New STEPs 360: May All-Awardee Meeting
Health Information Technology (HIT)
May 19, 2016

Marci: ... on our May, I'll say meeting. This is focusing on HIT [Health Information Technology] and HIT issues. I'll jump right in. Our objective for today, as Sarah sent around earlier, a few housekeeping items. Then we'll talk about onboarding HIT activities for the remaining states that we didn't get to in the last month. Then we'll go back and talk a little bit more about our HIT shared outcome measures.

We've been working on them a little bit, and would like to get your feedback since we're getting closer. Then we'll wrap up and have any other review or action items. Sarah, do you want to go over our housekeeping items for us?

Sarah: Sure. First, I just want to remind everybody, if you have activities that you've completed, to please remember to send us your invoices for year one. Year one is coming to an end pretty soon, at the end of August. Instead of waiting till the very, very last moment to submit your year one invoices, it would be great if you could submit any now that you have. You can just send them directly to me.

On the same lines, as year one coming to an end, it's already time to start thinking about your year two subcontracts, but I promise this is a lot, lot easier than the first one. For year two subcontracts it is really a contract amendment. You'll just have to update your budget and scope of work with your year two activities, as well as provide a budget justification.

The only thing that's a little different this year is that you have to ... The university is requiring a commitment form. It shouldn't be that bad. Pretty much you just have to fill that out and send that to us as well. Another thing that's a little different for the year two is, for the kick-off meeting, we're going to ask that you write in travel funds into your budget. This will be in addition to the $50,000 that you're allotted for timeliness activities.

You would just write in the travel to this year's kick-off meeting. It's that. I know that some States have some trouble requesting travel funds in their budget, so if that State is you, that is completely fine. We will just proceed like we did last year and cover your travel. Then, for the kick-off-

Marci: We will send what information about that budget?

Sarah: Yes, sorry. For the subcontract information, I will send a year two contract package at the beginning of June. Just be on the lookout with that, and that will have instructions, more information about including the travel funds for the in-person meeting into that budget, as well as all the forms that need to be completed. Just be on the lookout for that, beginning of June. If you would like it earlier let me know, and I can see if we can get that done for you as well.

Then, lastly, just for the kick-off meeting, again that's going to be November 16th and 17th in Washington, DC. If you need travel approval from your States, please

go ahead and start requesting that soon. I know most of those States require an agenda, and we don't necessarily have an agenda right now, but I can come up with a rough sketch, based on last year's agenda, for you.

Speaking of agendas, if you have any suggestions, or topics, or conversations, discussions, that you would like to see included in year two in-person meetings, go ahead and shoot me an email. Let me know what you would like to accomplish or do for those two days, or if you're interested in being part of the planning committee, let me know as well so we can make sure that you're included in conversations regarding the agenda and workbooks, and things like that. Anybody have any questions, you can email me or call me. I'm always there.

Marci: Thank you, Sarah. Right now we'll move on to the next section. Health Information Technology (HIT) activities and the States that we have to report today are Nebraska, Minnesota and Puerto Rico. NYMAC is scheduled to report but they are actually at their regional collaborative meeting today, or their advisory committee meeting, so they're not available on the call today to report for themselves ... .

These are the questions that we outlined for HIT activities. Really what we want is an update of what it is you're doing and what are your biggest wins and your biggest challenges so far? From Nebraska, Julie are you on? ... I'd like to see if we can find Julie. I see her. It looks like, Julie, you're muted.

Julie: Yes.

Marci: There we go.

Julie: Now can you hear me?

Marci: Yeah.

Julie: Nebraska, briefly what our goal is, is to improve timeliness of reporting results to submitters and hence to the primary healthcare providers via supporting four hospitals obtaining the HL7-compatible electronic interface that will allow them to do the ordering and the resulting more in real time, within an hour of real time. I guess it's updated about every hour.

The partners that we have for this are, of course, our laboratory, PerkinElmer Genetics. We have four hospitals, St. Elizabeth here in Lincoln; Chadron, which is a smaller hospital way in the far northwest corner of Nebraska; Great Plains Health, which is a little bit larger regional hospital in western central Nebraska; and Sydney Hospital, which is in western Nebraska.

We've got most corners of the State covered and different sizes of facilities, because they need ... There's a pretty large birthing facility and Great Plains medium, and Chadron and Sydney much smaller. That's the goal. Wins so far, we've got the contracts in place with all four of the hospitals. From my perspective, challenges so far not terribly difficult, but just more time consuming getting things in place and set up for them to do it, just administrative stuff.

