Partnership SFY 2023-2024 Strategic Plan Accomplishments
1:00	New Strategic Plan Metrics
1:20	Trusted Exchange Framework and Common Agreement Discussion
1:40	Vice Chair Nominations
1:45	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

Ms. CAROLINE BEOHM, Policy Director, Pennsylvania Insurance Department
(Insurance Commissioner Designee)

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)

Dr. ROBERT DANOFF, Director of Family Medicine Residency Program
Jefferson Health Northeast (Physician or Nurse 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)

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

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

Mr. MARK VOLOVIC, VP & Chief Information Officer, Indiana Regional Medical Center and
Punxsutawney Area Hospital (Hospital 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 Committee Updates

Phyllis Szymanski

President

ClinicalConnect HIE

HIE Trust Community Committee

Chairperson:

- Richard Kerr, R.Ph., Admin., Clinical/Revenue Cycle Software Applications Management LVHN Technology

HIE Trust Community Committee Meeting Summaries:

- HIETCC Meeting Agenda, July 10, 2024
- HIETCC Meeting Minutes, June 6, 2024
- HIETCC Meeting Minutes, May 8, 2024
- HIETCC Meeting Minutes, April 12, 2024

Recent HIE Trust Community Committee Topics

- Cyberattack Preparedness and Communication Strategy
- P3N SFY23-24 Accomplishments
- New Strategic Plan Metrics
- Kicked Off Annual Certification Package Review
- PA NAVIGATE Implementation and Integration Efforts
- Admission Discharge Transfer (ADT) Message Sharing
- ARPA Funded Programs to strengthen PA Navigate
- Efforts to Close Hospital “white space”
- Adding OB Needs Assessment Forms and AAA Care Plans to P3N Care Plan Registry
- P3N Performance Workgroup
- Consent Workgroup
- Trusted Exchange Framework and Common Agreement (TEFCA)
- CMS P3N MMIS Enhanced Funding Granted
- Cognosante P3N Time-Out Errors and Data Quality
- P3N Operations and Transparency
- Possibility of Sharing ADTs with Ohio
- New PHG Connections

PA eHealth Partnership Program Initiatives

Martin Ciccocioppo

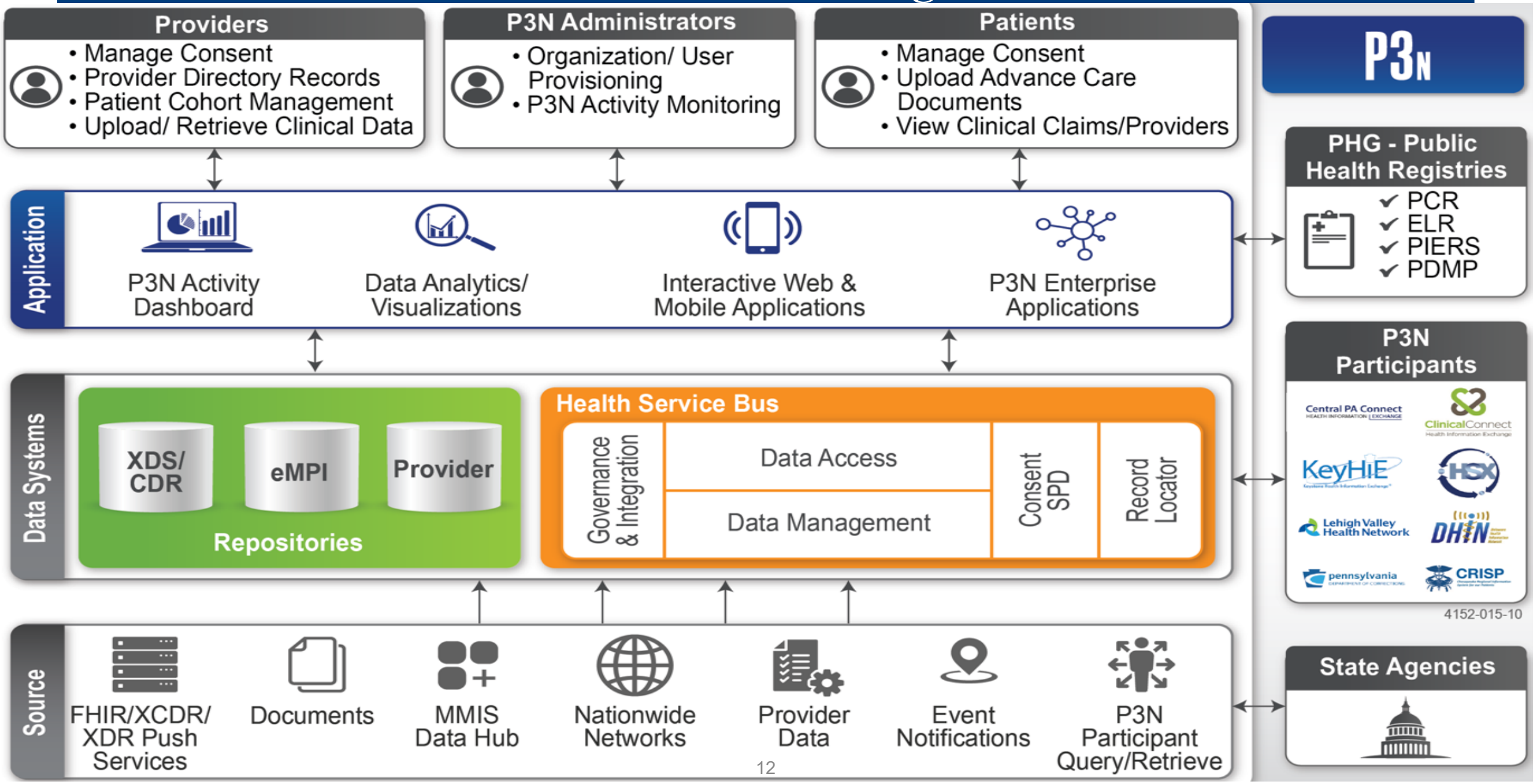
Director

Pennsylvania eHealth Partnership Program

Office of Medical Assistance Programs

Pennsylvania Department of Human Services

P3N Functional Diagram



Pennsylvania Patient and Provider Network (P3N)

Statewide Connections with five Certified Participating HIOs

- ClinicalConnect Health Information Exchange (Connected: November 316)
- Central Pennsylvania Connect HIE administered by Penn Medicine Lancaster General Health (Connected: May 2019)
- HealthShare Exchange of Southeastern Pennsylvania (Connected: April 2016)
- Keystone Health Information Exchange (Connected: May 2016)
- Lehigh Valley Health Network (Connected: May 2022)

State Agency EHR Connections

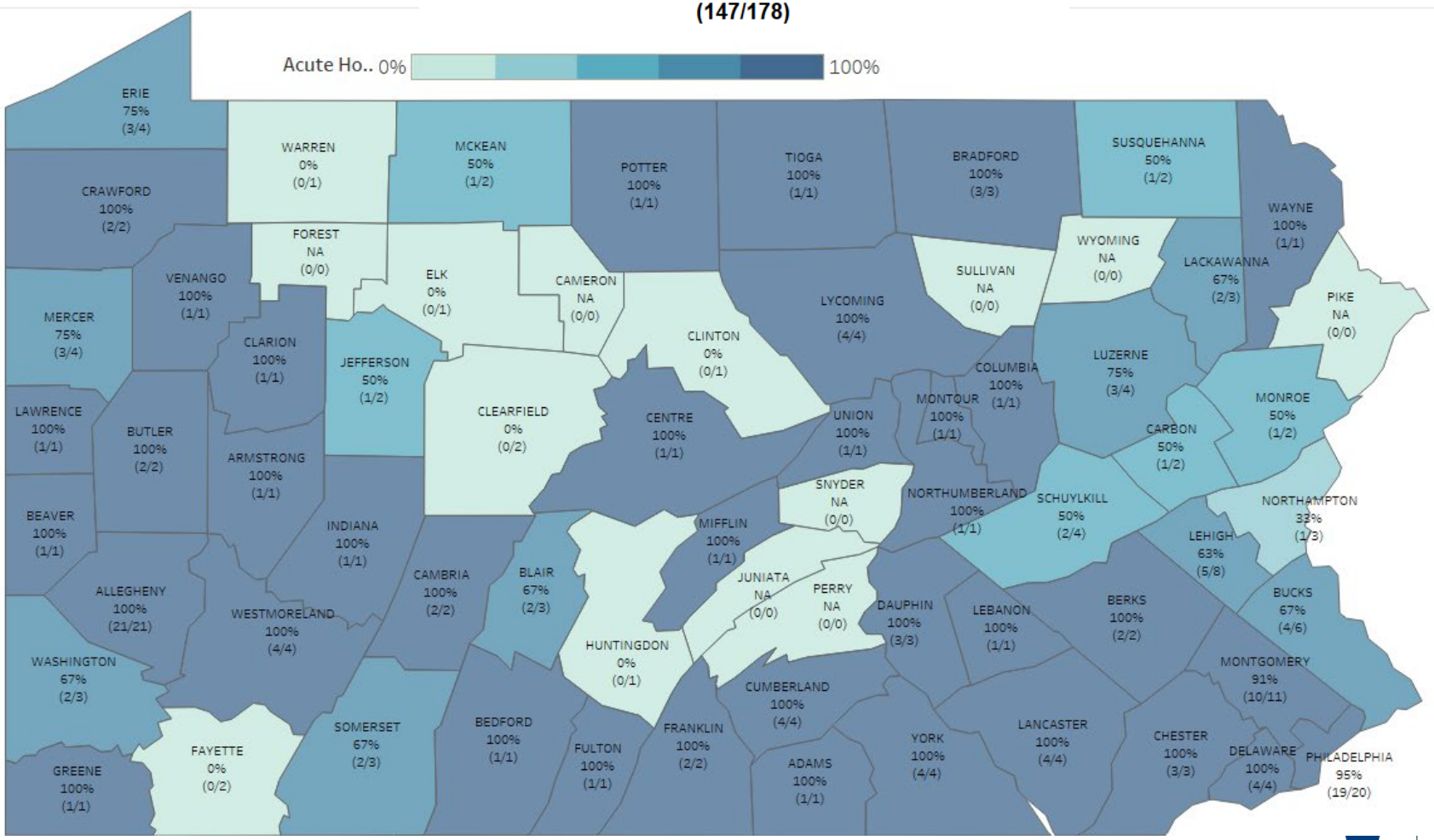
- PA Department of Corrections (Connected: September 2019)
- OMHSAS State Hospitals' NetSmart EHR (Anticipated: August 2024)

Interstate Connections

- Delaware Health Information Network (ADTs only: January 2022)
- CRISP Shared Services for Maryland, West Virginia, District of Columbia, Connecticut, and Alaska HIEs (ADTs only: August 2023)
- Ohio Health Information Partnership (ADTs only, Anticipated CY2025)

Acute Care Hospitals

Percent and Number of Acute Care Hospitals with Emergency Departments that are Affiliated with an HIO
Last Updated July 2024
83%
(147/178)



89 percent of Acute beds are connected to a P3N-HIO

Acute Care Hospitals Not Affiliated with a P3N HIO

BARNES-KASSON COUNTY HOSPITAL
BRADFORD REGIONAL MEDICAL CENTER
BUCKTAIL MEDICAL CENTER, THE
CHAN SOON-SHIONG MEDICAL CENTER AT WINDBER
GEISINGER ST. LUKE'S HOSPITAL
LECOM HEALTH CORRY MEMORIAL HOSPITAL
LOWER BUCKS HOSPITAL
PENN HIGHLANDS BROOKVILLE
PENN HIGHLANDS CLEARFIELD
PENN HIGHLANDS CONNELLSVILLE
PENN HIGHLANDS DUBOIS
PENN HIGHLANDS ELK
PENN HIGHLANDS HUNTINGDON
PENN HIGHLANDS MON VALLEY
PENN HIGHLANDS TYRONE
REGIONAL HOSPITAL OF SCRANTON
ROXBOROUGH MEMORIAL HOSPITAL
SHARON REGIONAL HEALTH SYSTEM
ST. LUKE'S HOSPITAL - ALLENTOWN CAMPUS
ST. LUKE'S HOSPITAL - ANDERSON CAMPUS
ST. LUKE'S HOSPITAL - BETHLEHEM CAMPUS
ST. LUKE'S HOSPITAL - CARBON CAMPUS
ST. LUKE'S HOSPITAL - EASTON CAMPUS
ST. LUKE'S HOSPITAL - MINERS CAMPUS
ST. LUKE'S HOSPITAL - MONROE CAMPUS
ST. LUKE'S HOSPITAL - SACRED HEART CAMPUS
ST. LUKE'S HOSPITAL - UPPER BUCKS CAMPUS
SUBURBAN COMMUNITY HOSPITAL
WARREN GENERAL HOSPITAL
WILKES-BARRE GENERAL HOSPITAL

Cognosante P3N Services

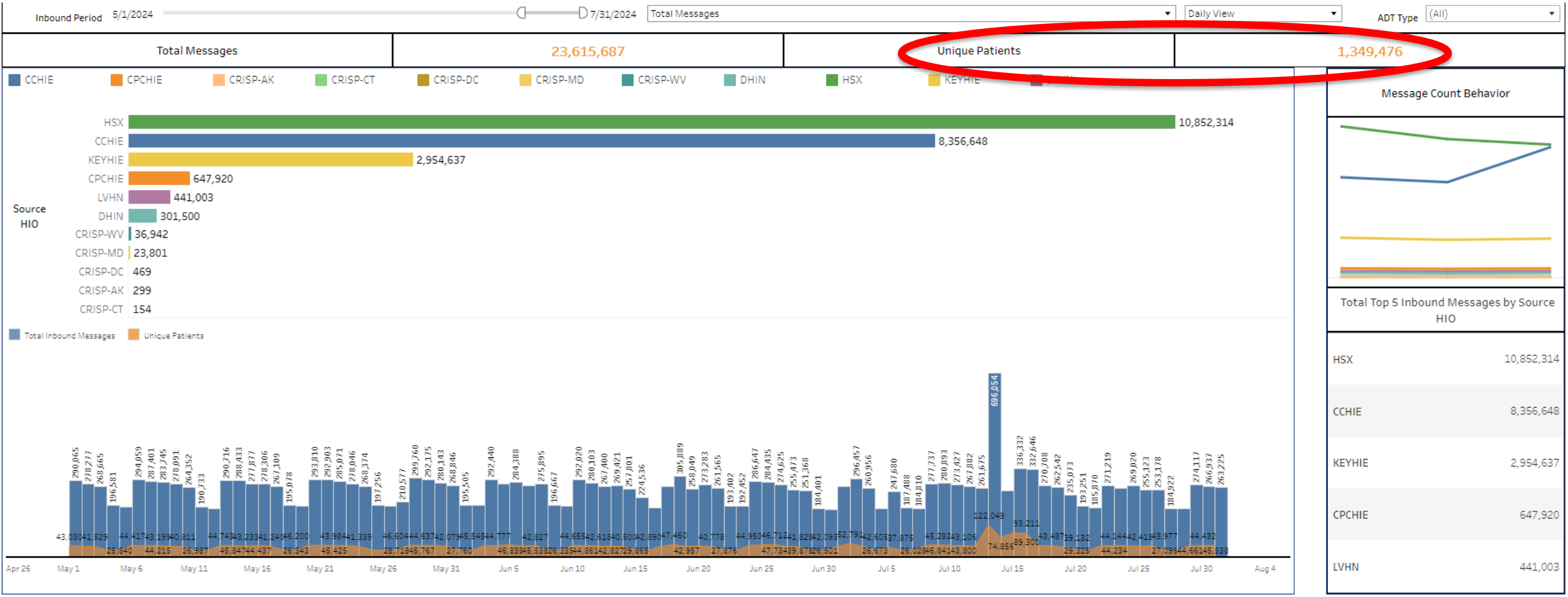
Core P3N Services

- **P3N Master Patient Identifier (Verato)**
- **Statewide Query and Retrieve**
- **Statewide and Interstate Alerting**

