The Business and Clinical Case for Direct Exchange Webinar - Transcript June 17, 2015

Laurie: On behalf of the Quality insight, Quality Intervention Network Team, I'd like to welcome you to today's webinar, The Business and Clinical Case for Direct Exchange. My name is Laurie Fink and I am the Communication Specialist for the Improving Outcomes by Optimizing your EHR initiative. Before we get started with the formal presentation, I would like to take just a few minutes to review some house-keeping items.

First, all participant lines have been muted and remain in a listen-only mode during the presentation. There will be a question and the answer session following the presentation, so if a question comes to mind at any time during the session, please feel free to type it in a Q&A box which can be found on the right of your screen and it will be addressed during the Q&A session. Please note this seminar is being recorded and the recording will be posted on the Quality Insight Website later today at www.thequalityinsights-qin.org. Both resources will be posted under the events tab as a high-end event.

At this time I would like to introduce you to today's presenter, Dr. David Kibbe, who currently served as the president and CEO of Direct Trust, a non-profit industry alliance that recently received a co-operative agreement award from Glenn-C, as part of the exemplar HIE government's program. Direct served as a reform and governance program for persons and entities engaged in direct exchange of electronic health information as part of nation-wide health information network.

Dr. Kibbe is a senior advisor to the Center of Health IT at the Higgins Academy of Family Physicians and sole proprietor of Kibbe Group, LLC which assists organization to develop and bring market, innovative, clinical information technology based on standards for inner operability and health information exchange. Without further ado, I will hand things over to Dr. Kibbe.

Dr. David: Thank you, Laurie, and good afternoon everybody. You can tell I am a family doctor and I very much enjoy talking with caregivers, practice ... physician's nurses, front office and back office staff about what has become a hot topic now, the ability to come information exchanges through directive exchange. What we want to do today is give you some information and answer some of the practical questions you have about Direct such as, where do you get it, how much does it cost, how do you find direct addresses? Then I am going to try to leave at least 20 minutes for additional questions that you may have about your particular vendor or your particular location and how to make Direct work in community to help you and your colleagues in the community to take better care of patients through inter-operability and collaboration.

Just very quickly moving through some slides, I think most of you probably know many of these things but I will go over them quickly just to make sure that we all are at the same page. Some definitions that you'll need; the Direct project, the direct project is the office of the national coordinator program that developed in order to make a simple

secure inter-operable protocol for our exchange of health information possible across American healthcare systems. That was started in 2010.

Direct protocol is a term we used for the specifications of the standard self. You really don't need to understand very much about this part of it, but I will go through some slides to give you just sort of a basic technical overview so you will have an understanding if it works. If you use Direct to send or receive messages and attachments, we call that direct exchange, it's a short hand term for this note of sending and receiving direct messages and attachments regardless of you as a user are using for your edge plant or your electronic health records.

Direct exchange is what we call agnostic with respect to the electronic health records. It was built to be capable of being a part of, and integrated with, any electronic health record but it is also available for users on handheld devices and websites as well as iPads and other devices.

A health information service provider or HISP is the entity that does the work behind the scenes to make your Direct message secure and [inaudible 00:04:58] validated. Some electronic health record vendors are themselves HISPs for example looking at health a clinical HISP and some health some EHR vendors pair or partner with HISP just epic partners with subscription that allies and I'll probably mention some others as we go along.

One of the things you have to figure out is, your EHR vendor in your hospital or in your medical practice, someone who is a HISP, why are they using someone else as a HISP because that could be an important relationship and then I know everybody understands stage two meaningful use. We can, I will give answers to some questions about the some changes that are occurring and the stage two meaningful uses as a result CMS's latest roles but I think we all know that this is a big problem. I will be going over to access where Direct Exchange fits in with the stage two meaningful use and a stage three meaningful use object with some metrics [inaudible 00:06:03] stage three.

Just some quick background I put this slide in mostly so you'd have it for reference, things have been moving quickly, that project was launched in 2010 as a means of providing the simple secure standard based way to send health data over the internet between different users of electronic health records. It took a year for that program to come to fruition and the specifications and protocols get published. That then a trajectory for the rules of the road work group led to the development and the establishment of direct trust as a non-profit trade alliance which the academy have had in positions who had a hand in ... Which came with the presence in 2012.

