District of Columbia Health Information Exchange Policy Board
Meeting Minutes

November 19, 2015
1:00 p.m. – 3:00 p.m.

Members present (4): Christian Barrera (Office of the Deputy Mayor for Health and Human Services), Angela Diop, MD (Unity Health Care), Victor Freeman, MD (Nuance Communications), and Shelly Ten Napel (Department of Health Care Finance),

Members present via teleconference (3): Barry Lewis, MD (Medstar Family choice), Brian Jacobs, MD (Children's National Medical Center), and Justin Palmer, MPA (DC Hospital Association).

Members absent (9): Barbara Bazron, Ph.D. (DC Department of Behavioral Health), Jamal Chappelle (The Chappelle Group), James K. Costello (DC Primary Care Association), Bernie Galla (Connect Care Consulting), Douglas Garland (DMG Scientific), Marina Havan (Department of Human Services), Brenda King, R.N (District of Columbia Nursing Association), Raymond Tu, MD (Progressive Radiology Washington Imaging Associates), and Arturo Weldon (DC Department of Health).

DHCF Staff present (2): Chris Botts (HIE) and Michael Tietjen (HIT).

Guests (5): Scott Afzal (CRISP), Selwyn Eng (Mary's Center), Spence Heron (DOH), Donna Ramos-Johnson (DCPCA), and Anjali Talwalkar, (DOH).

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Call to Order	Shelly Ten Napel (Chair) called the meeting to order at 1:05 pm. Chris Botts (Project Manager) recorded the meeting.
Approval of the Minutes of the Previous Meeting(s)	Ms. Ten Napel presented to the Board the minutes from the Sept. 16th meeting for review and approval. She also moved for approval of the minutes drafted for the Board meetings from July 13th and 15th, which could not be voted on previously due to lack of quorum during the Sept. 16th meeting. Dr. Diop motioned to approve the all three sets of minutes, which was seconded and approved by the group present save one abstention by Dr. Freeman. All minutes were approved as presented. A copy of the approved minutes will be made available on the DC HIE webpage (www.dchie.dc.gov) under the hyperlink for the DC HIE Policy Board.
Old Business: HIE Policy Board and	Dr. Freeman requested clarification as to how the HIE Policy Board relates to the current SIM HIE Work Group efforts. Ms. Ten Napel reminded the group that the SIM efforts created 5 subcommittees, one of which was focused on HIE. Rather than duplicate efforts, SIM stakeholders were invited to

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Subcommittee Updates	participate in the HIE Care Coordination and Technology Subcommittee meetings, which were specifically commissioned by the Board during one of the previous meetings. While the results of the subcommittees will help inform the SIM process, Ms. Ten Napel reminded everyone that they all are facilitated by a Board member and report back to the Board and. Additionally, Ms. Ten Napel emphasized that the recommendations from the HIE Policy Board will feedback into the final SIM plan. Ms. Ten Napel reminded the group about the previous conversations around using IAPD funds to help improve the exchange of health information within the District. The Board commissioned 2 subcommittees (Care Coordination and Technology) during the Sept. 16th meeting. Thus far, each subcommittee has met twice, with a third Care Coordination meeting set for mid-December. Dr. Diop, who is the chair for the Care Coordination Subcommittee, updated the group on what has happened to date in those meetings. The first meeting focused on presentations from various HIEs within the District. In responding to a question from Mr. Barrera, Dr. Diop emphasized that there is still a gap in integrating these systems with the care coordination efforts necessary to improve care. Dr. Talwalkar asked for clarification around how the group defines an HIE. Dr. Freeman suggested that the group come up with a standard definition, suggesting that an HIE must exchange information between Health Information Organizations (HIOs). Dr. Diop went on to state that the Care Coordination group identified a number of potential HIE initiatives that could be implemented within the District, one of which was focused around the concept of care planning and the tools associated with creating them. A subcommittee was created and convened to dissect this idea in more detail. Unfortunately, the DHCF staff was unable to obtain specific samples of current care plan tools in use. However, they did present, with the help of CRISP, the idea of a concept called a Care Profile, which Dr. Diop mentioned is being considered as one of the funding options for the IAPD. This profile would summarize key aspects of care for a particular patient. A mock-up of this concept was created and included in the meeting's materials. Mr. Botts let the group know that he will be distributing a poll to the Board, and other key stakeholders, to receive feedback and will be requesting responses by Dec. 4th. Dr. Diop added that the Care Coordination Subcommittee will continue discussing the other potential HIE initiatives during the next scheduled meeting on Dec. 10th. Ms. Ten Napel provided for the Technology Subcommittee, which was originally chaired by Mr. Weldon who recently left his position with DOH. The Technology group met earlier in the week and discussed the list of potential data elements for the Care Profile in more detail. Subcommittee members present analyzed the potential sources of information for each data type. Ms. Ten Napel mentioned that more conversation is needed to determine how feasible some of these data sources are at least to