P3N Enhancements

- **Care Plan Registry**
  - Integrated Care Plan
  - OB Needs Assessment Form (ONAF)
  - Pediatric Shift Nursing Care Plans
  - Area Agency on Aging SAMS Care Plans
- **Public Health Gateway**
  - PA Immunization Electronic Registry System (PIERS)
  - Electronic Lab Registry (eLR)
  - Prescription Drug Monitoring Program (PDMP)
  - Cancer Registry
- **Individual Access Services (Patient Portal)**
- **Provider Directory (https://portal.p3nphg.org/public/providers)**

P3N Inbound ADTs and Unique Patients (May-Jul 2024)



P3N ADT Service Unique Patients Sent (May-Jul 2024)

Outbound Totals	Unique Patients Outbound Messages by Source HIO	823,241

Outbound Period 5/1/2024 – 7/31/2024 ADT Type (All) Unique Patients

Total Outbound Messages by Source HIO

(All)

CCHIE CPCHIE CRISP-AK CRISP-CT CRISP-DC CRISP-MD CRIS

Source Hio	Destination	
CCHIE	KEYHIE	330,556
	CPCHIE	170,819
	HSX	160,763
	LVHN	2,228
	CRISP-WV	1,187
	CRISP-MD	868
	DHIN	57
	CRISP-CT	46
	CRISP-DC	31
	CRISP-AK	7
CPCHIE	CCHIE	115,923
	KEYHIE	104,927
	HSX	57,988
	CRISP-MD	1,739
	LVHN	1,254
	CRISP-WV	454
	DHIN	69
	CRISP-CT	42
	CRISP-DC	15
	CRISP-AK	3
KEYHIE	CCHIE	58,070
	HSX	54,216
	CPCHIE	21,366
	LVHN	14,460
	CRISP-MD	319

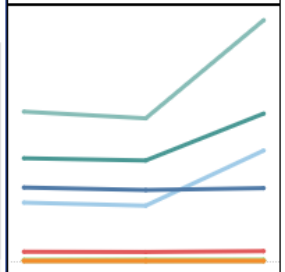
Total Outbound Messages by Destination HIO

(All)

CCHIE CPCHIE CRISP-AK CRISP-CT CRISP-DC CRISP-MD CRI

Destination	Source Hio	
KEYHIE	CCHIE	330,556
	CPCHIE	104,927
	HSX	59,039
	LVHN	36,412
	CRISP-WV	6,702
	DHIN	3,714
	CRISP-MD	2,268
	CRISP-DC	39
	CRISP-AK	30
	CRISP-CT	19
HSX	CCHIE	160,763
	CPCHIE	57,988
	KEYHIE	54,216
	LVHN	40,316
	DHIN	29,217
	CRISP-WV	4,623
	CRISP-MD	1,980
	CRISP-DC	43
	CRISP-AK	31
	CRISP-CT	22
CPCHIE	CCHIE	170,819
	KEYHIE	21,366
	HSX	20,907
	CRISP-WV	4,048
	DHIN	4,016

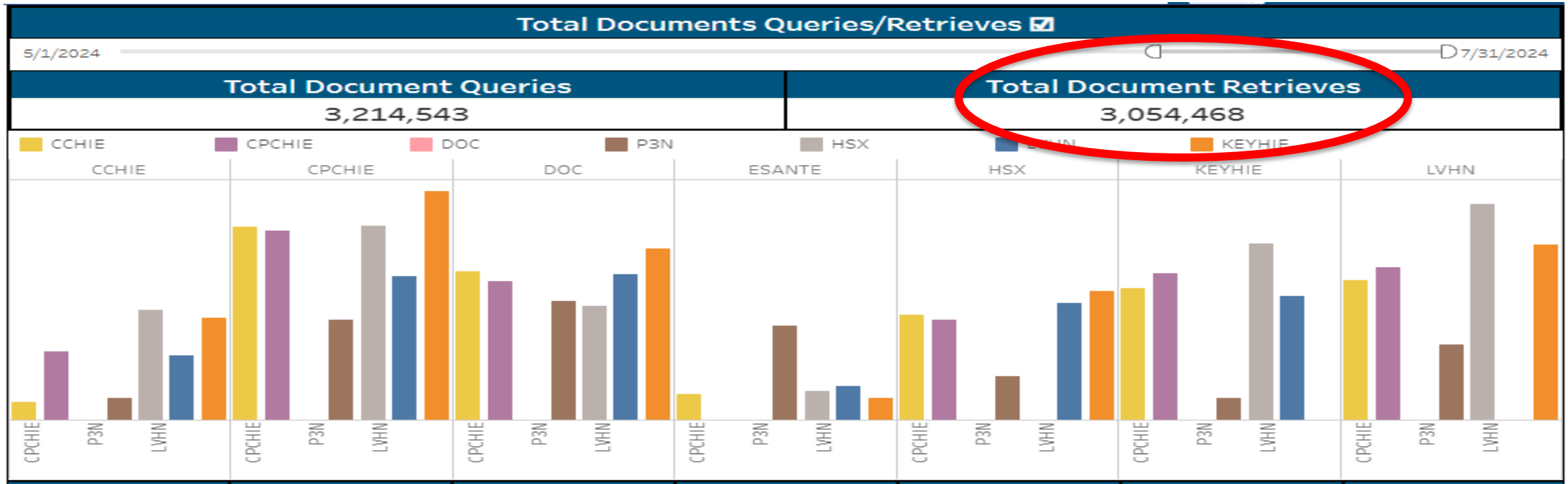
Message Count Behavior



Top 5 Outbound Unique Patients by Source HIO

CCHIE	420,859
CPCHIE	142,756
KEYHIE	96,777
HSX	86,645
LVHN	55,900

P3N Interop Report (May-Jul 2024)



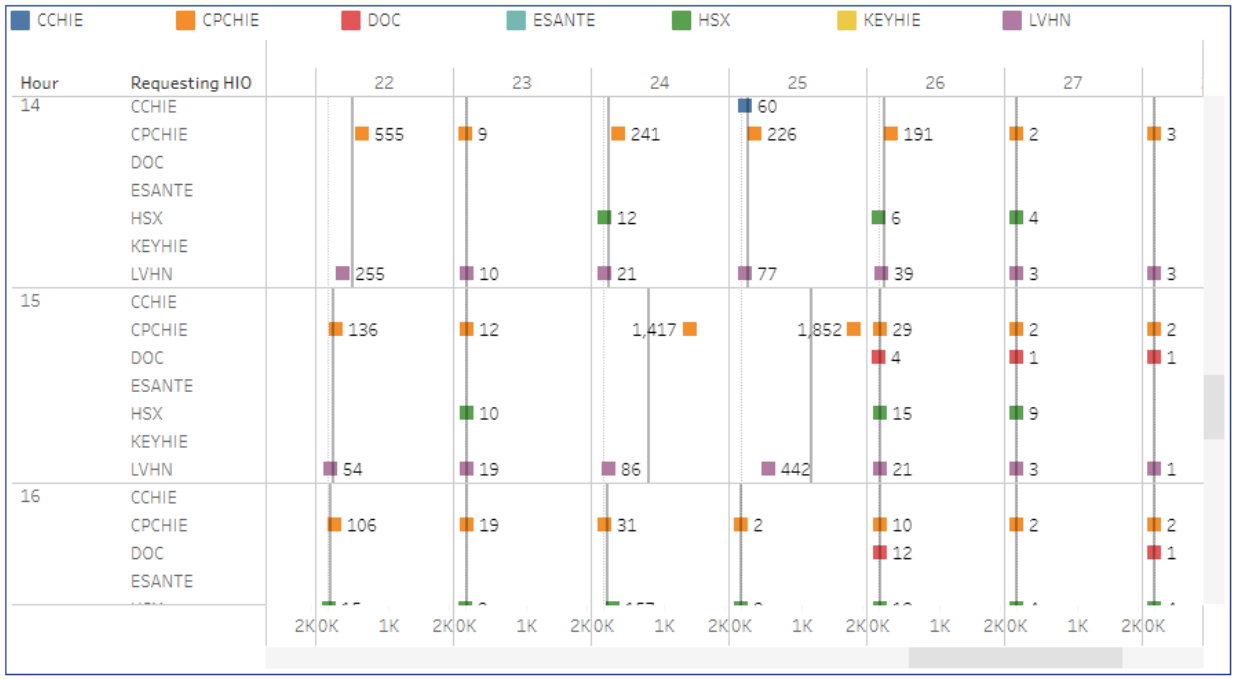
Document Queries: CCHIE	Document Queries: CPCHIE	Document Queries: DOC	Document Queries: eSante	Document Queries: HSX	Document Queries: KEYHIE	Document Queries: LVHN
2,088	2,264,598	77,166	391	6,263	77,621	786,416
Document Retrieves: CCHIE	**Document Retrieves: CPCHIE**	**Document Retrieves: DOC**	**Document Retrieves: eSante**	**Document Retrieves: HSX**	**Document Retrieves: KEYHIE**	**Document Retrieves: LVHN**
1,672	2,128,665	72,447	385	5,863	76,552	768,884

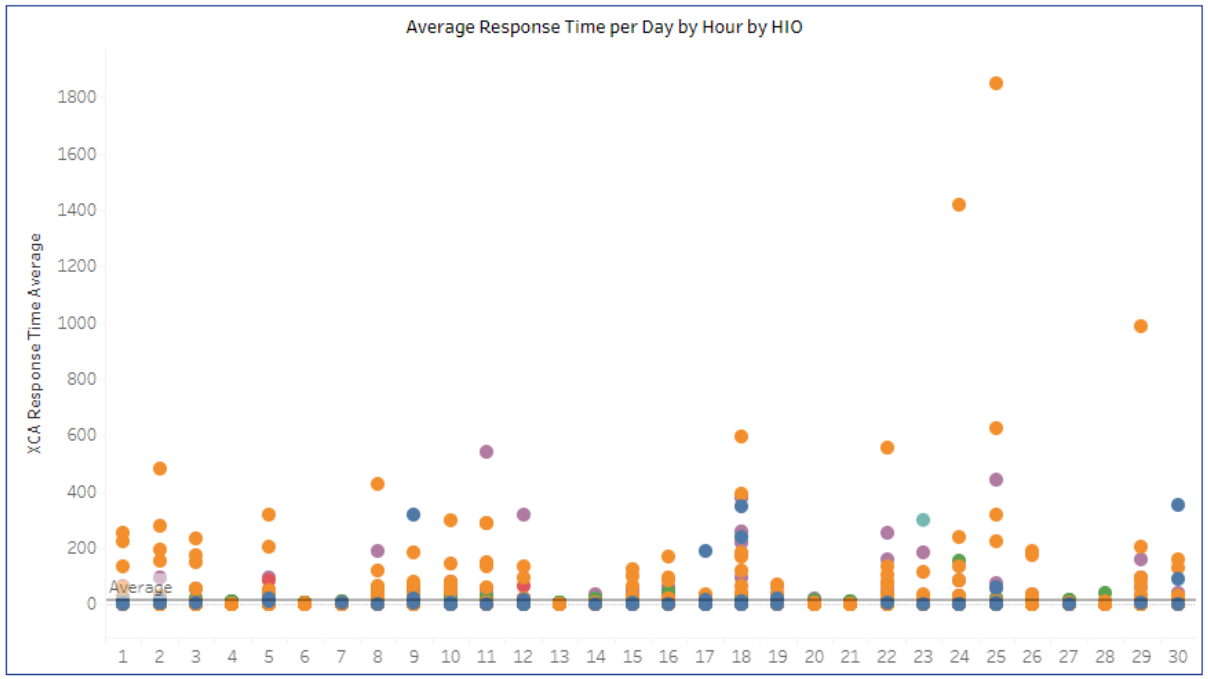
P3N Participant XCA Retrieve Timing Report (Jul 2024)

Overall Monthly Averages (seconds)

CCHIE	CPC	eSante	HSX	KEYHIE	LVHN
July	July	July	July	July	July
6.504	4.036	0.5311	3.797	16.50	1.122

Requesting HIO (All) Responding HIO KEYHIE





Public Health Gateway

PA Immunization Electronic Registry System (PIERS)

DOH successfully implemented new PIERS system in January 2024 and all restrictions on PHG throughput to PIERS have now been lifted.