Now a lot went on in 2013 but one of the things I want to draw your attention to here is that Trust started an accreditation for HISP and it became clear to the stage 2 meaningful use program would require direct change to be dealt into all electronic health records by 2014. All certified electronic accounts records now capable of receiving direct messages and attachments, some are a bit more easy than others which will probably do that but all have to be able to do this if they are going to be in the market place.

In June 2015 the network of Direct Change Service providers has branded nationally. Half of all the US hospitals and medical practices currently are able to do direct exchange. That's going to grow during 2015 and 2016 as increasing numbers of providers and eligible hospitals come online because you are probably aware that we are putting dietary stage two to meaningful uses have been tremendously reduced from 365 days to just 90 days that makes it a lot easier for hospitals to do that at the station for stage two, which is kind of complicated.

I would like to just say that there are a lot of requirements for stage two but if you look at the ones that have to do with health information exchange, it's about half and direct doesn't play a role in all of these but it can. For example hospitals are now starting to use Direct for example, reporting syndromic data even in [inaudible 00:08:50] which is interesting. It's focused down on the direct health that the station if we use direct there are two major ones.

Niftin is a transmit care summary for transitions for getting there. You are aware that 10% of such care summaries have to be electronically transmitted. They do not have to be transmitted via Direct but because of Direct's ubiquity and if used that is currently the preferred method of using and attesting for the transmittal care objective.

Now according to experience, there has been a lot of controversy lately. CMS specifically got rid of that for stage two meaningful use in 2015 and 2016 in a ruling that came down a couple of months ago. Then a tremendous amount of comment about that, I wouldn't be surprised if CMS reinstates it. It's probably going up, but change is a means of communication of being providers and other commercialist also means communication between providers and patients.

What I am looking at here, I guess we can still look at this for a minute; there are a lot of people in a light audience they say, "Oh that's a lot like an email software program." If I tick here they send a new message a pop up now message. This has true line and has copy two line and a subject line and you can make a [inaudible 00:10:48] and then write a note, in case the note says, "Dear Dr. Jones, thank you for your referral, the particular patient. Please find attached for ammendings of the copy of the plan." Just to show you the slide because the best electronic output [inaudible 00:11:08] vendors do that, look a lot like this.

That's a rule number for direct exchange looks like an email client, looks like Outlook or Yahoo mail or Gmail. Not exactly because some other fields in here and moving the files around and storing them in particular places but generally speaking this is a lot like e-mail. You can write message to a particular person or organization and you can read into your inbox which was the previous slide a message from your colleagues.

There are a couple of questions I've got in advance about to have a direct email address. In many institutions everyone is getting one but in many private care practices they are just tying to a three per practice because not every doctor or every nurse is necessarily going to be doing a referral process for example or handling electronic messages as these replace faxes. The fact that you can have direct email messages, addresses that are inbox@direct.familyaccessA.org or frontoffice@direct.familypractice.

Close the slides here and show you sort of how it works and what we have on this slide is a HISP on the left, call the sending HISP, the sender is down here using a sending system. Receiving the HISP, the receiver of the message is down here receiving system. What you see right in the middle is a direct protocol working over the internet. I want to point out that the Direct exchange is not a centralized server somewhere signing into a secure messaging service. You are actually able to send over the internet.

Of course this is a pretty dangerous environment, it's insecure so that is one of the reason that HISP success in order to securely validate the ages between two different parties. We fill in the blanks here a little bit and for those that in the scenario with drbob@direct.singlepractice.com wants to refer one of his patients to a cardiologist, drsusan@direct.cardiology.com and suppose that these two folks don't work in the same organization.

Dr. Bob is in a medical practice or a federal health care center and for Susan works in a large cardiology practice associated with the hospital. Both of the clients are sending systems and receiving systems via electronic health records. As I said before you can't have a receive system being a web browser just like I use websites for yahoo mail. Dr. Bob's EHR is [inaudible 00:14:24] and Dr. Susan's EHR is [inaudible 00:14:29].

