DISTRICT OF COLUMBIA HEALTH INFORMATION EXCHANGE
POLICY BOARD BYLAWS

ARTICLE I
Name, Purpose, and Membership

1. The name of the organization is the District of Columbia Health Information Exchange (HIE) Policy Board (hereinafter referred to as the "Board"). The Board is the governing body assembled in response to the District of Columbia Mayor's Order 2016-035 regarding Establishment of a Health Information Exchange Policy Board.

2. The purpose, functions and membership of the Board shall be as designated by virtue of the authority vested by the Mayor of the District of Columbia by section 422 (11) of the District of Columbia Home Rule Act, approved December 24, 1973 (Pub. L. 93-198, 87 Stat. 790; D.C. Official Code §1-204.22(11) (2014 Repl.)).

    a. The purpose of the Board is to advise the Mayor and the Directors of the Department of Health Care Finance, Department of Health, Department of Behavioral Health, Department of Human Services, and the Office of the Chief Technology Officer regarding the enhancement and sustainability of secure, protected health information exchange among health providers and other authorized entities.

    b. The functions of the Board shall consist of the following:

        i. Make recommendations regarding the development of policies essential to the broad implementation of the secure and protected exchange of health information among health providers and other authorized entities;
        ii. Make recommendations on the Health Information Exchange (**"HIE"**) efforts available and/or underway within the District (or surrounding regions), under the direction and supervision of the Department of Health Care Finance;
        iii. Make recommendations to the Mayor and the Department of Health Care Finance regarding improving HIE, including its operations, vision, mission, geographic scope, and functional scope; and
        iv. Make recommendations regarding applicable accountability mechanism(s), governance structure(s), and/or fiscal sustainability for HIE in the District and strategies to coordinate HIE activities among key stakeholders across state, regional, and local levels.

3. The Board shall be composed of twenty-two (22) members, who shall be appointed by the Mayor. These members shall consist of the following:

    a. Fifteen (15) public members, who are also voting members:
        i. One (1) representative from the District of Columbia Primary Care Association;
        ii. One (1) representative from the District of Columbia Medical Society;
        iii. One (1) representative from the District of Columbia Nurses Association;
        iv. One (1) representative from the District of Columbia Hospital Association;
        v. One (1) representative from a health plan;
        vi. Four (4) representatives from the public who are either a representative of, or advocates for, beneficiaries, that are not currently employed by an organization that directly provides health care services;
        vii. Five (5) medical providers who provide direct primary care or specialty care services, or individuals who work for a provider organization that provides primary care and/or specialty care services; and
        viii. One (1) individual with health care or information technology experience.

    b. Six (6) District government employees, all of whom shall be *ex officio* voting members:
        i. Two (2) employees of the Department of Health Care Finance;
        ii. One (1) employee of the Department of Health;
        iii. One (1) employee of the Department of Human Services;
        iv. One (1) employee of the Office of the Chief Technology Officer; and
        v. One (1) employee of the Department of Behavioral Health.

    c. One (1) employee of the Office of the Deputy Mayor for Health and Human Services, who shall serve as an *ex officio*, non-voting member:

ARTICLE II
Membership Terms

1. Public members appointed to the Board shall serve for a term of three (3) years (except as provided in subsection 2 of this section or pursuant to the Board's Conflict of Interest Policies and Procedures detailed in Article IX). The date on which the first Board members are sworn-in shall become the anniversary date for all subsequent appointments. After the 3-year term ends, public members shall be re-appointed by the Mayor.

2. Members shall be appointed to fill unexpired terms as vacancies occur. A member appointed to fill a vacancy in an unexpired term shall be appointed for the remainder of the unexpired term.

3. District government officials shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

ARTICLE III
Board Organization

1. The Board shall be chaired by one (1) of the two (2) *ex officio* voting member employees of the Department of Health Care Finance, who shall be appointed by, and serve at the pleasure of, the Mayor.

2. The Board shall establish subcommittees which may include persons who are not members of the Board, provided that each subcommittee shall be chaired by a member of the Board.

ARTICLE IV
Officer Elections

1. The officers of the Board shall consist of a Chair (as established by Article III, Subsection 1) and Vice-Chair.

2. The Vice-Chair shall be elected by members of the Board and shall serve in such capacity based on the membership terms stipulated by Article II.

ARTICLE V
Officer Responsibilities

1. The Board Chair shall be responsible for the creation of the meeting agenda and preside at all meetings of the Board.

2. The Board Chair shall sign all correspondence necessary to carry out the purpose and functions of the Board.

3. The Board Vice-Chair, in the absence or disability of the Board Chair, shall preside at all meetings of the Board, and shall possess the same powers and discharge all the duties of the Board Chair until they return, or a new Board Chair is designated by the Department of Health Care Finance.

ARTICLE VI
Subcommittees

1. The majority of the Board shall vote on the establishment of each subcommittee.

2. For each subcommittee created, the Board shall determine the length of time and frequency with which each subcommittee is to meet.

3. At least a week before the next scheduled Board meeting, the subcommittee Chair shall work with staff from the Department of Health Care Finance to submit a written report to the Board Chair that describes the discussions of the subcommittee that they preside over. Reports may include specific motions or recommendations to be acted upon by the Board.

4. Subcommittees shall take no action that goes beyond assigned fact finding and the preparation of reports and recommendations to the full Board.

5. All subcommittee reports shall be made a matter of public record.

ARTICLE VII
Meetings

1. The Board shall establish its own meeting schedule but should convene no fewer than once each calendar quarter.

2. The Board shall utilize telephone conferencing or video-conferencing technologies in satisfaction of the meeting requirements pursuant to the requirements set forth in D.C. Official Code § 2-577 (2012).

3. The Board shall follow Robert's Rules of Order for the purpose of conducting orderly meetings and business, except as otherwise prescribed herein.

4. At all regular or special meetings of the Board, a majority of the duly appointed non-governmental members, through physical presence or through telephone conferencing or video-conferencing pursuant to the requirements set forth in D.C. Official Code § 2-577, shall constitute a quorum for the transaction of business. Any action(s) taken at such meetings in which a quorum is present shall be the act of the Board.

5. All meetings shall be open to the public, except that a majority of the Board may vote in favor of a closed meeting pursuant to the requirements set forth in D.C. Official Code § 2-575, where the attendance shall be limited to members of the Board.

6. Special meetings of the Board shall be called by the Board Chair or by written request to the Board Chair by a majority of Board members.

7. Written notices of all regular or special meetings of the Board shall be given to each Board member at least five (5) business days before the date of the meeting and pursuant to the requirements set forth in D.C. Official Code § 2-576.

8. Board members are expected to attend all regularly scheduled or special meetings. The Board Chair may excuse a board member from attending regularly scheduled or special meetings for emergency or other approved reasons.

9. Board members who fail to attend, either in-person or by telephone, two (2) or more consecutive regularly scheduled or special meetings without notice shall be deemed voluntarily resigned from the Board. Non-participating members shall be notified in writing of their status by the Board Chair. Board members shall contact the Director of the Mayor's Office of Talent and Appointments, in consultation with the Board Chair, for the purpose of submitting an official letter of resignation that will be considered effective immediately. The Board Chair, in consultation with the Director of the Department of Health Care Finance, will report the resignation and vacancy to the Director of the Mayor's Office of Talent and Appointments.

10. Staff from the Department of Health Care Finance shall be in attendance at all meetings to provide administrative, clerical, and/or technical support to the extent that funds are available.

ARTICLE VIII
Agenda, Order of Business, and Voting

1. Agendas for all meetings of the Board are prepared by the Board Chair, taking into consideration the recommendations of the Board Vice-Chair and Chairs of the subcommittees. In the absence or disability of the Board Chair, the Vice-Chair shall prepare the agendas for all meetings of the Board.

2. All meetings of the Board shall follow the following order of business on the Agenda:
    i. Call to Order
    ii. Topics for Discussion [presented in the order in which they appear on the meeting agenda]
    iii. Announcement of a Quorum Present
    iv. Approval of Minutes of the Previous Meeting(s), if applicable
    v. Next Steps
    vi. Adjournment

3. The order of business on the Agenda for special Board meetings may vary dependent on topic(s) to be discussed.

4. When voting, the Board shall follow the following procedure:

    i. Each member of the Board shall have one vote;
    ii. In order for an item to be voted on by the Board, the vote shall be held at a meeting of the Board with a quorum present;
    iii. In order for an item to be passed, a majority of the votes cast on a matter shall be an affirmative vote in support of the matter that is being voted upon; and
    iv. In the event that a member of the Board is participating in the meeting through an approved electronic mode, the member shall be allowed to vote by such electronic mode.

5. The official vote on all decisions shall be documented in the Board's official meeting minutes. The meeting minutes of the meeting shall reflect the method each vote was cast and result of all votes, including a record of the vote of each member of the Board. No votes shall be taken by secret or written ballot.

ARTICLE IX
Reports to the Board Chair

1. The Chair of each established subcommittees shall file a written report with the Board Chair of each subcommittee meeting. Reports may include specific motions or recommendations to be acted upon by the Board.

2. An annual report outlining the Board activities shall be submitted to the Director of the Department of Health Care Finance through the Board Chair.

ARTICLE X
Compensation

1. Members of the Board and subcommittees shall serve without compensation. Reasonable expenses of the Board shall be reimbursed, when approved in advance by the Director of Department of Health Care Finance, or their designee, subject to the availability of appropriations for that purpose, and shall become obligations against funds designated for that purpose, when sufficient budget authority exists to allow reimbursement.

ARTICLE XI
Administration

1. As stipulated in Article VII, the Department of Health Care Finance shall provide administrative, clerical, and technical support to the Board to the extent that funds are available through appropriation.

2. Staff from the Department of Health Care Finance shall be responsible for recording accurate and detailed minutes of Board meetings.

3. Staff from the Department of Health Care Finance shall keep or cause to be kept on file, all correspondence and official papers of the Board including the minutes thereof. Copies of records shall be made available for public inspection pursuant to the requirements set forth in D.C. Official Code § 2-578.

ARTICLE XII
Approval or Amendment of Bylaws

1. The foregoing Bylaws shall become effective upon an affirmative vote of two-thirds (2/3) of the Board membership, subject to the approval of the Mayor, or their designee.

2. These Bylaws may be altered, amended or repealed, in whole or in part, by the affirmative vote of two-thirds (2/3) of the Board membership at a regular or special meeting and subject to the approval of the Mayor, or their designee. Notice of such alterations, amendments, or repeal and the nature thereof shall have been given to the members of the Board at least two (2) weeks prior to the date of the meeting at which such alterations, amendments, or repeal is to be presented for consideration.

ARTICLE XIII
Code of Conduct

1. All Board members shall comply with the most current "Code of Conduct" provisions contained in the following:

    a. The Code of Official Conduct of the Council of the District of Columbia, as adopted by the Council;
    b. Sections 1801 through 1802 of the Merit Personnel Act;
    c. Section 2 of the Official Correspondence Regulations, effective April 7, 1977 (D.C. Law 1-118; D.C. Official Code § 2-701 *et seq.*);
    d. Section 415 of the Procurement Practices Reform Act of 2010, effective April 8, 2011 (D.C. Law 18-371; D.C. Official Code § 2-354.16);

e. Chapter 18 of Title 6B of the District of Columbia Municipal Regulations (Responsibilities of Employees);
f. Conflict of Interest Provisions of the Ethics Act;
g. Local Hatch Act; and
h. Donations Act.

2. All Board members shall make a reasonable attempt to contact and discuss any potential issue(s) with District policies and/or initiatives with the Board Chair before making a public comment, which includes print and/or social media.

3. No member shall represent the Board without prior approval from the Director of the Department of Health Care Finance and the Board Chair. In general, only the Board Chair speaks on behalf of the board; however, on occasion, a Chairperson of a Board's standing and/or ad hoc group, such as a subcommittee, may issue a statement with an appropriate disclaimer. The Board shall approve the disclaimer itself in consultation with the Director of the Department of Health Care Finance prior to public release of the accompanying statement. The disclaimer should clearly state that the opinions expressed do not represent those of the Board.

ARTICLE XIV
Conflict of Interest Policy and Procedures

1. Pursuant to Section XIII of the District of Columbia Mayor's Order 2016-035, the Board shall develop and publish procedures to guard against conflicts of interest for its members.