Electronic Lab Registry (eLR)

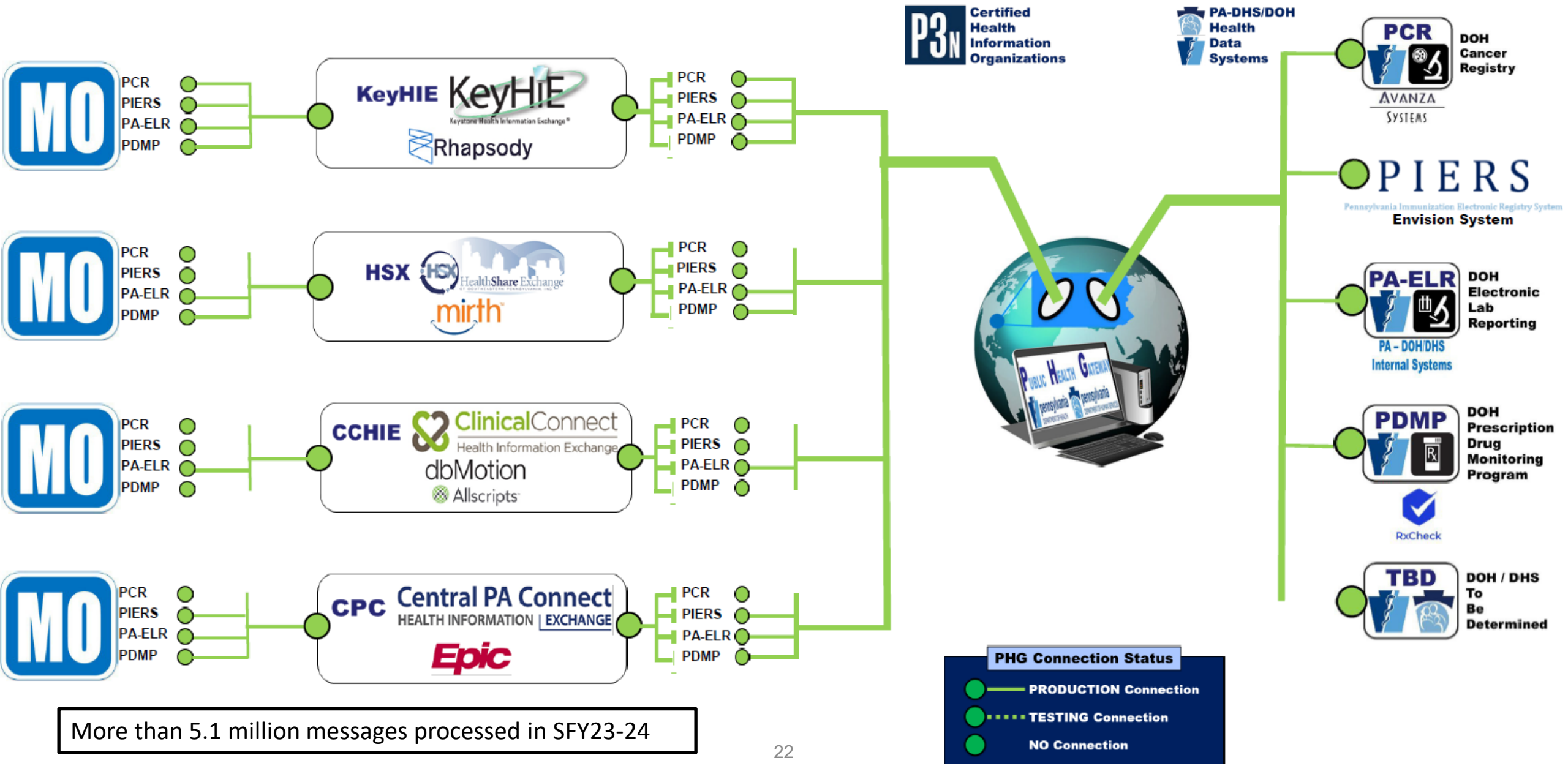
Washington Health has successfully sent production messages to eLR through ClinicalConnect and the PHG.

Prescription Drug Monitoring Program (PDMP)

Penn Medicine in Philadelphia has onboarded to the PDMP through Central PA Connect and the PHG, thus avoiding $250,000 a year in Bamboo Health licensing costs to access the PDMP directly.

The Public Health Gateway

PHG HIO/MO and Commonwealth Health Data Systems Connectivity Overview and Status



More than 5.1 million messages processed in SFY23-24

Engaging CBOs to Improve Patient Health

Beck Moore

Chief Executive Officer

Community Action Association of Pennsylvania

COMMUNITY ACTION ASSOCIATION OF PENNSYLVANIA

Engaging Community Based Organizations to Improve Patient Health

Beck Moore, CEO

The Community Action network is comprised of public and non-profit community-based organizations (CBOs) of Community Action Agencies across all 67 counties in Pennsylvania.

Each agency is uniquely addressing the Social Determinants of Health through various programming, informed by regular Community Needs Assessments, to understand the needs of those most vulnerable in every community.

What is Community Action ?

We are the anti-poverty authority.

- Over 1000 independent non-profit and public organizations covering every county in the United States.
- In Pennsylvania, Community Action Association represents 43 Community Action Agencies across the Commonwealth.
- Each agency receives direct federal funds from Community Services Block Grant (CSBG).
- Approaches and composition of programming is unique by Agency, but all are unified on ensuring the health-related social needs of their customers are being met.

Who is CAAP?

MISSION

To strengthen, advocate for, and empower the state network of Community Action Agencies to effectively address issues of poverty.

PURPOSE

A statewide membership organization representing 42 Community Action Agencies in the Commonwealth and the primary source of advocacy, technical assistance, collaboration, and networking for Community Action in Pennsylvania.

Community Action Agency Programs

- Advocacy/Community Education
- Asset Development/Financial Literacy
- Case Management/Emergency Services
- Child Development
- Community/Economic Development
- Education/Literacy
- Employment Training
- Energy Conservation
- Family Development
- Food/Nutrition
- Health
- Housing/Shelter
- Senior Services
- Veterans Services
- Transportation
- Other

475,816 Pennsylvanians were impacted by Community Action

225,150 Food bag/boxes were distributed

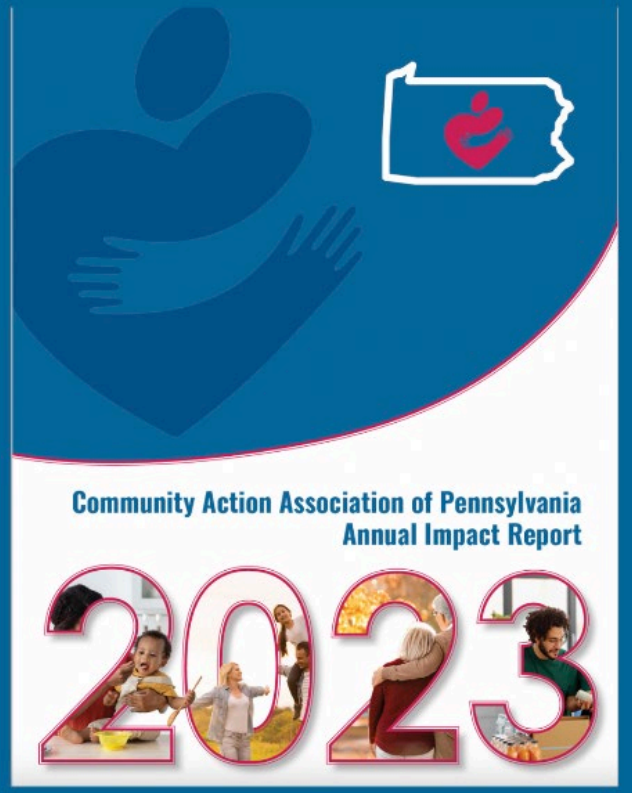
38,059 Prepared meals were served

40,025 Single parent households were served

42,869 Individuals/families received emergency rent payments

29,956 Maternal and child health services provided

11,570 Early child education opportunities served



Download our Impact Report

Learn more at www.thecaap.com/about

New Case Study

Community Action is the "go-to" network for social determinants of health (SDOH) and health-related social need (HRSN) services.

PA Navigate: connecting patients, providers, and community services to address the health needs of Pennsylvanians.

Pennsylvania Department of Human Services (PA DHS) has sponsored HIEs to develop a state-wide resource and referral platform to connect PA residents to their healthcare teams with CBOs and services that address their SDoH needs.

CAAP serves as the Community Engagement Partner to support and educate community-based organizations (CBOs).

To connect to the Community Engagement team, please email PANavigate@thecaap.org.

CAAP's Role in PA Navigate: Community Engagement Partner

- Serve as a regular contributor to several committees managing the project
  - Steering Committee, Community Engagement Committee, and
  - Communications Committee

- Serve as a subcontractor to FindHelp to educate, engage and convene with several goals:
  - # of CBOs that have claimed their programs
  - # of CBOs utilizing a referral tool
  - 60% or higher close loop referral rate of engaged CBOs
  - Quarterly CBO convening
  - Monthly reporting to Community Engagement Committee
  - Propose and manage incentive programs to assist CBOs in implementation

Engagement Strategy

A thoughtful, multi-layered approach to meet CBOs where they're at, support them through implementation, and give them opportunities to connect and share feedback.

Levels of CBO Engagement

No system today	• Use PA Navigate natively • Claim listing • Basic internet connection required
Using another system	• Claim listing • Integrate with PA Navigate • Share referrals, status, goals
Using FindHelp already	• Enable workflows/customer screener • Consider integration

General Strategy

- Passive / On-Demand
  - PANavigate@thecaap.org
  - Microsite
  - Online resource library
  - CAAPLearn – asynchronous, on-demand trainings, & knowledge checks
  - Social Media
- Sponsorship / Events
  - Homes within Reach
  - Tentative
    - CAAP Conference Session
    - CAAP DEI Summit
    - DHS Health Equity Summit
  - Other opportunities to be evaluated

Direct Strategy

- Large Scale & Audience Specific, Targeted CBO Campaigns
  - Direct Call & Email
  - 30, 60, 90-day follow-ups
  - Quarterly CBO Convening
  - Monthly Reporting
    - Engagement & Performance
      - Mitigation Strategy
  - Trusted Messenger Email Campaign
  - Surveying & Feedback
  - Open Forum
    - Demos
    - Open Office Hours
  - Investing in Data Integration (CAAP investment)

Timeline

Passive / On-Demand / High Level Deliverable Deliverables	2024							2025					
	June	July	August	September	October	November	December	January	February	March	April	May	June
PANavigate@thecaap.org email address	Done!												
Creation of CAAP/PA Navigate microsite		Mid											
Creation of CBO info hub		Mid											
Performance Monitoring of CBOS													
Engagement reporting													
CAAP Learn Course Built - 101													
CAAP Learn Course Built - 201													
PANavigate email from DHS & DCED introducing concept and CAAP													
CAAP Conference Session													
Sponsorship of Homes Within Reach Conference													
Investment in data integration and technology at CAAs													
Updated Strategy						Draft							
Evaluate large scale gathering opportunities for in person connections													
Social Media management													
Monthly Reporting on engagement													
Surveying & Feedback - Preparedness, Impact													
CAAP DEI Summit													
DHS Health Equity Summit													
Ongoing Community Engagement Deliverables for CEM Team Deliverables													
Agreements for Phase 1 Incentive Plan		Mid											
Direct Email Engagement		Mid											
Direct Call Engagement		Mid											
Partnership Email Engagement		Mid											
Weekly 101 - Intro to PA Navigate Demo Webinars		Mid											
Incentive targeted reachout campaign		Mid											
Bimonthly 201 Live		End		End		End		End		End		End	
Quarterly CBO convening - CEO hosted, HIO													
Open Office Hours													
Phase 2 Incentive Plan Recommendations					Tentative								
Targeted reachout webinar invitation													
1:1 Workflow Meetings													
PA Navigate email monitoring													


Q&A

Thank You

Need any more information?
Have questions?

Reach us at
PANavigate@thecaap.org

ClinicalConnect Health Information Exchange Overview

Phyllis Szymanski

President

ClinicalConnect HIE

ClinicalConnect
Health Information Exchange

ClinicalConnect HIE

Services Overview

About ClinicalConnect HIE

Health Information Exchange:
We are dedicated to securely aggregating data for better quality care, monitoring, and reporting

501©(3) Non-Profit Company

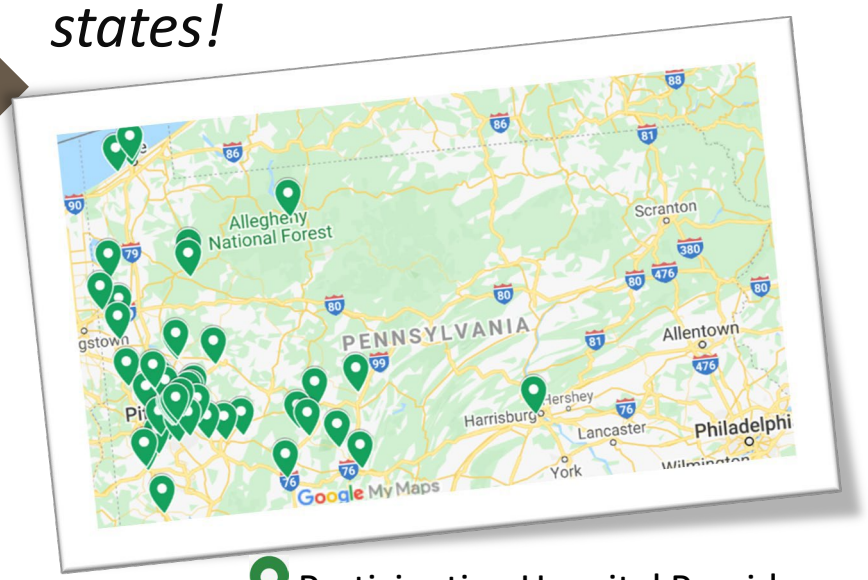
- *Founded in 2011 by nine western-PA area hospitals*
- *Meets highest privacy & security standards*
- *Follows an Opt-Out Patient Consent Model*

Comprised of >40 hospitals, plus physician practices, FQHCs, Health Plans, MCOs, ACOs, rehabilitation and post-acute care facilities

Connected regionally, state- wide, and nationally

Proud members of the P3N & eHealth Exchange

- *Located in western PA*
- *Offers vendor-neutral interoperability services*
- *>6 M patients are participating in our Exchange from across all 50 states!*



Participating Hospital Providers

clinicalconnecthie.com

ClinicalConnect HEALTH INFORMATION EXCHANGE

SERVICES

ConnectAlert REAL-TIME NOTIFICATIONS

REAL TIME ALERTS OF PATIENT EMERGENCY DEPARTMENT AND HOSPITAL ENCOUNTERS

ConnectChart CLINICAL DATA REPOSITORY

LONGITUDINAL PATIENT RECORD WITH QUERY/RETRIEVE ACCESS TO TRUSTED EXTERNAL PARTNER DATA

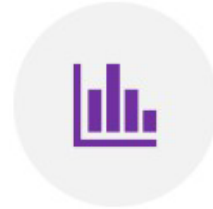
ConnectCommunity PATHWAY TO PA NAVIGATE

PA STATE-WIDE TOOL TO ADDRESS SOCIAL SERVICE NEEDS

ConnectDirect SECURE COMMUNICATION

HIPAA COMPLIANT, SECURE EMAIL SERVICE FOR THE EXCHANGE OF ELECTRONIC PROTECTED HEALTH INFORMATION

ConnectQuality CLINICAL DATA AGGREGATION



AGGREGATED CLINICAL DATA FOR QUALITY REPORTING AND CARE MANAGEMENT INITIATIVES

Data sources vary by CCHIE Service

24/7 support for all services Data provided only with patient consent
As applicable, Providers' contributed data is used throughout all CCHIE Servservicesices

