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**District of Columbia**<br>**Health Information Exchange**<br>**Policy Board Meeting Minutes**

Thursday, January 25, 2018<br>3:00 PM – 5:00 PM

Location:<br>One Judiciary Square<br>441 4th Street, NW<br>Main St. Conference Room, 10th Floor<br>Washington, DC 20001</td></tr>
<tr><td>**Board Members (Invitees):**</td><td>

**Members present (10):** Erin Holve (DC Department of Health Care Finance) – *Board Chair;* Donna Ramos-Johnson (DC Primary Care Association) - *Board Vice Chair*; Angela Diop, ND (Unity Health Care, Inc.); Eliot Sorel, MD (Medical Society of the District of Columbia); Pete Stoessel (AmeriHealth); Claudia Schlosberg (DC Department of Health Care Finance); Kelly Cronin (The Office of National Coordinator); Mary Jones-Bryant, RN (District of Columbia Nurses Association); Justin J. Palmer, MPA (DC Hospital Association); James Turner (Health IT Now Coalition)

**Members present via teleconference (4):** LaQuandra Nesbitt, MD (DC Department of Health); Victor Freeman, MD (JA Thomas & Associates); Zach (Aaron) Hettinger (National Center for Human Factors in Healthcare/MedStar); Alison Rein (AcademyHealth)

**Members absent (6):** Brady Birdsong (DC Department of Behavioral Health); Edwin Chapman, MD (Private Practice and Leadership Council for Healthy Communities); Dena Hasan (DC Department of Human Services); Brian Jacobs, MD (Children's National Medical Center); Barney Krucoff (DC Office of the Chief Technology Officer); Jay Melder (Office of Deputy Mayor for Health and Human Services)

**DHCF/HCRIA/HIE Staff present (5):** Michael Fraser; Nina Jolani; Eduarda Koch; Deniz Soyer; Noah Smith

**Guests (6):** Lucinda Wade (U.S. Department of State), Allison Viola (Kaiser Permanente), Laura Worby (NPADC), Ryan Bramble (CRISP DC), Elise Anthony (HHS/ONC), LaVerne Perlie (HHS/ONC)</td></tr>
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| AGENDA | |
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| **Call to Order, Roll Call & Announcement of Quorum, Charter and Attendance, New Staff Introductions**<br>[3:00 - 3:08 PM] | Board Chair, Dr. Holve, called the meeting to order at 3:03 PM.<br><br>Dr. Holve announced quorum at 3:06 PM.<br><br>Attendees were notified the meeting was being recorded. |
| **Approval of September 21, 2017 HIE Policy Board Meeting Minutes**<br>[3:08-3:10 PM] | **Board Action:** Motion was made by Dr. Holve to approve the minutes for the September 2017 HIE Policy Board meeting. The motion was seconded by Mr. Turner. The motion was passed unanimously. |
| **DHCF HIT/HIE Staff Reports**<br>[3:15 - 3:50 PM]<br>▪ Telehealth grants<br>▪ Technical Assistance and Outreach | Dr. Holve announced the addition of new staff on the DHCF HIT/HIE team. Dr. Holve recognized Mr. Smith, the State Health IT Coordinator, to introduce the new staff members. Mr. Smith introduced Ms. Jolani who was brought on the team in December to support activities related to the HIE Policy Board. Mr. Smith shared that members of the Board will be contacted by Ms. Jolani to offer their ideas on how to improve their overall experience serving on the Board. |