2. Members of the Board shall protect the needs of the District and ensure transparency around business, financial, and/or personal interests that may lead to direct, unique, pecuniary, or personal benefit. The Board shall consider actual or potential conflicts before discussing and/or voting on potential initiatives that might benefit, directly or indirectly, the private interest of a member.

    a. Each Board member shall sign a conflict of interest disclosure form that discloses all material facts relating to any actual or potential conflicts of interest during specific of their term that include, but are not limited to, the following:
        i. Initially, upon joining the Board;
        ii. Annually, *prior to the January Board meeting*, thereafter;
        iii. Prior to any new business transactions with actual or potential conflict of interest; and
        iv. Immediately upon becoming aware of an actual or potential conflict of interest.

b. Members will submit their signed conflict of interest disclosure forms to the Board Chair, or their designee.

c. The Board Chair shall review all declarations of conflict of interest and take one of the following courses of action:
    i. Instruct the member to recuse themselves from voting on a matter in which they have a verified conflict;
    ii. Instruct the member to recuse themselves from discussing a matter in which they have a verified conflict of interest;
    iii. Instruct the member to disclose their conflict to the full Board; or
    iv. Request the member to resign their current position on the Board and/or remove their name from consideration for a Board position if it is determined that a conflict(s) may prevent meaningful participation on the Board (See Article XV for Procedures).

d. Prior to their term commencing, the following interest(s) shall be declared on the conflict of interest disclosure form if either a Board member, or their relative(s) (i.e., spouse, domestic partner, children or sibling):
    i. Directly or indirectly enters into, or seeks to enter into, a Business Transaction with a for-profit company that sells products or services related to health information exchange;
    ii. Serves as an unpaid officer, director or advisor to a for-profit entity that sells technology or services related to health information exchange;
    iii. Directly or indirectly enters into, or seeks to enter into, a business transaction (excluding Medicaid reimbursement) with the Department of Health Care Finance;
    iv. Has material ownership, financial or investment interest in a for-profit entity that sells technology related to health information exchange; or
    v. Receives, or potentially receives, material consideration from a person or organization which enters into, or which seeks to enter into, a business transaction with a for-profit company that sells products or services related to health information exchange.

e. The Board Chair shall report back all of their findings to the rest of the Board during a regular meeting or special meeting; all minutes of Board meetings shall capture these results and how the conflict was managed.

f. The Board Chair may choose at their discretion to refer conflict of interest issues to the DC Board of Ethics and Government Accountability.

g. The following interest(s) may preclude a potential applicant from participating in this Board:
    i. Serve as an employee, consultant or contractor, or as a paid officer, director or advisor of a for-profit entity that sells technology related to health information exchange;

h. A Board member shall inform the Board Chair immediately if they believe another member has failed to disclose actual or potential conflict of interest(s).
    i. The Board Chair shall afford the accused member the opportunity to explain the failure to disclose before any further actions are taken.
    ii. If a breach is determined to have occurred, the matter shall be immediately referred to the Mayor's Office of Talent and Appointments and the Board of Ethics and Government Accountability for corrective action.

i. The above policies do not replace any relevant Federal or District laws regarding conflict of interest currently in place.

ARTICLE XV
Bylaws Violation and Arbitration Procedures

1. The Board Chair shall determine if any Articles associated with these bylaws have been violated.

2. In the event a violation has taken place, the Board Chair shall submit a written report to the Mayor's Office of Talents and Appointments for review. Conferring with the Board Chair, the Mayor's office will determine the severity of the violation and the appropriate ramification of those actions, which could include removal of the associated Board member from their position on the Board.

3. Board members may request an arbitrator within 3 business days of receiving a final decision from the Mayor's Office. Arbitration will be provided by the Board of Ethics and Government Accountability Office.

Approved:

Deniz Soyer, Board Chair, DC HIE Policy Board _____ Date

Subcommittee: HIE Operations, Compliance, and Efficiency

Chairs: Ms. Gayle Hurt

Date: October 19, 2023

Status: Draft

District of Columbia Health Information Exchange Policy Board

Recommendation on the DC HIE Glossary

I. SUMMARY

The HIE Policy Board Operations, Compliance, Efficiency (OCE) subcommittee proposes an updated DC HIE Glossary. This updated listing aims to foster consistency in the use of terms when describing the functions and activities of the DC HIE. The glossary is reviewed in conjunction with registered and designated entities. Each term and its respective definition are reviewed and approved by the subcommittee. The glossary is reviewed and updated on an annual basis.

II. PROBLEM STATEMENT

The HIE Final Rule identified key terms and definitions for the design and creation of the health information exchange in the District. As the DC HIE infrastructure is enhanced to meet new and evolving District needs, there is an ongoing need to identify and define terms that are used the operation, function, and maintenance of the DC HIE and its various tools. Additionally, a common nomenclature was needed to align with HIE educational content and to stay abreast with other national standards.

In response, the subcommittee, in collaboration with registered and designated entities, worked to catalogue the terms used in the function of the DC HIE and in communication with external stakeholders (such as educational materials, website and application interfaces, etc.).

III. SUBCOMMITTEE GOAL AND ACTIVITY

This activity can be added under the subcommittee's long-term goal to standardize language used in the District as it relates to health information exchange, consistent with DC HIE rule.

IV. DISCUSSION

The HIE Operations, Compliance, and Efficiency (OCE) subcommittee lists out eighty-three (83) key terms and definitions for the DC HIE glossary. Definitions for these terms are derived from various nationally recognized sources and cited wherever appropriate. Additionally, the subcommittee also reviewed and approved updates to existing definitions. The subcommittee voted to include the terms listed below. This glossary is located in *Appendix 1* of this document.

- Break-the-Glass Access
- Clinical Decision Support
- Patient panel
- FHIR endpoint
- Direct Secure Messaging
- Information Blocking

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In developing this glossary, the subcommittee underscored that DC HIE Glossary was not intended to be a compilation of Health IT terms – rather, the glossary aims to explain the specific ways in which terms are used. To that end, the subcommittee also discussed a set of standard questions that the subcommittee can use while reviewing terms. These include:

- Is there a standard definition (for example, within regulation) for the term?
- Do the definitions offer clarity and explain concepts in an easy-to-understand manner?
- Is the term and its definition aligned with the scope of the DC HIE functions and tools?

To ensure that this glossary remains updated, the subcommittee will annually review and update the glossary. This review will include updates to existing definitions and the addition of any prominent terms related to electronic health information exchange. Upon approval by the Policy Board, the finalized HIE glossary will be posted on the DHCF HIE website.

V. RECOMMENDATION(S) FOR BOARD ACTION:

The Operations, Compliance, and Efficiency (OCE) subcommittee proposes that the DC HIE Policy Board approve the DC HIE Glossary.

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***Committee Members*:** Ms. Gayle Hurt, Dr. Sonya Burroughs, Dr. Jessica Herstek, Ms. Lucinda Wade, Ms. Stephanie Brown, Mr. Ronald Emeni, Ms. Donna Ramos-Johnson, Mr. Jim Costello, Mx. Deniz Soyer, Ms. Adaeze Okonkwo, Mr. Robert Kaplan, Mr. Nathaniel Curry, Ms. Maava Khan, and Ms. Asfiya Mariam

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Appendix 1: DC HIE Glossary

DC HIE Glossary

This glossary is intended to provide definitions for key terms that are used in the operations and maintenance of the DC Health Information Exchange (HIE). Click on the term for the source and additional information.

21st Century Cures Act: Enacted by the 114th United States Congress and signed into law by President Obama on December 13, 2016, the 21st Century Cures Act includes a number of provisions that enhance electronic health information sharing and promote greater interoperability. The ONC Cures Act Rule, finalized in June 2020, implemented interoperability provisions that supported the exchange, access, and use of electronic health information.

42 CFR Part 2: Federal regulation on The Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2 (Part 2), that protects any information obtained by a "federally assisted" substance use treatment program that can directly or indirectly identify an individual as receiving or seeking treatment for substance use. This can include information beyond treatment records, such as name, address, or social security number. Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. When one regulation imposes a stricter standard than the other, the covered entity must follow the stricter standard. Generally, 42 CFR Part 2 imposes more strict standards than does HIPAA. 42 CFR Part 2's general rule places privacy and confidentiality restrictions upon substance use disorder treatment records.

Admission, Discharge, Transfer (ADT): An event that occurs when a patient is admitted to, discharged from, or transferred from one care setting to another care setting or to the patient's home. For example, an ADT event occurs when a patient is discharged from a hospital. An ADT event also occurs when a patient arrives in a care setting such as a health clinic or hospital.

ADT Message: A type of Health Level Seven® (HL7®) message generated by healthcare systems based upon Admission, Discharge, Transfer (ADT) events and the HL7 "Electronic Data Exchange in Healthcare" standard. The HL7 ADT message type is used to send and receive patient demographic and healthcare encounter information, generated by source system(s). The ADT messages contain patient demographic, visit, insurance, and diagnosis information.

ADT Notification: An electronic notification that a given patient has undergone an Admission, Discharge, Transfer (ADT) event. An ADT Notification is not a complete ADT Message.

Advance Care Planning: Involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know—both one's family and one's health care providers—about preferences. These preferences are often put into an advance directive or

other types of forms (e.g., MOST, MOLST, POST, POLST), a legal document that goes into effect only if the individual is incapacitated and unable to speak for themselves.

Advance Directive: A written document stating how a person wants medical decisions to be made if they lose the ability to make them for themself. It may include a Living Will and a Durable Power of Attorney for health care.

Authentication: The process of establishing confidence in user identities electronically presented to an information system.

Authorization: Has the meaning provided in 45 CFR § 164.508

Authorized User: A person identified by a participating organization or a HIE entity, including a health care consumer, who may use, access, or disclose protected health information through or from a health information exchange for a specific authorized purpose and whose HIE access is not currently suspended or revoked.

Breach: The meaning provided in 45 CFR § 164.402

Break-the-Glass: A term used when a health care provider, in the case of an emergency, gets access to a patient's records without the patient's consent. The Designated HIE entity routinely audits all emergency access activity.

Business Associate: The meaning provided in 45 CFR § 160.103

Certified Electronic Health Record Technology (CEHRT): In order to efficiently capture and share patient data, health care providers need an electronic health record (EHR) that stores data in a structured format. Structured data allows health care providers to easily retrieve and transfer patient information and use the EHR in ways that can aid patient care. CMS and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that EHRs must meet in order to qualify for use in the Promoting Interoperability Programs.

Claims Data: The most prevalent source for structured health data. Paid claims can help providers understand which services were rendered in a specific care setting. Claims may also reduce duplication of services. Two key types of information recorded on claims forms are (1) one or more procedure codes describing specific services the patient received, and (2) one or more diagnosis codes describing the problem that was being treated. The focus of the claims form is on the services delivered for payment, and so the diagnosis codes recorded on the claims form are not intended to be a comprehensive description of the patient's health problems and other characteristics, but to describe the reasons for delivering the service for which payment is being sought.

Clinical Data: Is most commonly exchanged in HIEs via Continuity of Care Documents (CCDs), which provide a common, structured format to share clinical data from the EHR. Elements of a CCD include

structured information on vitals (e.g. BMI or blood pressure), lab test results, and medications. Two key types of information in clinical data are the types of services that a patient receives and the types of health problems a patient has. Clinical data generally have information about more services and more health problems than are available from claims data, since they will include services that are not eligible for individual payment and therefore are not described on claims forms, and they will also include information about health problems that were not explicitly treated by the clinician and may not be recorded on a claims form.

Clinical Decision Support: Clinical decision support (CDS) provides clinicians, staff, patients or other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and better health care. CDS encompasses a variety of tools to enhance decision-making in the clinical workflow. These tools may include, but are not limited to –

- Computerized alerts and reminders to care providers and patients based on patient specific data elements, including diagnosis, medication, and gender/age information as well as lab test results
- Clinical guidelines/established best practices for managing patients with specific disease states
- Condition-specific order sets
- Focused patient data reports and summaries
- Documentation templates
- Diagnostic support
- Contextually relevant reference information

CMS Interoperability and Patient Access Rule: Promulgated in 2020 as part of the Trump Administration's MyHealthEData initiative, this final rule is focused on driving interoperability and patient access to health information by liberating patient data using CMS authority to regulate Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plan (QHP) issuers on the Federally-Facilitated Exchanges (FFEs). This final rule establishes policies that break down barriers in the nation's health system to enable better patient access to their health information, improve interoperability and unleash innovation, while reducing burden on payers and providers.

Chesapeake Regional Information System for our Patients (CRISP) DC: CRISP DC is the designated health information exchange (HIE) serving the District of Columbia sharing health information among participating doctors' offices, hospitals, care coordinators, labs, radiology centers, community-based organizations, managed care organizations and other healthcare providers through secure, electronic means.

Consent: In the context of privacy, consent is the ability of a data subject to decline or consent to the collection and processing of their personal data. Consent can be explicit, such as opting-in via a form, or implied, such as agreeing to an End-User License Agreement, or not opting out. Under many data protection laws, consent must always be explicit.

Consent Management: Consent management is a system, process, or set of policies that enables patients to choose what health information they are willing to permit their healthcare providers to access and share. Consent management allows patients to affirm their participation in electronic health

initiatives such as patient portals, personal health records (PHR), and health information exchange (HIE). Electronic Patient Consent Management is an attempt to balance the risks to patient privacy with the benefits of health information exchange and interoperability.

Continuity of Care Document (CCD): A harmonized format and interoperable standard for exchanging clinical information (including patient demographics, medications and allergies) among providers to improve patient care, enhance patient safety and increase efficiency.

