District of Columbia
Health Information Exchange
Policy Board Meeting

Thursday, March 10, 2016
2:00 – 4:00 PM

Location:
One Judiciary Square
441 4th Street, NW, 900 South
Washington, DC 20001

Board Members:	**Members present (16):** Christian Barrera (Office of the Deputy Mayor for Health and Human Services); Chris Botts (DC Department of Health Care Finance); Edwin Chapman, MD (Private Practice and Leadership Council for Healthy Communities); Kelly Cronin (The Office of National Coordinator); Victor Freeman, MD (JA Thomas & Associates); Aaron Hettinger, MD (MedStar); Donna Ramos-Johnson (District of Columbia Primary Care Association); David Siransky (DC Department of Health Care Finance); Tonya Royster, MD (DC Department of Behavioral Health); Alison Rein (AcademyHealth); Brian Sivak (Robert Wood Johnson Foundation and Civic Hall); Eliot Sorel, MD (Medical Society of the District of Columbia); Pete Stoessel (AmeriHealth); Sakina Thompson (DC Department of Human Services); James Turner (Health IT Now Coalition); and William Ward (Catholic Charaties) **Members present via teleconference (4):** Brian Jacobs, MD (Children's National Medical Center); Mary Jones-Bryant, RN (District of Columbia Nurses Association); LaQandra Nesbitt, MD (DC Department of Health); Justin J. Palmer, MPA (DC Hospital Association); **Members absent (2):** Angela Diop, MD (Unity Health Care, Inc.); Archana Vemulapalli (DC Office of the Chief Technology Officer) **DHCF/HCRIA/HIE Staff present (5):** Jordan Cooper, Lisa Fitzpatrick, Dena Hasan , Michael Tietjen, Joe Weissfeld **Guests (5):** Johanna Barrata-Cannon (Navigant), Selwyn Eng (Mary's Center/CCIN), Evan Carter (CRISP), Kory Mertz (CRISP), Anita Samarth (Clinovations GovHealth),
Please read:	N/A

AGENDA	
1. Call to Order	Chris Botts called the meeting to order at 2:05pm. Jordan Cooper (Management Analyst) recorded the meeting.
2. Old Business - Updates on Mayor's	Mr. Botts asked Mr. Walker from the Mayor's Office of Talent and Appointments to officially swear-in the

Establishment Order and Introductions for New Board Members	new Board. Mr. Walker asked all non-District government members present (11 total) to stand and he proceeded to administer the oath of office to the following: Edwin Chapman, Kelly Cronin, Victor Freeman, Aaron Hettinger, Donna Ramos-Johnson, Alison Rein, Bryan Sivak, Eliot Sorel, Pete Stoessel, James Turner, and Bill Ward. After completing the oath of office, Mr. Walker reminded all new Board members that they must attend one of the upcoming series of ethics trainings. Mr. Botts reviewed the agenda, requesting that all members introduce themselves. During introductions, Dr. Hettinger requested that he be referred to as "Zach" at future meetings.
3. Review Key Tenants of HIE Road Map and Goals for Policy Board Year	Mr. Botts moved into a review of the DC HIE Strategic Roadmap. He spoke to the overarching goals of current and future HIE efforts, emphasizing the need to align with District objectives particularly those that are a priority of the Executive Office of the Mayor. He continued to emphasize the imperative to both build upon previous investments and to break down silos, ensuring that the system is more connected, and improve multi-disciplinary communication. He said that we would like to build upon the partnerships that have already been built and the investments that have already been made. In essence, Mr. Botts encouraged members to think differently about healthcare, beyond how it has traditionally been defined, in order to improve the delivery of healthcare across a care continuum that has often been fragmented to the detriment of patient health. It is part of the role of the HCRIA to help support those efforts, creating tools and infrastructure that is necessary to meet those goals. He added that a new topic that has been discussed with increasing frequency over the past few years has been security, which essentially entails ensuring that whatever we're doing is done in a secure and standardized manner that protects Personal Health Information. The DC HIE Strategic Roadmap was built from three primary data collection efforts by the HCRIA team: 1)One on one stakeholder interviews, 2) HIE Summit (hosted in September 2014), and 3) Three subcommittees based upon the recommendations of some members of this Board and other community members. These are designed to address three areas that would form the basis of the Roadmap: Governance, Technology, and Finance.
4. Governance Subcommittee Recommendations	The Governance subcommittee determined that, regardless of who they are, there needed to be a local entity that would coordinate efforts to build a District-wide HIE infrastructure. Currently, the HIE Policy Board currently fulfills this role. The Governance subcommittee also discussed a general governance model that would be based upon a public utility model that would use the influence of key stakeholders to drive how we are going to manage this space. The consensus from the subcommittee was to use the funds and infrastructure that are currently in place and not to try to create alternate paths that may take away from our focus at hand. Some key functions were also discussed in the subcommittee regarding the governance structure including privacy laws, security, standards, and monitoring and evaluating the performance of the HIE. Mr. Barrera asked how the subcommittee's recommendations align nationally, especially in light of the federal