Ken may have more of the HIT perspective things to report on, any wins or challenges that he's perceiving. I know he was planning on being on the call today. I don't know if he made it. If he's on, you probably will have to unmute Ken.

Marci: I see a time, although it doesn't look like he has either phone or video capabilities. Ken, are you on? He might just be logged on to the computer without audio.

Julie: Okay. I don't want to speak for any of the IT things that they are running into because I'm virtually just not part of that, other than sending reminders. I sent a reminder out to all four hospitals. Three of them have reached out and are in process of working on things or working things out with PerkinElmer, and one of them, I don't think, had as of yesterday. I sent reminder notes out to all four of them that they do only a progress report by the end of May, so that might spur them on a little bit to move on it.

Marci: Could you talk a little bit about your RFP [Request for Proposals] process that you went through to find those four partners?

Julie: Yeah. It was not a request for proposal, but contract opportunity, and it was a competitive process. They did get scored on ... Oh my goodness, I need that in front of me. They got scored on nine or ten things. We had six applicants. One was late, and under our contract bidding rules in Nebraska, we could not review that. One just didn't score high enough at all. Then the remaining four are the ones we're funding.

One of those four actually wanted to fund four hospitals, so it'd been a group thing and they would have taken off 40,000, but it didn't score high enough. It would have had to been the top rated one. They didn't get the full 40,000 but they were able to at least get some money to get their own facility process. Did you want more details about what kind of questions we asked them on that?

Marci: It actually might be nice, because I think there was another State that might want to do something similar with looking for partners.

Julie: Let me find it here, right now.

Ken: Can you guys hear me now?

Marci: Yeah, I can hear you.

Julie: Oh, Ken.

Ken: All right, that's good.

Julie: While I'm looking for that thing do you want to speak about your perspective on things?

Ken: Yeah. The challenges so far, these are typical of any time we do an HL7 interface, is coordinating all the different groups of people. There's the hospital, IT staff. There's always the lab system vendor, like SunQuest or Epic or somebody. Everybody has a different level of understanding and different level of expectations about how they think it's going to work, how long they think it's going to take, what information's going to be involved, and how it will improve their processes.

It takes a little bit of time to have everybody get on the same page and have realistic expectations about how long it will take, and the benefits that they'll actually see from it. That's probably the biggest challenge, and that's typical of any time we do an interface like this with different groups of people. Some of the wins, it's more long term. It would be, when you get everybody on electronic resolve you usually see benefits with manual reporting.

It just improves the turnaround time for reporting. There's no immediate wins. It's a lot of the "get her done" phase now, where you just have to get everything set up and get the people coordinated. The wins are more long term, I'd say when their project is completed. Is there anything that ...? Something we could learn is, ideally you'd want everybody on this, all the data entry coming in through the electronic interface, but it just will never happen.

You always have a scenario where there's half coming in through electronically and half still being in the manual data entry. Just curious how other people have approached that. Do they have the same QA process? Is there something that differently, like the electronic versus the manual data entry? I'm just curious about how other people handle those mixed environments.

Julie: That's a great question.

Marci: What do the people on the phone need to do to unmute, Sarah? Is it Star-7?

Sarah: Yes.

Marci: Star-7 to unmute if you're on your phone, if anyone has comments or feedback for Ken and the Nebraska group about what to do when you have messages coming in in different ways ... Dari, I'm looking at you, now. See, this is the price you pay for being on video, is I can see you. I know you're there. I know that I always had some hospitals reporting electronically and some reporting still via traditional methods.

Do you have advice on what you do for quality assurance and how you deal with that? Do you have different systems in place? Dari, we can't hear you. I see your lips moving but you're ...

Sarah: You should be able to unmute yourself. Let me see. It doesn't look like you have ...

Marci: Try again, Dari ... Still can't hear you.

Sarah: I don't know if Dari's connected to the audio.

Ken: I had to hit, it was 9-7-# to join the audio. Then after that I had to right-click and then unmute myself. It's a couple of steps to get to this level. Maybe the other people may have to do that, if they want to say something.

Marci: Could you try unmuting everyone, Sarah? Let's see if we have any background noise. Hopefully the person who put us on hold is no longer ...

Ken There you go.