Companies chose to not to be a HISP partnered with server scripts which everybody uses for prescribing but they are also a very large HISP and so Dr. Bob uses epic to create the message send them just with an attachment to HISP. From Bob's perspective that's basically all there is to it. Behind the scenes what's happening, it is descending HISP, bearing out fairly complicated cryptographic set of functions that the identity of Dr. Susan then allow the message to be encrypted and then decrypt it and eventually send it on its way to Dr. Susan.

Here's a question that often comes up, "So, how does Dr. Bob know Dr. Susan's direct address?" Well, there is no directory at this point, but Direct trust is building one. However, right now there is no easy-to-use directory. HISP has its own directory and shares that out with EHR customers. You may in fact know a lot of parties in your community by virtue of the fact that is big EHR company.

What I tell folks in the community is, "Look, get together and have pizza for lunch exchange the E-Partners for the parties that you know you are going to communicate with anyways. Remember that there is no fax here either." I don't have a big directory; I am spooked so this is something that is best done normally through regular communication. This is to juts show you that that will work for this direct exchange is very large now. There are thirty six accredited HISPs in the Direct Trust network in business with over 300 certified electronic health records technologies.

They start over 40,000 health care organizations with direct exchange and now we are approaching a million direct addresses. This is already a big inter-structure. We are not going to allow you to reach every single person in the United States but it will allow you to reach most other providers who have electronic health records and are using electronic health records.

The recipient in this case is not another provider organization and that is a patient and using personal health records. There are now approximately three, I think by the end of the year, there'll be five personal health record companies that are accredited HISPs FTHR programmers.

Those are probably your team like an infusion because they are also patient portal companies. Not all of them, it depends on which of them are stand alone and what would be really important if we want to see happen over the next couple of years is just for Direct exchange to allow lateral communications so that buyers will be able to send clinical summaries to patients but patients will also be able to send direct messages back into the electronic health records of their primary physicians in order to ask questions or perhaps to report problems they are having or to even correct some of the clinical summary information perhaps to other medication that they are taking from some other provider.

You've heard about the HISP for using direct exchange and let me just make into that. The paths that the electronic health records that are teaching to meaningful use enabled and are capable of doing that not to our traditional fees, customers for using direct exchange. Take that in to their fee structure. Half of the electronic health records charge their customers an additional fee, somewhere between $10 and $20 per month per ask, its variable.

It's a very costly thing to do which is make the email and attachments encrypted and secure and there is significant value here and not just regular email to send this health information between providers, that kind of health records but you certainly can use direct exchange. You are really going to have to work that out with your particular vendor.

What I want to point out is the direct trust member HISP, those HISPs that are working with those 300 electronic health records not allowed to charge each other a fee. Sending HISPs texts or receiving HISP any or dime or whatever, or per transaction, they are prohibited from doing that as part of the Direct trust community.

Now that's one of the things that has helped to cut down on the cost when this whole thing started which wasn't so long ago, about 2 years ago. There were some HISPs in the HR Company said we are going to monetize this transaction. In order for Dr. Bob to send to Dr. Susan an escalation a direct switch will cost him a nickel but that's not any more. It's happening that's a proper line that I would love to know about.

This is of importance, why are we doing this and what benefit does it have? The answer of that really is payment is shifting from service to value based purchasing and if you are going through with your practice or your IPA or your hospital system. It works with medical practices to make, all of them is going to assume some risk in its payment negotiations, then you have that inoperability and collaboration for success. These ideas are starting to be talked more together and that's just a ... In the next slide.

HISPs in healthcare are ... They continue to go ... We all know there is a lot of waste in the health system and that waste comes from the inability to provide hand patients off very effectively and efficiently, strives up the number of [inaudible 00:21:52] because of the number of repeat hospitalizations. As you are I'm sure are aware of patients arriving at your door and feeling well. Didn't Dr. Kibbe monitor HISP, he said he was going to but and they never showed up. This is a huge problem and this next graph I think shows it in particular detail.