	government encouraging regional approaches to HIEs. Mr. Botts replied that indeed the federal government encourages regional and national alignment of HIEs but that despite this push there aren't many standards across the board. Governance models of the various HIEs across the country were developed organically in response to specific local requirements facing those entities. For example, Mr. Botts mentioned the governance model for Indiana's HIE, which began in the 1990s prior to the HITECH Act by coordinating the needs of five key hospitals in Indiana for the purpose of gathering research data. A long, drawn out legal process ensued while they slowly expanded the number and types of stakeholders involved in their HIE. Segueing from the example of Indiana's HIE to the topic of large health systems growing through acquisitions, Ms. Cronin voiced her doubt about the ability of an enterprise specific approach to lead to true care coordination. For example, Ms. Cronin said that ACOs are investing only in their own aging infrastructure and therefore will not achieve true care coordination. Yet as new payment models encounter challenges to true care coordination, HIEs are developing new solutions; e.g. query based exchanges are emerging as the next iteration of HIEs. In sum, Ms. Cronin concluded that we are in a better place from a standards and technologies perspective but HIEs remain challenged by governance issues. Dr. Sorel asked about identifying best practices among HIEs that are currently operating around the nation. Mr. Botts spoke of DHCF's efforts to review the HIE landscape nationally and reminded members that despite differences between populations, each state may not be as unique as one might think. Mr. Botts said that the DHCF team is reaching out to states with the understanding that DC is not the first jurisdiction to attempt to develop an HIE infrastructure.
5. Technology Subcommittee Recommendations	Then Mr. Botts proceeded to discuss the Technology subcommittee's recommendation that technologies need to be built in coordination with the five key HIE partners that we have in DC. There have been many efforts within DC to achieve the same goals that we are trying to achieve here. We want to partner with those entities effectively to move forward to create an organized, coordinated system in the future. He elaborated upon the many complications involved with caring for the vulnerable Medicaid population in DC and that creating a HIE will help providers manage and coordinate care for this population. CMS has been pushing efforts to grant states access to Medicaid claims data that can be helpful in managing their care and has emphasized the importance of pressing forward now with the development of an HIE using national standards to coordinate care within DC.
6. Finance Subcommittee Recommendations	Mr. Botts moved on to a synopsis of financing for the HIE. The Finance subcommittee recommended that the system should be sustainable over time (without CMS incentive payments or grants). Mr. Botts continued, stating that there has been a huge national push for alternative payment models and that the subcommittee suggested looking into potential subscription and/or transaction based-fees utilizing best practices from other HIEs might be able to be used successfully in DC.