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| ▪ Medicaid EHR Incentive Program (MEIP)<br>▪ State Medicaid Health IT Plan Update<br>▪ Update on HIE Designation Rulemaking Timeline | | Mr. Smith introduced Mr. Fraser, a new staff member on the team, to present on the telehealth infrastructure grants. Mr. Fraser shared that in his role he is to manage the majority of the health information exchange grants in addition to telehealth infrastructure grants. Mr. Fraser shared that the DC Council authorized several telehealth infrastructure grants for FY18. A request for proposal was set out to award innovative telehealth solutions to connect residents in wards 7 and 8. There will be four (4) grants awarded in the amount of $50,000 each for a total of $200,000. An additional grant, the Shelters and Public Housing Project, provides two (2) grants in the amount of $75,000 each for a total of $150,000. Mr. Fraser explained that these grants will go toward supporting innovative solutions to connect District residents in homeless shelters or public housing projects to telehealth services. The grants are to be awarded in February. Dr. Holve shared that the team will provide more information once the awards are released.<br><br>Mr. Smith introduced Ms. Soyer to provide an update on the FY2018 Technical Assistance and Outreach activities. Ms. Soyer shared that in March 2017, DHCF entered into a technical assistance and outreach contract with the DC Primary Care Association (DCPCA). The first year of the contract focused on assisting providers in the first year of the Medicaid EHR Incentive Program (MEIP) to adopt, implement or upgrade an EHR. She shared that part of the work included drafting a new State Medicaid Health IT Plan (SMHP). This year's focus is to target providers in achieving meaningful use objectives. She shared that DHCF will host and engage in outreach events, webinars, in-person provider educational sessions, as well as developing health IT, HIE, and MEIP clearinghouse to support the DC Provider Community. Ms. Soyer presented that another component of this work is to support a comprehensive provider network analysis. She stated that this establishes greater understanding of District providers, including where they practice and how they use technology. The analysis will: define the universe of providers in the District using Health IT; create a mapping of Medicaid providers to organizations, and; gather information on health IT behavior status through a provider survey.<br><br>Ms. Soyer introduced Ms. Koch to provide an update on the Medicaid EHR Incentive Program. Ms. Koch shared on the growth of the incentive program. Starting in Program Year (PY) 2015 the program had 64 paid providers, in PY2016 the program successfully tripled in growth with 152 providers that were paid and in process to be paid, and in PY2017 150 plus providers are projected. All 150 plus providers will need to attest to a single set of 10 objectives and measures in PY2017 (calendar year 2018). Each provider is eligible to receive $8,500. Ms. Koch shared that since the inception of the program, in 2013, DHCF has awarded over $32 million to Eligible Providers (EPs) and Eligible Hospitals (EHs) in the District. As a result of the contract with DCPCA, DHCF continues to support providers in the District to meet meaningful use requirements and to submit attestations. Ms. Koch noted that there are a few measures that are particularly important and a few that are new that providers need to attest to. The first one is objective 5, health information exchange by providers. An additional step in PY2017, is not only does an EP have to create a summary of care, but more than 10 percent of transition of care and referrals must be electronically sent to a receiving provider. Another measure that increased from 2015 is patient electronic access. Currently, measure 2 requires more than 5 percent of unique patients in the population to have electronic access to download or transmit their health information during the EHR reporting period. The next measure she shared is secure electronic messaging, which went from requiring one (1) patient to now more than 5 percent of the patient population seen by the EP that need to |

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| | | engage in response to a message or send a message to their health care provider. The last measure, that has been a standing measure between 2015 to 2017 program years, is public health reporting. Two of the three following measures must be met: immunization registry reporting, syndromic surveillance reporting, and specialized registry reporting. If a provider cannot meet a measure due to their state not having a functioning registry that the provider can attest to, then they can exclude from the measure, or if the provider (i.e. dentist) does not satisfy the requirements for registry reporting, an exclusion can be made.<br><br>Ms. Soyer provided an update on the State Medicaid Health IT Plan.<br>Ms. Soyer shared that DHCF has been working with Clinovations for the past year to revamp the SMHP. Per CMS guidelines, states are to capture health IT and HIE infrastructure implementation and expansion, and it is to be a living document that will be updated every two years. In the past eight (8) months, DHCF has: conducted an environmental scan, engaged with stakeholders, and reviewed reports published by other agencies. The SMHP work consisted of 25 interviews with stakeholders, six (6) focus groups, including two (2) with patient populations to define the needs in the District. There was also an analysis of connectivity to HIE. Ms. Soyer shared that these findings will be integrated into the SMHP to create a roadmap for health IT/HIE activities for the District. The SMHP is divided into five sections: the District's health care system and challenges; the current state of health IT and HIE in the District; an assessment of stakeholder needs; the health IT and HIE roadmap (2018-2023); and a monitoring and evaluation framework. The plan integrates four (4) guiding principles to support delivery system transformation, those being to: expand access, improve quality, promote health equity, and enhance value and efficiency. Ms. Soyer shared the timeline for the publication of the SMHP, which includes: an internal review period, a public comment period in April and May 2018, and a final publication and submission to CMS in May 2018.<br><br>Ms. Soyer continued with an update on the HIE designation Rulemaking timeline. She shared that the purpose of the designation process is to create the technical structure for the DC HIE and to sustain health information exchange in the District. In early 2017, the board convened a Designation subcommittee of DC stakeholders and technical experts to provide recommendations on technical privacy and security requirements. The effort supported the development of a Rule that is specific to the needs of the District. Ms. Soyer thanked the Designation subcommittee for all their guidance in helping develop the Rule. Ms. Soyer shared that the Rule allows DHCF to establish and maintain a standard for HIE entity operations in the District. She continued with the opportunities for registered and designated HIE entities and requirements for both. Ms. Soyer shared a visual of the DC HIE that depicts it as a market-based system of registered and designated HIEs sharing information between participating providers and entities. Ms. Soyer concluded the update by letting the Board know that they will be notified once the Rule is posted during the 30-day comment period. |
| **Presentation of the ONC Trusted Exchange Framework and Common Agreement**<br>[3:50 – 4:20 PM] | | Dr. Holve introduced Ms. Elise Anthony, the Director of Policy at the Office of the National Coordinator (ONC) for Health IT, to present on the ONC Trusted Exchange Framework and Common Agreement (TEFCA).<br><br>Ms. Anthony shared that TEFCA is one of the provisions under the 21st Century Cures Act. There are two key sections in TEFCA Part A and B. Part A outlines a set of six (6) principles for trusted exchange and provides guardrails to engender trust between the Health Information Networks. These principles include: 1) standardization; 2) transparency; 3) cooperation and non-discrimination; 4) |

