District of Columbia Health Information Exchange Policy Board
Meeting Minutes

July 21, 2015
3:00 p.m. – 4:00 p.m.

Members present (3): Barbara Bazron, Ph.D. (DC Department of Behavioral Health), Arturo Weldon (DC Department of Health), and Shelly Ten Napel (Department of Health Care Finance).

Members present via teleconference (6): Brian Jacobs, MD (Children's National Medical Center), Christian Barrera (Office of the Deputy Mayor for Health and Human Services), James K. Costello (DC Primary Care Association), Barry Lewis (Washington Hospital Center), Justin Palmer, MPA (DC Hospital Association), Brenda King, R.N (District of Columbia Nursing Association)

Members absent (7): Jamal Chappelle (The Chappelle Group), Douglas Garland (DMG Scientific), Raymond Tu, MD (Progressive Radiology Washington Imaging Associates), Marina Havan (Department of Human Services), Victor Freeman, MD (Nuance Communications), Bernie Galla (Connect Care Consulting), Angela Diop, NP (Unity Health Care).

DHCF Staff present (3): Michael Tietjen (HIE/HIT), Joe Weissfeld, DHCF, Alla Abudullah

Guests: Donna Ramos-Johnson, DCPCA; LaQuandra Nesbitt, DOH

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Call to Order	Shelly Ten Napel (Chair) called the meeting to order at 3:00 pm. Michael Tietjen (Project Manager) recorded the meeting.
Approval of the Minutes of the Previous Meeting	Ms. Ten Napel announced that there was not a quorum and therefore minutes from the previous meeting would be tabled. She also announced that there was a mix up in sending out the minutes for that meeting, and that a corrected version was sent out.
Old Business	Ms. Ten Napel reported that the Road Map with the majority and minority views on governance is being reviewed by Director Turnage and that he has not yet forwarded his final recommendations along to the Deputy Mayor's office. Ms. Ten Napel will report out on when it has been transmitted to the DM's office.
New Business: Conflict of Interest Policy	Ms. Ten Napel stated that the DC HIE Policy Board does not have a conflict of interest or disclosure process. She asked if there are any financial interests or conflicts that would preclude anyone from being on

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	the Policy Board or if there are conflicts that need to be disclosed by members. She asked the group to consider whether or not there should be a committee and/or process that reviews conflicts. She gave an example of someone who works for a for-profit HIE vendor. Dr. Jacobs shared that at CNMC employees sign documents regarding personal or family financial gain as a result of participation, as a model. Arturo mentioned that when initially appointed, members were required to sign financial interest and conflict of interest forms. Ms. Ten Napel clarified that those are broad forms, but they didn't have specialized criteria to the HIE Policy Board. Dr. Nesbitt said that it is up to various boards and commissions to set specific criteria for their bodies. Ms. Ten Napel said that DHCF staff would draft some initial language for the board to review at a later date.
New Business: IAPD Projects	Ms. Ten Napel introduced the subject of seeking 90/10 federal matching funds from CMS for health information exchange activities. She stated that DHCF is interested in leveraging this funding stream as a way to execute on some of the use cases and activities discussed by the board. She said that it pays for design, development, and implementation related costs, but not for long-term operations. She also said that one of the program requirements is that CMS requires how to allocate Medicaid's 'fair share' of an HIE project. She mentioned that the first IAPD will go in August and will include requests for HIT activities, as well as the FQHC-iCAMS connection project. Additional projects will be submitted in a later update to the document. CMS accepts IAPD requests on a rolling basis. Shelly then reviewed the suggested IAPD projects from the handout: iCAMS/FQHC – This is a connection of the FQHC and the iCAMS hub, as well as a connection to CRISP. There would be CCDA's to transmit information through to the HIEs. Dr. Nesbitt asked about funding for the FQHC, CCIN, CPC activities. Donna Ramos Johnson mentioned the grant funding sources (e.g., CMS and GWU Prevention at Home) were used to support these activities. C-CDA Exchange – This is likely the largest request budget-wise and for effort. Would encourage increased use of CCDA's throughout the DC health care market and to make C-CDAs more user-friendly for stakeholders. CCDA exchange is more robust data than ADT feeds. There has been limited use of C-CDA within certain HIE hubs so far. This project would begin moving them among stakeholders. A 'face-sheet' would be created to facilitate the transmission and usability between stakeholders. Mr. Weldon asked if there would be a data warehouse of de-identified C-CDA information. Ms. Ramos-Johnson said this was not likely the project for that, but the other IAPD projects might be more suitable for that objective. Dr.

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	Jacobs described how C-CDAs have worked at CNMC. He said the limitation of the current system is that information is not consumable by EHRs. Ms. Ramos-Johnson said that an objective of this project should be able to make C-CDA data consumable. Prescription Drug Monitoring – Already operational in Maryland by CRISP for controlled substances. It should not be relatively easy to implement in the District. Ms. Ten Napel added that in addition to controlled substances, it could be scaled for all prescription drugs. Dr. Nesbitt explained the current state of the PDMP rulemaking process at DOH and that once the rulemaking process is over, then DOH could move forward on technology solutions to support the PDMP. Quality Measure Reporting – There are tools that are able to extract EHR data and turned them into eCQM and other measures. Ms. Ten Napel explained that CRISP has made some progress on such a project that DC could coordinate with. Mr. Weldon added that he felt it was important to get aggregated data for health planning purposes. Dr. Jacobs added that he sees two types of quality data, one is aggregated data for population health and planning, and also risk stratified patient populations for hospitals and practices. Ms. Ten Napel suggested community wide risk stratification methodology development that could be shared across stakeholders (e.g., payors, hospitals, etc). Claims Data – Can be used to do risk stratification, utilization and medication history. Ms. Ten Napel stated that there is significant insight that can be gleaned from claims data that DHCF already has and asked how it can be best deployed. Dr. Jacobs added that aggregation of all claims data (regardless of payor) would be important to an HIE. Additional ideas include imaging notification, common patient portal and electronic referrals. These need additional research and may be included in a later IAPD. Also, there we will be additional resources requested in the IAPD for MU program including outreach. Getting providers to meet MU goals will help create infrastructure for HIE goals. Dr. Nesbitt stated she would share data from the recent Board of Medicine survey on EHR use. Mr. Weldon added that there should be a focus on MU Stage 3 requirements. Mr. Weldon and Dr. Nesbitt added that there is a need for enabling technology for providers to submit certain public health data to DOH electronically directly from their EHR. Ms. Ten Napel added that the grant application to ONC to connect ambulatory providers is still outstanding. As a next step, Ms. Ten Napel added that staff will take input from this meeting and others and present refined ideas in the near future. Mr. Weldon suggested a meeting or committee to discuss the technical architecture and other details

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	needed to support these projects.
Next Board Meeting	A meeting will be convened in September and staff will send out a notice to select a date.
Adjournment	The meeting was adjourned at 4:05 pm.

Approval of Minutes: _____ 12/10/16

Shelly Ten Napel, Chair, DC HIE Policy Board — Date