Core elements of the Master Patient Index: The minimum elements that are:

a) Required for an HIE entity to identify a particular patient across separate clinical, financial, and administrative systems; and
b) Needed to exchange health information electronically.

Community Resource Inventory (CRI): The DC Community Resource Inventory is a District-wide publicly available directory of resources reflecting regional programs and organizations in the community.

Data Use Agreement (DUA): This is a specific type of agreement that is required under the HIPAA Privacy Rule and must be entered into before there is any use or disclosure of a Limited Data Set (defined below) from a medical record to an outside institution or party for one of the three purposes: (1) research, (2) public health, or (3) health care operations purposes. A Limited Data Set is still Protected Health Information (PHI), and for that reason, HIPAA Covered Entities or Hybrid Covered Entities like University of Colorado must enter into a DUA with any institution, organization or entity to whom it discloses or transmits a Limited Data Set.

DC HIE: The District's statewide health information exchange, an interoperable system of registered and designated HIE entities that facilitates person-centered care through the secure, electronic exchange of health information among participating organizations supported by a District-wide health data infrastructure.

Designated HIE: An HIE entity that has applied for and received designation from the Department of Health Care Finance in accordance with Chapter 87, District of Columbia Health Information Exchange, of Title 29, Public Welfare, of District of Columbia Municipal Regulations.

Digital Health: Digital health is a broad scope of categories that include mobile health (mHealth), health information technology (Health IT), wearable devices, telehealth and telemedicine, and personalized medicine.

Direct Secure Messaging: Providers use a Direct address to exchange health information with each other over the internet in a standardized, secure manner. In general, "Direct" is a technical standard for exchanging health information between health care organizations. Direct is similar to email, but different in important ways. For example, Direct messages are authenticated and encrypted in a specific way to ensure that data are sent and received only by authorized parties.

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Disclosure: The release, re-disclosure, transfer, provision, access, transmission, communication, or divulgence in any other manner of information in a medical record, including an acknowledgment that a medical record on a particular health care consumer or recipient exists, outside the entity holding such information.

District Automated Treatment Accounting (DATA): A performance monitoring system in development by the Addiction Prevention and Recovery Administration (APRA) based on the Web Infrastructure for Treatment Services (WITS)

eClinical Quality Measure (eCQM): A standard for quality measures from electronic health records (EHR) and/or health information technology systems to measure health care quality. The Centers for Medicare & Medicaid Services (CMS) use eCQMs in a variety of quality reporting and incentive programs. eCQMs are an improvement over traditional quality measures because if the EHRs are not used, the work to gather the data from medical charts, e.g. "chart-abstracted data," is very resource intensive and subject to human error.

Electronic Health Record: An electronic record of health information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.

Fast Healthcare Interoperability Resources (FHIR): A standard that defines how healthcare information can be exchanged between different computer systems regardless of how it is stored in those systems. It allows healthcare information, including clinical and administrative data, to be available securely to those who have a need to access it, and to those who have the right to do so for the benefit of a patient receiving care. The standards development organization HL7® (Health Level Seven®) uses a collaborative approach to develop and upgrade FHIR.

FHIR endpoint: Also known as a FHIR Service Base URL, these endpoints describe the technical details of a location that can be connected to for the delivery/retrieval of information. API users require these endpoints to interact with an API. The Office of the National Coordinator for Health Information Technology (ONC) maintains the *Lantern* tool – an open-source tool that monitors and provides analytics about the availability and adoption of FHIR API service base URLs (endpoints) across healthcare organizations in the United States. Lantern also gathers information about FHIR Capability Statements returned by these endpoints and provides visualizations to show FHIR adoption and patient data availability.

Firewall: An inter-network connection device that restricts data communication traffic between two connected networks. A firewall may be either an application installed on a general-purpose computer or

a dedicated platform (appliance), which forwards or rejects/drops packets on a network. Typically, firewalls are used to define zone borders. Firewalls generally have rules restricting which ports are open.

Health Care Consumer: Any actual or potential recipient of health care services, such as a patient in a hospital.

Health Care Provider:

a) A person who is licensed, certified, or otherwise authorized under District law to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program;
b) Government agencies involved in the provision of health or social services;
c) A facility where health care is provided to health care consumers or recipients; or
d) An agent, employee, officer, or director of a health care facility, or an agent or employee of a health care provider.

Health Data Utility: A standards-based and governance-led, interoperability-first strategy is key to integrating care because it makes certain that care partners are: 1) digitally connected to each other; 2) able to view the same information regarding the individuals that they collectively serve; and 3) using the same "language" regarding symptoms and therapies. This strategy enhances communication of data between stakeholders on the health care continuum and/or those involved in the delivery of care, with the goal of advancing disease control, treatment efficacy, and health equity.

Health information: Any information, whether oral or recorded in any form or medium, that:

a) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
b) Relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person, or the past, present, or future payment for the provision of health care to a person.

Health Information Exchange (HIE): A system that facilitates person-centered care through the secure electronic exchange of health information among approved, qualifying partners in support of health data infrastructure according to nationally recognized standards.

Health Information Technology (Health IT): The programs, services, technologies and concepts that store, share, and analyze health information in order to improve care.

HIE Entity: An entity that creates or maintains an infrastructure that provides organizational and technical capabilities in a system to enable the secure, electronic exchange of health information among participating organizations not under common ownership.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub.L. No. 104-191, 110 Stat. 1938 (1996)). HIPAA is a series of regulatory standards that outline the lawful use and disclosure of protected health information (PHI).

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HITECH Act: The Health Information Technology for Economic and Clinical Health Act (Pub. L. No. 111-5, Title XIII, 123 Stat. 226 (2009)). Enacted as part of the American Recovery and Reinvestment Act of 2009, HITECH was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. It also addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Home and Community-Based Services (HCBS): Types of person-centered care delivered in the home and community, rather than institutions of other isolated settings. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care. HCBS programs generally fall into two categories: health services and human services. HCBS programs may offer a combination of both types of services and do not necessarily offer all services from either category.

Incident Response Plan: The documentation of a predetermined set of instructions or procedures to detect, respond to, and limit consequences of a malicious cyber-attacks against an organization's information system(s).

Information blocking: In general, information blocking is a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of Health and Human Services (HHS) as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information (EHI). The official definition within regulation is listed in 45 CFR 171.103.

Interoperability: As cited in section 4003 of the 21st Century Cures Act health information technology that— "(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; "(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and "(C) does not constitute information blocking as defined in section 3022(a)."

Master Patient Index (MPI): A database that maintains a unique index identifier for each patient whose protected health information may be accessible through an HIE entity and is used to cross reference patient identifiers across multiple participating organizations to allow for patient search, patient matching, and consolidation of duplicate records.

Medical Orders for Scope of Treatment: A documented provider's order that helps patients keep control over medical care at the end of life. In DC, the Medical Orders for Scope of Treatment (MOST) program provides a more comprehensive approach, empowering terminally ill patients the right to make decisions on their end-of-life care options, in consultation with their DC-licensed authorized healthcare provider (Physician (MD/DO) or Advanced Practice Registered Nurse (APRN) only).

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Multi Factor Authentication (MFA): Multi-factor authentication is a layered approach to securing data and applications where a system requires a user to present a combination of two or more credentials to verify a user's identity for login. MFA increases security because even if one credential becomes compromised, unauthorized users will be unable to meet the second authentication requirement and will not be able to access the targeted physical space, computing device, network, or database.

Non-HIPAA Violation: The acquisition, access, use, maintenance, or disclosure of health information in a manner not permitted under District or federal law:

a) which compromises the security or privacy of the health information; and
b) is not a HIPAA violation.

Opt-In: When an individual makes an active indication of choice, such as checking a box indicating willingness to share information with third parties such as an HIE.

Opt-Out: A health care consumer's election not to participate in the HIE, so that the HIE entity shall not disclose such health care consumer's protected health information, or data derived from such health care consumer's health information, except as consistent with this chapter.

Participating Organization: An entity that enters into an agreement with an HIE entity that governs the terms and conditions under which its authorized users may use, access, or disclose protected health information by the HIE entity.

Patient Panel: For every organization that participates in the DC HIE (such as a hospital, clinic, etc.), a patient panel is a list of patient names and demographics in that organization that is used to document an ACTIVE patient/provider treatment relationship.

Point-to-Point Transmission: A secure electronic transmission of PHI, including, but not limited to, records sent via facsimile or secure clinical messaging service, sent by a single entity that can be read only by the single receiving entity designated by the sender.

Population Health Management: The activities that a clinician or care team performs to provide care management for a group of patients for which they are accountable, sometimes referred to as a "patient panel." Health IT assists providers by giving them a high-level view of defined health trends and needs across the patients in their practice through analytic tools. Specific functions include list creation and health registries that catalogue patients with a condition that requires action, as well as analytics tools that help providers monitor quality of care.

Program Eligibility and Participating Data: Provides information on eligibility and participation in programs that support individual health and wellness (e.g., case management, supportive housing, food assistance, and transportation).

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Protected Health Information (PHI): A subset of health information that has the same meaning as given in 45 CFR § 160.103 and includes sensitive health information.

Psychiatric Advance Directives: A legal instrument that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Public Health: Public health activities assess and develop interventions to improve the health of all residents who share a specific geography, condition, or other characteristic. Health IT allows data from providers across the District to be efficiently and electronically shared, analyzed, and acted upon to design timely and effective interventions to improve the health of District residents.

Qualified Service Organization Agreement: A two-way agreement between a Part 2 program and the entity providing the service. The QSOA authorizes communication only between the Part 2 program and QSO.

Registered Resident Agent: An agent of an entity who is authorized to receive service of any process, notice, or demand required or permitted by law to be served on the entity.

Registered HIE: An HIE entity that has applied for and received registration from the Department of Health Care Finance in accordance with Chapter 87, District of Columbia Health Information Exchange, of Title 29, Public Welfare, of District of Columbia Municipal Regulations.

Secondary Use: Is the use, access, or disclosure of health information through the registered HIE entity that is not for a Primary Use; subject to any limitations under HIPAA or federal law.

Sensitive Health Information: A subset of PHI, which consists of

a) 42 CFR Part 2 information; or
b) Any other information that has specific legal protections in addition to those required under HIPAA, as implemented and amended in federal regulations.

Self-Reported Data: Includes information, such as health status, collected directly from individuals. This data has proven highly reliable and can be predictive of key health outcomes.

Single Sign-On (SSO): The functionality that allows a user to sign on to multiple related, yet independent software systems with a single user identification and password.

Social Determinants of Health (SDOH): The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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Substance Use Disorder Syndrome: Patterns of symptoms resulting from the use of a substance that a person continues to take, despite experiencing problems as a result.

Systems Administrator: An individual employee within a participating organization (or an individual employed by a contractor to the participating organization) who is designated by the participating organization to manage the user accounts of specified persons within the participating organization in coordination with an HIE entity.

Trusted Exchange Framework and Common Agreement (TEFCA): Published by the Department of Health and Human Services Office of the National Coordinator for Health IT (ONC), the overall goal of TEFCA is to establish a universal floor of interoperability across the country. The Common Agreement will establish the infrastructure model and governing approach for users in different networks to securely share basic clinical information with each other—all under commonly agreed-to expectations and rules, and regardless of which network they happen to be in. The Trusted Exchange Framework describes a common set of non-binding, foundational principles for trust policies and practices that can help facilitate exchange among health information networks.

Telehealth: The delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies.

Third-Party System: Hardware or software provided by an external entity to a participating organization, which interoperates with an HIE entity to allow an authorized user access to information through the HIE entity and may include an electronic health record system.

Unqualified Opinion: A written statement by an auditor that financial statements fairly reflect the results of the business organization's operations and its financial position according to generally accepted accounting principles.

Unusual Finding: A finding that there was an irregularity in the manner in which use, access, maintenance, disclosure, or modification of health information or sensitive health information transmitted to or through an HIE entity should occur that could give rise to a breach, a violation under this chapter or a violation of other applicable privacy or security laws.

User: The meaning in 45 CFR § 164.304. User means a person or entity with authorized access.

Subcommittee: HIE Community Resource Inventory

Chairs: Ms. Ms. Lucy DeOliveira and Mr. Khalil Hassam

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District of Columbia Health Information Exchange Policy Board

Recommendations on Operational Best Practices for the DC Community Resource Inventory

I. SUMMARY

HIE Policy Board Community Resource Inventory subcommittee proposes the publication of best practices for the DC Community Resource Inventory (CRI) on Inclusion/Exclusion (I/E) criteria and the CRI Style Guide. This activity is in response to a previously approved recommendation on operational elements for the DC CRI. These best practices include work completed by the DC Positive Accountable Community Transformation (PACT) CRI Action Team as well as updates from recent subcommittee discussions. Given that these operational elements are likely to change over time, the subcommittee also recommends that these practices be updated on a regular basis. Together, these best practices aim to support the long-term availability of information regarding community resources in the District.

