

TITLE 410 INDIANA STATE DEPARTMENT OF HEALTH

LSA Document #18-282

SUMMARY/RESPONSE TO COMMENTS FROM THE PUBLIC HEARING

The Indiana State Department of Health's (ISDH) Executive Board reviewed a draft version of the rule on March 14, 2018. ISDH published the proposed rule in the October 17, 2018, Indiana Register. A public hearing was held in Indianapolis on November 8, 2018, to solicit comments from the public on the proposed rule.

The following parties made comments during the public hearing:

Charles Christian, Vice President of Technology, Indiana Health Information Exchange (IHIE)
Andrew VanZee, Vice President, Indiana Hospital Association (IHA)
James Groh, Surveillance Epidemiologist, Marion County Public Health Department

The following parties made written comments during the public comment period:

Brittany Yarnell, Surveillance Epidemiologist, Marion County Public Health Department

The following is a summary of the comments received and ISDH's responses thereto (similar comments have been grouped together with one response):

Comment from Charles Christian: I am just here to look at the changes and to make sure IHIE understands what the timing of the rule is because there will need to be transactional/system changes made at each one of the hospitals and possibly the health information exchanges that transmit data to the state.

Comment from Andrew VanZee: Mr. VanZee echoes Mr. Christian's comments that this is a process with getting hospitals into compliance with this new rule. It gives an opportunity to bring all of the interfaces up to the current NIST standards. He expects that this is something that will take the next year or so to begin to bring all of the facilities in line with the new standards.

Response: ISDH anticipates the effective date of the rule to be the middle of April to early May (2019). We understand that this will be an ongoing and collaborative process and we anticipate hospitals will be able to come into compliance with the rule as soon as practical.

Comment from Andrew VanZee: There are potentially some costs associated to this effort both from hospital staff time as well as potential vendor costs associated for some of the smaller facilities. Some of these facilities are in the midst of changing out their electronic medical records so he foresees some variability between hospitals with respect to being in compliance with this rule and some of the challenges he sees with items like triage notes. However, IHA is

committed to working with both the state and our members to try to bring that compliance to as high of a level as possible.

Comment from Charles Christian: The critical access hospitals are very dependent upon their vendors to make system changes and those vendors do not do it for free. The smaller facilities may not have the ability to capture triage notes electronically so the flexibility provided in the rule to make allowances for those that cannot report triage notes is very much appreciated.

Response: All but one (“Triage Notes”) of the seven additional Data Elements that ISDH is adding to the rule are already required in the Centers for Disease Control and Prevention’s Public Health Information Network (PHIN) 2.0 guide required by the Centers for Medicare and Medicaid Services (CMS) Meaningful Use rule. The “Triage Notes” Data Element will provide information that aids in deciding the need for, or likelihood to benefit from, immediate medical treatment. Some hospital emergency departments are already sending the seven new variables to ISDH. The hospitals that are not currently reporting are not reporting due mostly to technical oversights or issues with changing over to a new electronic medical record (EMR) system. The syndromic surveillance piece of reporting (covered by this rulemaking) is part of the CMS Meaningful Use criteria so the hospitals all have the capability to report. Almost all hospitals in Indiana are participating in Meaningful Use, which in turn provides for reimbursements from CMS for participation. The few hospitals that do need to upgrade their systems will pay a small fee (approximately \$2,000 depending on their vendor contract), but the costs will be offset by the reimbursements provided by CMS. Overall, ISDH expects only a small cost to hospitals. ISDH has made “Triage Notes” a voluntary field, not a requirement, so any costs associated with adding this field would be voluntary on the part of the hospital and not included in our fiscal impact calculations. Small hospitals, that do not have an emergency department, would not fall under the scope of this rule change.

Even though ISDH expects a small cost to hospitals, ISDH also recognizes the following benefits for including “Triage Notes:”

Benefit example: To effectively monitor overdose related emergency department visits, it is important to have as much data about the visits as possible. Fields such as chief complaint, discharge diagnosis, and triage notes are crucial to identifying true overdose related cases. While ICD-10 codes are specific, they unfortunately are not specific enough. The ICD-10 code, T40.2, poisoning by other opioids is useful to determine if opioids are the cause of overdose but it is not specific enough to identify which opioid(s) caused the overdose. Triage notes could potentially provide more insight by listing drug names mentioned by the patient or summarizing lab result findings. Without this information, it is almost impossible to determine which drugs, such as fentanyl, are causing overdose visits. Once overdose visits are identified, they are shared with local partners to assist local health departments and community stakeholders in addressing the opioid crisis.