This is an actual community here in Phoenix, Arizona. One of the cause problems is the fragmentation of hair pounded by the lack of exchange of information. We live most of us in a multi-vendor environment now. In a particular community there were 6,400 physicians, using over 70 electronic health record products. Even an [inaudible 00:22:48] was established in this community, in about 8% of that county's physician are [inaudible 00:22:53] which meant that you'd have to check everywhere to communicate with those 8%. But then 92% of the communicants in the community which [inaudible 00:23:05].

That's not to mention that we have other parties that are not strictly providers or EHR users like [inaudible 00:23:13] and pharmacies, formation extends a system, drastic imaging centers, long term care facilities and hospice and home health. Increasingly we are seeing around the country home health and home care facilities start to use direct exchange so that they communicate more effectively to the hospitals who are the primary care providers. Kind of inter-operability that is absolutely necessary if you are going to participate in a program like the Medicare, or care explanation management program, they should make that a cross-chair management program.

Here's how my care practice made [inaudible 00:24:01] within a matter of hours a patient has been discharged from the hospital. In fact it's even better if you get that information at the long-term care facility and primary care practice keep that information even before discharge whereas environment is very difficult. Their Direct exchange is starting to show its colors and I get calls from all over the country now for part of their health. We have a major vendor in our midst but they are very good at communicating with other EHR community they get over that using Direct. Think about it.

I was still using paper charts and faxes and courier services in 2015; this is what it feels like sometimes when you are trying to heal a specialist. We actually used to talk to each other on the phone regularly, that doesn't happen all that much, people are just too busy. I think that now we have become more aware, this simple thing that is moving data electronically, getting it to the right person at the right time.

The most important aspect of using electronic health records, producing digital data from [inaudible 00:25:44] and actually sharing that is the single most important contribution our medics can make to a better health care in our country. This is a group by the way, this is from Mark Bronstein at Georgia Tech who is interested to get a short overview of what is going on in health IT in this country. It's a great book to me.

I am [inaudible 00:26:13] the growth of data exchange starting back in the second quarter of 2013, clearly just looking at year's-worth of growth here in record change so this is a number of organizations that are being supported by direct exchange. We know that this is a little out-of-date, we know that it is close to 48,000. This is the timing was all health information exchange, it's this period of time where we've seen the electronic health records have [inaudible 00:26:55] and utilize direct exchange and to see the tremendous growth in the number of organizations.

Direct addresses that have grown, again, its these exponential growth looks a lot like a HISP deck that I've had primarily early in the on-boarding process for stage two meaningful use. In the middle of 2014 to the middle of 2015, patients and consumers with direct addressed, and this doesn't seem like a lot, probably 56-55,000, but when you built to the first time we were able to even see data on the use by consumers of the addresses 2014, it's focusing enough to get [inaudible 00:27:50], it's probably giving you an identity. Although, well if that issue was download and transfer to the changes that have been made, steadily increase by CMS on that be, may affect the number of consumers who use direct address.

To summarize the direct change facts for you, the meetings we use for probably request providers in the hospitals to use electronic data change for 10% of all referrals, in terms of care. The number goes up to 50% per stage three. Wandering around the country is that as soon as providers and hospital systems start to use direct exchange to solve the clinical number rating from their institution to wherever they are going the number may go way above 10%.

If they are going to do it for 10% you might as well do it for 50% and if you can do it for 50% you might as well do it for 75%. Some are probably still having problems just figuring out how to do it period, but once you get it working its better than fax. It creates a secure change for you to use with people who are your colleagues. You get to know them just as you would someone who was an email partner.

You have to use ... So far you have to be certified and your preference of who in the hospital is in your midst. Who is a platform testing for many please. I'm going to have to use certified EHR technology. Strong metrics and balance. It's pretty easy and way better than fax.

My last slide, I see there is a real business extreme operability via Direct exchange and that it is real and it is strong. It is stronger than just state meaningful use. We used to talk a lot about that today but I think its probably long term more important with where you are, whether you are a patient or a provider or a [inaudible 00:30:28] health care services. The exchange of health information has to be good, if it can't be good then get better. If you purchase for IPA services this operable exchange of health information should be a requirement.

It's starting to become a requirement for contracted suppliers. Started to seek what are called narrow networks of flyers organized by companies, for example. For those to be required, I had to have operability from a health information exchange or via Direct exchange.