PARTICIPATING ORGANIZATIONS

* = Founding Members † = Current Data Contributors

ACCOUNTABLE CARE ORGANIZATIONS
- Bridges Health Partners

INDEPENDENT PHYSICIAN PRACTICES
- Direct Care Pittsburgh: Highland Park
- Eye Doc Associates
- Jules Kann, MD and Malcolm Harris, MD, PC
- Nulton Diagnostic & Treatment Center
- Pediatric Care Specialists†
- South Hills Family Medicine†
- Sean Unice, DO
- Vest Home Therapy

INTERMEDIATE CARE FACILITIES
- Verland†

FEDERALLY QUALIFIED HEALTH CENTERS
- Community Health Clinic†
- Cornerstone Care Community Health Centers †
- Hamilton Health Center†

HOSPITALS & OWNED PHYSICIAN PRACTICES
- ACMH Hospital*†
- Conemaugh Health System
- Heritage Valley Health System*†
- Independence Health*†
- Indiana Regional Medical Center
- Meadville Medical Center†
- Millcreek Community Hospital †
- St. Clair Health*†
- Pediatric Specialty Hospital†
- UPMC*†
- Washington Health System*†

HEALTH PLANS
- UPMC Health Plan

MANAGED CARE ORGANIZATIONS
- AbsoluteCare
- Community Care Behavioral Health
- PA Health & Wellness

HEMOPHILIA TREATMENT CENTERS
- Hemophilia Center of Western PA

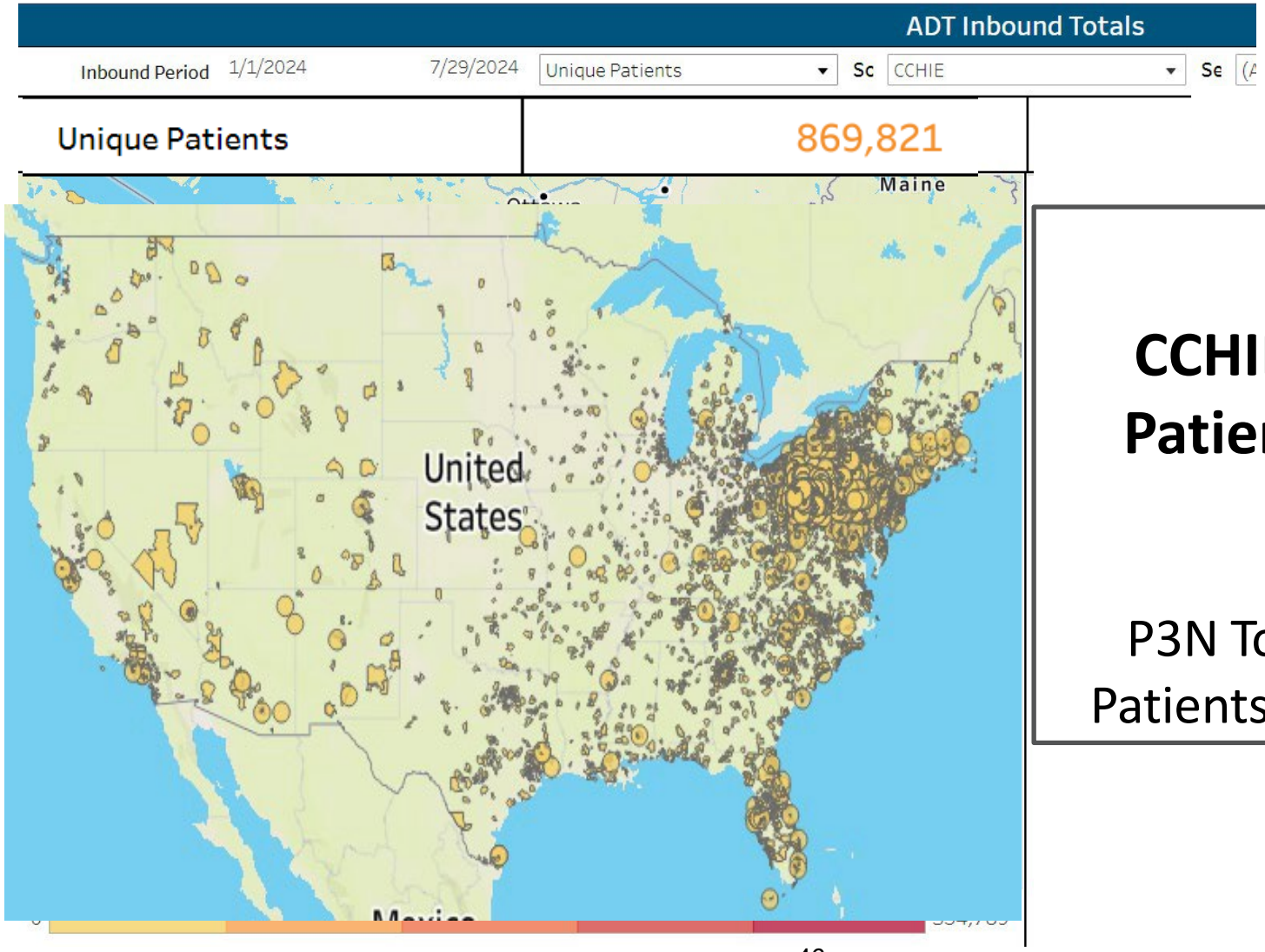
SOCIAL SERVICE AGENCIES
- Allegheny County Department of Human Services
- PA PACE

Updated 7/25/2024

†As applicable, contributed data is used throughout all ClinicalConnect HIE services

2024 Data YTD

P3N Admission Discharge Transfer Messages Dashboard - Facility



CCHIE Unique Patients = 37%

P3N Total Unique Patients = **2,337,041**

Patient Participation in ClinicalConnect HIE

- ClinicalConnect HIE follows an **Opt-Out** patient consent model = *data is exchanged unless the patient requests to not participate*
- Patient's participation decision is captured through each providers' registration system during ConnectChart onboarding
- Communicated to patients via providers' Notice of Privacy Practices (NOPP)
- Provider must have Patient Opt-Out process
- **Technically, ClinicalConnect HIE tracks all patient decisions and honors the last received**

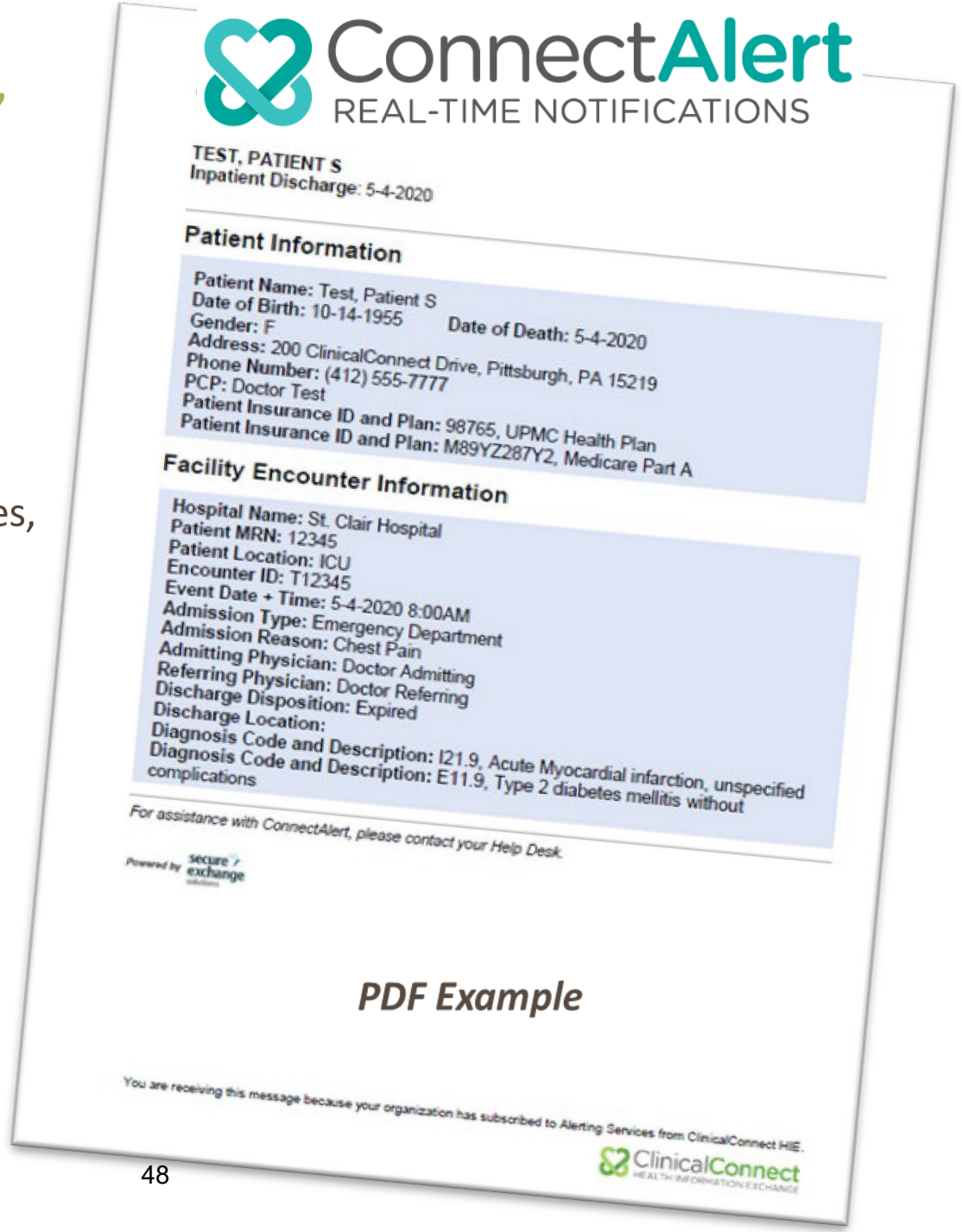
Various Notification, Output & Delivery Options Available

Notification Types

- Emergency Department Admissions & Discharges
- Inpatient Admissions, Discharges, Transfers & Cancellations

Output / Delivery Options

Output Type	Delivery Option	Delivery Method	Delivery Schedule
PDF	Direct Messaging	• EHR Inbox • ConnectDirect Portal	Real time
CCD	Direct Messaging	• EHR Inbox • ConnectDirect Portal	Real time
.csv File	Electronic	• SFTP *(Secure File Transfer)*	3x Daily: *9am, 3pm, 9pm Eastern*


ConnectAlert
REAL-TIME NOTIFICATIONS

TEST, PATIENT S
Inpatient Discharge: 5-4-2020

Patient Information

Patient Name: Test, Patient S
Date of Birth: 10-14-1955
Gender: F
Date of Death: 5-4-2020
Address: 200 ClinicalConnect Drive, Pittsburgh, PA 15219
Phone Number: (412) 555-7777
PCP: Doctor Test
Patient Insurance ID and Plan: 98765, UPMC Health Plan
Patient Insurance ID and Plan: M89YZ287Y2, Medicare Part A

Facility Encounter Information

Hospital Name: St. Clair Hospital
Patient MRN: 12345
Patient Location: ICU
Encounter ID: T12345
Event Date + Time: 5-4-2020 8:00AM
Admission Type: Emergency Department
Admission Reason: Chest Pain
Admitting Physician: Doctor Admitting
Referring Physician: Doctor Referring
Discharge Disposition: Expired
Discharge Location:
Diagnosis Code and Description: I21.9, Acute Myocardial infarction, unspecified
Diagnosis Code and Description: E11.9, Type 2 diabetes mellitis without complications

For assistance with ConnectAlert, please contact your Help Desk.

Powered by secure exchange

PDF Example

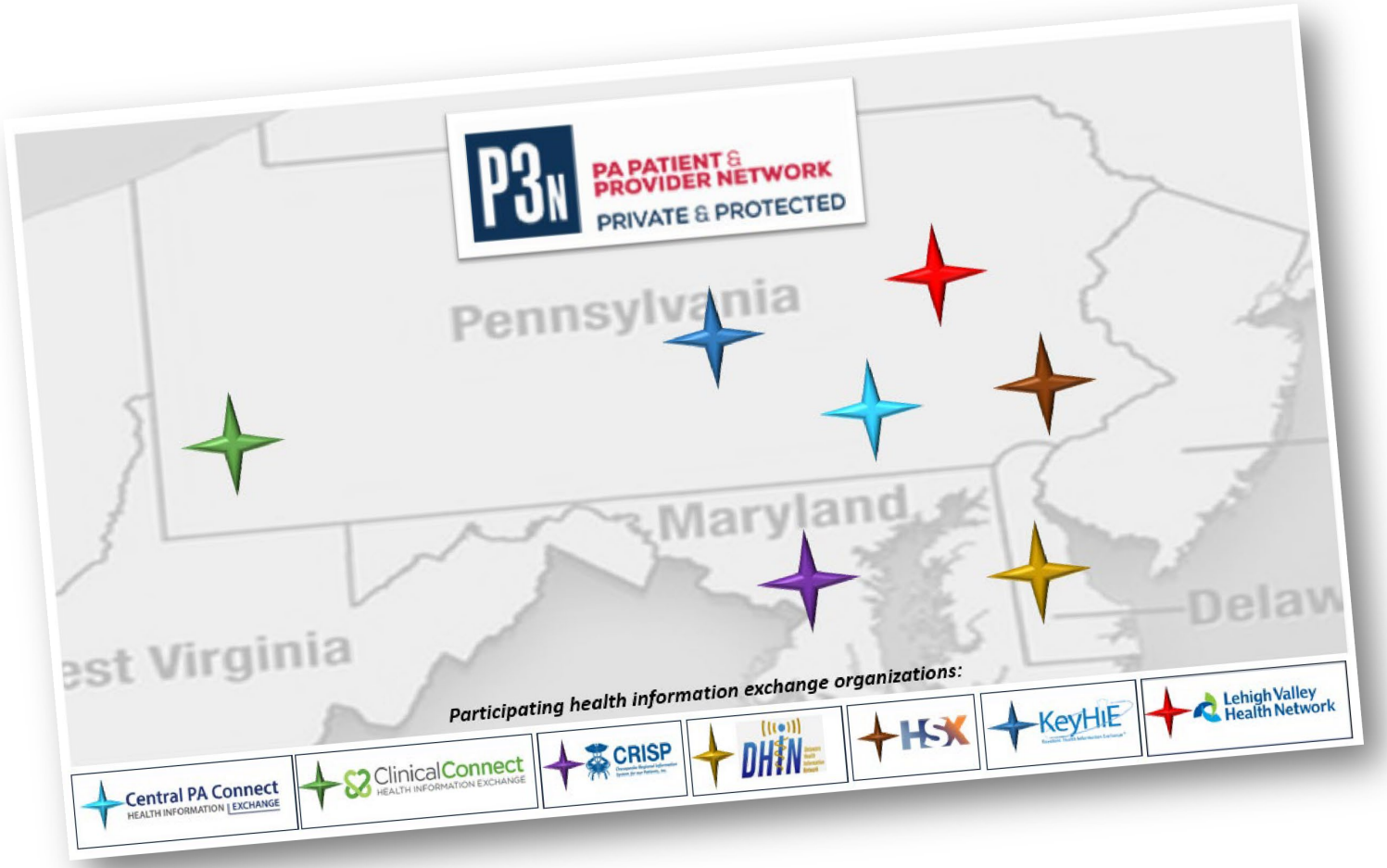
You are receiving this message because your organization has subscribed to Alerting Services from ClinicalConnect HIE.