Marci: I can hear it, but we still can't hear Dari ... We might need to mute people again, sorry. I was hoping that might work. All right, Dari, if you could ... Dari, I might give you the information if you can call in on your phone. Are there others who've had that experience of some programs doing one thing and some doing another? Nebraska, I'm wondering, one thing you didn't say is you've already had this in place for four hospitals. This is a new round of four hospitals but you had four who you then ... who have been sending messages to you already, is that correct?

Ken : Yeah, that's correct.

Marci: You've been dealing with this for a while and struggling with that differences in quality, how to do that quality assurance check with those current hospitals already.

Ken: Yeah. I mean, the volume will increase a little bit. Then this is just something we'll have to solve sooner or later, but I mean, now for the most part we just merge everything into the manual data entry systems, so it's not ... One point we would like to do more, especially as the volume increases, do more with the orders that come in, because the only benefit we're really seeing now is with the results going out, the electronic results.

Marci: ... Julie, did you want to share the questions?

Julie: ... Yeah, I was just going to say that the hospitals enter eight or nine fields of data. That goes electronically to the lab with the order sent, but the lab then still has to enter a whole bunch of other information off the filter paper, so I think that's what Ken's talking about is-

Ken: Yeah.

Julie: Then how do we quality control that as far as who omitted the data, or who made the data entry error? How can we improve things there if we don't know where things are happening? Can we get it more standardized?

Marci: That makes sense ... Go ahead, Julie.

Julie: I was just wondering if Dari has some lessons learned, if he can't get on today, if he wouldn't mind sharing those with me and Ken, with our team.

Marci: Sure. I think he might be working on trying to call in.

Julie: That'd be great.

Marci: Because Dar] always has good lessons learned for us. Are you trying to call in, Dari? Is that what you're doing?

Dari Shirazi: I'm called in now.

Marci: Dari's in! All right, Dari, tell us your lessons learned. What can you help us with?

Dari Shirazi: Actually this is a bit of a struggle for everyone. The problem is, as you guys can imagine, there's two source of information where there used to one before. The trouble that we are getting into is some information even ... It's not just lack of information. The card comes with some of the fields full, and some of it comes electronically sometimes. There's actually discrepancy between what's on the card and what comes out electronically.

Now, with our Unity Point Hospital, they said go with what comes in electronically because it's usually more accurate, more up to date than what comes on paper. We actually, the laboratory tries to the best job of verifying. If there is a large discrepancy, then what the system does, they autofax a test request. It's something like a test request form, but it's actually a piece of paper that says, "Please verify," or "Please provide us this information, these fields of information."

That's about it. If there is a discrepancy and one of them says five gram, one of them says 2,500 gram, you have to check. There's no clear solution. Like I said it depends on the hospital. Some hospitals, they go by what's electronically. Some hospitals, they go by what's on the paper.

Marci: ... Thanks, Dari.

Dari Shirazi: Are you guys keeping track of what came in to what in your lens as well?

Ken: Yeah, we have pretty basic reports about volume from electronic orders and the other volume. Everything comes in through paper. It's just in addition we may or may not have the electronic orders. We keep track of all that.

Dari Shirazi: The data entry staff or newborn screening can override any of the fields

Ken: That's similar what we do.

Dari Shirazi: Yeah. Unfortunately there is not ... If you had third source of information. We just brought a huge interface up with one of our local hospitals here. It's probably one of the biggest hospitals. Not for birthing, but it's good size hospital for birthing. The data is by far cleaner than it was before because of the new system that they went to. They're getting a lot more information from their ... It's called Epic Beaker. I don't know if any of you guys have seen that interface.

What's so good about it is, Epic Beaker now, at the time of collection, now it lets you record the data and time of collection. Before it was estimated date and time and collection, because they had a process where, when the baby was born, they would automatically put an order in for 24 hours from then. That information was almost 100% incorrect, so they had to transpose what was coming on the card. That has been fixed, but it's a struggle.

Until everybody either goes 100% electronic and forget the card and they just send in the bar code and a five spot, I think we're going to have this dilemma.

Marci: Do you think, Dari, if you don't mind I ask that. That sparked a question for me. Getting to that point, wouldn't we still need one or two items of information on the filter paper besides the bar code, like at least a baby's name and date of birth?

Dari Shirazi: What [crosstalk 00:21:11] I'm not disagreeing at all. What [inaudible 00:21:18] says, from what I understand, and it cannot make sense, what it says that it must be unique. Now, what they mean by unique, if you take Dari Shirazi sample, well, can be the multiple Dari Shirazis? Absolutely, so that in itself is not unique. They usually append date and time of birth, or date of birth, or something like that. That makes the combination of Dari Shirazi on my birth date be unique.