II. PROBLEM STATEMENT

The CRI subcommittee developed two (2) recommendations that were approved by the HIE Policy Board in July 2023. These recommendations included operational elements regarding content collection, management, and curation.

Following the approval of these recommendations, the subcommittee determined that there was a need to address some open operational questions. Specifically, these questions centered around the inclusion of certain services (such as payer organizations, hospital services, and geographic limits to services), formatting of service record information, as well as common terms and definitions for inclusion within the larger DC HIE glossary. The subcommittee determined that these best practices were critical to ensure that the CRI is responsive to the needs of District residents and stakeholders.

III. SUBCOMMITTEE GOAL AND ACTIVITY

This activity can be added under the subcommittee's overall goal to develop recommendations for consideration by the HIE Policy Board that are related to the use, exchange, sustainability, and governance of community resource directory data through the District HIE infrastructure.

IV. DISCUSSION

The HIE Community Resource Inventory (CRI) Subcommittee proposes the following best practices related to the DC CRI. These best practices are located in *Appendix 1*. To develop these best practices, the subcommittee reviewed existing documents that were originally developed in Phase 1 of the DC Community Resource Information (CoRIE) initiative. The subcommittee also researched several industry standards as outlined by Inform USA (formerly known as the Alliance of Information and Referral Systems or AIRS) and any exchange specifications identified by the Office of the National Coordinator for Health IT (ONC) Interoperability Standards Advisory (ISA). These items are described below in further detail:

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- *Inclusion and Exclusion (I/E) Criteria*: Inclusion/Exclusion criteria represent a set of characteristics that determine if a social service should be listed in the DC CRI. Such a policy outlines the scope and limitations of any resource database. The uniform application of these criteria ensures reliability of the organizations and services listed in the CRI. The subcommittee reviewed the previously established I/E policy and made decisions on the following:
    - Inclusion of payer, hospital, and web-based educational services;
    - Geographical limits to services displayed on the CRI; and
    - Special considerations and exceptions to the I/E criteria.

- *Style Guide*: A Style Guide is a set of policies that is used by the DC CRI to ensure that all social care organizations and services have a clear and consistent structure. This includes rules for phrasing free-text service descriptions, person-first terminology, and other requirements for data fields for services listed in the DC CRI. The subcommittee voted to include the existing CRI style guide without any changes as part of best practices.

As mentioned in the subcommittee's previously approved recommendation in July 2023, the subcommittee underscored the importance of updating operational practices on a regular basis, while also ensuring the involvement of community stakeholders in the process. To that end, the subcommittee also discussed an annual review of these best practices to ensure that they remain responsive to the needs of District residents while ensuring alignment with the latest industry/national standards. Upon approval by the Policy Board, the finalized set of best practices will be posted on the DHCF HIE website.

V. RECOMMENDATION(S) FOR BOARD ACTION:

The Community Resource Inventory (CRI) subcommittee proposes that the DC HIE Policy Board approve the best practices on Inclusion/Exclusion (I/E) criteria and the CRI Style Guide in *Appendix 1* for publication on the DHCF website.

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***Committee Members*:** Ms. Luizilda DeOliveira, Mr. Khalil Hassam, Mr. Luis Diaz, Ms. Stacey Johnson, Dr. Eric Marshall, Ms. Tamara Moore, Mr. Greg Bloom; Mr. David Poms, Ms. Sabrina Tadele, Ms. Ariana Wilson, Mr. Tommy Zarembka, Mx. Deniz Soyer, Ms. Asfiya Mariam

Appendix 1: Best Practices

Best Practices – Inclusion / Exclusion Criteria

Best Practices – Style Guide

Best Practices – *Inclusion / Exclusion Criteria*

The HIE Community Resource Inventory (CRI) subcommittee recommends the following best practices for Inclusion/ Exclusion criteria for the DC Community Resource Inventory (CRI). These represent recommended practices for the District's Designated HIE entity in maintaining the DC CRI. As with any policies or best practices for the DC CRI, the Inclusion/Exclusion (I/E) criteria should aim to address the needs of District residents.

These best practices were derived from existing national standards outlined by the Office of the National Coordinator for Health IT (ONC) Interoperability Standards Advisory (ISA), the initial set of I/E criteria developed by the CRI Action Team, and the Alliance of Information and Referral Systems (AIRS) or Inform USA standards.

General

- The I/E policy may choose to prioritize services and/organizations that are frequent recipients of referrals.

- The organization is encouraged to develop a policy for appeals for any social care organizations and/or services that may not appear in its database.

- The organization is encouraged to publicly share its I/E policy in an accessible location (for example, on its website).

Types of Organizations and Services that are Included

- The CRI should include all social care organizations that are accessible to District residents, including all appropriate services located in neighboring states within a fifteen (15) mile radius.

- The CRI should include non-profit organizations that are located in the District that offer free or low-cost services. These can include, but are not limited to:
    - Governmental agencies and programs;
    - Organizations that provide health and social services;
    - Community associations and social clubs that offer services to the community at-large; and
    - Organizations that offer education, library, employment, legal, and recreational services.

- The CRI should include licensed hospitals, health clinics, personal care homes and specialty outpatient departments (such as infectious disease, cancer, cardiology) that offer services for low-income patients.

- The CRI may choose to include for-profit organizations, non-profit self-help groups, and mutual aid groups when they offer free, low-cost, or sliding scale services.

- The CRI may choose to include the following services with appropriate labelling and access information such that individuals are able to select a service that best meets their needs:
    - Payer organizations with any services they have for the community at-large;
    - Clinical and non-clinical hospital-based services that are directly accessible to residents;
    - Faith-based organizations that offer services to the community;
    - Advocacy organizations or grassroots efforts; and

- Web-based self-paced courses or other similar educational offerings.

Excluded Organizations and Services

- The CRI should not include organizations that explicitly deny services on the basis of color, race, religion, gender, sexual orientation, ancestry, gender identity, or nationality.

- The CRI should not include any organizations that provides services to its own members (such as a faith-based organization that only offers food pantry services to its members).

- The CRI should not include:
  - Private medical, behavioral health, and social work practices that do not accept Medicaid or offer programs for low-income individuals;
  - Organizations that are unlicensed to offer services for which licensing is typically required;
  - Organizations that have not been in existence for at least one (1) year; and
  - Housing services that do not have oversight by a governmental or regulatory body.

Special Considerations

In special instances (such as a public health emergency), the CRI may choose to include for-profit organizations that offer critical services (such as COVID-19 vaccinations from Walgreens or CVS). In such cases, the organization responsible for managing the CRI must ensure that exceptions are uniformly applied to all organizations.

The following questions may be considered when determining if an exemption to the I/E policy should be applied:

1. Can any member of the public access the organization/service?
2. Is the organization/service considered ‘unique’ or ‘critical’ (for example, language translation or mental health services)?
3. Does the organization/service charge any fees (including donations) as a pre-requisite to accessing services?
   a. If yes, does the organization/service offer a sliding scale for low-income individuals?
4. Does the organization/service have the capacity to address a large number of referrals?
5. If the organization has not been in existence for at least one (1) year, is the organization backed by a governmental entity?

Updates

In accordance with AIRS or Inform USA standards, any I/E policies established by the DC CRI should be reviewed on an annual basis. This includes, but is not limited to:

- Reviewing top recipients of referrals;
- Examination District assessments to ensure that services listed are responsive to the needs of District residents; and
- Coordination with District data stewards to incorporate any resources that are deemed relevant.

Any changes or updates to the I/E policy should be reviewed and approved by the DC HIE Policy Board.

Best Practices – *Style Guide*

DC CRI Style Guide Based on the AIRS Style Guide (2021)

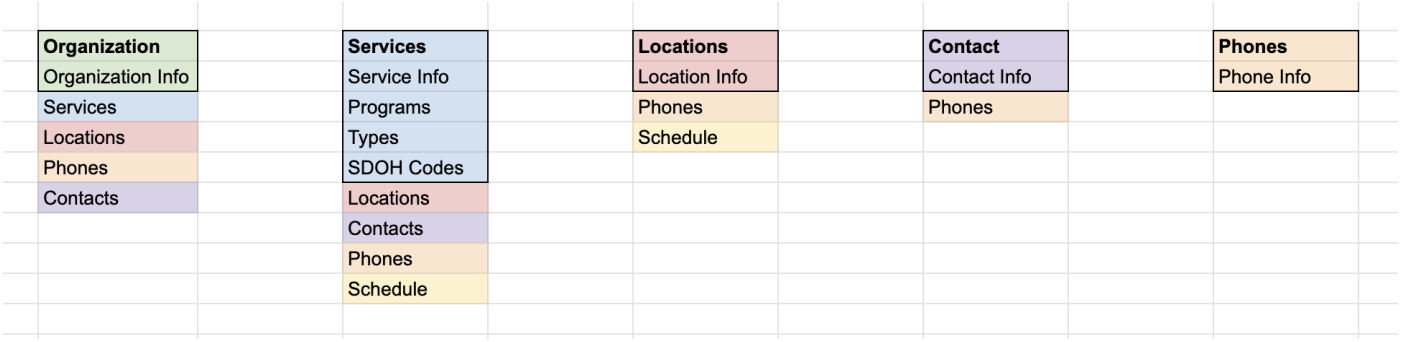
Licensing and usage terms and conditions for the AIRS Style Guide

Adapted by the DC Primary Care Association for the DC CoRIE project, 2021

Data Structure

Data Model

The basic structure of most resource databases, including this one, begins with the information on the Organization that provides the services, the Locations from which one or more services are available, Phones, Contacts, and the Services themselves.



Data Dictionary

Section	Element	Data Type	Status
Organization	Organization Name	string	Required
	Alternate Name	string	Required
	Description	long text	Required
	Email	email	Required
	URL (website)	string	Required
	Facebook URL	string	Recommended
	Twitter URL	string	Recommended
	Instagram URL	string	Recommended
	Tax Status	string	Recommended
	Website Rating	dropdown	Recommended
	Tax ID	string	Recommended
	Year Incorporated	string	Recommended
	Legal Status	dropdown	Required
	Code	string	–

	Organization Status	*backend*	–
Service	Service Name	string	Required
	Service Alternate Name	string	Required
	Organization Name	dropdown	Required
	Service Description	long text	Required
	Service URL (website)	string	Required
	Service Email	email	Recommended
	Eligibility Requirement	dropdown	Required
	Application Process	string	Required
	Fee Options	dropdown	Required
	Fee Details	string	Required
	Service Area	dropdown	Required
	Licenses	string	Recommended
	Wait Time	string	Required
	Accreditations	string	Recommended
	Code	string	–
	Service Status	*backend*	–
Program	Program Name	string	Recommended
	Program Description	string	Recommended
Types	Category Type	dropdown	Required
	Category Term	dropdown	Required
	Eligibility Type	dropdown	Required
	Eligibility Term	dropdown	Required
	Detail Type (i.e. required docs)	dropdown	Required
	Detail Term	dropdown	Required
SDOH Codes	SDOH Categories	checkbox	–
	SDOH Conditions	select	–
	SDOH Rank	dropdown	–
Contact	Contact Name	string	Required

	Contact Service	dropdown	Required
	Contact Title	string	Required
	Contact Department	string	Required
	Contact Email	email	Required
	Contact Visibility	dropdown	Required
Location	Location Name	string	Required
	Location Alternate Name	string	Required
	Location Transportation	string	Recommended
	Location Description	long text	Recommended
	Location Service	dropdown	Required
	Address	string	Required
	City	dropdown	Required
	State	dropdown	Required
	Zip Code	string	Required
	Location Details	string	Recommended
	Regions	dropdown	Recommended
	Accessibility	dropdown	Recommended
	Accessibility Details	string	Recommended
Schedule	Regular Opens (M-S)	time dropdown	Required
	Regular Closes (M-S)	time dropdown	Required
	Regular Closed All Day (M-S)	checkbox	Required
	Holiday Start	date	Required
	Holiday End	date	Required
	Holiday Opens	time dropdown	Required
	Holiday Closes	time dropdown	Required
	Holiday Closed All Day	checkbox	Required
Phone	Phone Number	string	Required
	Phone Extension	string	Required
	Phone Type	dropdown	Required

	Phone Language	dropdown	Required
	Phone Description	string	Required
	Main (check box)	checkbox	Required

Organizations

An organization is an entity that delivers services. An organization can be incorporated, a division of government, or an unincorporated group that offers, for example, a food pantry or support group. The organization operates from the main location where the administrative functions occur, where the organization's director is generally located and where it is licensed for business. An organization may or may not deliver direct services from this location.

On occasions, Data Steward services may choose to designate a middle level of the organization as the organization. For example, a county Department of Human Services may offer dozens of services but is often recognized by the names of its component programs such as Social Services, Health Department, etc. It is acceptable to use those components as 'organizations' as long as their relationship to the larger Department of Human Services and the county itself is acknowledged in the description or by the way the data record is structured.