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	implement on the short and/or medium term. Mr. Eng added that be believed the identification of these data sources was a great jumping off point for further, more concrete discussions.
Old Business: Conflict of Interest Policy	Mr. Botts updated the Board on the status of the draft Conflict of Interest Policy, which had been discussed during the last few Board meetings. He mentioned that a draft policy was with MOTA, specifically their legal team, for review and the DHCF team awaiting their feedback. Mr. Botts stated that updates will be distributed to the Board as soon as an approved draft has been created.
New Business: Mayor's Establishment Order and Board Appointments/Applications	Mr. Botts let the Board know that MOTA is also reviewing draft changes pertaining to potential updates to the Mayor's original Establishment Order that created this specific Board. According to Mr. Botts, the Establishment Order, originally created in 2012, requires some cosmetic changes, such as replacing the Department of Mental Health with the Department of Behavioral Health, in addition to some more substantive updates that will allow to Board to better match the current HIE needs of the District. He stated that the DHCF staff is still waiting for comments/guidance from MOTA and will update the Board as soon as those have been received. Ms. Ten Napel expressed her frustrations with not being able to update the Mayor's Order sooner, particularly with the Board having several vacancies that need to be filled. She also added that there have been several promising applications that have been received and hopes to get this process resolved by the end of the year. Mr. Barrera asked for clarification around the types of changes that were proposed to the Establishment Order. Mr. Botts responded stating that in addition to the Department of Behavioral Health change, DHCF has proposed an update to the definition for the 4 Public Board to ensure clarity around the qualifications for those positions. Additionally, proposed language was submitted to allow the State HIT Coordinator seat to be used as a floating position since it has been vacant for quite some time now. Mr. Botts covered other proposed changes including adding language around the implementation of a Conflict of Interest policy and the creation of more staggered term for Board members. Ms. Napel responded to Mr. Barrera's question that all board seats have currently ended, although there is language in the Order that allows for members to stay on until their seats can be filled.
New Business: Potential HIE IAPD Funding Opportunities for FY16-17	Ms. Ten Napel presented a slide deck focused on the upcoming IAPD submission and the potential funding opportunities currently being considered by DHCF. She reminded the group that an IAPD is a Federal Government vehicle to provide 90-10 match to support HIE/HIT system development, but not system sustainability. She also discussed the broader goals of the IAPD process, which include increasing health care system integration and care coordination, supporting the upcoming DHCF Health Home initiative, assisting with quality reporting and panel management requirements, and greater