ClinicalConnect

ConnectAlert
REAL-TIME NOTIFICATIONS

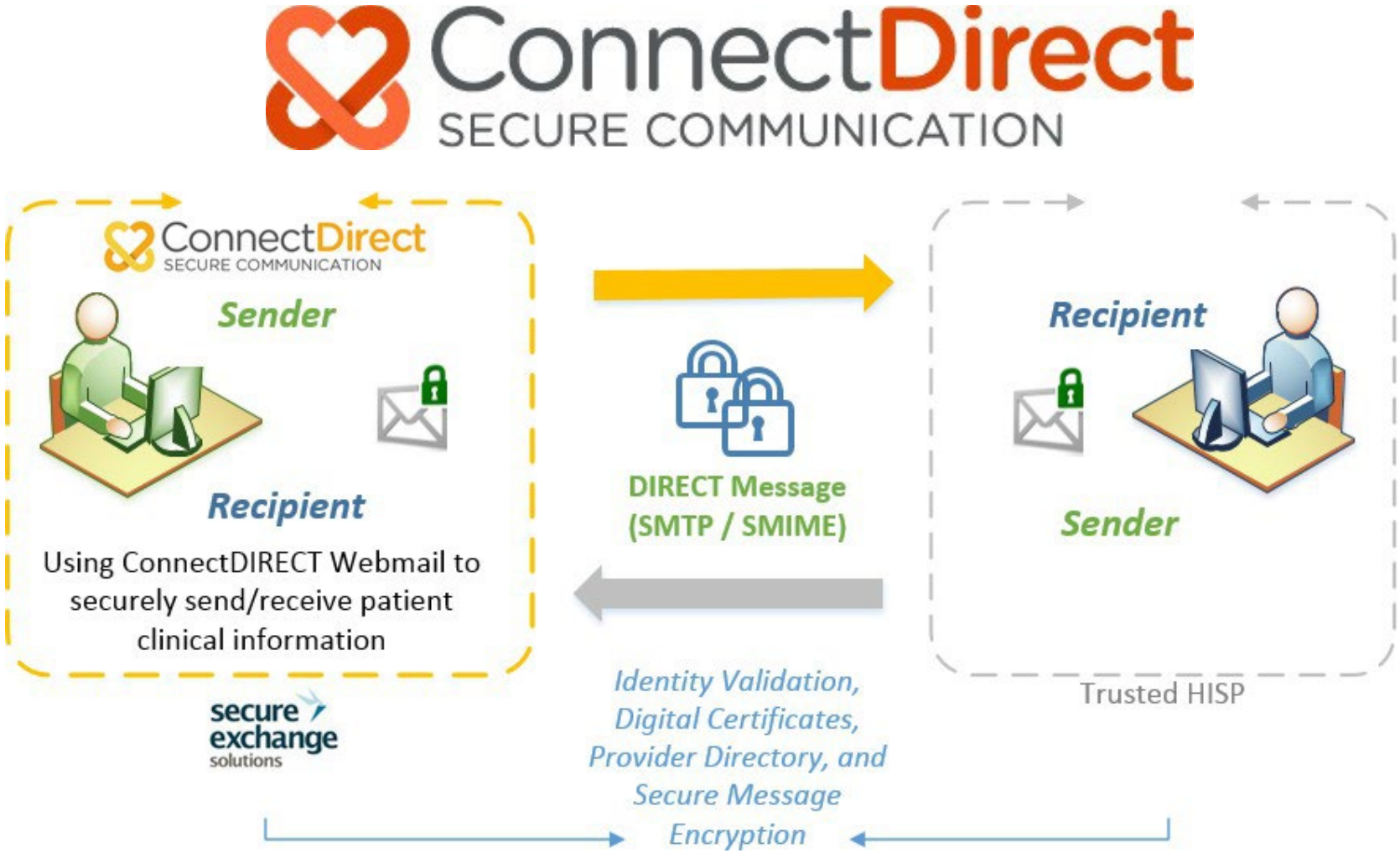
Additional Data Sources

Through our engagement with the P3N, CCHIE also sends alerts* from providers *who participate with other P3N health information organizations if:*



- ✓ **Patient seen at a CCHIE *provider,***
- ✓ **Patient demographics match between HIOs,**
- ✓ **Patient is opted into CCHIE**

**Inpatientand ED Alerts Only*


ConnectDirect
SECURE COMMUNICATION
ConnectDirect
SECURE COMMUNICATION
Sender
Recipient
Using ConnectDIRECT Webmail to securely send/receive patient clinical information
secure exchange solutions
DIRECT Message (SMTP / SMIME)
Identity Validation, Digital Certificates, Provider Directory, and Secure Message Encryption
Recipient
Sender
Trusted HISP

ConnectChart
CLINICAL DATA REPOSITORY

ConnectChart CLINICAL DATA REPOSITORY

Trusted External Data Sources*

- Allegheny Health Network
- Conemaugh Health System
- DaVita Dialysis
- Veterans Health Administration, including Department of Defense, Naval Hospital and Army Medical Center
- West Virginia Health Information Network
- CRISP *(designated Health Information Exchange in Maryland and the District of Columbia)*

eHealth Exchange™

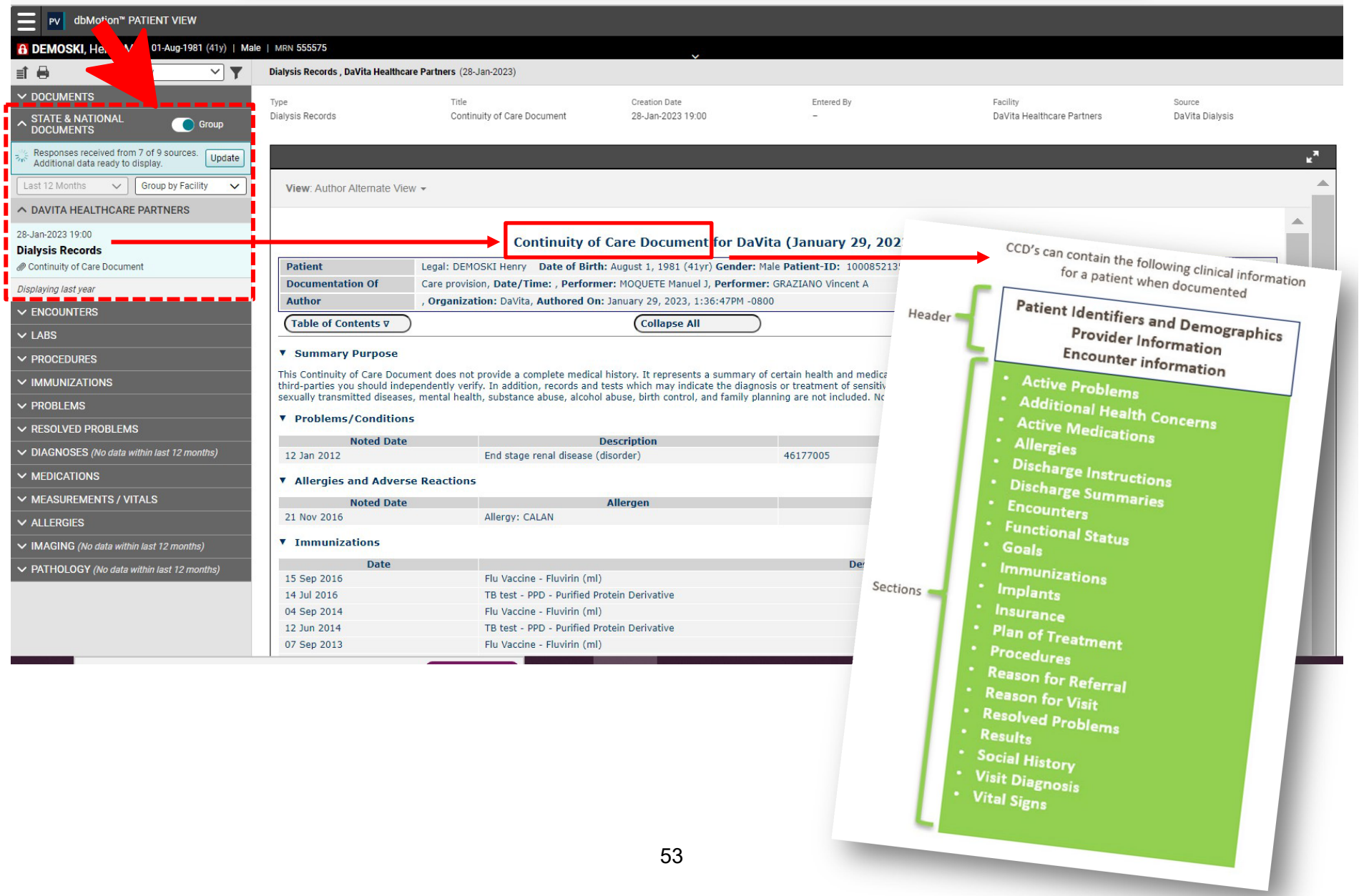
P3N PA PATIENT & PROVIDER NETWORK PRIVATE & PROTECTED

- Central PA Connect
- Delaware Health Information Network
- HealthShare Exchange
- KeyHIE
- Leigh Valley Health Network

**** C-CDA only available from External Sources; represents a "snapshot" of a care plan at a single point in time for transmission to other providers and teams to ensure continuity of care.***

ConnectChart
CLINICAL DATA REPOSITORY

External Partners Clinical Data



ConnectQuality
CLINICAL DATA AGGREGATION

A clinical data aggregation, data standardization, and data delivery service for Health Plans.

– As patients receive healthcare services, they move across multiple healthcare providers and organizations

– Electronic Health Record Clinical documentation occurs, but varies, at each organization

– After a patient visit occurs, CCHIE electronically receives patient information from participating healthcare organizations

– ConnectQuality aggregates and standardizes the data

– **Patient Data is summarized and delivered electronically to Health Plans via an XML SUMMARY CCD**

Health Plans use the data for HEDIS Reporting, Care Management, and Quality Analytics

ConnectCommunity PATHWAY TO PA NAVIGATE *is PA Navigate!*

A statewide community information network designed to address health and social care needs for Pennsylvanians by connecting them to community services.

PA Navigate Public Launch : 1/23/2024
URL: pa-navigate.org
Questions: info@pa-navigate.org