The device ID, if you could record it in a way that was foolproof, like bar code. You would bar code it or something like that, where the user, when they enter that information, they electronically send it to you, they would also use that bar code. I would think that would be very good. Is it possible to make a mistake? Yes, but as I'm going through a bunch of data records now, even when you have the first name and last name and date of birth, sometimes they transpose information which makes the matching very difficult.

Julie: True ... All right, thank you.

Marci: Great. Thanks Nebraska, and thanks, Dari, for chipping in.

Dari Shirazi: My pleasure.

Marci: Minnesota, I think I see the big yellow wall of Minnesota. There's Amy and Jane ...

Jane: Can you hear us?

Marci: We can hear you.

Ken: All right.

Marci: Our biggest challenge thus far has been unmuting ourselves. [crosstalk 00:23:11] HIT States, I guess, does it?

Jane: No, we realize this is a little concerning. Our goal, I think, like a lot of others are to decrease data entry errors and missing information by trying to remove as much manual entry as possible, both on the hospital side as well as our side. Then

increase the timeliness of reporting back to our submitters by using electronic submission of results. Those are our main goals.

So far, we are partnering with our biggest health system in Minnesota, Allina Health. I believe Heather is on the call, as well. We had already started working with [inaudible 00:24:00] systems in terms of collecting EHDI [Early Hearing Detection and Intervention and CCHD [Critical Congenital Heart Disease] data. We do have our ADT feed built actually [inaudible 00:24:09] for all of Allina sites. This is pulling basic demographics at this point, so we're not getting some of the specimen card information that we would need in terms of time of collection, data collection, transfusion, feeding status, those types of things.

We do have the feed built, the VPN tunnel built. It's actually turned on and live in three facilities right now. I would say that's probably been our biggest win. The challenges are pretty much what everyone else has been discussing, is how to get that other information. We really want to utilize a bar code. We have facilities that already utilize a label, and it still has its issues.

Either the label is not complete so there's still some handwritten portions, particularly the date and time of collection, which are often not actually entered then, or we have different labels on the same specimen, or we have some handwritten on the card that contradicts with what's on the label. We're trying to think of a way to, I think, try to get rid of just printing out the information but to capture it in a bar code, either the pre-printed bar code already on the card, or on a label that has a different bar code on it.

I think at this point we're really just trying to figure out what's going to make sense and what's going to fit into Allina regarding their process, what's going to fit best into their workflow, because they believe ... Like most hospitals it's a split workflow where they have a unit coordinator, someone filling out the demographics, but then a separate person collecting the specimen and filling out other information.

We have met with Allina to talk a little bit about this. They took it back to their team and are looking at some potential options. We're also awaiting assignment of a project manager from their end for this particular project.

Marci: I think that's Jane, so we should ... Do you guys have anything else?

Dave: I'm boarding a new limb system [crosstalk 00:26:31] this summer, so that the awesome data that's going to be accurate is going to have to get imported into our new limbs. That'll be good, too, but definitely liked hearing some of the other challenges and stuff to make sure that we don't have conflicting data. I thought that was actually probably the most important thing that I've heard today and stuff, to make sure that the sample that was collected was from that baby and everything's right, and then gets imported without extra entry and stuff.

Marci: You guys are really changing things up in Minnesota. You've got lots of things-

Dave: [crosstalk 00:27:12] We like to do that when the permafrost thaws.

Marci: [crosstalk 00:27:19] have to do everything! [crosstalk 00:27:22] Could you remind us what your timeline is, when you'd like to have those hospitals and that system up and running?

Jane: That's a good question. I mean, for at least the office portion they will be pretty much up and running by the end of the fiscal year as far as for those basic demographics. Jill's not here. I can't remember what our timeline is for the lab ordering bar code piece, but sometime ... sometime.

Marci: Good I'm glad it's sometime, sometime [crosstalk 00:28:02]. Sometime, maybe. I should have pulled up your report, too.

Dari Shirazi: Can I ask a question? It's Dari.

Marci: Yeah.

Dari Shirazi: Have you guys run to any problem with practices in the hospitals where they just say "Baby One, Baby Two," regardless of whether the baby has a name or doesn't have a name?

Jane: Yeah, absolutely. I think that most of our hospitals do not update the child's name until after discharge. They remain Baby Boy One, Baby Boy Two, or whatever designation they're giving their kid, until the child's been discharged. What we've had to do is work with OZ. Previously we were just collecting three messages, three ADT messages, so the AO1, AO8 and AO3, the admission, update and discharge.