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	connectivity within the District in general. Drs. Diop and Freeman asked for clarification about the source of these goals. Ms. Ten Napel responded stating that the goals listed were either driven by this Board or internally at DHCF and/or its sister agencies (e.g., DOH, DBH, etc.). Four types of initiatives were covered as part of this discussion: 1) Patient Care Profile, 2) Ambulatory Connectivity, 3) Electronic Clinical Quality Measurement and Reporting, and 4) Obstetrics (OB) Authorization Form. Patient Care Profile Ms. Ten Napel provided an overview of the Care Profile concept, which she stated would create an on-demand document of patient summary data. Data, at least initially, would be queried using available Application Program Interfaces (APIs) for each data source rather than creating a central data repository. Ms. Ten Napel mentioned that multiple data sets would feed into the Care Profile tool, particularly ADT feeds from EHRs and Medicaid Claims Data. Other potential data sources include DOH and DHS for immunization and housing information, respectively, among others. Ms. Ten Napel stated that more discussion is needed around how this type of tool could best support future analytical needs of the users. Ms. Ten Napel highlighted some of the major pieces of information that could be captured, which included patient demographics (name, addresses, phone numbers, etc.), known members of patient's care team, housing status, chronic conditions, immunizations, medications, care management program designation (if applicable), available care plan(s), risk score, and most recent hospital/ambulatory usage. Mr. Barrera asked for clarification about where the ideas for the care profile came from. Ms. Ten Napel responded stating that these potential data areas were the result of the current process (e.g., subcommittees and work groups) as reviewed earlier in the meeting. Dr. Freeman asked for clarification about the amount of information necessary to be included in the IAPD submission. Ms. Ten Napel responded stating that the IAPD can be used to either flush out this concept in more detail and/or used to implement it. She added that it is not required to submit every level of detail as part of the submission in order to receive approval. CMS will need high level details, description of how it will be sustainable, and how it fits into the District's overall HIT/HIE plan. There was an additional discussion around whether ADT data included any useful clinical information or was primarily administrative. Dr. Freeman felt like the ADT data was primarily administrative. On the other hand, Ms. Ramos-Johnson felt that ADT feeds did include potentially useful clinical information, such as the initial diagnoses, chief complaint, and visit type, among others. Dr. Jacobs added that while there is clinical information in these feeds, including data round allergies, it is often inaccurate and variable from organization to organization. Dr. Jacobs stated that Children's usually ignores the clinical information entirely from the ADT feeds and only focuses on the administrative information captured.

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	Dr. Freeman asked Dr. Jacobs what the advantage of using this type of tool would be for a care manager working for a payer. Dr. Jacobs responded stating that the manager most likely doesn't have complete access to all of this information. The tool would also provide more timely data than what is currently accessible within their own system, particularly if it hasn't even been billed out yet. Ms. Ten Napel added that this tool could also help with managing care transitions. Dr. Jacobs agreed stating that he thought it could help reduce redundant (and potentially conflicting) care management plans. Dr. Lewis echoed the same sentiment adding that the Care Profile would be helpful in identifying who is in the patient's care team, which in many instances is unknown to providers. Dr. Freeman stated that care managers he has talked with (who were not DC-based) mentioned that this type of tool would not change how they would provide care since they have their own accountability structure that they are focused on. Ms. Ten Napel responded that DHCF is working to build programs like Health Homes to require more shared accountability and need to look at tools such as this one that would be required to help support that type of shared structure. Dr. Lewis added that contacting members can be very cumbersome and this type of tool could help expedite that process by helping the user identify the last person that was in contact with that patient. Dr. Talwalkar asked for clarity around the difference between this tool and the Continuity of Care Document (CCD) (e.g., focused different audience, etc.). Ms. Ten Napel responded stating that CCDs include a lot of clinical information, which can difficult for users to navigate quickly. The thought around the Care Profile would be to pull information from some of the same sources and create something that is both user-friendly and easily consumable. Ms. Ten Napel added that if a user does want more specific clinical information, such as detailed lab values, they can still use the CCD. Dr. Jacobs agreed stating that he believed that the CCD would be complimentary to this Care Profile. Mr. Eng asked whether the fields will be static or dynamic. Ms. Ten Napel responded stating while this is still being discussed, ideally the fields would be dynamic to give the user some options to view more information if needed. She added that this type of tool would also allow for more potential analytics of patient panel management. Dr. Diop responded that CPC-HIE has project presently in place that is focused on transitions of care using CRISP data. She stated it is currently very difficult to do panel management because you have to look at each line of the daily feeds received. <u>2) Ambulatory Connectivity</u> Ms. Ten Napel started off describing the overall goal of getting more folks connected to the HIE, understanding that hospitals are much farther along than ambulatory practices with regard to HIE connectivity. She stated that the IAPD funding would be used to help improve the ambulatory