Very large IPAs around the country are starting to implement Direct in order to attract business from the insurance companies. As a matter of fact, if you are not able to move data across your IPA you have a disadvantage in this marketplace because the health care insurance companies are going to be looking for IPAs that can provide that service.

If you buy health care services, care coordination supported by directive change really does need to be a necessary requirement for all professionals; their practice is hospital and outreach facilities. I don't mean that every doctor, every nurse, and every health care official needs to have a direct address and those parties with who you are likely to share patients with, patients who are at high risk for hospitalization or EHR visits or patients to patients who are particularly at higher risk, like diabetic patients, congestive heart failure cancer patient.

It really is important that you how to direct this change to be able to move the data wherever the patient goes in close to real time and a multi-vendor environment that hasn't been possible before. Some hospitals have spent a lot of money with HR and extra solutions based on your practices and there is still a connection between your electronic health record and a particular laboratory. A connection between yourself and that particular laboratory, of course this is very expensive the way they move their data.

I think that the future is all about patience and consumers and increasingly patients are, and you may be experiencing this yourself, going to their docs and saying, "I want an electronic copy of my medical record." Not because they want to leave your medical practice or sue you but it's because they are starting to use personal health records and begin to organize their health information in a way that they can understand and they can manage.

Maybe that is what you want as a patient too and that is what you want for your parents. Probably everybody listening today has some story about how a child or a parent or a family member had some problem caused by the information not being able to be available when it was needed.

I had a medical problem and at the end of the week I had four patient portals from different patients, three doctor's offices and hospital. It's not very good either because rather than go to four different portals to receive and organize my medical records. I wanted them to be four-phased and I want the other providers to be able to send information to that one place I choose.

I think going to start to see this, we see it happen in the news, we see congress get involved in this and we're able to see legislation that makes it easier for patients to access their health information. It's a little bit via direct exchange to places where they can organize the control and manage their health information; use it when they need it.

There are a couple of things here, just so you know direct trust is a fairly high organization, very collaborative, they have really good people in for kinds of organizations. It's next to organization for vendors. The clinic and vendor be able to many health care organizations are members of Direct Trust.

According to my watch we have about twenty five minutes for questions and your comments and this is the part that I really like because I get some specific questions to know whether or not there are things that I covered. Listing things that you are interested in, do you have some questions for me?

Laurie: Yes, and just a little reminder, if anyone has any questions, your phones are muted so you will have to enter them either in the Q and A feature or the chat feature and I will direct them to Dr. Kippe. The first question asks, can EHR vendors share their lists of direct email addresses with someone who asks for it? Why share with the client as it defeats the purpose of electronic exchange?

Dr. David: That's a great question; you know you think that electronic health vendors would share their customer list with other HISPs but in fact electronic account record company's contracts prevent them from doing that so with said, the providers, it will be kind of difficult to move these information.

Actually our biggest problem right now is that some of the large HISPs like [inaudible 00:36:45] have contracts with their customers that prohibit them from sharing information with the consent of the provider or organization.

Will they give that consent actually when they understand how valuable it is to them, yes I think so but it's a little bit like, will you move first and if you are jealous of this information there are some reasons for putting this information?

There are a lot of people out there that spam us and usually don't want to have their direct spam coming from all sorts of people who want to sell your practice or your doctor some service. There are ways of course of filtering out that spam but they are not always good This is a problem, I think it is unlikely that there will be any instant good solution, I think it will probably might be another 2 years. My advice to you is, get a list of the organizations with whom you bear any health information that will include more hospitals, if they include several specialty groups.

It may include some long-term care facilities. I would characterize those parties and go to them either by phone call and writing an email and say, "We want to start using direct exchange for some percentage of our referrals to you or to receive referrals from you. Will you please let us have the direct addresses of these persons or these departments?"

I think there is some value to this beyond just getting the directory because in order for direct exchange to work in coordination you have a will, you have to really want to do your coordination in the first place. Secondly, you have some established work clothes and change is a new technology so it may require some new work clothes, it's not exactly like fax, it's better than fax once it gets working but you have to have those work clothes in place.