That was not getting us the baby's actual name, so we've added the capability to collect the A31 message, which is a post-discharge update message to capture the child's name, if that makes sense.

Dari Shirazi: Yeah, it does. How does that fix updating your records after the sample is received?

Jane: That is a good question. Okay, I'm trying to think of ... You're thinking timeline. If we receive a specimen and it's under Baby Boy Johnson and then we get that message and it changes to Joe Smith?

Dari Shirazi: Right.

Jane: What does that look like?

Dari Shirazi: Yeah.

Jane: I think that's TBD for us right now. I don't know, because we're not linking to our limbs yet, because we're in the process of switching limbs. I can't tell you what that looks like, but I think it's a good concern and good question.

Dari Shirazi: Yeah, because we are running to something similar and I was wondering. I mean, it's a practice unfortunately. I was wondering if you guys were running to the same thing. Thank you.

Jane: Yeah, absolutely ...

Marci: Great. Any other questions from Minnesota? ... All right, thanks [inaudible 00:30:41] the big yellow wall, the big white wall. [NIMAC's 00:30:48] not able to be here today. Puerto Rico, I thought Sulay's on the call. Sulay, can you report for what's going on in Puerto Rico, Star-7 to unmute ... Sulay ... I don't think she's connected to her phone. Sarah, do you have Sulay's number so we can unmute her particular line? ... All right, what I'm going to do is come back to Puerto Rico.

We'll figure out the technical difficulties. Maybe, Sarah, if you could chat with Sulay on the chat box and figure out what's going on. I'm going to move on to the next slides and then we'll come back and end with the Puerto Rico update. The next slides are HIT shared outcome measure. We all know that HIT measures are perhaps harder than ... I think she's on the phone ...

Sulay, if you have, press Star-7. I'm not sure why we're having so many technical difficulties today. We're going to come back to you Sulay. I promise we'll get back to you.

Sarah: It's the rain in Texas. We decided that this morning.

Marci: Is that what it is?

Sarah: Yeah.

Marci: With HIT shared outcome measures, it's going to take a long time to actually see change in using HIT, to see a change in timeliness using HIT as our mechanism for quality improvements. We're going to do our best to show change over this three-year time period in which we have funding, and yet, how can we really show baby step changes in the meantime? How can we show that we are making those connections with states.

We at the in-person meeting, discussed the shared outcome measure to identify something that could be shared across all the 360 teams that are working on an HIT focus area, to measure the progression of their hospital engagement in electronic data sharing. You may remember from last month or two months ago, I guess, we talked about categories of engagement that we borrowed from the State of Minnesota.

These were those categories. Amy had put together a really nice figure to show the very complex nature that is hospital implementation. What does that really look like, that the yellow line shows they're not active and then all of a sudden people are becoming active and they're moving back and forth across different levels of engagement and activity? What we heard from people, and I know Willy was one of the contributors on that call who said, "These are too high level. We want to have very basic levels."

In the State of Virginia their HIT initiative is to engage six hospitals and they're all engaged at some level now, but how do we capture the various stages of early engagement, that they're not going to be sending a message for a while, but how do we capture that? We took Amy's spreadsheet, we took that, we've talked internally here at NewSTEPs. Then we also talked with Amy a little bit more about what that might look like.

I'm proposing the following. This is proposed measures, fake data, but instead of those just engaged/not engaged, on hold, this is what we came up with. The hospital has engaged and expressed interest, so you have a hospital that says "Yeah, I'm willing to share an HL7 message with you. I want to engage in this process," but that's all you've got. You have a hospital who said, "Yeah, I'm willing to do this."

The second stage would be a key contact or a champion who's been identified, that you have that HIT person who's engaged and really wants to work with you and partner with you to get that data. The next stage would be, you've identified and agreed upon key data elements. You know what those key data elements are. This stage needs a little more work. Is it just that you've identified what those key elements are, or that you have identified them and agreed upon them and can actually find them in the medical record?

Because there's several stages in there. We need to define that a little bit more. The transport mechanism, our system has been chosen that it's going to be through an HL7 method, you're going to do it through a flat file, you have the integration engine. There's lots of different components within that, but that that hospital we're working with at [saintlak 00:35:50] has determined how they're going to do that.