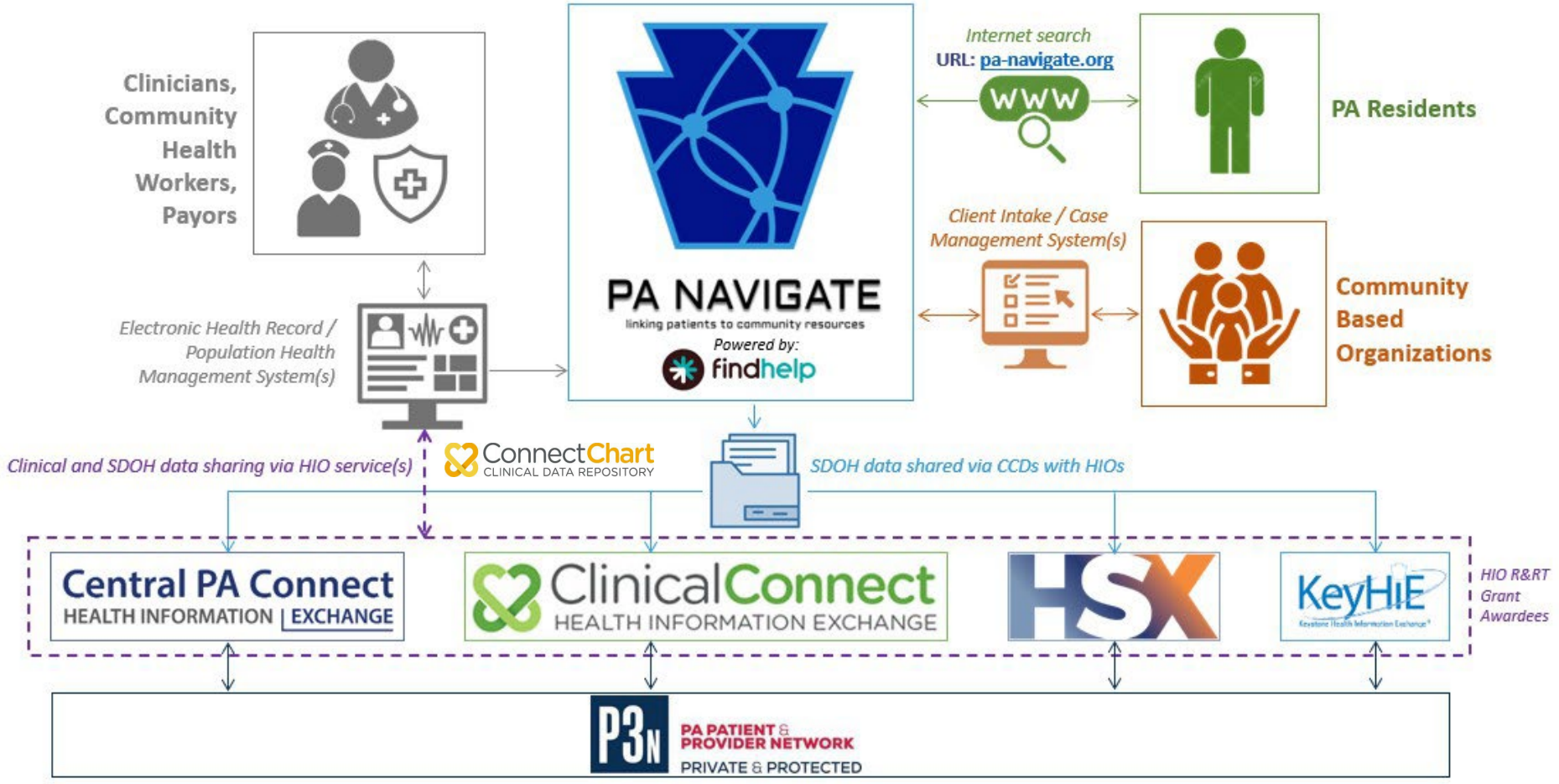
PA NAVIGATE

PA Navigate Goals

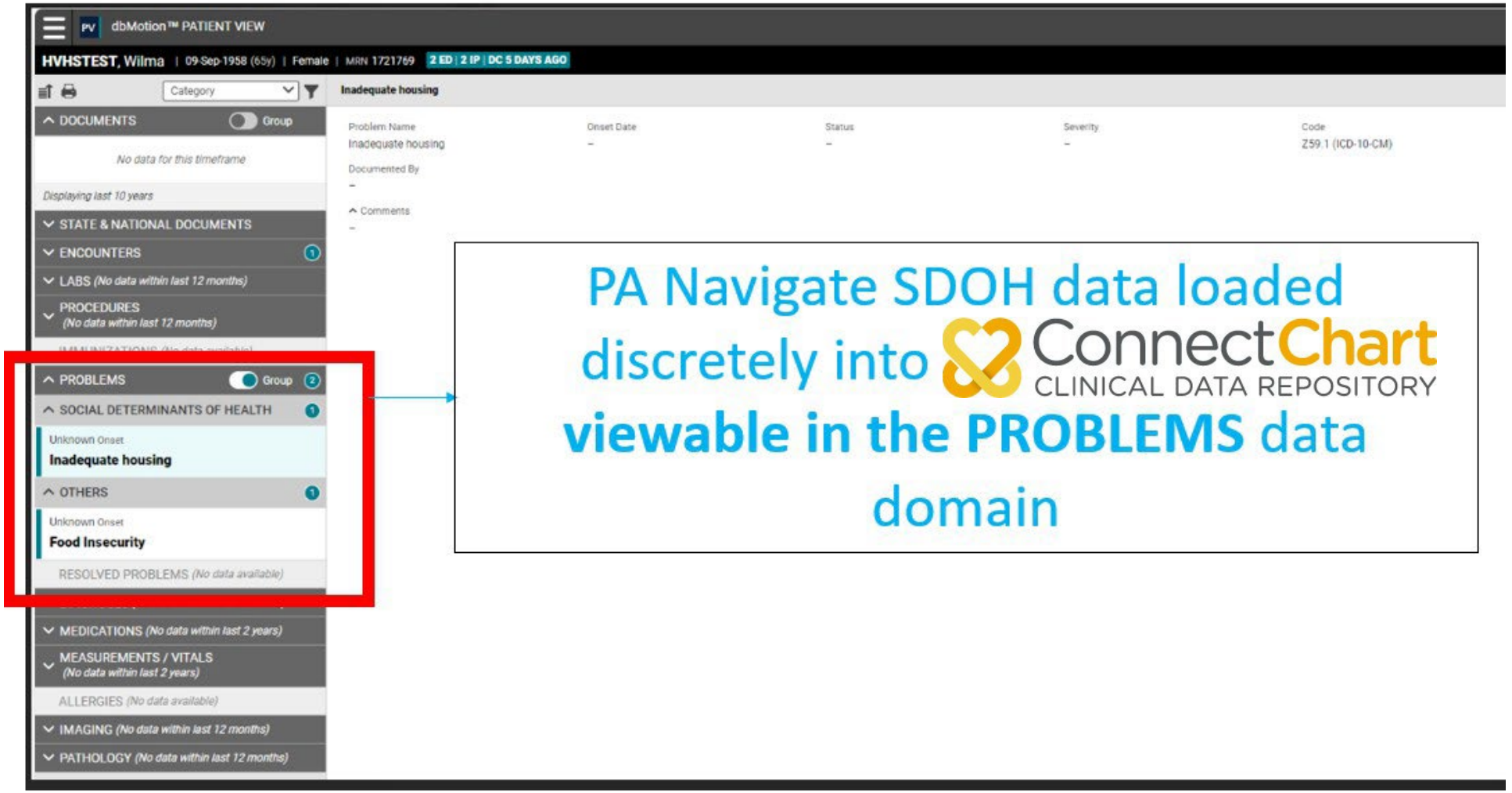
- *Build a PA statewide platform for connecting patients to social services*
- *Make SDOH data as shareable as clinical data*
- *Enable a population-level view of citizens' needs & CBO capacities to meet them*
- *Help make Social Care sustainable*

ConnectCommunity
PATHWAY TO PA NAVIGATE

Data Flow



New SDOH Data




thank you!

PA eHealth SFY 2023-2024 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 2023-2024 Accomplishments:

- Began bi-directional ADT exchange with CRISP for the states of MD, WV, DC, CT, and AK
- LVHN began ingesting P3N ADTs in August 2023
- PA Navigate HIOs contracted with findhelp as the statewide platform to facilitate closed-loop referrals for Health-Related Social Needs (HRSN); PA Navigate launched in January 2024.
- Began discussions with Ohio on exchanging ADTs with the P3N
- Successfully completed testing for new state hospital EHR; first one to go live in August 2024
- CCHIE added three hospitals (Millcreek, Conemaugh and Indiana)
- LVHN added three new hospitals (Gilbertsville, Macungie, and Highland Avenue) to the P3N
- Many PA Navigate and P3N presentations to stakeholders
- National presentations at Civitas Annual Meeting and State Health IT Connect Summit
- Began using P3N Patient Portal on a pilot basis
- Extensive discussions throughout the year with HIETCC and Advisory Board regarding TEFCA and the potential chilling effect it could have on regional and statewide HIE as EHR vendors become QHINs
- Raised TEFCA concerns directly with Civitas, ONC, and CMS

2. Increase timely access, accuracy, and availability

Fiscal Year 2023-2024 Accomplishments:

- New onboardings to PHG eLR were Washington Health and Punxsutawney Area Hospital
- New onboarding to PHG PDMP was Penn Medicine
- Helped educate providers on the electronic Case Reporting
- Created new P3N Performance Workgroup, which began monthly meetings in January 2024
- Created new P3N Consent Workgroup, which began monthly meetings in January 2024
- Better monitoring implemented for Inbound ADTs and HIO response time to P3N
- Continued work with ODP on condition-specific surveillance of ADTs
- Implemented PA Navigate
- Secured DHS access to PA Navigate activity dashboard/reports
- Secured additional incentive funding for CBOs to claim their PA Navigate listings and respond to PA Navigate referrals

3. Improve upon our existing P3N services

Fiscal Year 2023-2024 Accomplishments:

- Expanded monthly reporting to CMS
- CMS awarded enhanced MMIS funding (75/25) for P3N maintenance and operations
- Facilitated extensive discussions with DHS and findhelp to enable bi-directional data sharing
- Renewed discussions with Department of Aging on hosting AAA care plans to the P3N Care Plan registry

4. Alert patient care teams to relevant patient encounters

Fiscal Year 2023-2024 Accomplishments:

- Began bi-directional ADT data sharing with CRISP for MD, WV, DC, CT, and AK
- Encouraged the onboarding of LTC to the P3N ADT Service
- Conemaugh Memorial Medical Center began sending ADTs to the P3N ADT Service with incentives from UPMC Health Plan
- Increased the number of emergency departments sending ADTs to the P3N ADT Service by 161% to 391 EDs
- Increased the number of inpatient facilities sending ADTs to the P3N ADT Service by 122% to 436 inpatient facilities
- Increased the number of ADT messages sent by the P3N by 15%, more than 62 million
- New enhanced P3N Inbound ADT Dashboard provides facility-specific ADT message information for mapping and for various patient demographic characteristics
- Continued developing capability to identify possible abuse/neglect cases for ODP program participants

5. Support care coordination to improve quality

Fiscal Year 2023-2024 Accomplishments:

- Major health system saved hundreds of thousands of dollars per year by switching from Bamboo Health to PHG for accessing the PDMP
- PA Navigate went live in January 2024 as a statewide closed-loop referral network to address health-related social needs (HRSN) and integrate with P3N-certified HIOs
- DHS submitted 1115 Waiver Request to CMS to address HRSNs
- Met with MCOs and HIOs to ensure valuable access to alerts, clinical and quality data
- Conemaugh Health and Indiana Regional Medical Center onboarded to P3N ADT Service
- Pursued a P3N change request to better support CCHIE ENS
- Discussed having HIOs facilitate health plan access to immunization information for their enrollees

6. Improve patient outcomes and satisfaction

Fiscal Year 2023-2024 Accomplishments:

- Worked with OA on requirements for a newer technology for identity-proofing P3N patient portal access
- Worked with Optum and MCOs to authorize the sharing of ONAF forms with the P3N
- Incorporated Tableau heat mapping in new P3N monitoring dashboard
- Developed and received CMS approval for an RFP for a competitive re-procurement of the P3N
- Successfully transitioned from PA SIIS to PIERS providing improved access to immunization information through the PHG

7. Optimize HIE stakeholders' experience

Fiscal Year 2023-2024 Accomplishments:

- Created new P3N Tableau Dashboards for understanding ADT activity and P3N responsiveness
- P3N Performance Work Group has helped to identify problems with HIO responsiveness to P3N queries
- Trained HIOs on the use of P3N Tableau Dashboards

New Strategic Plan Metrics

Aleissa “Lisa” McCutcheon

Sr. Data Analyst

Pennsylvania eHealth Partnership Program

Office of Medical Assistance Programs

Pennsylvania Department of Human Services

PA eHealth Vision and Mission (2024-2027)

VISION

Champion healthy communities for all Pennsylvanians through the secure sharing of health and community information.

MISSION

Providing value and efficiency for all Pennsylvanians by aligning with health care partners to improve whole person care.

Strategic Plan (July 1, 2024 through June 30, 2027)

GOALS	OBJECTIVES
1. Enable ubiquitous, robust health data sharing while maintaining privacy and security.	A. Expand the number and types of stakeholders actively participating in health information exchange (HIE). B. Educate stakeholders, including patients and their advocates, on the value of participating in HIE. C. Align health information exchange with federal HIT goals and objectives.
2. Increase timely access to usable health and community information.	A. Integrate P3N into the Medicaid Management Information System (MMIS). B. Integrate PA Navigate with Compass. C. Make health related social needs data available through PA Navigate.
3. Improve upon existing Pennsylvania Patient and Provider Network (P3N) services.	A. Support advancements for access to clinical information. B. Support for electronic digital performance measures.
4. Expand care coordination to improve quality and reduce health care costs.	A. Expand the number and types of Admission Discharge Transfer (ADT) messages contributed to the P3N ADT Service. B. Capture meaningful information from ADTs for analysis and population health reporting. C. Reduce duplicative or unnecessary services.

Strategic Plan (July 1, 2024 through June 30, 2027) continued

GOALS	OBJECTIVES
5. Increase closed loop referrals for health-related social needs	A. Promote health equity. B. Support and collaborate with PA Navigate.
6. Expand our collaboration with commonwealth agencies.	A. Expand and improve access to public health reporting registries. B. Provide P3N access to state program areas. C. Expand P3N and/or PA Navigate access to Pennsylvania county facilities, local entities, and county agencies.
7. Advocate for sustainable HIO funding. Expand care coordination to improve quality and reduce health care costs	A. Creation of MA Care Coordination Grants. B. Expand use of P3N services by the HIOs to reduce duplication of services.

GOAL 1: Enable ubiquitous, robust health data sharing

Goal 1: Enable ubiquitous, robust health data sharing while maintaining privacy and security.

OBJECTIVES	METRICS	Definition	BASELINE
A. Expand the number and types of stakeholders actively participating in health information exchange (HIE).	1. Increase number of long-term care facilities participating in HIE by 2% per year 2. Increase number of hospitals connected to certified HIOs by 2% per year	1. The number of Skilled Nursing Facilities (**SNF**) connected to an HIO out of the current 663 SNF in PA 2.A The number of **ALL** Hospitals connected to an HIO out of the current 251 Hospitals in PA 2.B The number of Hospitals with an ED connected to an HIO out of the current 176 **ACUTE** Hospitals.	**As of 6/23/2024** **SNF:** 174/663 **ALL:** 162/253 **ACUTE:** 143/177
B. Educate stakeholders, including patients and their advocates, on the value of participating in HIE.	1. Increase patient portal usage by 5% per year 2. Increase number of Pa eHealth website hits by 5% per year	1. The combination of the monthly number of Medicaid Patient Portal **Total Logins**, **Unique Logins** and **Clinical Reads ,** averaged over the State Fiscal Year (SFY) 2. The number of monthly total Page Views for the published Pa eHealth web pages averaged over the State Fiscal Year (SFY)	**6/1/24 – 6/30/24:** **TOTAL LOGINS:** 15 **UNIQUE LOGINS:** 3 **CLINICAL READS:** 652 **Page Views:** 652
C. Align health information exchange with federal HIT goals and objectives.	1. Secure contract with new P3N vendor that meets federal requirements by 1Q2026	N/A	N/A

GOAL 2: Increase timely access to usable information

Goal 2: Increase timely access to usable health and community information.

OBJECTIVES	METRICS	Definition	BASELINE
A. Integrate P3N into the Medicaid Management Information System (MMIS).	1. Complete MMIS integration by 2Q2027, including exposing MA claims information to the P3N 2. Investigate possibility of paying for MA in lieu of services through PA Navigate in SFY 2024/2025	N/A	N/A N/A
B. Integrate PA Navigate with Compass.	1. Expose closed-loop referrals to Compass in CY2025 2. Expose Compass program participation information to Pa Navigate in CY2025	N/A	N/A N/A
C. Make health related social needs data available through PA Navigate.	1. Increase number of organizations integrated with Pa Navigate by 5% per year	Total number of organizations integrated with PA Navigate	As of 6/30/2024: TBD

GOAL 3: Improve upon existing P3N services

Goal 3: Improve upon existing Pennsylvania Patient and Provider Network (P3N) services.