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	connectivity and onboarding of providers/provider groups. Ms. Ten Napel reminded the group that DHCF is on the verge of receiving approval for a separate IAPD request to support provider outreach and education with regard to the MU Incentive Program. Dr. Freeman responded stating that the Board needs to challenge the idea that the District has good connectivity between hospitals. While 6 out of 8 hospitals are connected to CRISP, Dr. Freeman is unsure useful information is actually flowing between those entities and how reliable that information is, which Dr. Diop agreed with. Ms. Ramos-Johnson stated that a lot of those issues are related to what hospitals are able to send rather than with limitations with what they can receive. She stated that the focus should be on figuring out how to resolve the variability amongst hospitals. Mr. Afzal added that the 6 hospitals connected to CRISP provide several different data types: outbound ADT, lab results, and radiology reports (not images). He also stated that they provide, at minimum, the following types of clinical data: discharge summaries, history of physicals, operative reports, and consult reports. Mr. Afzal also mentioned that Providence Hospital is triggering outbound CCD documents at discharge. He added that the primary issue with CRISP's discharge summaries is that they only present the final summaries. Therefore, it is possible that another hospitalization can occur before the discharge summary can be signed and finalized. Mr. Afzal did emphasize that CRISP is in the process of trying to expedite that process. Dr. Freeman responded questioning the usefulness of that amount of information and stated that it will differ depending on the type of provider looking to consume that information. For some providers, according to Dr. Freeman, downloading all labs for a patient would be tedious and time consuming to review. Mr. Afzal stated that in his experience, most providers do not download that level of information. Additionally, he added that the 4 clinical data types he listed were the minimum types that were being sent and that some hospitals send even more than that. Ms. Ten Napel agreed that this usability question is critical and has been an important driver for these initiatives. She stated that there is obvious work that needs to be done around the use of CCDs and determining what EHR data is available. While there have been some conversations around a CCD top sheet, Ms. Ten Napel mentioned that it would require more folks to actually send those documents. She did add that due to CMS requirements and other factors that the use of CCDs has dramatically increased over the past several months. Mr. Afzal verified that CRISP is implementing a CCD top sheet pilot in MD, which Ms. Ten Napel stated could be another partnering opportunity for the District. <u>3) Electronic Clinical Quality Measurement and Reporting</u> Ms. Ten Napel discussed MU's requirements around electronic clinical quality measure (eCQM) reporting, which she stated can be populated using a provider's EHR system. She mentioned that CRISP

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	has received funding through their latest IAPD submission to set-up a system by which eCQMs could be extracted from EHRs. Results can then be reported back to the providers or payers through some type of patient panel. CRISP has already built and is currently implementing this type of system for some Maryland providers. Ms. Ten Napel believed this eCQM system provides a good partnering opportunity for the District since the infrastructure has already been built (assuming the current implementation process is successful). Additionally, she added that this type of system could be a huge asset to providers as CMS increases their requirements around submitting eCQMs. The dashboarding functionality would also allow providers to analyze how they are performing on certain measures in comparison to others, according to Ms. Ten Napel. Ms. Ramos-Johnson asked whether it DHCF's intent to create a CMS-approved registry that would allow providers to submit measures directly to CMS. While Ms. Ten Napel wasn't familiar with that type of structure, she responded stating that the intent of this tool is to make reporting easier for providers. Ms. Ramos-Johnson described the process with which other states have created these CMS-approved registries to assist providers in submitting measures. Ms. Talwalkar added that this type of tool could be extremely helpful in sharing lessons learned and best practices among the various provider groups. 4) OB Authorization Form Ms. Ten Napel reviewed the DHCF requirement around the OB Authorization and First Assessment form, which is to be completed for every person that is pregnant. She stated that the form is meant to help providers review the various risk factors that can lead to issues such as low infant birth weight and infant mortality, among others. Currently, it is completed as part of a paper process. Dr. Diop confirmed that completing this form in its current format is a huge burden to providers. Ms. Ten Napel presented two potential approaches that could be implemented to improve the use of this form. The first would be to automatically extract required data from an EHR to populate an electronic version of the form, which would be housed within the same EHR system. The second approach would create a separate system to house the electronic form so that providers who do not have the ability to use the EHR function can still submit the form electronically. Ms. Ten Napel added that there are still discussions about whether this should be driven/housed by DOH or DHCF. She also reminded the group that this initiative, like the others, is a first step in the overall HIE plan for the District and could be expanded to support other uses cases in the future. Mr. Barrera asked about what type of information is captured currently using this form. Dr. Talwalkar confirmed that it includes a physical, in addition to a psycho-social, assessment. Dr. Freeman asked whether this is a required form. Ms. Ten Napel and Ramos-Johnson both believed that it is a Medicaid required form.