Organization Name

This is the name of an organization that provides services that are included within the resource database. It is the name that an organization uses to identify itself and by which it is best known to others. In most cases, this will be its full legal name but it may be the name under which the organization is more commonly known or is "doing business as" – for example, YWCA instead of Young Women's Christian Association. (An organization might also have an **alternate name**; this is addressed below.)

Preferred style examples

- Abacus Child Care Center
- Anytown Parks and Recreation Department
- Arizona Department of Labor
- Big Brothers and Big Sisters of Anytown
- Burton D Morgan Foundation
- Evergreen Youth Services
- Gathering Place
- George Dodge Intermediate School
- Saint Jude's Emergency Shelter
- Saint Vincent de Paul Society
- South Carolina Department of Health
- Yellow County Social Services Department
- YMCA Bluetown

Guiding information

- Use full names without abbreviations and ampersands (for example, Anytown Parks and Recreation Department rather than Anytown Parks & Rec. Dept.).
- Avoid beginning an organization name with the word "The" (such as The Gathering Place). A failure to follow this principle tends to create hard-to-follow alphabetical listings with dozens of organizations called "The X …" and "The Y …".
- Sometimes the official name may make that organization harder to find in a listing of alphabetical names (for example, the official name may be Anytown Big Brothers but most users would search for – and expect to find – the name under Big Brothers, so it may be styled accordingly. Similarly, the official name – and the name provided to you by the organization – may include

legal words or phrases (such as “Inc”) that are not relevant and not part of the everyday name. When this is the case, omit them. However, in these examples, the organization itself may insist on their preference. A database administrator can argue that the key factor is user-friendliness but in the long run, it is best to maintain positive relations with the listed organization and respect their request. In these instances, make use of the Alternate Name field to accommodate an additional naming convention.

- Use apostrophes in the same manner as the organization, but use a version without the apostrophe in the Alternate Name field (for example, Saint Jude’s Emergency Shelter with Saint Judes Emergency Shelter as an Alternate Name), to help seekers who may difficulty handling apostrophes in searching.
- When entering names of government organizations, be consistent in the naming structure for divisions of the same level of government throughout the database. For example, Sycamore County Public Health Department rather than Public Health Department of Sycamore County, which would lead to similar stylings such as Sycamore County Social Services Department. As a general rule, always structure these records with the level of jurisdiction listed first (for example, Arizona Department of Motor Vehicles or Armstrong County Sheriff’s Department). This way, the organizations within a resource database appear in a single list, and all of those government records will be grouped together in a consistently logical fashion.
- If the common name is an abbreviation, omit the punctuation (for example, ARC rather than A.R.C.). This holds true if the organization or the location name is taken from someone’s initial (for example, CJ Correctional Facility rather than C.J. Correctional Facility).
- Do not abbreviate Street, Avenue, Boulevard, Mount, Road, etc. when these words appear in organization names (for example, Spruce Street Community Center).
- Do not use abbreviations for geographic areas (for example, AZ Department of Labor; US Postal Service).
- Follow the way an organization consistently spells out its name in regular text, rather than how it might appear on its corporate logo which may play with capitalization, abbreviations and punctuation for design reasons.
- If an abbreviation is a well-known part of a name and the name would otherwise seem “odd” to anyone in the community, then the abbreviated version should be preferred with the full name going into the Alternate Name field.

As with all of these “style preferences,” in the area of organization names, there will often be exceptions to every rule.

Alternate Name

An **alternate name** is another name by which an organization, location or program may be commonly known. An organization name, location name or service name may have an alternate name which is an acronym, former name, popular name, legal name, doing business as name, or some other alternative. An alternate name may also be any type of name under which the organization, location or service might reasonably be searched by a user (such as a variation in spelling conventions). For example, if the organization name is Saint Bartholomew’s Catholic Church, then St. Bartholomew’s Church and Saint Bart’s might be added as alternate names.

If an organization does not commonly use its full legal name, then that legal name should be included as an alternate name with the designation (legal name) indicated. Similarly, a former name should also be labelled as not everyone might be aware of the name change.

The alternate names can sometimes also be used to “flip” preferred name “stylings” around if desired. For example, if a decision has been made to use YWCA Anytown as the preferred organization name, then Anytown YWCA could be used as an alternate name.

Preferred style examples

- Anytown Recreation Division
- Anytown Big Brothers and Big Sisters
- Anytown YMCA
- Big Sisters Anytown
- EYS
- Northtown Home Care Association (former name)
- Jude's Place
- Saint Judes Emergency Shelter
- St Jude's Shelter
- Info Greentown
- Community Information Center of Greentown (legal name)
- St Vincent de Paul Society

Organization Description

The organization description is a summary of the organization's primary purpose and mission. It is a helpful way of understanding the broad nature of an organization if its name is not well known or its purpose is not very evident from its title, and to highlight aspects that may not be commonly associated with that organization. **The description should be brief and not duplicate the more detailed service records.**

If an organization has an affiliation or a relationship with other organizations that might not be obvious from their title, then this should be mentioned here (for example, Hamilton Youth Services might be formerly affiliated with the National Boys and Girls Clubs).

Preferred style examples

- Children's mental health clinic
- Comprehensive employment center
- Emergency shelter for assaulted women
- Federal government financial assistance program for income eligible older adults
- Food pantry and meal program
- Multiservice organization operating a variety of neighborhood programs, services and supports
- Support services for assaulted women, including an emergency shelter
- Resources for veterans (online only)
- Social and recreational services for youth. Affiliated with Boys and Girls Clubs of America

Email

Email refers to a mail address for online communication. This should refer to the main email address of an organization (for example, info@organization.org rather than the email of an individual such as an Executive Director. The email address must be entered in the standard format of a valid email address (i.e. x@x.yyy).

Preferred style examples

- info@airs.org
- ymca@isp.net
- airs@info.org
- ourtowninfo@gmail.com

Website URLs

A URL (Universal or Uniform Resource Locator) is a way of specifying the location of a file or resource on the Internet. Also commonly known as a website or web address. In the resource database, the organization URL should be the official main website of the organization.

In most instances, the fixed structure should be along the lines of www.orgname.org … in other instances, the URL may point to a specific file/resource within an organization's website (for example, www.airs.org/standards.asp). Avoid using *http://*www ... (although there will be occasional websites that only use the http:// designation).

Preferred style examples

- www.airs.org
- www.arbitrary.com
- http://airs.org
- www.air.org/application.doc
- Resource Database: www.211ourtown/resourcedatabase
- Twitter: www.twitter.com/ourorganization
- Facebook: www.facebook.com/ourorganization

Social Media

The URL can be pointing to a social media address other than a website (for example, www.twitter.com/ourorganization). A location or service/program URL should only be included if it is unique to either that particular location or service/program.

Preferred style examples

- Twitter: www.twitter.com/ourorganization
- Facebook: www.facebook.com/ourorganization

Tax Status

The **tax status** of an organization describes the type of organization or conditions under which the organization is operating. For example, a private, nonprofit corporation, a for-profit (commercial, proprietary) organization, a government (public) organization, or a grass roots entity such as a support group that is not incorporated and has no formal status as an organization.

Preferred style examples

- Nonprofit
- Private corporation
- Government
- Other

Website Rating

The Website Rating is a field that supports data verification efforts. The quality of information available on an organization's website can be rated on a 1-5 scale. This is purely for verification purposes and is not meant to criticize an agency's appearance or clout. This is somewhat subjective so use your best judgment and make sure to remain consistent in your ratings!

5 - Excellent: Information is exceptional & recent, leaving minimal to no call verification work needed
4 - Good: Information is well outlined with some gaps that require call verification work
3 - Fair: Information is present but has significant gaps that require substantial call verification work
2 - Poor: Information is incredibly scant and requires almost all verification to occur over the phone
1 - Absent: No website is present

Tax ID

A **Tax ID** number, also known as Employer Identification Number (EIN), is a unique nine-digit number (xx-xxxxxxx) that the IRS (United States Internal Revenue Service) assigns to business entities. The IRS uses this number to identify taxpayers that are required to file various returns. Tax ID numbers are used

by employers, sole proprietors, corporations, partnerships, nonprofit organizations, government organizations, certain individuals and other business entities. **Preferred style example**: 87-8573645.

Year Incorporated

The **Year Incorporated** field is the year the organization was incorporated or founded. This field is a string - dates should be rendered as four-digit full year (e.g., 1999, 2017).

Legal Status

The legal status defines the conditions that an organization is operating under. This field is structured as a dropdown, with the options being non-profit, private corporation, government organization and other.

Code

The **Code** field is for internal use - please disregard this field.

Contacts

Contact Name

Contact Name is a string field that should contain the contact's first and last name in Title Case (e.g., Jane Doe). The name preferably includes both the first and last names and should be entered in full. The preference is to omit any gendered or honorary titles unless the organization specifically requests it. However, if a preferred pronoun is provided, it should be included. A medical doctor is an exception in which case 'Dr' is all that is needed. Generally, omit credentials that come after a name (for example, MSW or PhD) unless insisted upon by the organization.

If an organization provides a formal expression of the main contact's name (for example, Mrs N M Wilkinson), then that should be respected.

Preferred style examples

- Dr Jenny A Jenkins
- Jim Jameson
- Father John Seymour
- S. W. Rodriguez
- Hanif Mohammed
- Anne Hughes-Simmons
- Victoria Allinson (they/their)
- Alex Henderson (she/her)
- A. Thatcher (he/him)

Contact Service

If the contact is associated with a specific service (e.g., project coordinator) select the corresponding service from the **Contact Service** dropdown list. Not all contacts will be associated with a specific service. Some contacts will be associated with more than one service, in which case you should select all services that apply.

Contact Title

The contact title reflects the formal job position of the person. Generally, titles are written in full (for example, Executive Director instead of ED). Occasionally, you may encounter an organization that describes itself as a Collective. In this case, it is best to simply ask for one name to serve as the "Office Contact".

Preferred style examples

- President and Chief Executive Officer

- Chief Medical Officer
- Administrator
- Office Coordinator
- Director
- Director of Operations
- Coordinator

Contact Department

If the person is a member of a specific department, type it in in the **Contact Department** free text field. Examples of Contact Departments could include Mental & Behavioral Health, Community Engagement, Legal Department, etc.

Contact Email

Contact Email refers to a specific contact's personal email address. This should refer to the individual person's email address, and not the main email address of the organization or service. The email address must be entered in the standard format of a valid email address (i.e. x@x.yyy).

Preferred style examples

- info@airs.org
- ymca@isp.net
- airs@info.org
- ourtowninfo@gmail.com

Contact Visibility

Contact Visibility is a functional field that determines whether a Contact's information will be displayed publicly. Sometimes, it is beneficial to store certain contacts' information in the system for verification purposes, but it would not be appropriate to list their number publicly. In this case, select "Private" so the Contact's information will be hidden from the public-facing site. If the Contact's information is listed in relation to a certain service and/or sharing the information is beneficial to users, the Contact should be listed as "Public."

Locations

Locations are the physical locations (sometimes called branches) at which clients access services provided by an organization. An organization must have at least one location but can have several (although web-based services may have no physical location).

Location records contain identifying information about the specific location (such as address, telephone number, manager, hours, and any other detail that appears helpful about the specific location).

Some location elements (such as Phone Number) should be styled in the same manner as their counterpart element within the "Organization" record. However, the content must be specific to that location (for example, any URL should be specific to that location and not the main organization URL that was already entered at the Organization level).

Location Name

This is the name of the location. If an organization has only a single location, then, the organization name is usually the location name. For example, if Abacus Child Care Center is the organization name and there is only one location, then that location name is Abacus Child Care Center. However, if Abacus operates from a second location, the organization might have an existing name that it applies to the location such as Abacus2 Child Care Center or Jane's Place. If not, the Data Steward might have to devise a way to identify the location name such as Abacus Child Care Center (Middletown Branch).

In some instances, the location name may have a distinct alternative title that has no obvious relationship with the main organization. For example, the CM Mathewson Mental Health Clinic may be a location of the regional public health authority.

In other cases, the location name may be drawn from the function that it provides for the organization. For example, if the local Salvation Army operates a thrift store at a unique location, the location name might be "created" as Salvation Army Thrift Store. If it operates a couple of thrift stores, maybe the location names become Salvation Army Main Street Thrift Store and Salvation Army Broad Street Thrift Store. The main thing is to be consistent in the naming style used when creating a location name.

Note that the location name is not necessarily the same as a 'building name' which is really part of a standard address format.

Preferred style examples

- Grey County Social Services Department – Youth Club
- Lakeside Library (Riverfront Branch)
- Mountainside Neighborhood Association – Satellite Office
- Ocean Hospital Outpatient Clinic
- Salvation Army Homeless Shelter
- YMCA – Mary Street Child Care Service

Location Alternate Name

An alternate name is another name by which a location or program may be commonly known. A location name may have an alternate name which is an acronym, former name, popular name, legal name, doing-business-as name, or some other alternative. **Location Alternate Name** is a free text field.