What's the integration engine? What are they going to do? How's that message going to happen? Or how's the message going to get transferred? Then the next one is to actually have it developed. Then the third step of that is, yes, you have tested it. Then the final stage would be, yes, you have ongoing submission of data and you're in full production. You are receiving data from that State.

Based on that, I developed a spreadsheet that was similar to Amy's. I just put in six States, because it was complex to create a bunch of fake data for lots of States. These are just six hospitals, I mean, various levels based on, here's where they have implemented. From this fake data I went on and put them in a spreadsheet. Then I created a very simple Excel spreadsheet.

Now, mine are all ... I didn't have the non-engaged hospitals, so Amy shows the drop of non-engaged hospitals, which I think is a nice touch that we could add to this. I also assumed in this spreadsheet that once they were engaged at a certain level they didn't go backwards. Amy's real data would demonstrate to us that hospitals can go back and forth between levels but they're engaged and then they go, "We can't quite do this," and they go back and forth.

This is very simplistic, but this would give us a feel for something that we could collect across States. Here are my questions, and then I'll go back to the categories, because I know you all want to see those again. One, do these categories work? What else do we need to consider? Then, what's the collection time frame? That would be the collection time frame for what we would want to collect it locally, from you at the national level.

You might want to collect things ... You would likely collect things on an ongoing basis as things changed, but I don't think we would want to collect things more often than quarterly so as to minimize the burden. Those are my questions and I will go back to this. I'm happy to go back and forth between other slides if you would like. I'll open it up for discussion ...

Dari Shirazi: This is Dari. To me these are more of a milestone rather than outcome measures. Bear with me. I'm thinking as I'm saying things, so bear with me just a bit. I think if you want to tell a story, what would be extremely powerful story to tell would be how you have improved either the collection side, the timeliness on the collection side of the samples. For example, you can say, "Our laboratory can log in the samples faster because 30% of our samples come in electronically. They are recorded. It used to take us eight hours to get all our samples into the limbs. Now we can do it in four hours, so that we have improved the timeliness there."

Also the timeliness on the back end of it, where we used to have to send postal results out, and now we are down from two days to five minutes, or ten minutes, or an hour. This to me is more of a milestone. If you want to sell it, I don't know. I'm just talking a lot. I think it would tell a more powerful story if we could actually have some timings where things have improved significantly.

Amy: Dari, this is Amy. Can you hear me?

Dari Shirazi: I can.

Amy: I totally agree. I think that, and correct me if I'm wrong Marci, is the purpose of this really was to show your progress in implementing the system, which ultimately will improve your chosen outcome, which is really going to be the compelling data of why you did this. I think the concern is, if we just look for that compelling data, we're not going to have anything to share with each other for two years.

This was just a way to show progress toward implementing the system, and then once that implemented then you can go back and start to show your true improvements that are actually impacting public health. Is that right, Marci?

Marci: Yeah, exactly, yes. Well said, Amy [crosstalk 00:40:37]

Dari Shirazi: Sorry? [crosstalk 00:40:38] This is just for us, right? Just for the project.

Marci: This is just for the project.

Dari Shirazi: Okay. [crosstalk 00:40:44] I would-

Marci: Go ahead.

Dave: I was going to call these, these are your deliverables to implement your improvement, and then you can measure those, how good those deliverables are. I think, and we were talking internally, that what's not on this that actually is key, is right after you get that champion identified, is they need to put their money where their mouth is, and assign a formal project manager, get that formal project management structure. That's when budgets are assigned.

Then you start getting things because important people make sure that the project is going on task and stuff like that. When it goes off, when it gets derailed, then people get talked to. I think that is something that we've noticed in larger hospital systems that we've been working with, is when they have a formal project management structure, even though it still could take quite a while to implement, you know that it's going to happen because there's money behind it now and there's personnel assigned. That's all I had.

Marci: Thanks, Dave ... Willie, I know you had some thoughts earlier that the other ones wouldn't ... Higher level data wouldn't collect what you needed. This would be able to allow you to show some progress. What are your thoughts? She can't talk but she's going to ... Can we try on getting everybody to ... If everyone can mute themselves if you're not talking, that way we're giving you control of your mutes.

Willie: [inaudible 00:42:37] I'm good.

Marci: Yay! Thank you. We've hit Star-7 about 85 times. I don't know, but the 86th time it works. Go ahead. It's a charm.