security and patient safety; 5) access; and 6) data-driven accountability. Part B is focused on the terms and conditions of the Framework. It is a minimum set of terms and conditions for ensuring common practices are in place and required of all participants who participate in TEFCA. Ms. Anthony shared factors that contributed to Congress requiring TEFCA. The first factor being to create one “on ramp” no matter where an entity is in the landscape of networks. Secondly, cost was another need to address through TEFCA; healthcare organizations are currently burdened with the creation of many, costly, point-to-point interfaces between organizations.

Ms. Anthony followed with an overview of the goals of TEFCA:

- Goal 1: Build on and extend existing work done by the industry
- Goal 2: Provide a single “on-ramp” to interoperability for all
- Goal 3: Be scalable to support the entire nation
- Goal 4: Build a competitive market allowing all to compete on data services
- Goal 5: Achieve long-term sustainability

Ms. Anthony shared that many stakeholders can use TEFCA, including: federal agencies, individuals, providers, public health, payers, and technology developers (noting not only EHR vendors, but more broadly like registries and analytical companies, etc.).

TEFCA aims to create a technical and governance infrastructure that connects health information networks (HINs) together through a core of qualified health information networks (QHINs). The HIN is the foundation of the principles that were identified and the QHIN are a special group of entities that will be able to move information across the network. TEFCA will allow HINs and their participants access to more data on the patients they currently serve and as a result this will enhance care coordination and care delivery use cases. In addition, TEFCA ensures that there is no limitation to the aggregation of data that is exchanged among participants. For health systems and ambulatory providers, TEFCA will: enable them to join one network and have access to data on the patients they serve regardless of where the patient went for care, and enable them to eliminate one off and point-to-point interfaces. For patients and their caregivers, TEFCA will enable them to find all of their health information from across the care continuum; even if they don’t remember the name of the provider they saw.

Ms. Anthony presented on what TEFCA will look like, which starts with the Recognized Coordinating Entity (RCE) that would in turn closely work with ONC. Ultimately, the (RCE) is responsible for working directly with the QHINs and will support operationalizing the eventual common agreement. The QHINs would connect directly to each other to serve as the core for nationwide interoperability; they would do this through connectivity brokers (record locator services). Each QHIN represents a variety of networks and participants that they connect with, serving a wide range of end users (participants). Health information networks as a definition must be responsible for overseeing the administrative policies or agreements related to business operational, technical, and other components for facilitating active exchange of health information and have to do so between two or more unaffiliated individuals and entities. There are classes or groups of HINs that can apply to be a qualified health information network; in addition, to meeting the foundation requirements for an HIN, they must also meet other requirements to qualify as a QHIN. Some things that would qualify a HIN as a QHIN are: they are able to respond to directed queries, and