7. Updates on FY16-17 IAPD Submissions	An Implementation Advanced Planning Document (IAPD) is funding request to CMS by which CMS provides financial support to the development of a HIE and HIT infrastructure to support the Meaningful Use/EHR Incentive Program. Through IAPDs, States can request a 90/10 federal match contribution to help providers meet MU where there will be a 90% federal match for funded programs as long as the state can come up with the 10% matching funds. It has been in effect for the past few years for the EHR incentive program and in 2013 there was an expansion to HIE. Ms. Rain inquired about the extent to which the goal of a HIE is to benefit the health system that it serves versus being designed specifically to improve care. Mr. Botts identified that the idealistic goal is to create an Exchange that benefits the people of DC. Medicaid should not take on the sole responsibility of creating a HIE but it is a good place to start. Ms. Rain continued, stating that much of what will drive the health and well-being of Medicaid beneficiaries are those elements that are outside the sphere of healthcare services. Mr. Botts elaborated upon the State Innovation Model (SIM) process that has initiated a conversation about social determinants of health that are found outside of the four walls of a physician's office (i.e. traditional healthcare approaches). Dr. Sorel implored other board members to support a public health approach that accounts for risk factors and protective factors affecting the cost of the health system. Mr. Turner then asked where the patients and the caregivers (i.e. family members) are in the schema and Mr. Botts responded that they are included within the central term 'Accountable Entity.' He continued, stating that payment and incentive structures could initiate the discovery of the identity of patient caretakers (who are often unidentified by the care delivery system). In response, Mr. Turner emphasized Telehealth as an area of particular importance and relevance to the process of identifying caregivers. Mr. Botts transitioned the conversation to an update on the DHCF's proposed updated to their IAPD. As a recap, DHCF submitted an application for the first time in July 2015 that included funding requests for HIE-specific initiative. Approval was been received in February to use the e-Clinical Works (ECW- an EHR vendor) hub to connect DC FQHCs to DBH's iCAM system in support of the Health Homes 1 initiative that launched in January 2016, which supports individuals with severe mental illness (SMI). He explained that IAPD funding works on two fiscal year cycles; there's 2016/2017, 2018/2019, and 2020/2021 (when funding ends). Five initiatives were settled upon for use with IAPD funding: 1. Dynamic Patient Care Profile 2. eCQM Tool/Dashboard 3. OB/Prenatal Specialized Registry 4. Analytical Population Dashboard 5. Ambulatory Connectivity/Support

	Through discussions with the Policy Board and SIM Work Groups, it was determined there was a core set of data elements that any provider, regardless of the type, would want to see. The work groups came up with about ten data elements in their recommendation, which turned into the Patient Care Profile. Mr. Botts explained that this profile, will pull claims data, housing data from DHS, and potentially DOH immunization registry information into a single document. The project will allow more real-time accessibility of patient data points. Ms. Cronin said that there is a HL7 care plan being used in NYC by Epic that DC should look into. Mr. Botts spoke about The Impact Act and its push for quality improvement standards. Based on the currently and future landscape in the quality improvement space, DHCF is looking to create an Electronic Clinical Quality Measurement (eCQM) tool that can be leveraged as part of electronic quality clinical measurement programs. DHCF is also looking to create a Prenatal Specialized Registry that would capture information electronically that is currently gathered through the paper-based assessment form, which is cumbersome to use. DHCF is looking to integrate an electronic form into the FQHC's EHR system, eClinicalWorks, in addition to creating a separate portal for providers to electronically and voluntarily submit information into this registry. Lastly, DHCF is proposing to conduct outreach efforts to ambulatory providers to encourage their participation in and utilization of the suite of HIE services available in the District. Mr. Botts stated that the initial feedback from CMS on the first draft of the IAPD was very positive.
8. Current HIE Landscape in DC	Mr. Botts went on to review the envisioned healthcare landscape within the District at the center of which would be an Accountable Entity (at the center of which would be the patient) that would be supported by team based care, a lead patient navigator, and community linkages to address social determinants of health. The HIE would connect all these entities, building upon the five HIE entities that already exist in the District: 1. DC Department of Behavioral Health (iCams) 2. DC Department of Health 3. Chesapeake Regional Information System for our Patients (CRISP) 4. Capital Partners in Care (CPC) 5. Children's National Medical Center (CNMC) IQ Network. Mr. Botts presented the current HIE landscape: DC has up until now lacked a coordinated effort to create a uniform, coordinated approach to creating a HIE in DC that will deliver the information that providers need at the point of care. The hope of DHCF is to work with the Board and the broader community to build core infrastructure and rules of the road to create a strong foundation for the DC HIE. Mr. Stoessel asked for clarification if CPC is the only HIE in DC that is completely grant funded. Mr. Botts affirmed the statement, adding that the other four HIEs are subscription/fee funded. Ms. Ramos-Johnson provided background about the funding of CPC through two grants (a CMMI grant and funding from GWU).
9. Future HIE Landscape in DC	Mr. Botts introduced his sense of where we ought to direct the future HIE landscape. He identified the following three buckets:

	1) Create a cohesive and coordinated HIE structure for the District that would have a formal District designation that builds upon DHC's grant making authority. This would build increased connections with the public. There should be a formal designation process within the District that would build upon public grant-making authority that DHCF has in order to get money out of our door to build connections with the community. This structure should have a core set of standards (rules of the road), which the DC HIE currently lacks, that must be followed in order for entities to be recognized as a HIE. These rules should be based upon national principles and standards. 2) A long term sustainability strategy needs to be discussed by multiple stakeholders to ensure that HIEs will ultimately be sustainable without federal funds in the future. The HIE will be more sustainable if it successfully engages additional payers beyond those covering the Medicaid population (i.e. commercial payers). 3) The Board ought to create a repository of priority use cases to advance for IAPD and other future (limited) sources of funding.
10. Defining the HIE Audience (Use Case Scenarios)	Mr. Sivak asked for an example of a use case scenario. Mr. Botts provided a use case scenario: 'as a user of the healthcare system, what tools would help me get where I want to go?' Mr. Sivak said that HIEs have gotten in trouble nationally because technology has often been built before addressing use cases. Ms. Hasan offered a HIE use case scenario for beneficiaries afflicted with physical chronic conditions: 'a provider could access a one stop shop with all information in one place on one patient.' Mr. Sivak asked, rhetorically, if providers could take advantage of such a system today if it were placed in front of them, suggesting that HIEs are not always built with the end user in mind and need to be capable of being integrated into a provider's workflow before we will see Meaningful Use of the HIE. Ms. Rein opined that 'use case scenarios' is an abstract term with 'weedy, technical' language and that the Board ought to use discrete and concrete language to capture the perspective of physicians and beneficiaries. She offered that the Board ought to instead focus on who should be awarded funds in the future. Ms. Cronin added that it is not the PCP but the case manager who accesses EHRs and who is sometimes the primary end user. Mr. Botts said that Michigan has a repository of use cases that could serve as a reference point for the DC HIE. Dr. Freeman suggested that developing a use case scenario is useful for obtaining feedback to improve the HIE. Clinicians have frequently provided feedback that the HIE format wasn't working for them, and often this is because the product was not designed for them. HIEs must distinguish between stakeholders because the care delivery experience is very different for primary care and specialty physicians. Thus the creation of many use cases would provide different perspectives for how a HIE can be used and will ultimately benefit many end users. Even with a use case scenario, Mr. Botts added, there remain the challenges of funding the project and ensuring that the desired standards are met. It is therefore necessary to establish a certain level of rules of the road before an HIE sandbox is opened up.

	Continuing to define the HIE audience, Mr. Turner encouraged the Board to look towards a grander, more long-term vision. He mentioned the need to benefit visitors to DC (e.g. with cherry blossom season being upon us). Mr. Botts said that we don't want to reinvent the wheel and we want to stay coordinated with what our regional and national partners are doing but the difficulty is that our HIE is not yet at the place where we're even serving District residents. He continued that one day we would love to be able to serve visitors as well but that we need to prioritize operationalizing the HIE to meet the needs of District residents for the time being. Mr. Botts did, however, mention an example of a use case where Philadelphia hospitals exchanged information with hospitals in Italy prior to the Pope's visit last Fall and so it is possible for a HIE to serve the needs of tourists. Mr. Freeman responded to Mr. Botts's and Mr. Turner's comments by suggesting that managed care beneficiaries be the top priority for the HIE.
11. Updates on HIE Designation Process	The designation process for HIEs would work based on certain criteria; an entity would be designated as a DC HIE entity and would therefore have access to the grant money available through DHCF without going through the grant process. Ms. Hasan said that DHCF already has statutory grant making authority. Mr. Berra recommended that efforts not be duplicated and therefore that all efforts on this front be directed by the results of an environmental scan. Dr. Sorel opined that the ACA was a good idea with poor execution in part because the public did not understand it. Whereas the execution of the ACA was very poor, the implementation of the HIE should be done in accordance with input of providers, caregivers, and community members. He suggested that the Board translate its work to the public so that the Boards work is understood and the Board can receive feedback to guide the implementation process. The DC HIE program will be more successful if it launches a public relations campaign to translate and to communicate to the public the mission of this Board and how that mission is relevant to the public interest. Such a campaign would have the potential to create a feedback loop involving both providers and the public so that the Board can successfully iterate new versions of the HIE by incorporating input from those who are receiving what the Board implemented. In sum, he encouraged the creation of a feedback loop early on in the process of creating this HIE. Dr. Hettinger added to the conversation, advocating for the creation of a HIE that leverages user input to develop products that are more easily incorporated into providers' daily workflows. Dr. Hettinger said his own practice has long had access to CRISP but that he never used it until the Prescription Drug Monitoring Program (PDMP) was integrated into the EHR; he now uses it many times every day. Mr. Botts clarified his goals by reminding the Board of the need to be flexible and to pivot throughout the designation process while respecting guideposts that are established, agreed upon, and in alignment with the District objectives. He added that there are many things we can do and only so much time in which to do it. He reiterated that our charge is create the foundational infrastructure of the HIE for use as guide posts, and that we will have flexibility as we work between those guideposts.