Benefit example: At this time, Syndromic Surveillance is an integral element necessary for the rapid response and containment of novel infectious diseases, outbreaks, environmental contaminations, and terrorism. More specifically, the collaboration in using surveillance tools between the hospitals and government was vital to preventing the spread of Ebola within the

states of Texas and Ohio. Through monitoring hospital admission in a noninvasive manner, these state and federal public health officials provided a timely response to suspected cases, all the while preventing disruptions within the usual hospital workflow. Furthermore, syndromic surveillance allows public health officials to conduct further investigations necessary to identify the scope and sources of disease. This work aims to inform clinicians and provides context behind outbreaks of foodborne and waterborne illnesses. In conclusion, through the data supplied by hospitals for the use of syndromic surveillance, the ISDH and hospitals can work symbiotically to ensure the health of Hoosiers alike.

Benefit example: Electric Scooters and Triage Notes (January 1 – November 20, 2018)

1. There is currently not a good ICD-10 code for electric scooters, with the only options being nonmotorized scooters or motorized mobility scooters. This makes it challenging to use Discharge Diagnosis.
2. Including Triage Notes does increase the number of visits likely not to have been caused by the electric scooters. However, it also adds 31 visits that may be linked to the electric scooters (Table 1).
3. Triage Notes also are more likely to contain words that may indicate that electric scooters were involved than chief complaints alone (22 visits with Triage Notes included; 5 visits with Chief Complaints only).
4. Triage Notes also can inform us of how the injury occurred, severity, drug and alcohol use, and other information that can help identify visits of interest.

Table 1. Marion County Emergency visits for those younger than 60 years old for possible scooter-related injuries

| | Total number | Identified 'scooter' in CC | Identified 'scooter' in DD and not CC | Identified 'scooter' in TN and not CC or DD | Mention 'electric, motorized, Lime, Bird, mph (20 MPH or under), or downtown' in CC or TN | Probable False Positives |
|---------------------------|--------------|----------------------------|---------------------------------------|---|---|--------------------------|
| Query with CC and DD only | 93 | 77 | 14 | 0 | 5 | <5 |
| Query with CC, DD, and TN | 135 | 77 | 14 | 31 | 22 | 13 |

Benefit example: Flu Season Restrictions

1. Marion County uses emergency department (ED) numbers and influenza-associated deaths to advise hospitals of when flu restrictions should be put in place.
2. Here is a combination of the general process and our recommendations when hospital restrictions should be advised:
 - a. Internal discussion between the Marion County Public Health Department's Syndromic Surveillance Epidemiologist and Nursing staff when the Weekly Influenza-like Illness (ILI) has reached 2.5% OR increased 1% or more between weeks.
 - i. Will discuss if we should begin conversations with MESH and the hospitals for visitor restrictions.
 - b. Once ILI has reached 3.5% of all visits OR if there is a higher mortality rate than we normally see the Epidemiology Department will recommend implementing visitor restrictions.

Comment from Andrew VanZee: He appreciates ISDH's willingness to be flexible with the rules in our discussions with him (i.e. building in flexibility for hospitals to notify ISDH of unanticipated outages and the flexibility for the reporting of triage notes if a hospital is unable to provide that information).

IHA is committed to working with both the state and our members to get this information out to the facilities and to work in a timely manner so that we can bring everyone into compliance and to benefit the state in receiving this information.

Comment from James Groh: He pretty much liked all of the changes that are being made and is pretty supportive of the changes.

Response: Thank you for your comments. ISDH appreciates your continued support with the development of the rule.

Comment from Brittany Yarnell: Sec. 8. (b)(1): In regards to the requirement that electronic transfer of a patient's data shall occur immediately at the time from the emergency department visit, but not later than twenty-four (24) hours from the time of the patient's visit, we would like clarification as to what is considered the "time of the patient's visit." For example, is this when the patient is first admitted to the emergency department or when they leave?

Response: The "time of a patient's visit" may vary from facility to facility due to the variation in messages sent. Facilities send the following message variations: A01/A08/A03, A04/A08/A03, A04/A01/A08/A03. This means that the date and time of a patient's visit will vary from facility to facility depending on the message that first reaches the system, either A04, or A01 depending on which one the facility is sending. Requiring facilities to send only one type of message (A01 vs. A04) is not time or cost effective and would place a significant burden on the sending facilities since they would have to work with vendors to change their workflows. Therefore, ISDH does not plan to make changes to section 8 (b)(1) at this time.