One of the problems and I'll tell you that organizations around the country are experiencing and I just talked with a family like this in Tennessee the other day is that

hospital is a critical [inaudible 00:39:24] business, 45 pages long. We don't want attachments for meaningful use, the attachment that is required for meaningful use in order for you to attest that you have done a referral via Direct exchange. You'll call the CCDA and it's in a whole document.

Well this document has 45 pages worth of initiatives and it's probably not worth more, it's not very helpful, it could be more problem than it is helpful and clearly they needed to get together and say, this is ridiculous. This should be a clinical summary, it should have a list of the patient's current problems, her medications, her allergies, shouldn't have every piece of information, every drug that was administered for example and the hospitalization. Those problems require people to get together to talk about their tech-coordination programs, and do some significant planning, directives and create technology, for this, but it's not the solution. It doesn't instantly create care coordinatorship program.

Don't [inaudible 00:40:37], your EHR company will have a directory, but for the directory to be useful, it also has to add in, the directory, instantly to add some other parties and get community ready in order to work with EHR and those parties who did that job. Okay? Well that's some good work.

Laurie: That was a hard one. Okay, our next question to ask, do you find it difficult to convince physicians who are not trying to achieve meaningful use to contact their vendor and get a direct email address setup?

Dr. David: The usual thing about physicians and direct exchange is that most of them don't even know it exists yet. Once they find out it's there, it's entitled to that, and they want the face in their electronic output to be better than it is. It is more of a thing where once you start having people complaining about it, you know that it has some value because they want it to work.

I think that state [inaudible 00:41:51] meaningful use, and meaningful use has been a real driver for the infrastructure to be in place. I don't think that meaningful use is a real driver for actual ... needs to occur. Just coming out with a server direct change messaging at the end of the month and it's interesting, about half of the respondent said that in the absence of state steam meaningful use, that it would do direct exchange.

In the real sense out there, yeah, this is really great for emissions across or on other reason across to help keep some boundaries about the meaningful ... The drivers in the long term was evaluate patients. Thanks.

Laurie: Thank you. I have another question, don't you think every provider in a practice needs their own direct email address, needs the name for your summary of care medical agreement?

Dr. David: No they don't. As a matter of fact it's probably not a good idea to provide direct addresses to every provider in an organization that's just starting to use direct

exchange. I think that it's going to matter on personal choice. I don't practice anymore, but if I was practicing I would want [inaudible 00:43:27] at the trial because I communicated with other provider and I would use direct exchange to start communicating with my patients.

I'm one of the, would probably is regular email, fairly regularly. That's not secure so this is a much better way to do it. We also there are [inaudible 00:43:53] frustrating much. They are liked and we don't want to communicate with people. I think you have to go through a process of learning, probably having an inbox at direct.medicalpractice main, or front office or plus your name.

If you are an administrator person, or you're a front office person, it's your name. To be working fairly well around the country. In some instances it's just easier for the vendors to provide with a direct address. There is no problem with that, but it's probably not going to be used by every physician.

Laurie: We have a couple here. This one's from a Mecasin practice partner with two problems, in our operability service starts randomly and they cannot find the problem, so messages are not being received. The problem is we have no way of knowing that without calling the receiver. Your advice on what they should do about those two problems.

Dr. David: Sure, and Mecasin really health is a member of direct trust and I'm sure they'd be very interested in the problems that you're having. [inaudible 00:45:18] you might have heard is that ... Let me back up a little bit. When you send out a direct message, that diagram, actually let me go ahead and get up to it, here. You should be notified, we have what's called an MDI message, this position notification.

That is a signal that the [inaudible 00:45:48] receives your message, so when, remember here as in towards your scripts to first hit someone sends the message to the EHR and the [inaudible 00:46:04] sends the message back to the [inaudible 00:46:07] totally up to them. Now ... EHR vendors have ... Are not very good at receiving these messages. They are full EHR vendors that receive the message into their system, but it doesn't have the right attachments, or it does lead to some rules of the patient host on the message they [inaudible 00:46:36] and necessarily to tell the [inaudible 00:46:41].