Location Transportation

Location Transportation is a description of the access to public or private transportation to and from the location. Location transportation is a free text field that can include information about public transit, such as Metro and Bus accessibility.

Preferred style examples

- Nearest Metro station is Farragut North (Red) - 8 min walk from location
- Nearest bus stop at 34th and K. Bus lines include 57, 345, and N 68.

Location Service

Location Services describes the services provided at the location. This field is a lookup for the services provided by the organization, allowing the data steward to select multiple services that are offered at the location. Please select all relevant services.

Location Description

The location description is a brief statement of no more than 1-2 sentences that describes the primary activities that take place at the location. If the organization has a single location, then this is covered by the organization description and need not be duplicated. If the organization operates from more than one location, then a brief location description is recommended for each one. In some instances, when the same services are available at each location, the location descriptions might all be identical.

Preferred style examples

- Mental health drop-in
- Training center
- Commercial childcare center
- Emergency shelter for homeless men

- Federal government financial assistance program for income eligible older adults
- Food pantry and meal program
- Thrift store

Address, City, State, Zip Code

Address

The **address** describes the physical address of the location(s) from which the organization operates. The components of a street address should follow the standard US Postal Service format for addresses. In the DC CRI, all addresses are entered as Locations/Locations associated with the Organization or Program/Service.

Some organizations may withhold their physical address for confidentiality reasons (for example, shelters for domestic violence/abuse survivors). In these cases, if the address is provided, enter "Address Confidential"

Note that there may be organizations that have no actual or relevant physical address. In these cases, leave the address information blank but make sure there is a clear indication that an organization is 'Online only' in its description field.

Preferred style examples

- 100 Main Street, Suite 400
- City Hall, 100 Main Street West, 7th Floor
- 14 Fir Crescent
- 587 4th Street
- 85 Acorn Boulevard
- 9206 Willow Street NW, Unit 470
- 9206 South Willow Street West, 4th Floor
- Hawthorn Heights Building, 500 Orange Blossom Street, Unit 4
- Online only

Guiding information

- Although there are standard abbreviations (for example, Ave) that will be read by geo-mapping programs and are officially approved by the postal service, if the software field permits the number of characters, use the full spelling (for example, Avenue) to remove any possibility of ambiguity.
- Some addresses will be provided by organizations in the style of "234-111 Cedar Street." Although this is officially recognized, it is not intuitive for users so enter the address as "111 Cedar Street, Suite 234" to be clear. If you are unsure whether it is a "suite", use the more flexible word "unit."
- Do not use "#" as an introduction to a number. For example, change 16 Balsam Avenue, #24 to 16 Balsam Avenue, Unit 24.
- If the street name incorporates a "direction" (such as Young Street North or Old Avenue South), enter that in full. The exception is for cities that have addresses that reflect a larger grid. In these cases, an abbreviation can be used if it is the established format (such as 453 Wood Road NW or 67 SE Stone Place). There may also be some other exceptions based on accepted local terms such as 678 MLK Boulevard.

City

This is the part of the physical address that describes the major city or town in which the location operates. The name of the city follows the street address and precedes the state/province and ZIP/postal code in conventional postal service format.

Again, standard and full spellings should be used. The key is consistency. All organizations in a certain defined community should have the same city address.

Preferred style examples

- Davistown
- Gillespieville
- Saint Paul
- Parkerton

State/Province

The designation of the state/province must be part of the location address of the organization. Use only the official two-letter code for all states, provinces and territories. Do not use a period to denote the abbreviation (for example, use AK rather than AK.) and always use upper case (for example, AK rather than Ak).

Preferred style examples

- AZ
- DE
- MA
- PR

ZIP Code

The ZIP code and the postal code must be part of the location address. This element must use the fixed official structures used by the respective national postal services of the United States and Canada. The 'extended' US ZIP code contains five numeric digits along with a hyphen followed by four additional digits. However, the first five are the only ones required, and denote a wider area in which individuals place themselves (for example, "I live within the 40812 ZIP code") and which are used for searching. Do not enter the additional four digits. A Canadian postal code consists of six characters – alternating upper-case alphabetical and numerical elements (ANA NAN) with a single space between the pairs of three characters.

Preferred style examples

- 40125
- 68516
- 21742

Regions

Regions is a field that can be used to further specify the location. Regions is a dropdown menu that allows the user to select multiple options. In the DC CRI, Regions is primarily used to specify Wards 1-8.

ADA Compliant

ADA Compliant is a field that indicates whether the location is compliant with the Americans with Disabilities Act (ADA). This is a dropdown field with the following options: Blank, ADA Compliant, Not ADA Compliant. If you are unsure of whether the location is ADA compliant, you may select "Blank."

Accessibility Details

This describes the factors that either help or hinder access to the location/location for persons with physical disabilities. There is a checkbox to indicate ADA compliance, as well as a free text field to explain further. In instances where accessibility is not clear, the following standard phrase should be included. "Visitors with concerns about the level of access for specific physical conditions, are always recommended to contact the organization directly to obtain the best possible information about physical access."

Remember that access for persons with physical disabilities covers more issues than wheelchair access. If the service is only offered online, web-accessibility information should be added when possible. Ask the organization if the website includes any text, audio, or video alternatives, or if it has been designed to be keyboard accessible. More information about the guidelines can be found on the Web Content Accessibility Guidelines (WCAG) Overview.

Preferred style examples

- Wheelchair access to main entrance via ramps
- Accessible washrooms
- No wheelchair access
- Accessible apartments including wheel-in shower
- Lowered elevator buttons
- Wheelchair-level button opens main doors
- Designated parking spaces
- Wheelchair access possible with appointment
- Braille elevators and signage
- Tone elevators
- Visual alert systems
- Wheelchair access – but call for details

Schedule

Regular Schedule

This refers to the days and times an individual can access either the administrative hours of a facility or the hours of a particular service/program.

In the DC CRI, this information is organized in a structured way as per the following table which can allow for filtered searches (e.g. Food Pantries and Friday). For **Opens** and **Closes**, the field is structured as a dropdown with 30-minute increments. You can type in more specific times if needed. There is also a check box to indicate "Closed All Day." Similarly, holiday schedules are captured in a structured table.

Weekday	**Opens:**	**Closes:**	**Closed All Day**
Monday	From:	To:	[ ]
Tuesday	From:	To:	[ ]
Wednesday	From:	To:	[ ]
Thursday	From:	To:	[ ]
Friday	From:	To:	[ ]
Saturday	From:	To:	[ ]
Sunday	From:	To:	[ ]

Finally, an unstructured field for a string of text is available to collect the information that can't easily be captured in the structured field, such as "Closed for Lunch." In some cases, a service may only be available on a seasonal basis in which case that information may also be entered in this area.

Holiday Schedule

The **Holiday Schedule** refers to alternate schedules. For each Holiday Schedule, you'll need to select the date that the alternate schedule begins and ends (e.g., 12/24 - 1/2) and enter in the new hours of operation. There is also a check box to indicate "Closed All Day." These fields are structured in the following way:

Start	**End**	**Opens:**	**Closes:**	**Closed All Day**
Date	Date	From:	To:	[ ]

Users can add as many holiday schedules as needed by selecting the '+' button at the top right corner of the table.

Phone

Phone Number

This details the **Phone Numbers** (and now, text) used to reach a particular organization, location or service/program. In addition to the actual number including possible extensions, there may be contextual information that describes the type and/or function of the phone (e.g., toll-free, administration, intake, etc.).

In the DC CRI, there are separate fields for phone number, extension, and phone type, as well as phone language and phone description.

An organization might have several phone numbers for different purposes (e.g. after-hours, Spanish only, alternative number). Note that phone numbers for locations and/or services are only included if they are different from the main organization phone numbers.

Preferred style examples

- (250) 467-9836
- 1-800-976-9760
- 1-800-435-7669 (1-800-HELP-NOW)
- 2-1-1
- 9-1-1

Guiding information

- The construction (250) 675-8615 is clearer for users than 250-675-8615.
- Even if all of the phone numbers in a database share the same area code, you still need to include it in each instance for the use of those contacting an organization from another region.
- Use hyphens for 9-1-1 and 3-1-1 to ensure the digits stand out clearly.
- Toll-free numbers should include the "1" to make sure that is clear. The words "Toll-free" should also be added in another area. Try to establish where the toll-free service is available.
- If there is a "named" number, such as 1-800-HELP Now, list the actual number of the service (for example, 1-800-435-7669) but try to transfer the 1-800-HELP-NOW reference into another data area.

Phone Extension

This **Phone Extension** field is an option for listing an extension, if relevant. An extension should only be used if it is helpful (particularly where there is an automated switchboard, and the extension saves a great deal of menu choices) and/or is recommended by the organization itself. In most cases, calls to organizations go to a main switchboard and are then diverted to the person.

Phone Type

Use the **Phone Type** field to indicate whether the number is for voice, fax, intake, hotline, etc. A fax is usually entered as a separate data field and identified as a 'fax number,' although the relevance of a fax number is diminishing. The logical assumption is that a call is going into a "normal" voice telephone unless indicated otherwise. This dropdown field provides some contextual information about the type and/or purposes of a phone number, including whether it is a voice, text, TTY or fax number. This field can also be used to indicate that a number is an intake line for the Organization's service(s).

Preferred style examples

- Fax

- TTY
- Text
- Intake Line
- Spanish Line
- Hotline
- Voice

Phone Language
The **Phone Language** field is a dropdown field that indicates which languages are available for callers. If there are multiple language options for the phone lines, they should be indicated here. Users can select more than one language. The options included in the DC CRI are English, French, Amharic, Chinese, Korean, and Vietnamese.

Phone Description
The **Phone Description** field is a free text field that allows users to add more information about the phone line. For example, users can indicate that this phone line is for a particular program, service, or office. Information that can be captured is the structured fields provided should be entered there.

Main (check box)
The **Main** check box should be selected to indicate that the phone number is the main number for the Organization. Selecting this box will ensure that the "Main" number shows up first on the Organization's page so that users can find the best number easily and increase their chances of accessing services easily.

Services
A service record describes the types of assistance an organization delivers to its clients. Technically, "services" are specific activities that can be classified using Taxonomy terms. Specific types of services should be essentially the same no matter what organization is providing them.

Sometimes organizations will provide a group of services (some primary and some secondary) and organize them as a "program." Programs may be considered as groups of services under a specific title (which could be a well-established name such as the WIC Program or a name locally created by the organization itself). For example, a job training program may be made up of a number of services such as vocational assessment, a resume preparation class and job placement assistance.

While services are essentially the same across organizations, the definitions of programs may differ significantly. (Just to make it more confusing, sometimes a program name will contain the word "Service" and sometimes an organization will promote a service under the name "Program."). Service records generally include a description that offers a summary of what is provided, in addition to other key data elements such as eligibility and application procedures.

Service Name
If there is no formal service name, one may need to be formulated by a resource specialist based on the clearest expression of the activities provided. This same service name would then need to be applied consistently to all activities delivering essentially the same thing. Generally, the service name should relate closely to the relevant Taxonomy indexing term. And yes, the 'service' name might sometimes include the word 'program'.

Preferred style examples of services
- Utility Assistance
- Food Pantry
- Adult Literacy Service
- Afterschool Program

- Parenting Class
- Vocational Training
- Bereavement Counseling

Service Alternate Name

The free text **Service Alternate Name** field should be used to capture any other names used to describe the service so that users can easily find the one that they're looking for.

Organization Name

The dropdown field **Organization Name** allows the user to select the parent organization that offers the service from the list of existing organizations in the DC CRI.

Service Description

A service description provides an opportunity to more fully describe the nature of a service in order to help someone make an informed decision on a referral.
In many ways, it is the most important field and the one that requires the most skill in terms of deciding the content and then delivering that content with concision and clarity.

The service description is the place to provide contextual information (for example, on secondary and ancillary services). It is also a place where other data elements (such as appropriate licensing information or affiliations can be added if there are no specific fields for those elements and their inclusion would be helpful. Where relevant it can also be the place to provide additional information.

The description should be written in specific enough terms to enable community resource specialists and the general public to determine whether this resource is an appropriate referral.

The description must reference and describe all of the services that are referenced by taxonomy terms .

Preferred style examples

- Mutual support group for alcoholics. Regular meetings at a variety of times and locations throughout Rockland County.
- Licensed child care center for toddlers and preschool children.
- Works with Green State Department of Labor to secure placements, part-time and full-time employment for Grey County Community College students and alumni.
- Support for day laborers within the Spanish-speaking communities providing a safe place for workers to wait to be picked up for daily jobs. Light breakfast available and referrals to ESL programs.
- Classes, workshops and conference offered multiple times throughout year for unpaid caregivers who are looking after an adult family member or friend. Classes and events include Powerful Tools for Caregivers, Caring for Your Loved One at Home, Yoga for Caregivers and annual caregiver workshops. Respite may be available with early registration. Website includes calendar of upcoming events.
- Local branch of national organization. One-to-one meetings to assist patients and families with free advice to help solve problems related to finances, insurance, employment and costs resulting from a cancer diagnosis.
- Online support service for caregivers, includes live chat support.
- Health care services provided in-home for illness or injury. Includes wound care for pressure sores or surgical wounds, patient and caregiver education, intravenous or nutrition therapy, injections monitoring serious illness and unstable health status.
- Alternative to court system for resolving civil and minor criminal disputes such as tenant/landlord problems, neighborhood disputes, small claims and family conflicts. (Note that this is not appropriate for disputes associated with domestic violence.)