Comment from Brittany Yarnell: Sec. 8. (b): We would suggest adding another rule regarding the onboarding process for new emergency departments. More specifically, we believe it is important to clearly outline the time frame which new emergency departments have to notify ISDH of when they are opening and when they should start submitting electronic medical records (e.g. new emergency departments are required to submit electronic medical records within 30 days of opening).

Response: Facilities should begin sending data within 60-90 days upon opening. ISDH is working with the Indiana Hospital Association and acknowledges that this will be an ongoing and collaborative process. Adding another rule would hinder ongoing collaboration by limiting reporting time flexibility; therefore, ISDH will not be adding another rule at this time.

Comment from Brittany Yarnell: Sec. 8. (c)(5): In regards to the submission of the street address of the patient’s residence, we believe it is important to emphasize that this address should be the patient’s residence and not a mailing address. Mailing addresses, such as PO boxes, often make it challenging to track, monitor, and follow-up disease outcomes.

Response: The Centers for Disease Control and Prevention’s Public Health Information Network (PHIN) 2.0 guide lays out data standards required by the Centers for Medicare and Medicaid Services’ Meaningful Use program; it states that “patient address” should be the mailing address of the patient. We cannot request patient residence without going against the PHIN guide requirement so we are unable to add this language to the rule.

| | | | | | | |
|-----------------|----|-----|-----|----|--------|--|
| Patient Address | 11 | XAD | 513 | RE | [0..1] | Definition: This field contains the mailing address of the patient. Note: Expecting only the patient primary (current) address information in the supported components. Not expecting street address information. |
|-----------------|----|-----|-----|----|--------|--|

Comment from Brittany Yarnell: Sec. 8. (c)(10): We suggest specifying that the date and time of the emergency department visit should be the date and time of admittance to the emergency department. The way the rule is written, the date and time to be used is ambiguous as it could be the date and time of triage, when the patient was seen, or when the person entered the emergency department.

Response: ISDH interprets “the date and time of the emergency department visit” to mean the first message that reaches the system, either A04 or A01. Some facilities send A01/A08/A03, A04/A08/A03 and some send A04/A01/A08/A03. Due to the messaging variation, specifying the date and time of visits would impose burdening business work flow on facilities. Therefore, ISDH does not plan to make changes to section 8 (c)(10) at this time.

Comment from Brittany Yarnell: Sec. 8. (c)(17): In regard to the submission of triage notes, we suggest specifying what it means for a hospital to be “unable” to send the information. As surveillance epidemiologists, triage notes provide insightful information regarding the context, cause, and severity of disease/injury which allow us to effectively monitor diseases and protect the public’s health. Specifying what it means for a hospital to be “unable” to send information will improve the compliance of sending triage notes which will ultimately benefit the public’s health.

Comment from James Groh: Marion County Public Health Department uses triage notes a lot for doing surveillance work. One issue they might foresee with this rule is that triage notes is not clearly defined. He would like to have some sort of stipulations in the rule as to when someone is unable to upload triage notes.

Response: ISDH acknowledges the benefits of having triage note data available for surveillance work. There are a few reasons why a facility might not be able to send triage notes such as their small size, paper records, lack of staffing, etc. To accommodate facilities that are unable to send triage notes at this time, ISDH will leave the language as “may be empty if the hospital is unable to send the information” so that the field will be a voluntary field, not a requirement. The specifications for this field and rule language was discussed with the Indiana Hospital Association during the rule development. Imposing requirements on the Triage Notes field would impose significant burden on sending facilities.

Comment from Andrew VanZee: One item he would like is to have is more clarity in the “triage notes” field: do you want nursing triage notes or physician triage notes? He stated that depending on the EMR system, those could be different and separate so a clarification of what that field should contain would be beneficial.

Response: ISDH would like facilities to send nurse triage notes. ISDH is working with the Indiana Hospital Association to clarify the details and trouble shoot questions about the data that is to be transmitted.

Comment from Andrew VanZee: What is the maximum character length for the “triage notes” field in ESSENCE?

Response: The maximum character length is 4,000. ISDH can implement code logic that trims off excess characters to keep the ‘triage notes’ field at or below 4,000 characters.