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	5) Other Potential Projects Ms. Ten Napel asked the group if there were any other areas that had not been discussed that should be potentially included in the IAPD submission. Dr. Freeman responded stating he felt uncomfortable with what is already in place and is hesitant to build more tools on top of an infrastructure that has a lot of unknown details. He suggested potentially making a larger investment to perform more detailed analyses on what is already in place. Dr. Freeman also recommended pursuing potential tools to support current and future DOH initiatives, to which Ms. Ten Napel agreed. Ms. Ten Napel added that DHCF has already set up a meeting with Dr. Nesbitt and DOH which will be used to discuss these potential collaborative areas in more detail.
New Business: HIE Designation	Mr. Tietjen presented a slide deck reviewing the idea of establishing a process to which the District could formally designate an entity (or entities) as an official DC HIE. He emphasized that this idea is still in the early stages of internal formulation at DHCF and additional discussions underway to discuss exactly would be needed to implement such a concept. Mr. Tietjen stated that DHCF is looking at this as a legislative process that would allow three things: 1) Provide Authorization for the Director of DHCF, 2) Create a requirement for partnership agreement(s) with selected entity(ies), and 3) Provide DHCF with grant making authority. Mr. Tietjen added that this would help ensure approved entities meet the District's standards around areas such as privacy and security, interoperability. Mr. Tietjen also added that it would help streamline the ability for the District to share both financial and technical resources. Lastly, according to Mr. Tietjen, an HIE designation would help operationalize some of the elements the Board had included in the HIE Roadmap, particularly the creation of more formal and legal partnerships with the HIE entities that had been identified (CRISP, CPC-HIE, etc.). Mr. Tietjen highlighted the fact this type of public-private partnerships is fairly commonplace amongst other states with almost ¾ using this type of arrangement for their HIEs. He included specific examples from other states including Maryland, Wisconsin, and Pennsylvania noting that there isn't a perfect example out there for what the District would like to do. However, these states do include elements that the District could potentially include in its designation process. Mr. Tietjen reviewed Maryland's process which provided legislative authority to the Secretary of Health to designate official HIE entities, with which CRISP was designated as the statewide HIE. An entity within the state was also given grant making authority to provide resources for CRISP. Wisconsin passed legislation that authorized the governor to designate an HIE entity, while also required specific guidelines to be followed. It also authorized the state to make payments directly to the designated organization. Lastly, Mr. Tietjen reviewed Pennsylvania's arrangement, which authorized an agency within the state to organize a public-