This is actually then called information blocking, it is the subject of other EHR subjects of percentage invasion period that's been going on and will continue to go on. It's happened again, of course you have towards from Mecasin of course. You might also try working through the CIO or the chief medical information officer at ... Who has the receiving system. Tell them what's going on, if that fails, let me know and I will get together with engineers at Mecasin and whoever you're trying to [inaudible 00:47:25] too, we'll see if we can work it out.

Laurie: The question asked, how do they direct email account be handled when a provider leads a practices or practices at multiple sites?

Dr. David: Well, it brings up the question, can providers have more going on through direct [inaudible 00:47:48], somebody answers, “Sure.” If you work at two places, you may want to have or they want to have directors to both of those places. The real issue here is what happens when a provider is no longer associated with that organization? The answer is that that address should be retired so that if that person is not, with those messages and system is not burdened by messages being spent to an address that normally represents someone working at that organization.

The problem with having more than one address it can become a problem if someone works at so many institutions that they share a patient and, that share patients and you have to wonder well where is the information going to end up? What’s going to be the most authentic and the authorized flavor for inbox for that person? The organization is starting to come to [inaudible 00:49:01]. It’s time for them to split up.

Laurie: Hi, yeah I have a few coming in. If a certain set of physicians have direct addresses, how do the other providers meet [inaudible 00:49:20] for use TLC metric?

Dr. David: Okay, it’s probable to meet the transitions of TR metrics, with ... If you don’t have a direct address. As long as the [inaudible 00:49:37] that is sending the direct message on your pass, right? Someone from the organization, suppose I’m many.jeffo@directaccess.com and I send out the messages out on behalf of four other providers, that’s perfectly legitimate. Therefore our health record system has to be able to track those [inaudible 00:50:03] make sure that they are in the numerator for those projections. I think you can see, it’s quite [inaudible 00:50:13] especially why wouldn’t we be sending all of our referrals or as many as we possibly can to get a direct so that all of our referrals go into that numerator regardless who is actually spending some [inaudible 00:50:27].

Yeah these places between the hospital systems, it’s the key managers who have the direct addresses sending the care measures somewhere else. For example intended hospitals, the Hunter Kenneth Hospitals extentures can do the discharge planning direct message, to direct addresses. They are sending the [inaudible 00:50:54] at discharge to do as Hardy says the hand on the outside. They have, because about 30% of the discharges go to long term post care facilities, which has worked with over 100 long term facilities in the places where there is attended hospitals mostly in the south of California.

Now managers in those long term facilities have direct addresses. When a patient gets discharged that’s where it goes. It’s really been interesting because what’s happened is that the managers know who they are, each other. They’re starting to communicate and ask for additional information. Like well, it’s great to have care summary, but do you have a geometic case in dosage form? Because the care has it that the medications of the patient was charged on, doesn’t have the times, the administration time of those medication in the hospital. Sometimes long term care facilities or rehab centers have to know that before they dose medications again in the rehab.

They have a two communication going now, the channel people. That’s much better than fax and more better than phones as well because it’s assymetrical.

Laurie: Have you had [inaudible 00:52:18] and the way EHR vendors set up the direct email accounts, a provider out of practice has to have an account. Retail workflow, she wants practices since providers did not necessarily manage that information flow. What are solutions or ways to manage these individual accounts?

Dr. David: People in the room here probably remember a couple of years of E-prescribing, and tremendous mess it was. Thos EHR vendors integrated the E-prescribing role and supported it well, and furnished it and improved it on as a source of feedback they got from their customers in those practices. They did a horrible job and I can remember [inaudible 00:53:10] complaints. Where we used E-prescribing because we don't know which pharmacies in our community are using E-prescribing, so therefore, we can't communicate with them.

The interface is lousy and I have to do things all over again. I don't want to do the prescribing, I want somebody to do it for me, can they just do it for me. I think these are all the kinds of issues that are likely to occur in new technology and the customer electronic health records have to work out with their vendors.

This is a particular strain for people like the person that's here in question. I understand there's [inaudible 00:53:56] stays too meaningful use it's been so crammed full of all the different things you have to do. Direct exchange is ... We're really important, it's one of the reasons why we had meaningful used program but it's just one of many actions and upgrades impressions that have to be made to these alternate health records. To be fair to the HR vendors, it's really hard for them to do this.