Willie: I guess, I think I'm going to echo what Amy said about, we want to be able to show incremental progress even before we're even actually receiving and sending messages, so this helps a lot. I guess what I'm sitting her wrestling with, though, is what category I will choose. In a lot of cases we're going to work with OZ. They're going to set up the capability to build that label, just with that label on a sample and they want to be able to implement that before we actually even get the electronic file.

I think they're even [inaudible 00:43:26] steps [inaudible 00:43:27] They will develop that and test that and we will go into production with that. Then we will start receiving the message. I may even have things at a more granular level I would love to be able to report on.

Marci: Yeah.

Willie: That's the only [crosstalk 00:43:46] I'm worried about.

Marci: In my mind there's a couple of levels here ... [inaudible 00:44:02] both your computer and your phone, you need to mute one of them. In my mind there's a couple of issues. It's what do we want to collect nationally to show, "Here's how

all of us are moving forward, and how granular do we want to get there?" Because at the national level I don't want to know your hospital's specific data.

I would rather know this level of data. What percent of hospitals are at each stage across different times? In January versus October what movement have you made at the aggregate level? Then this level is what you would get for your own individual state. We need to be a little more granular, what you would report nationally, so we can compare what Minnesota's doing, what Virginia's doing, and have some comparisons there without becoming too burdened, because I don't want to have this become you're reporting so much data to us that it's unmanageable. I'm happy to dig down a little bit deeper here and come up with some more granularity, if that's helpful.

Robin: Hi Marcie. This is Robin in California.

Marci: Yeah, go ahead, Robin.

Robin: I like this chart, but what I would like to add or recommend adding is [inaudible 00:45:32] barrier, so that you can see at any time what's happening, why isn't a hospital progressing, and simple definitions of some of the most common barriers, so that you could see if 50% of your hospitals can't progress because they don't have funding, or something, or they don't have the infrastructure, so that you can see on a big picture what's holding some of the facilities back.

Marci: Yeah. Having another line here for each hospital, or maybe several lines that allows you to collect barriers so you can track what that is. I think it was Minnesota who said earlier that having somebody who's actually that team manager, the project manager for that. That's what I see some other States have, is that's where it's also part. You get the champion involved, they're excited, they're ready to do it, but they don't have the authority to put the money towards it.

Speaking to what you just said, Robin, they can't dedicate money and that's the barrier. They might sit at that stage for a year because they don't have money [inaudible 00:46:35] I like that, that it gives us a little more of that qualitative data to support the date.

Sarah: Marci?

Marci: Yes, ma'am?

Sarah: Question. Some of these issues that folks are bringing up, I'm wondering, maybe we're the only ones that have contracts with the hospitals that required them to make those commitments ahead of time, before they were given a ... I mean, in the proposal they had to agree to those kinds of things. Do the other States not do that kind of a process? Is that what's weird about it?

Marci: I don't know if that's weird about you ... Others have comments?

Robin: I can say in California we are not contracting with hospitals to do HL7 messaging. It's a voluntary thing at this point. We are not funding them to do so.

Marci: Okay. [crosstalk 00:47:43] Go ahead.

Heather: This is Heather from Michigan. We are funding the hospital systems to give them incentive to do the HL7 project with us. With that being said, in order for them to get funding, we have to have them meet certain milestones. We're not going to give them the whole chunk of money at once. It's going to be allocated to them in three different allocations. In order for them to get that money they have to reach certain milestones.

Marci: Okay ... [inaudible 00:48:27] cue to answer your phone, we're getting feedback, so you can mute one of them. I love the idea of the barriers, adding the barriers to this. Are there other thoughts? I don't think we'll be able to finalize this today. What I'd like to do is, I will send these slides out to everyone, and I'd like you to take this and really, critically think about it and say, "I would like some additional lines here." We heard from Minnesota that having that project manager and team management identified, there's a financial impact.

We kept that line in. Willie had some ideas of other places that she would like to see some more granularity. Other people that I'd like to get a draft circulated amongst us, so that in the next couple of months we can agree on something to be able to collect data moving forward. Are there any more specific comments? Okay what I'd like to do is try to get back to [Soolay 00:49:40] to make sure she has a chance to present what's going on in Puerto Rico.

Sulay Rivera: Hi everyone, can you hear me?

Marci: We can hear you.

Sulay Rivera: Hi everyone. This is Dr. Sulay Rivera from Puerto Rico. I wanted to talk with, what is our problem. Right now our problem is that we are reporting manually each result yet. Of course, this contributes to delays in reporting our results, which is our goal. We use that [fon 00:50:19]. What we want is to complete implementation of the Specimen Gate. That's our electronic reporting system.