- Supports young volunteers in programs geared towards environmental quality and awareness. Individuals can commit 675 hours of service year-round or 300 hours over the summer. Living stipend is provided and a monetary educational reward is given upon completion of service hours.
- Promotes healthy lifestyles, good nutrition and home budgeting to food stamp recipients/applicants. Classes and home visits from dieticians and home economists.

Guiding information

- Construct the narrative with the most important information coming first and the least crucial piece of information listed last.
- As a general rule, adjectives and adverbs can be eliminated.
- When creating a list, use commas rather than semi-colons. If a list exceeds four items, a simple bullet format can be used, (and the format chosen should be consistent across the database).
- Write in third person.
- Use active verbs and clear language.
- Do not accept the narrative directly from the organization.
- Service descriptions should be precise but also meaningful. They should anticipate any questions that a client might reasonably ask that have not been addressed in other fields. However, it should not include every conceivable piece of detail – these issues are best addressed by the client contacting the program directly.
- Avoid using full sentences such as "This program provides peer counseling within a supportive environment …" if "Peer counseling available" gets to the point quicker and is easier for the community resource specialists to read.
- Avoid overelaborate phrases (usually supplied by the organizations themselves in their completed surveys) such as "Provides a family-focused model based on empowerment and individualized expression ..." Ask yourself, "What are they actually doing and what would a potential client – someone looking for solutions to their specific concerns and experiences – really want to know?"
- Avoid abbreviations such as e.g. or i.e. if possible. Use "for example" and "that is" or "that means."
- Avoid subjective language (such as "highly qualified staff) and social service jargon.
- Prefixes and hyphens: The common-sense rule is only to use a hyphen if the word looks strange without it. Generally, if the prefix ends with a vowel and the word that follows it begins with a vowel, then a hyphen may be needed (for example, pre-empt rather than preempt). Some words, however, are well established enough to not require a hyphen (for example, coordinate and cooperate).
- Within your own database, try and standardize your descriptions for identical services as much as possible. For example, all services describing utility payment assistance programs should be written in a similar fashion.
- Omit minor details that would be hard to consistently update and that can be left to the client to discover when contacting the organization.

Service URL

The **Service URL** field should be used to capture a website or webpage that provides information on a specific service. Sometimes, organizations will have a page for each service they offer, and linking these pages directly to their relevant services can help users find more information about services quickly.

Preferred style examples

- www.airs.org
- www.arbitrary.com
- http://airs.org
- www.air.org/application.doc

Service Email

Service Email refers to an email for a specific service. The email address must be entered in the standard format of a valid email address (i.e., x@x.yyy).

Preferred style examples

- info@airs.org
- ymca@isp.net
- airs@info.org
- ourtowninfo@gmail.com

Eligibility Requirement

The **Eligibility Requirement** field is a Yes/None dropdown that allows you to indicate if there are requirements to access the service. This structured field allows users who query the database to search for services that are open to them without certain eligibility requirements. If there are requirements to ccess the services (e.g., referral required), select "Yes." If you select "Yes," be sure to define the requirements in the **Application Process** free text field.

Application Process

The **Application Process** free text field that provides clients with information on the "next steps" to take to access a particular service. In many cases, the directions are fairly obvious such as "Call or walk in for service," but many organizations have very specific requirements (for example, walk-ins will not be accepted, individuals must call first … or there must be a professional referral). In many cases, the field can simply read "Call for more information."

Preferred style examples

- Appointment required
- Call to apply
- Walk in for service
- Physician referral required
- Call or walk in for service
- Referral required
- Online only
- Intake conducted Mon-Fri 9am-2pm; Phone Mon 9am-5pm for an appointment.

Fee Options

The **Fee Options** field is a dropdown that indicates what type of fee should be expected to access the service, if any.

Most services within the DC CRI are 'free,' although 'no fee' is a better way to describe that fact as there is always a 'cost' to provide a service. Clients need to know if there is a fee and, if so, approximately how much it is and/or how it is calculated.

Fee Details

The **Fee Details** free text field captures the cost of receiving a service. It can also include information about how a particular service can be paid for (e.g., if it might be covered by certain benefit programs).

Typical phrases include "sliding scale" and "no charge" or "fixed fee." Specific dollar amounts are generally omitted. It is helpful to provide clients with some idea of fees when they are applicable but it is difficult to effectively maintain that information.

Preferred style examples

- No fees

- Medicaid
- Medicare or other third-party payment accepted
- Call for details
- Sliding scale. Call for details
- Suggested donations
- Nominal cost
- Membership fee
- Fees vary by program. Call for details
- Medicare, private insurance and private payment accepted
- Sliding scale if no insurance
- Sliding scale if no insurance but no one refused service
- Private insurance and/or private payment only
- Private payment only

Service Area

The dropdown **Service Area** field refers to the physical boundaries in which a service is available and by definition, not available to clients outside of those boundaries. The concept of "area served" is different from "location" as a service may be located in one area but serve several definable areas or only serve parts of the one area.

This geographic "boundary" is represented by the eight wards. You may select multiple wards. If the service is available to all wards, select the "All Wards" option.

Licenses or Accreditations

There are separate free text fields for **Licenses** and **Accreditations**. If an organization operates either with or because of a license or accreditation secured through an external entity, then this should be recognized within the Data Steward database record. For example, a child care center of a certain size could only legally conduct business if it has a license, or a nursing home would require specific accreditation to operate.

When possible, it is helpful to provide the full name of the licensing body to provide users with the opportunity to confirm credentials. This can also be helpful when reviewing an organization for inclusion if only certain types of organizations are included if they are licensed, such as assisted living facilities or child care centers.

It is best to use this field with discretion. For example, a school board would obviously only employ teachers who are licensed to teach. The emphasis should be on providing helpful information to help-seekers, particularly in service areas where perhaps some organizations are licensed but others are not (for example, with home help).

Preferred style examples

- Home care provider licensed by Green State Human Services License Directorate
- Community health clinic accredited by Red State Hospitals Board

Wait Time

The free text **Wait Time** field is used to capture how long a client may expect to wait for services. You can use this field to describe whether there is a wait, whether walk-ins are accepted, and any other pertinent information. (e.g., not accepting new patients, walk-ins accepted).

Program Name

This refers to the specific name of a program. A program name is the approved name that an organization specifies in reference to a set of services, rather than a name created by the Data Steward service. And yes, the 'program' name might sometimes include the word 'service.'.

Preferred style examples of programs

- Employability
- Family Literacy Program
- Head Start
- Mental Health Assessment Services
- Substance Abuse Prevention Program
- Utility Assistance Program
- Vocational Training Services

Program Description

The free text **Program Description** field should be used to describe the Program. This should be rendered as a short phrase that gives more information about the purpose of the program.

Preferred style examples

- Connecting job seekers to employment opportunities
- Wraparound educational services for low-income families
- Comprehensive substance abuse support and prevention

Category Type & Term

The Service Category section is important because it helps people find the right type of service for their needs. We ask that you select categories only for primary services, i.e.,, services that an individual can access at the point of entry without being required to enroll in other services. For Case Management, one might select "Care," which includes the sub-category "Navigating the System." Additional services available to those already enrolled in case management, such as financial counseling, are secondary services and should not be categorized, but should be described in the Description field, as noted above in the Definition of a Service section.

Please add all relevant categories describing primary services. The **Type** field is the general category. After selecting a **Type** you can select more specific terms from the **Term** field.

The Category Types are:

- Care
- Education
- Emergency
- Food
- Goods
- Health
- Housing
- Legal
- Money
- Transit
- Work

For a full list of Category Types and Top-level Terms, scroll down to the Service Category Table.

Subcategories within the **Term** field are indicated using the number of hyphens as shown in the picture below. Please select the term that best describes the service.

Eligibility Type & Term

The Service Eligibility section outlines important information about who is able to access this service. **Please add all eligibility requirements.** Any information about the application process (e.g., referral required, call to apply) should be captured above in the **Application Process** field until "Additional Info"). If a referral is required, please select "Yes" in the Eligibility **Requirement** field.

The **Type** field is the general category. After selecting a **Type** you can select more specific terms from the **Term** field.

- General
- Age Group
- Armed Forces
- Citizenship
- Criminal History
- Disability
- Education Status
- Emotional State
- Employment Status
- Gender
- Geography
- Guardianship
- Health Conditions
- Household
- Housing Status
- Income
- Insurance
- Language
- Race/Ethnicity
- Role
- Sexuality
- Survivors
- Urgency

For a full list of Eligibility Types and Terms, scroll down to the Service Eligibility Table.

Detail Type & Term

The **Detail Type** and **Term** dropdown categories can be used to describe various aspects of services. The **Detail Types** include categories pertaining to *Insurance, Required Documents, Transportation, Cultural Competencies,* and *Translation.* The benefit of capturing details in these structured fields is that the data can be filtered by these dimensions when a user searches.

Insurance

The **Insurance** dropdown describes whether and which types of insurance are accepted. If multiple types of insurance are accepted, click the '+' button on the top right to add another **Insurance** entry. The types of insurances included in the DC CRI are Medicaid, Medicare, Private, and Under/Uninsured.

Required Document

Required Document refers to documents that clients will need to provide the organization to access services when following up with the referrals.

There is a dropdown box to make data entry easier, eliminate typos and ensure consistency. Multiple required documents can be added in. If multiple documents are required, click the '+' button on the top right to add another **Required Document** entry.

Preferred style examples

- Proof of income
- Utility bill or notice
- Proof of spouse/dependents
- Application
- Proof of address
- High school diploma
- Photo ID
- Proof of hardship
- Prescription
- Proof of financial crisis

Transportation

The **Transportation** dropdown includes three options that describe transportation accessibility in general terms. The options included are Bus Accessible, Metro Accessible, and Can Provide Transportation. These service-specific details should be filled out in addition to the location-specific transportation and accessibility information that is captured at the **Location** level.

Cultural Competencies

Cultural Competencies describes cultural populations to which this service caters. The options included are Muslims, Orthodox Jews, and Women of Color. If the service caters to multiple populations, click the '+' button on the top right to add another **Cultural Competencies** entry.

Translation Available

The **Translation Available** field describes specific languages (other than English) that are consistently available in a particular service. In the "Details" section you can enter in information about Translation services available.

In order to facilitate searching by language availability, some Data Steward services structure language information in a format that supports the ability to filter data. Users are then able to search for a particular type of service in Spanish and the system will filter in those that match the criterion.

Agencies often tend to exaggerate language availability. Try to only list languages that are consistently available. There is a difference between a program that provides Spanish services as part of its mandate and one that has a part-time volunteer who speaks Vietnamese.

If a number of languages are available, include English (if it is one of those languages) and list it first, with the other languages listed in alphabetical order. The options included in the DC CRI are English, French, Amharic, Chinese, Korean, and Vietnamese.