Some of them are doing it really well, and some of them are really doing an awful job. We just have to keep pestering them and let them know, it's go to your user group meetings. Those user group meetings are where EHR vendors really focus on what their customers want. If things change rather quickly when people at a user group meetings stand up and say, you know what, I've got to get this better for us, because we're thinking about changing vendors.

At it, I think the source is for you to work with. Your [inaudible 00:55:09] physicians, we are fully interested what to map problems like this. We try to respond. We just send a message to, let's make the executive vice president of direct, of PAFP just sent us a very for message to the president, the CEO of E-Clinical works because of problems that I'm glad are being worked out now. Sometimes it just takes some help from your professional organizations and your doctors or per hospital's professional organizations.

Laurie: This is ... being in that offering direct messaging ed. The thing is what you recommend for practices on that EHR.

Dr. David: Some electronic health records are not signed, or are not yet certified for any meaningful use. Therefore, they have not developed the capability or usability within the product for [inaudible 00:56:23] exchange. Others have certified that there implications is so awful that people can't use it. What do you do if you still want to use

direct exchange? Well one of the things you can do is you can find a HISP who can offer you a web based, a website for direct exchange.

I know it's inconvenient because you have to leave the electronic health record and go to your browser and sign in to the HISP who can offer you a web-based, a website for direct exchange. I know it's inconvenient because you have to leave the electronic health record and go to your browser and sign into to the HISP service. You can use it successfully in a number of places around the country.

Of course that's all what's happening in the long term health facilities and nursing homes and some home health and hospices because they don't use electronic health records. HISP sure spreads in [inaudible 00:57:12] and ICA and other ones have these programs that you can actually find at our website and get direct program or application within that website. Works just to secure but it is a kind of work around solution. Electronic health record will [inaudible 00:57:34]. I had a better solution than that problem. If there is a way to get direct access, there is a way to get connected. I think that we're going to see most electronic ... There are too many electronic health records anymore that don't do direct but there are a few.

Laurie: Looks like we have time maybe for one more question. I'm going to ask is it alternative to secure texting.

Dr. David: What a good question. We are actually working on a direct testing solution that simulates our follow the same way that we have with direct exchange. The problem our ... is the testing of use such as a SMS in our phones. It's been to our smart devices our smart phones is that's not secure, because it's going over Verizon or AT&T or what other telephone networks, they don't encrypt it.

The solution right now is that, just as before where you could get secure email messaging from a services that would sell you that and everyone would sign in to a particular server, but you had to be a member of that server, right? To apply in the texting and texting anybody else, we didn't know our working in the trust on a direct texting service.

If you have a direct address, and you can do direct messaging, you can start doing direct texting on your smart phone. It would be pure and inoperable and compliant. It wouldn't matter if you used Mechasm and you get your service through Mechasm it would be like how you can communicate via direct texting, somebody who's using a [inaudible 00:59:36]. That's very exciting.

We think that there is a pretty significant demand for this because doctors and nurses we all use our smart phones now. I'd like to use my smart phone as a computer as often as I use my desktop, so we need to move in that direction. Wonderful transcript [inaudible 00:59:59] and Laura, thank you so much for this opportunity and for those of your in the audience, please talk to me if you have a question in regards to trying [inaudible 01:00:05] health.

Laurie: Thank you so much Dr. [inaudible 01:00:10] that was a great presentation and a lot of really good useful information for our providers. I want to thank everyone who called in today for joining us to learn more about direct exchange. If you have any additional questions be sure to reach out to your local quality insight team member. If you're sure who that person is, you can visit the quality insight website and click on the 'get local' tab to see who the health HT coordinator is in your state.

I mentioned earlier the presentation slides and the recording of today's event will be posted on the quality insight website at www.qualityinsight.qin.org. Both resources will be posted through the events tab as in archived it yet then. There will be a very brief evaluation at the close of this session. If you would please take a minute to complete your input areas help us plan for a future program.

I'd like to thank you again for taking the time to join us today and have a great day, bye.