We started with this project some years ago, but it has been a little bit difficult for our implementation because of different reasons, principally the lack of access to IT personnel. We are part of the University of Puerto Rico, and as part of the university we use the IT staff that the leadership provide to us. They are only two persons and they have to cover all the institution, so they are not enough for all the work that we have here in the University of Puerto Rico.

That's our main barrier, the lack of access to IT personnel. I need to mention something, is that we are going from [inaudible 00:51:18] from PerkinElmer. It's a light version of the Specimen Gate, because the whole version is really expensive for us. That light version is only the reporting part, the demographic part is not going to be included for us. The plan that we have is that we will combine a Specimen Gate with our current electronic health system, which is NeoMed, and that this is then only works with the demographic part.

The plan is that the Specimen Gate will send their results to NeoMed and in NeoMed we will fill out a report that will be [prefit 00:52:09] to send it to the hospital. I have to mention that we are really far from ... To send electronically with those two hospitals, so that is then combining the Specimen Gate with NeoMed is an internal system to try to accelerate the reporting out of the results.

That system is only going to work here in our institution. It's only to report internally using an electronic format, but the results are not going to be sent electronically to hospitals. It's just to try to accelerate the manual process. What we're going to do with the funds that we receive, is that first our plan is that we will pay for an IT personnel in order to this person to help us with implementation of the Specimen Gate, because that has been our main barrier.

We share, our partners, of course our institution, UPR, and also PerkinELmer, which is going to provide us the Specimen Gate. Right now we are identifying the person that's going to help us, the key person that's going to help with this project. Our first option is to consider someone from our institution, so our planning to identify someone that we can pay extra hours or an additional compensation to work regularly with our project.

This is our first option, but also we can consider an external person in order to do this work. In terms of what we want to learn from other programs as far as they are doing same stuff with activities, I would like to hear if any other program is having, like us, a combination of two systems to generate electronic reports, because that's our case. We are going to have Specimen Gate in combination with NeoMed to finally have these electronic reports. I will like to hear the experience of any other program if there's any, if they have a similar situation like us. That's it. That's what we have.

Marci: Excellent. Thank you Sulay. Anyone have experiences to share of that, using two systems to report the data?

Willie: This is Willie from Virginia. We kind of have the reverse of that. We actually have Specimen Gate, but we also have [Arlimt 00:55:02] which is a product of [Starlimt 00:55:03] but we have internal developers that have modified it to suit Virginia's specific needs. We bring our samples into the [Starlimt 00:55:15] system, accession them, pass that data off to Specimen Gate for all of the analytical testing, punching, worksheet generation, all the way through till the results are ready to report.

Then Specimen Gate feeds that back to [Starlimt 00:55:34] for us to report out in [Starlimt 00:55:38]. But we have had the experience of working with two different systems and having to make sure that there's a good handshake between the two and who's going to be responsible for what, and that can be quite challenging.

Sulay Rivera: Yeah, that's what we believe that's going to happen, that's going to be a little bit difficult, but that's what we have so now I know that Virginia has similar experience, so thanks very much.

Willie: You're quite welcome. Call us if we can help in any way.

Sulay Rivera: Okay, thank you very much.

Marci: Sulay, I suspect there are others who are in similar situations that maybe [inaudible 00:56:23] connect, we will ... [inaudible 00:56:30] mute if you're on both your computer and your phone, mute one of the two. Sarah, maybe mute everybody real quick ... As we reach the top of the hour, and I'm not sure why tonight they gave us a special set of technical difficulties. We'll have to try to problem solve that.

Thank you so much for a really good conversation. We will be sending out the information regarding these specific short outcome measures so we can measure progress, the baby steps of progress, as we're onboarding these hospitals for HL7 messaging, or other types of shared messaging. We have, the last couple of months, felt that there was a need to have two different calls, have an HIT call and an education call to really get both of these groups going.

Our anticipation is that, from this point forward, we will have one call per month, and we'll rotate through different topics, because we want to respect everyone's time. It is a lot. Most of you are joining both calls each month, and that is a lot to expect. We'll get back to one call, but we'll definitely have these calls where we can focus on these HIT issues. I encourage you to use the ListServe as well.

If you'd like to pose a question, put it out there. That ListServe is posed to just these group of funded programs, so it should be a good resource for you. With that, I will wish you a happy Memorial Day, and we will see you all next week for the education call. Thanks so much.