OBJECTIVES	METRICS	Definition	BASELINE
A. Support advancements for access to clinical information.	1. Hosting ONAF forms in P3N clinical data repository by end of CY2024	N/A	N/A
	2. Hosting Department of Aging SAMS care plans by end of CY2025	N/A	N/A
	3. Automated identity proofing and enrollment of patients in the P3N patient portal in CY2025	N/A	N/A
B. Support for electronic digital performance measures.	1. Increase operational efficiency by reducing XCA and ADT errors by 3% per year	1.A The Number or XCA errors reported monthly by Cognosante, normalized by deleting messages that had identical transaction code and averaged over the SFY 1.B. The Number of monthly Parsing Errors from all sources averaged over the SFY	**6/1/24 – 6/30/24:** 1.A **XCA:** TBD by Cognosante 1.B **ADT:** 644,107
	2. Reduce number of PIX records with missing information by 3% per year (all sources)	2. The number of monthly Pix Records from all sources w/ at least 1 missing field of data averaged over the SFY	2. **Records Missing info:** 931,023

GOAL 4: Expand care coordination

Goal 4: Expand care coordination to improve quality and reduce health care costs.

OBJECTIVES	METRICS	Definition	BASELINE
A. Expand the number and types of Admission Discharge Transfer (ADT) messages contributed to the P3N ADT Service.	1. Increase inter-state ADT sharing by 1 state per year 2. Increase volume of ADTs sent from the P3N by 5% per year	1. Count of states/districts that exchange ADTs with PA, currently AK, CT, DC, DE, MD, WV 2. Count of Outbound ADT msgs sent by the P3N to HIOs	**As of 6/30/24: States/Districts:** 6 **7/1/23 – 6/30/24 ADTs Sent by P3N**: 62,270,700
B. Capture meaningful information from ADTs for analysis and population health reporting.	1. Create ADT surveillance system for support of program areas such as abuse and neglect in CY2024 and poison control in CY2025	Implement Dashboards based off Diagnostic Codes within an ADT message.	COVID Dashboard Exists
C. Reduce duplicative or unnecessary services.	1. Increase the number of reports accessed by P3N participants by 10% annually	The number of total Documents retrieved by all HIOs	**7/1/23 – 6/30/24 Docs Retrieved:** 13,684,700

Goal 5: Increase closed loop referrals for HRSNs

Goals 5: Increase closed loop referrals for health-related social needs

OBJECTIVES	METRICS	Definition	BASELINE
A. Promote health equity.	1. 10% increase in number of closed-loop referrals in PA annually	N/A	N/A
B. Support and collaborate with PA Navigate.	1. Leverage the P3N MPI with PA Navigate by CY2025	N/A	N/A
	2. Leverage the P3N for closed-loop referral notifications to the HIOs by CY2025	N/A	N/A

GOAL 6: Expand our collaboration with commonwealth agencies

Goal 6: Expand our collaboration with commonwealth agencies.

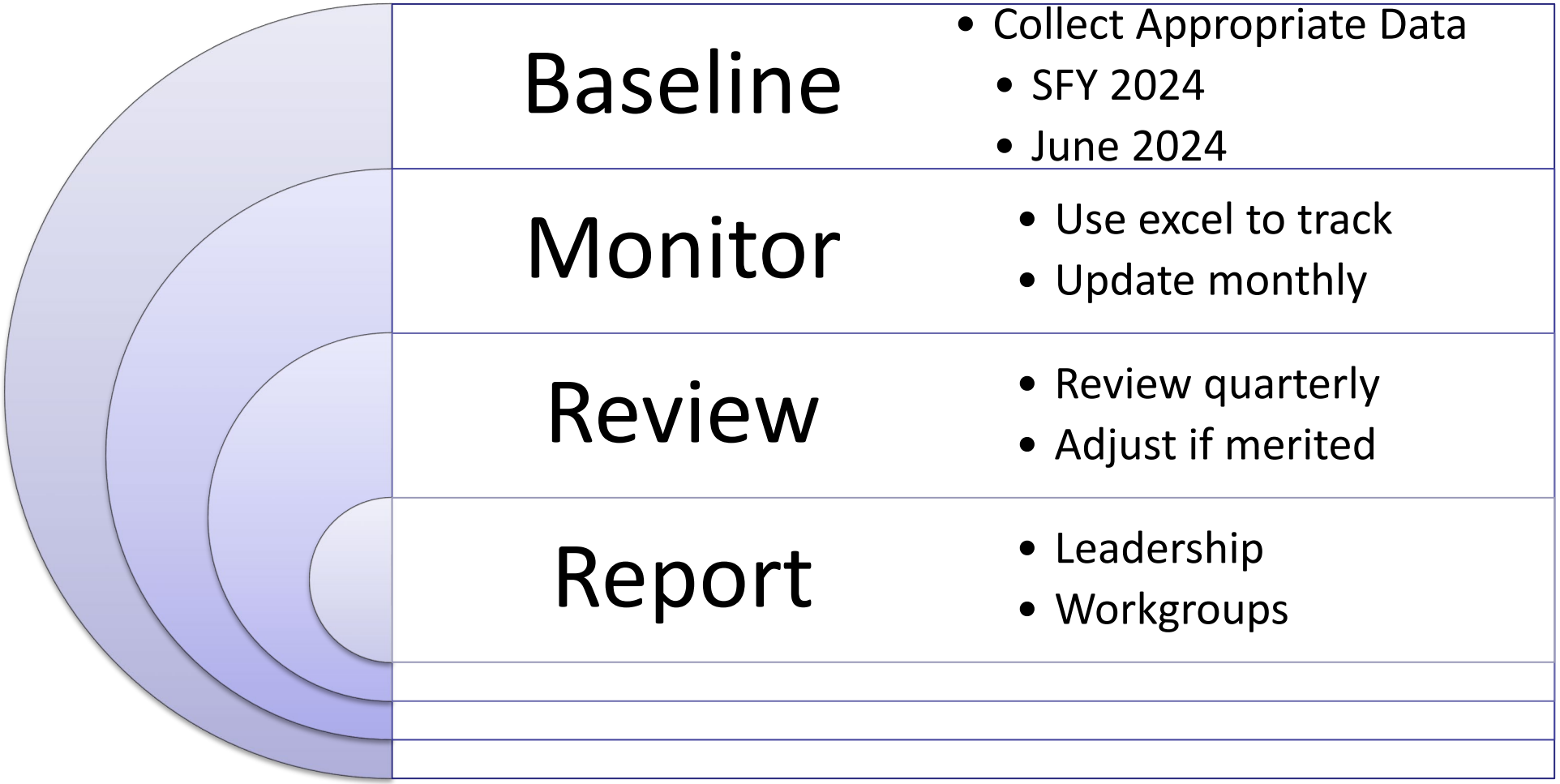
OBJECTIVES	METRICS	Definition	BASELINE
A. Expand and improve access to public health reporting registries.	1. Increase the volume of messages traversing the public health gateway by 5% per year	1. The volume of messages traversing the public health gateway	**7/1/23 – 6/30/24 MSGs:** 5,108,700
	2. Increase the number of registries participating in the public health gateway by one per year	2. The number current registries available which include ELR, PDMP, PIERS and Cancer	**As of 6/30/2024: Registries:** 4
B. Provide P3N access to state program areas.	1. Increase the number of state programs accessing the P3N by 1 per year	The Number of program offices with P3N eSante Portal access. Currently Office of Developmental Programs (ODP) and Fee For Service (FFS)	**As of 6/30/2024: Programs:** 2
	2. Integrate P3N with the Enterprise Case Management System by CY2025	N/A	N/A
	3. Integrate P3N with state EHRs (OMHSAS by CY2024, DMVA by CY2025)	N/A	N/A
C. Expand P3N and/or PA Navigate access to Pennsylvania county facilities, local entities, and county agencies.	1. Increase number of county prisons connected to certified HIOs by 2 per year	The number of County prisons connected to an HIO	**As of 6/30/2024: County Prisons:** 0
	2. Increase number of PA county and local programs using PA Navigate by 5% per year	N/A	N/A

GOAL 7: Advocate for sustainable HIO funding

Goal 7: Advocate for sustainable HIO funding. Expand care coordination to improve quality and reduce health care costs

OBJECTIVES	METRICS	Definition	BASELINE
A. Creation of MA Care Coordination Grants.	1. Implement MA Care Coordination Grants in FFY2025	N/A	N/A
	2. Continue and increase MA Care Coordination Grants each year	Funding provided to HIOs to improve Care Coordination	$0
B. Expand use of P3N services by the HIOs to reduce duplication of services.	1. Enhance the P3N ADT service to meet HIO needs for alerts and notifications by CY 2024	N/A	N/A

Plan for Reaching Our Goals



Sample Excerpt of Metrics Tracking

WBS (Goal-OBJ-Metric)	Data Driven Metrics	How to measure	Assignee	Baseline			Goal		Achieved	State Fiscal Year 2025 July 1, 2024 - June 30, 2025											
				Definition	Timeframe	Value	Inc / Dec	Target		JUL Value	AUG Value	SEP Value	OCT Value	NOV Value	DEC Value	JAN Value	FEB Value	MAR Value	APR Value	MAY Value	JUN Value
4.C.1	Increase the number of reports accessed by P3N participants by 10% annually	In the Interop Dash, pull 7/1/23 - 6/30/24 for baseline and report the number of total docs retrieved as shown in total box of dashboard. Populate each month in value column using filters to show 1st - last	Deb	The number of total Documents retrieved by all HIOs	7/1/23 - 6/30/24	13,684,111	10.00%	15,052,522	No	0	0	0	0	0	0	0	0	0	0	0	0
5.A.1	10% increase in number of closed-loop referrals in PA annually	No Baseline, Work with Martin and PA Nav to determine how to	Kay	The number of provider referrals that were seen by the agency referred to	As of 6/30/24	0			No	0	0	0	0	0	0	0	0	0	0	0	0
6.A.1	Increase the volume of messages traversing the public health gateway by 5% per year	Pull from excel report generated by DOH	Dana	The volume of messages traversing the public health gateway	7/1/23 - 6/30/24	5,108,700	5.00%	5,364,135	No	0	0	0	0	0	0	0	0	0	0	0	0
6.A.2	Increase the number of registries participating in the public health gateway by one per year	Pull from excel report generated by DOH	Dana	The number current registries available which include ELR, PDMP, PIERS and Cancer	As of 6/30/24	4	1	5	No	0	0	0	0	0	0	0	0	0	0	0	0
6.C.1	Increase number of county prisons connected to certified HIOs by 2 per year	Ask DOC if any county Prisons are connected	Deb	The number of County prisons connected to an HIO	As of 6/30/24	0	1	1	No	0	0	0	0	0	0	0	0	0	0	0	0
6.B.1	Increase the number of state programs accessing the P3N by 1 per year	Enter the Number of program offices with access as of 30 June 2024 in baseline, Each month enter the number of new areas added.	Deb	The Number of program offices with P3N eSante Portal access. Currently Office of Developmental Programs (ODP) and Fee For Service (FFS)	As of 6/30/24	2	1	3	No	0	0	0	0	0	0	0	0	0	0	0	0
6.B.2	Increase number of PA county and local programs using PA Navigate by 5% per year	No Baseline, Work with Martin and PA Nav to determine how to	Kay	The number of PA county and local programs using PA Navigate	As of 6/30/24	0	5.00%	0	No	0	0	0	0	0	0	0	0	0	0	0	0
7.A.2	Continue and increase MA Care Coordination Grants each year	Baseline will be 0 Enter monthly amounts awarded in appropriate Month	Christy	Funding provided to HIOs to improve Care Coordination	As of 6/30/24	0	$1	$1	No	0	0	0	0	0	0	0	0	0	0	0	0
Date Driven Metrics			**Assignee**	**Target Date**			**46,022**	**Completed Y/N**	**Date Completed**												
Meet in SFY 2025							**46,022**														
4.B.1 (a)	Create ADT surveillance system for support of abuse and neglect in CY2024		Kathleen	31-Dec-24			46,112	**No**	**0**												
6.b.3 (a)	Integrate P3N with state EHRs (OMHSAS) by CY2024.		Kathleen	31-Dec-24				**No**	**0**												
3.A.1	Hosting ONAF forms in P3N clinical data repository by end of CY2024		Kathleen	31-Dec-24			46,295	**No**	**0**												
7.B.1	Enhance the P3N ADT service to meet HIO needs for alerts and notifications by CY		Kathleen	31-Dec-24			46,568	**No**	**0**												
2.A.2	Investigate possibility of paying for MA in lieu of services through PA Navigate in SFY 2024/2025		Kay	30-Jun-25				No	0												

Sample Excerpt of Leadership Report

Strategic Plan Metrics - SFY 2025									
Data Driven	Baseline			Current July 2024		Target	Date Driven	Target	Completed
PA Hospital Coverage	Definition	Timeframe	Value	# with HIO connection	Total Facilities	Target	Meet in SFY 2025		
Increase number of long-term care facilities participating in HIE by 2% per year	The number of Skilled Nursing Facilities (SNF) connected to an HIO out of the current 663 SNF in PA	As of 6/30/24	174			177	Create ADT surveillance system for support of abuse and neglect in CY2024	31-Dec-24	00-Jan-00
Increase number of All hospitals connected to certified HIOs by 2% per year	The number of All Hospitals connected to an HIO out of the current 251 Hospitals in PA	As of 6/30/24	161			164	Integrate P3N with state EHRs (OMHSAS) by CY2024.	31-Dec-24	00-Jan-00
Increase number of Acute Care hospitals connected to certified HIOs by 2% per year	The number of Hospitals with an ED connected to an HIO out of the current 176 Acute Hospitals	As of 6/30/24	142			145	Hosting ONAF forms in P3N clinical data repository by end of CY2024	31-Dec-24	00-Jan-00
User Access	Baseline JUN 2024			Current JUL 2024		Target	Enhance the P3N ADT service to meet HIO needs for alerts and notifications by CY 2024	31-Dec-24	00-Jan-00
	Definition	Timeframe	Value				Investigate possibility of paying for MA in lieu of services through PA Navigate in SFY 2024/2025	30-Jun-25	00-Jan-00
Increase Total Logins by 5% per year	The number of Medicaid Patient	6/1/24 - 6/30/24	17			18	Meet in SFY 2026		
Increase Unique Logins by 5% per year	The number of Medicaid Patient Portal Unique Logins	6/1/24 - 6/30/24	4			4	Expose closed-loop referrals to Compass in CY2025	31-Dec-25	00-Jan-00
Increase Clinical Reads by 5% per year	The number of Medicaid Patient Portal Clinical reads	6/1/24 - 6/30/24	17			18	Expose Compass program participation information to Pa Navigate in CY2025	31-Dec-25	00-Jan-00
Increase number of Pa eHealth website hits by 5% per year	The number of total Page Views for the published Pa eHealth	6/1/24 - 6/30/24	652			685	Hosting Department of Aging SAMS care plans by end of CY2025	31-Dec-25	00-Jan-00