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	private partnership and convene a board of public and private stakeholders. This authority helped in creating a network of private HIE organizations, in addition to developing interoperability standards, among other initiatives. Mr. Tietjen asked several questions to the Board including whether they believed an HIE designation was warranted, what the evaluation criteria should be if a designation process was put in place, and defining the roles and responsibilities of the designee(s) as part of the partnership agreement(s). Dr. Freeman started off the discussion asking whether there is precedence in other states for having multiple HIE designees in one region. Mr. Tietjen responded saying that he wasn't personally aware of any, but could do some more research into that topic. He did mention that many states, such as NY, have multiple designated HIEs that cover specific sub-regions. However, he noted that the identified HIE's within the District are more segmented by provider type than specific regions. Ms. Ramos-Johnson also responded stating that she believed that it makes sense to recognize the assets the District has and create a more formal designation process. She went on to say that this would provide additional credibility to those specific entities that would be designated. Ms. Ramos-Johnson added that while Maryland has a state designated HIE, they also have a separate process that designates and recognizes other HIEs within the state. Those who received such a designation are able to receive some sort of benefit. Mr. Afzal included several examples of MD HIE designated entities including Trivergent Health Alliance and Medstar Health. Ms. Ten Napel responded stating that this process could also encourage the use of best practices around certain standards, such as privacy/security and data sharing, among others. She did note that it is not the intent of the District Government to create strict standards, but allow a vehicle to develop and implement such protocols overtime as the board coalesces around these issues. Ms. Ramos-Johnson added that the hope would be to create a pathway where entities can contribute data for the betterment of the District. Mr. Barrera asked whether designation was also synonymous with oversight of these potential entities. Ms. Ten Napel responded saying she at least believed that there would be some regulatory language involved, which could also potentially provide additional negotiating power to the District. Mr. Barrera stated that it will be important to make sure the potential regulation language doesn't prevent the current progress in the HIE space from continuing or make it more difficult to move forward with current initiatives already in place. Dr. Jacobs stated that he believed that the concept made sense in general, particularly as it supports care coordination and interoperability. However, he voiced concerns about potential over regulation and/or credentialing requirements. He referenced his experience with Maryland's Management Service Organization (MSO) designation program. Maryland's regulatory requirements were so onerous and the program was so expensive to facilitate that it distracted from the

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	core mission at hand. Based on that experience, Dr. Jacobs emphasized how important the structure of such a designation will be for its ultimate success. Ms. Ten Napel noted that this process from her point of view would initially be voluntary to help facilitate potential partnerships and funding opportunities for the core HIE goals of the Board and District. Ms. Ten Napel transitioned to asking the group about what specific elements the District should potentially ask these designated entities to adhere to. Ms. Ramos-Johnson responded that the designation should include requirements around specific core HIE principles. She also added that the HIE Policy Board could become the body to which those designated entities must report, which could be done on a periodic or annual basis. Mr. Barrera asked whether it is necessary to approach the specific identified HIE's to be designated or open the process more broadly. He mentioned that he was OK with either approach. Dr. Freeman stated that he did not want to encourage the creation of even more HIEs since the District already has HIEs that still don't communicate with one another. He added that he was unsure what the benefit would be to the potential designated HIE entity. Dr. Diop responded stating that this type of arrangement would create a more formal partnership with the District and could allow access to additional funding opportunities that currently aren't available to such entities, including those associated with the IAPD process. Ms. Ramos-Johnson also added that it isn't just about what benefits the designees receive, but also what the District gains in return. Brian Jacobs concurred stating that he believed that designation is closely linked with partnership which ultimately leads to sustainability and the overall improvement of the care received within the District. Ms. Ten Napel added that this process would help expedite the implementation and facilitation of the District's HIE initiatives at the speed of technology rather than requiring each piece of work to be competitively bid. Lastly, she added that the District has data assets as well and would love to see that information more readily accessible to the public. Ms. Ten Napel requested a "Yes/No" vote on the designation process and whether it is at least something that should be pursued further. Mr. Barrera preferred to see something that is flushed out a bit more before voting yes or no. Dr. Freeman moved to approve this concept for further refinement and the group unanimously agreed with no opposition.
Next Board Meeting	A meeting will be convened in January or February of 2016. DHCF staff will send out a notice to Board members to finalize a date.
Adjournment	The meeting was adjourned at 2:57 pm.

Approval of Minutes:

Chris Botts, Chair, DC HIE Policy Board

4/26/16

Date