	Ms. Cronin requested that the major milestones of the HIE development process be laid out on a timeline. Only by implementing an integrated, actionable, practical, and transparent process, she said, would the Board be able to capture analytics and improve population health. Building upon Dr. Hettinger's previous assertion, she suggested that the Board address the questions of who will be training providers to incorporate the use of a HIE into their daily routines and who helps support the change in the workflow. The conversation turned towards a discussion of broader missions beyond the scope of the DC HIE. Mr. Botts gave an example of a National Patient Identifier being a topic that reflects a national policy discussion that will have an influence on the Board's discussion but that cannot be addressed by the members of this Board at this time. Ms. Rein agreed with Mr. Botts that we should limit our discussion to topics that are within the purview of this Board. Ms. Cronin mentioned that MedStar and other large (non-payer) organizations in the area touch a huge number of Medicaid beneficiaries and so the Board would do well to avoid limiting the scope of its interest only to a payer perspective. She continued that the Board must create a HIE that will be useful to and accessible to every healthcare stakeholder in DC. She warned that if this effort would be limited to creating a HIE that only serves Medicaid beneficiaries (i.e. if the HIE does not include private payer covered lives) then providers will not use the HIE because they "won't switch between five different playbooks."
12. Updates on Data Mapping Efforts	Dr. Chapman then asked if we have any geo-mapping of Medicaid beneficiaries in DC. Mr. Botts replied in the negative but that it would certainly be beneficial to have more robust data from the data warehousing team. Mr. Sivak said that the Office of the Chief Technology Officer (OCTO) has all of the data analytics and GIS resources that could be needed. Dr. Chapman explained that he doesn't know any pediatricians or PCPs in certain areas of the city to whom he could refer patients and therefore having geo-mapping of their locations would enable the technology to be useful.
13. New Business – State Medicaid Director's Letter re: IAPD funds	Mr. Botts notified the Board of an announcement from CMS in the form of the State Medicaid Director's Letter that expanded the use of IAPD funds for non-MU Eligible Professionals. These funds, however, cannot be used to purchase EHRs for these newly expanded provider types.
14. State Innovation Model State Health Innovation Plan (SHIP)	Mr. Botts briefly updated the group and let them know that the State Health Innovation Plan (SHIP) is on track to be finalized by the end of July 2016.
15. Future Meetings: Bylaws, Governance, Scheduling	Mr. Botts introduced a discussion on structure, notifying the Board that a special session will be organized in which the Board will discuss Bylaws, which haven't been updated since 2012. Mr. Botts let the Board know that it would behoove them to discuss the creation of a Conflict of Interest policy (which does not currently exist) and a policy on the Public Conduct of Members. A new Vice-Chair needs to be appointed as well as sub-committee chairs. All members were advised that, should they have an interest in serving in any of these positions, they should indicate their interest by email to Mr. Botts. In turn, Mr. Botts will distribute those

	names to the entire Board and then a vote will be held. Mr. Botts then proposed that an annual calendar be agreed upon by the entire board (June, September, November). Dr. Sorel seconded the motion and all Board members present voted unanimously in favor of this proposal. Additionally, Dr. Sorel asked if there would be an annual report that assesses the performance of the Board and Mr. Botts responded by stating this suggested would be taken into consideration when drafting the updated bylaws.
16. Adjournment	Mr. Botts adjourned the meeting at 4:05.

Approval of Minutes: _____ 4/26/16

Chris Botts, Chair, DC HIE Policy Board — Date