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| | | they are able to exchange a core set of information (identified as united core dataset for interoperability). Ms. Anthony shared that there are several permitted purposes aside from treatment, which are: payment, healthcare operations, individual access, benefits determination, and public health. ONC is looking to receive comments on whether this is the right set of permitted purposes.<br><br>Ms. Anthony concluded that the current public comment period closes on February 20th.<br><br>Dr. Sorel asked, how will the data integrity be preserved so that there is no discrimination between physical and mental illness? Ms. Anthony responded that in terms of data integrity, TEFCA is respective of state laws.<br><br>Ms. Schlosberg asked, if there was any funding and how TEFCA would be supported? Ms. Anthony responded there would be some federal funding attached for those applying as a Recognized Coordinating Entity. The Office of the National Coordinator (ONC) for Health IT is open to ideas but for the time being there is no other funding attachment.<br><br>Dr. Diop asked, how TEFCA would be integrated into CareQuality, CommonWell Health Alliance, etc.? Ms. Anthony responded that if an entity qualifies for a RCE, HIN or QHIN, and meet the requirements, as described, then they can apply for either. It depends on how they view themselves.<br><br>Dr. Holve asked, how Ms. Anthony sees the current HIE designation structure fitting into TEFCA? Ms. Anthony responded that there has been a look at how different HIEs can work through their roles and what they would like to see across the landscape; determining how they fit into the landscape as a HIN, QHIN, etc. |
| **Demo New HIE Tools and Discuss Next Steps to Promote Adoption**<br><br>[4:20-4:50 PM] | | Dr. Holve introduced Mr. Ryan Bramble, Interim Executive Director of CRISP DC, to demo and present on CRISP DC and the New HIE Tools.<br><br>Mr. Bramble provided a brief background on CRISP, explaining its regional structure and its placement of Executive Directors in each region. CRISP has four (4) core services for providers, those being: 1) Encounter Notification Service (ENS); 2) Clinical Query Portal; 3) CRISP in workflow; 4) Enhanced HIE Tools for DC. CRISP DC partnered with DHCF to deploy the following specific tools:<br><br>▪ Patient Care Snapshot: provides key elements of clinical and claims data in one screen for a patient that a person may be treating and providing care management to. It is meant to be an at a glance view of the important things a provider may want to see. There is also the unified provider landing page that allows the provider to go to the various tools with single sign-on. It allows for role based granularity by region, use case, etc.<br>▪ Analytical Patient Population Dashboard: is the My Health GPS program and provides more aggregate level ability to track patients.<br>▪ Electronic Clinical Quality Measurement Tool and Dashboard: the tool is called Calipr and it allows providers to use the claims data but also clinical data to calculate how they are doing in terms of electronic clinical quality measures against their whole panel of patients, how many of them are getting the necessary screening, who hasn't gotten a screening, and allows them to understand that toolset. |

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| | | ▪ Obstetrics /Prenatal Specialized Registry: CRISP is working closely with DCPCA for specialized assessments.<br>▪ Ambulatory Connectivity and Support: is teaching people how to use the CRISP tools and helping them get connected.<br><br>Mr. Bramble provided a demo of the described tools from the CRISP unified landing page.<br><br>Mr. Bramble continued the presentation by providing an overview of CRISP's privacy laws to protect health information. CRISP follows HIPAA guidelines. Everyone is required to sign up and there is vetting of all the users. There is a requirement for a point of contact at each site that authorizes user access. There is a process of tracking unauthorized access by users not intended to use or see the data. CRISP speaks to the privacy officer of an organization to resolve the issues in a timely manner. Patients can opt-out of CRISP whenever they would like; the only thing they can't opt-out of is the Maryland Opioids.<br><br>Dr. Freeman asked if Mr. Bramble can conduct a longer demo over webinar? Dr. Holve shared that this would not be part of a formal board meeting but that Ms. Jolani would coordinate schedules for all interested in attending. |
| **2018 HIE Policy Board Planning** | | **Board Action:** Dr. Holve asked the Board for a vote to table the 2018 HIE Policy Board Planning agenda item in the interest of time. The motion was made by Dr. Diop and seconded by Ms. Bryant. The motion was passed unanimously. |
| **Next Steps**<br>[4:50 – 4:55 PM] | | Dr. Holve reminded the Board that they will hear from Ms. Jolani to discuss how to improve their experience on the Board.<br><br>Dr. Holve reminded the Board that they will be notified when the HIE Designation Rule and the SMHP will be published for public comment.<br><br>**Board Action:** Dr. Holve requested the Board to vote to hold a special HIE Policy Board session in early April 2018 to review and comment on the State Medicaid Health IT Plan. Motion was made by Mr. Palmer. The motion was seconded by Dr. Diop. The motion was passed unanimously.<br><br>Dr. Holve shared the date for the next HIE Policy Board meeting, Thursday, April 26, 2018. |
| **Public Comment**<br>[4:55 - 5:00 PM] | | There were no comments from the public during the public comment portion of the meeting. |
| **Adjournment**<br>[5:00 PM] | | **Board Action:** Motion was made by Dr. Holve to adjourn the meeting. The motion was seconded by Mr. Palmer. The motion was passed unanimously.<br><br>Dr. Holve adjourned the meeting at 5:01 PM. |

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