Service Category Table (Type & Top-level Terms)

Food	Community Gardens	Care	Adoption & Foster Care
	Emergency Food		Animal Welfare
	Food Delivery		Community Support Services

	Food Pantry		Daytime Care
	Meals		End-of-Life Care
	Help Pay for Food		Navigating the System
	Nutrition Education		Residential Care
Housing	Temporary Shelter		Support Network
	Help Find Housing	Education	Help Find School
	Help Pay for Housing		Help Pay for School
	Maintenance & Repairs		More Education
	Housing Advice		Preschool
	Residential Housing		Screening & Exams
Goods	Baby Supplies		Skills & Training
	Clothing	Work	Help Find Work
	Home Goods		Help Pay for Work Expenses
	Medical Supplies		Skills & Training
	Toys & Gifts		Supported Employment
Health	Addiction & Recovery		Workplace Rights
	Dental Care	Legal	Advocacy & Legal Aid
	End-of-Life Care		Mediation
	Health Education		Notary
	Help Pay for Healthcare		Representation
	Medical Care		Translation & Interpretation
	Mental Health Care	Emergency	Disaster Response
	Sexual & Reproductive Health		Emergency Food
	Vision Care		Temporary Shelter

Money	Financial Assistance		Help Find Missing Persons
	Government Benefits		Immediate Safety
	Financial Education		Safety Education
	Insurance		Emergency Payments
	Loans	Transit	Help Pay for Transit
	Tax Preparation		Transportation

Service Eligibility Table (Type & Top-level Terms)

General	Anyone in Need	Guardianship	Foster Youth
Age Group	All Ages		Runaways
	Infants and Toddlers (0-2)		Unaccompanied Minors
	Young Children (3-5)	Health Conditions	Alzheimer's
	Youth (6-12)		Cancer
	Teens (13-19)		Chronic Illness
	Young Adults (20-30)		Hospitalized
	Adults (31-54)		Infectious Disease
	Seniors (55+)		Living with HIV or AIDS
	Ages 18+		Mental Illness
	Ages 21+		Multiple Chronic Conditions
	Ages 50+		Neuromuscular Disease
	Ages 55+		Pregnant
	Ages 60+		Seizure Disorder
Armed Forces	Active Duty		Severe Mental Illness (SMI)
	National Guard		Substance Dependency
	Veterans		Terminal Illness
Citizenship	Immigrants	Household	Couples

	Refugees		Families
	U.S. Citizen or Permanent Resident		Individuals
	Undocumented	Housing Status	Home Renters
Disability	Developmental Disability		Homeless
	Hearing Impairment		Homeowners
	Homebound		Near Homeless
	Intellectual Disability		Young Adults Leaving Foster Care
	Learning Disability	Income	125% Federal Poverty Line
	Limited Mobility		150% Federal Poverty Line
	Living with a disability		200% Federal Poverty Line
	Living with Developmental Disability		Income at or below 30% Median Family Income
	Mentally Incapacitated		Income at or below 60% of Area Median Income (AMI)
	On the Autism Spectrum		Income at or below 80% of Area Median Income (AMI)
	Physical Disability		Income-based
	Visual Impairment		Low-income
Education Status	Elementary School Students		Public Benefit Recipient
	Enrolled in College	Insurance	Medicaid Recipient
	Enrolled in Vocational School		Medicare Recipient
	High School Students		Not eligible for Medicaid
	No High School Diploma		Privately Insured
Emotional State	Grieving		Uninsured
Employment Status	Employed	Language	English as Second Language
	Unemployed		Limited English
Gender	Female	Race/	African American

	Male	Ethnicity	Asian Pacific American
	Transgender/Gender Non-conforming		Latinx
	Transgender Women	Role	Caregivers
Geography	DC Resident		Dependents
	Maryland Resident		Fathers
	Virginia Resident		Mothers
	Ward 5 Resident		Mothers with Young Children
	Ward 6 Resident		Parents
	Ward 7 Resident		Spouses
	Ward 8 Resident	Survivors	Abuse or Neglect Survivors
	Montgomery County Resident		Burn Survivors
	Northern Virginia Resident		Holocaust Survivors
	Resident of 20001 Zip Code		Natural Disaster Survivors
	Resident of 20002 Zip Code		Sexual Assault Survivors
	Resident of 20005 Zip Code		Survivors of Human Trafficking
	Resident of 20009 Zip Code		Survivors of Intimate Partner Violence
	Resident of 20010 Zip Code	Urgency	In Crisis
	Resident of 20011 Zip Code		In Danger
	Resident of 20017 Zip Code	Criminal History	Formerly Incarcerated
Sexuality	LGBTQ		Perpetrator of Intimate Partner Violence

Infrastructure & Connectivity

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These updates are related to the HIE connectivity and integrations as well as infrastructure tools that support the six (6) Core Capabilities of the DC Health Information Exchange. Below are some of the major accomplishments this quarter

Consent to Share (eConsent tool)

The eConsent tool allows for exchange of data protected by 42 CFR Part 2 via the DC HIE. The tool is accessible both via the CRISP DC web portal and the CRISP InContext application – both modes of access aim to ameliorate the process of obtaining affirmative patient consent. As of October 2023, 400 patient consents have been recorded using the tool. To boost provider use of the tool, CRISP DC, in collaboration with the HIE Stakeholder Engagement subcommittee, developed a multi-phase outreach plan that prioritizes strategies to increase usage and adoption of the consent tool. The plan includes four phases that includes leveraging existing champions of the Consent tool, engaging with previous high utilizers, and outreach to new participating organizations.

Advance Care Planning

In partnership with DC Health, the Advanced Care Planning tools in the DC HIE support the electronic exchange of advance directives and electronic Medical Orders for Scope of Treatment (eMOST) forms. This user-friendly platform by A|D Vault, *MyDirectives for Clinicians*, is directly embedded in the HIE and allows providers to create, upload, and view advance care planning forms (such as the DC MOST, national POLST, Psychiatric Advance Directive, and Universal Advance Digital Directive). Since its launch in early March 2023, 36 documents have been created, with over 170 credentialed users across 17 organizations. The team is finalizing enabling single sign-on (SSO) access to this tool via the CRISP InContext application. The team is also working to develop educational webinars that will include an opportunity for providers to earn continuing education (CE) credits.

PopHealth Analytics Tool

Formerly known as CRISP Reporting Services (CRS), the PopHealth Analytics tool enables population-level and patient panel-level management through clinical and administrative data – it is designed with the diverse group of DC Hie users in mind to support their analyses and interventions. The tool provides reports on demographic and health system utilization, quality measure monitoring, and risk stratification to identify trends in cost, utilization, and chronic disease.

The team is working to credential new groups of users, including case management agencies, to access the Medicaid Redetermination report available in the platform. This report, initially deployed to FQHC-based users, allow provider organizations to identify and monitor upcoming Medicaid redetermination dates to avoid gaps in coverage. The team is also working on an initial prototype of a medical adherence risk model that will be reviewed in November by a technical evaluation panel (TEP) through the DC HIE Policy Board's OCE Subcommittee.

DC HIE Interagency Data Use Workgroup

The DC HIE Interagency Data Use Workgroup was created to analyze technical and policy implications of use cases that request the use of DC HIE data. This new process of adjudicating use cases was implemented by the Digital Health Division in January 2023. It includes a centralized process to receive, triage, and implement use case requests from various DC government agencies. District agencies can use our standardized form **linked here** to submit use cases.

Most recently, the Workgroup approved a use case in July to enhance the DC Health Cancer Registry with race and ethnicity data flowing through the HIE. The CRISP DC Clinical Committee is reviewing this at its October meeting, originally scheduled for August. Subsequently, the CRISP DC team will coordinate with DHCF and DC Health to develop, implement, and maintain the use case.

Technical Assistance & Outreach

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DHCF is leveraging American Rescue Plan Act (ARPA) Enhanced Funding for Medicaid Home and Community Based Services (HCBS) to enhance, expand, and strengthen HCBS digital health infrastructure to support a more integrated and accessible person-centered system in the District. To that end, the DHCF team is working with the District of Columbia Primary Care Association (DCPCA) and its sub-grantees – collectively known as the eHealthDC team – to deliver tailored and vendor-neutral technical assistance to HCBS providers. These are centered around three (3) broad areas:

1) **Program Management Services:** To identify, outreach to, and enroll eligible practices, with the goal of conducting practice readiness assessments.
2) **Promoting Interoperability (PI):** To identify, select, implement, and/ or optimize CEHRT/ HIT systems, with the goal of connecting to the DC HIE. Providers can earn incentives from DHCF for meeting six program milestones within one of three program tracks.
3) **Telehealth:** Enhance adoption and implementation of telehealth services by providing customized, practice specific telehealth guidance, tools, and workflows, with the aim of maximizing telehealth utilization and increasing access to care. *Please note that the HCBS telehealth program is not an incentive program.*

We are pleased to report the following key accomplishments:

- **Engagement and Interagency Collaboration** – The team continues to engage stakeholders via bi-monthly HCBS Stakeholder Advisory Committee meetings. The team is working closely with the Department of Behavioral Health (DBH), Department of Disability Services (DDS), and Department of Human Services (DHS) to collaboratively support provider adoption of CEHRT. The team has also conducted several tailored TA activities, including a webinar on EHR best practices, vendor demos, meetings to discuss post go-live issues, and other individualized support.

- **HCBS Provider Organization Outreach** - The eHealthDC team has conducted outreach to 176 distinct HCBS provider organizations, including Mental Health Rehabilitation Services (MHRS), Adult Substance Abuse Rehabilitation Services (ASARS), Housing Supportive Services (HSS) providers enrolled by DHCF, Long-Term Services and Supports (LTSS) providers, and Disability Services (DDS) providers.

- **HCBS PI Program Incentives** – Of the 176 organizations that the eHealthDC team have contacted, as of 10/13/2023:
  - **Eighty-Seven (87) have met Milestone 1:** 45 MHRS, 12 ASARS, 10 HSS, 9 LTSS, and 11 DDS provider organizations have signed a participation agreement for the program
  - **Eighty-Two (82) have met Milestone 2**: 43 MHRS, 12 ASARS, 10 HSS, and 9 LTSS, and 9 DDS provider organizations have signed a scope of services and work plan
  - **Fifty-Eight (58) have met Milestone 3:** 38 MHRS, 11 ASARS, 4 HSS, 3 LTSS, and 4 DDS provider organizations have purchased new CEHRTs
  - **Twenty-Four (24) have met Milestone 4:** 16 MHRS, 9 ASARS, and 1 HSS, provider organizations have completed technology go-live and training for their selected system.
  - **Sixteen (16) have met Milestone 5:** 8 MHRS and 8 ASARS provider organizations have connected to CRISP and began sending encounter data to the DC HIE.

The team is pleased to share that a total of **$1,703,000 (up from $905,500 in July 2023)** in incentives have been distributed to participating provider organizations!

- **Telehealth** – The team has continued to enhance enrollment and onboarding activities for organizations that are beginning to offer telehealth services. This quarter, the team will be fielding a telehealth survey sent to MHRS and ASARS providers to better understand utilization, obtain feedback, and inform tailored telehealth support.

Policy & Governance

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These updates are related to the policy and governance activities that support the DC Health Information Exchange. The HIE Policy Board and its four (4) subcommittees aim to develop and discuss recommendations on the secure and protected exchange of health information in the District.

HIE Policy Subcommittee Update

Chair: Justin Palmer

Mission and Purpose: Provides recommendations on the development of HIE policies and analyzes the impact of regulatory and legislative trends for the broad implementation and sustainability of secure, protected health information exchange.

Information Blocking: In alignment with Goal #2, the subcommittee is continuing to work on educational materials related to information blocking and a summary of the recent HHS OIG final rule on penalties for information blocking (88 FR 42820). The subcommittee recently reviewed a policy summary document and deliberated on how it should be structured, which details should be included, and the inclusion of links that reference existing ONC educational materials.

Health IT Policy Trends: In alignment with Goal #1 and Goal #3, the subcommittee is continuing to keep abreast of various regulatory and legislative releases to determine their impact (if any) on the DC HIE. The subcommittee reviewed several options to operationalize these goals and has decided on reviewing a weekly email sent by Digital Health team staff to document and discuss new HIE/HIT trends. Looking ahead, the subcommittee hopes to take a proactive approach in discussing policy trends to determine their impact on the DC HIE. This includes review of relevant sections of the April 2023 ONC proposed rule on Health Data, Technology, and Interoperability (88 FR 23746) for changes regarding information blocking, information on decision-support interventions, and potential requirements regarding patient-requested restrictions to data sharing.

HIE Stakeholder Engagement Subcommittee Update

Chair(s): Dr. Yavar Moghimi and Dr. Mary Awuonda

Mission and Purpose: Aims to gain and maintain stakeholder engagement for long-term operational and financial sustainability of health information exchange in the District. The subcommittee works to provide recommendations to the HIE Policy Board on strategies to promote the value of HIE through discussions and forums with identified stakeholders, as well as the SMHP measurement framework and priorities.

Meaningful Engagement and the DC HIE: In alignment with Goal #1 and its long-term goals, the subcommittee continues to evaluate methods for stakeholder engagement, with a focus on understanding meaningful engagement in the DC HIE. This quarter, the subcommittee has held several dynamic discussions on current CRISP DC outreach strategies and identifying which tools are 'best' for different organization types. Below is a summary of accomplishments:

- Informed the rebranding of *CRISP Reporting Services (CRS)* to *PopHealth Analytics* to enhance HIE user awareness and adoption.
- Defined meaningful engagement as an iterative process with clear steps. This was further developed into a framework that described various tiers of engagement.
- Reviewed a new CRISP DC utilization dashboard that tracks the use of the HIE and its tools for any users who access the HIE via the CRISP web portal.
- Drafted an initial listing of the 'best' HIE tools and functions across five organization types – behavioral health, hospitals, ambulatory care, long-term care, and MCOs. This was further refined by further categorizing tools based on likelihood of use.

- Offered robust and targeted feedback on the CRISP DC eConsent tool outreach plan regarding webinar speakers, outreach methods, and provider engagement strategies. For example, the subcommittee offered comments regarding re-structuring webinars to increase participation, suggested language for survey questions for high utilizers of the tool, and proposed changed to the CRISP DC website.
- Engaged with CRISP DC representatives during the summer re-engagement initiative related to the Provider Directory and Image Exchange tools.

As part of this work, the subcommittee continues to work with other committees (such as the HCBS Stakeholder Advisory Committee) to coordinate activities. The subcommittee is also continuing discussions on how the HIE can help improve health outcomes and supports the use of academic partners to help study the use and impact of the HIE.