Sample Excerpt of Workgroup Report

Strategic Plan Metrics - SFY 2025					
Data Quality Metrics	**Baseline JUN 2024**			**Current JUL 2024**	**Target**
	Definition	**Timeframe**	**Value**		
Increase operational efficiency by	Increase operational	6/1/24 -	69,672		67,582
Error Read	Error Read	6/1/24 - 6/30/24	128		124
SOAP	SOAP	6/1/24 - 6/30/24	40,412		39,200
Socket	Socket	6/1/24 - 6/30/24	2,455		2,381
Timed Out	Timed Out	6/1/24 - 6/30/24	26,677		25,877
Increase operational efficiency by reducing ADT errors by x% per year	The Number of monthly Parsing Errors from all sources averaged over	6/1/24 - 6/30/24	629,792		610,898
Reduce number of records with missing information by 3% per year	The number of monthly Pix Records from all sources w/ at least 1	6/1/24 - 6/30/24	901,154		874,119

TEFCA Discussion

Martin Ciccocioppo

Director

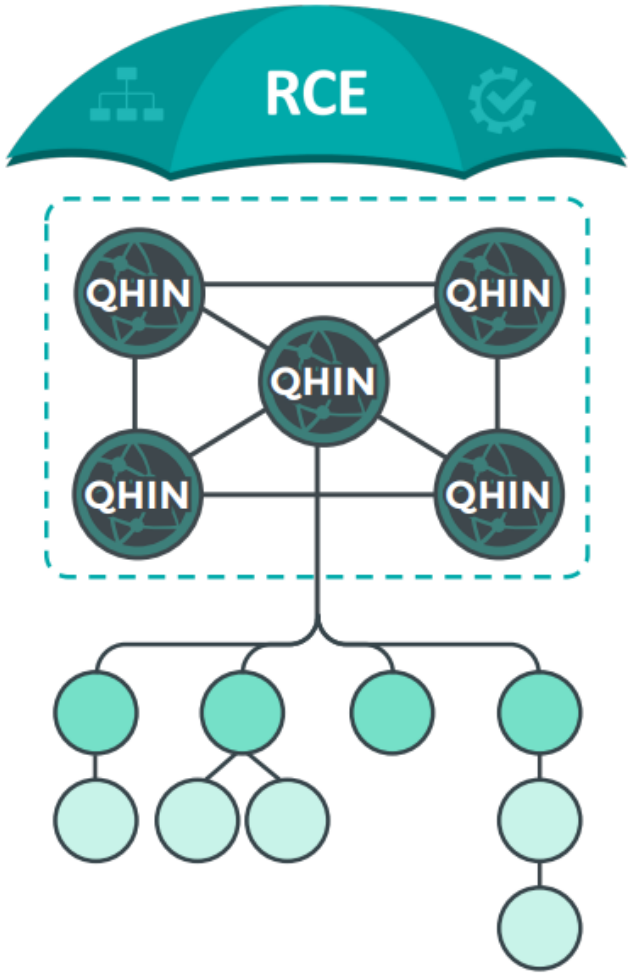
Pennsylvania eHealth Partnership Program

Office of Medical Assistance Programs

Pennsylvania Department of Human Services

Exchange Under TEFCA

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

QHINs connect directly to each other to facilitate nationwide interoperability

Each QHIN connects Participants, which connect Subparticipants

Participants and Subparticipants connect to each other through TEFCA Exchange

- Participants contract directly with a QHIN and may choose to also provide connectivity to others (Subparticipants), creating an expanded network of networks
- Participants and Subparticipants sign the same Terms of Participation and can generally participate in TEFCA Exchange in the same manner

TEFCA is Live

commonwell® HEALTH ALLIANCE

eHealth Exchange™

Epic Nexus

HEALTH® GORILLA

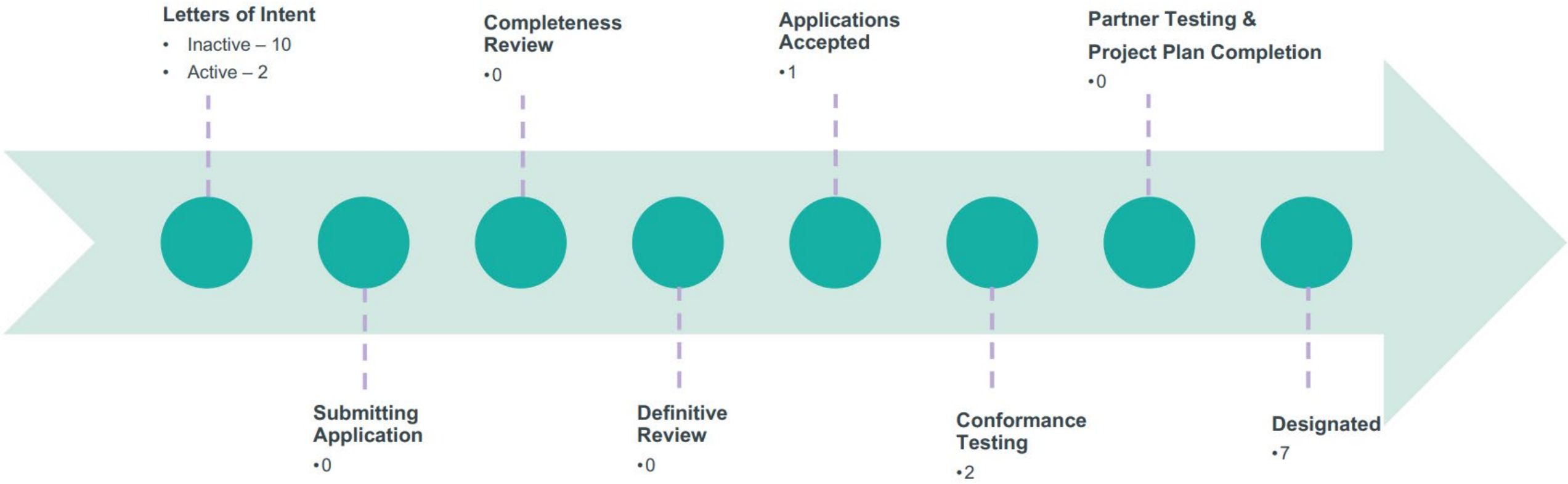
Kno2®

KONZA NATIONAL NETWORK

MedAllies

Candidate QHINs include eClinicalWorks and Surescripts Health Information Network.

QHIN Application and Onboarding & Designation



Common Agreement Versions At-A-Glance

January 2022

Common Agreement V 1

The Common Agreement version 1 was the initial version of the Common Agreement and reflected policies developed with extensive public input.

Related QTF Version: 1
Related FHIR Roadmap Version: 1

December 2023

Common Agreement V 1.1

The Common Agreement version 1.1 included changes required by HHS prior to TEFCA exchange going live. *This is the version in operation as of the official launch of TEFCA exchange.*

Related QTF Version: 1.1
Related FHIR Roadmap Version: 2

July 2024

Common Agreement V 2.0

The Common Agreement version 2.0 includes enhancements and updates to require support of HL7 FHIR® based transactions.

Related QTF Version: 2 – DRAFT
Related FHIR Roadmap Version: 2

Transition from Version 1.1 to Version 2.0

- **TEFCA is currently live on Common Agreement Version 2.0 for QHINs**
- Applicable Flow-Down provisions are applied to Participants and Subparticipants
- There is a transition period to allow for adoption of the new Framework Agreements by those who are already live
  - 60 days for the Common Agreement
  - 180 days for the Terms of Participation
- During the transition, all TEFCA connected entities can engage in TEFCA Exchange for approved Exchange Purposes
- QHINs are responsible for adding new TEFCA connected entities to the RCE Directory as they sign the Terms of Participation

May 2024

- May 1: Common Agreement and Terms of Participation published in Federal Register

June/July 2024

- July 1: Common Agreement 2.0 is effective for QHINs (60 days after publication)
- RCE and newly designated QHINs sign version 2.0
- Final QTF version 2.0 published and expected to be in production
- Facilitated FHIR SOP expected to be published and in production
- New Participants and Subparticipants sign the Terms of Participation

Summer 2024

- Additional SOPs are released on a rolling basis

December 2024

- Dec 27: Terms of Participation compliance date for any Participant / Subparticipant that signed a flow down agreement prior to June 30th

Standard Operating Procedures (SOP)

What is an SOP?

- An SOP is a written procedure or other provision that is incorporated by reference into the Framework Agreements to provide detailed information or requirements related to TEFCA Exchange
- SOPs address, among other things, governance, privacy and security requirements, RCE directory services, and QHIN application and designation
- Each SOP identifies the parties to which it applies (QHINs, Participants, Subparticipants)

What is the Exchange Purposes (XPs) SOP?

The XPs SOP details specifications relevant to when and how information can be requested or shared through TEFCA Exchange

What is an Exchange Purpose (XP) Implementation SOP?

XP Implementation SOPs provide additional details for specific use cases, as needed

Why SOPs?

- SOPs create the flexibility for TEFCA to evolve and expand over time
- SOPs will be created and modified as needed and finalized through a defined change management process
- Access the SOPs on the RCE website

Expected SOP Batch Release

Published July 1, 2024

- QHIN Technical Framework (QTF) Version 2.0
- Facilitated FHIR Implementation SOP
- Individual Access Services (IAS) Provider Requirements
- Governance Approach SOP
- Delegation of Authority SOP
- Expectations for Cooperation SOP
- Exchange Purposes SOP
- RCE Directory Service Requirements Policy SOP
- Security Incident Reporting SOP
- XP Implementation SOP: Treatment

Expected Summer/Fall 2024

- XP Implementation SOP: IAS Demographic Matched
- XP Implementation SOP: Public Health
- XP Implementation SOP: Health Care Operations
- QHIN Security for the Protection of TEFCA Information (TI)
- Participant/Subparticipant Additional Security Requirements SOP
- QHIN Onboarding & Designation/Application SOP
- QHIN Application SOP
- Updated Governance SOP

SOP: Exchange Purposes (XPs)

TABLE 2. REQUIRED RESPONSE AND PERMITTED FEES

Authorized XP	XP Code	Required Response (Yes/No)	Permitted Fees (Yes/No)
Treatment	T-TREAT	No	No
TEFCA Required Treatment	T-TRTMNT	Yes	No
Payment	T-PYMNT	No	Yes
Health Care Operations	T-HCO	No	Yes
Public Health	T-PH	No	Yes
Electronic Case Reporting	T-PH-ECR	No	Yes
Electronic Lab Reporting	T-PH-ELR	No	Yes
Individual Access Services	T-IAS	Yes	No
Government Benefits Determination	T-GOVDTRM	No	Yes

Key Highlights

- Each transaction must be accompanied by the appropriate XP Code
- Table 2 list the XPs that require Response, unless an exception applies, per the XPs SOP
- Responses to required XPs must include all Required Information maintained
- Responding Nodes may only charge fees to an Initiating Node if permitted in table 2
- The XPs SOP lists the exceptions to required Responses

Chilling Effect of TEFCA on HIE in Pennsylvania

TEFCA is like a national version of the federated health information exchange ecosystem we have in Pennsylvania.

In Pennsylvania we have a very robust federated statewide health information exchange (i.e., Verato referential MPI, two-way access to public health registries, query and retrieve, Admission Discharge Transfer (ADT) message alerting service, care plan registry, and patient portal) that we call the Pennsylvania Patient and Provider Network (P3N) with a newly integrated statewide closed-loop referral system for addressing health-related social needs (HRSN) that we call PA Navigate.

Our participants include: Department of Human Services, which hosts the P3N; five P3N-certified health information organizations (HIOs); Department of Health, which hosts several state registries (i.e., PIERS, PDMP, eLR, cancer) our participants access through the P3N; Department of Corrections, which has a P3N-integrated EHR; and neighboring state HIEs for ADT sharing.

TEFCA just became operational over the last few months with a very limited query and retrieve use case. Since health care provider EHRs can only be connected to a single TEFCA Qualified Health Information Network (QHIN), and several EHR venders and national HIEs are now Designated QHINs, TEFCA participation growth in Pennsylvania is a threat to our much more robust health information exchange in Pennsylvania.

Chilling Effect of TEFCA on HIE in Pennsylvania continued

At this time, all P3N-Certified HIOs have opted out of the National eHealth Exchange (eHX) QHIN and have opted out of the Epic QHIN, because so many of their provider members use EHR vendors that are, or are becoming, designated HIO. While Epic is not mandating customer participation in its QHIN, Epic is forcing our Epic-based HIOs to join the Epic QHIN in order to stay on the Epic Honor Roll to get up to 10% Epic fee rebates.

The firm requirement that a health care provider's EHR can only be a participant, or downstream participant, in a single QHIN poses a very real threat not only to our regional and statewide HIE, but many local HIEs across the country.

TEFCA was designed for HIEs like the P3N to become QHINs, not for EHR vendors to become QHINs. Now that EHR vendors are QHINs, HIEs are largely prevented from participating in TEFCA for fear that their participants will not be able to be a member of their EHR vendor's QHIN and a local HIE that participates in a QHIN.

The first TEFCA QHINs were designated in December 2023; we are still waiting to see what impact HIO members' participation in their EHR vendor operated QHIN in Pennsylvania will have on P3N HIO participation.

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 1, 2024, Advisory Board for Calendar Year 2025.

2024 Advisory Board Meetings

- Friday, November 1, 2024, in-person at 2525 North Seventh Street, Harrisburg, 10 a.m. – 2 p.m.

Public Comment

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

Online Resources

PA eHealth further information:

eHealth Partnership | Department of Human Services | Commonwealth of Pennsylvania

PA eHealth Partnership Advisory Board:

eHealth Advisory Board | Department of Human Services | Commonwealth of Pennsylvania

P3N HIO Certification Package:

HIO Connection | Department of Human Services | Commonwealth of Pennsylvania

P3N Certified Health Information Organizations (HIO) Information:

Choose your HIO July 2023 v8.pdf (pa.gov)

List of clinical documents available by each HIO and HIO Member Organizations:

https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/ehealth/documents/Discrete%20Data_October%202023.xlsx

List of facilities sending ADTs through their HIO to the P3N:

23-APRIL-2024_WEBPOST-P3N-ADT-Onboarding.xlsx (live.com)

PA Navigate:

http://pa-navigate.org