

Delaware Health Information Network
Meeting of the DHIN Board of Directors

Wednesday, April 25, 2018
2:00 p.m. - 4:00 p.m.

Christiana Data Center
One Reads Way
New Castle, DE
Conference Room 400

Meeting Minutes

CALL TO ORDER:

Board Chair Randy Gaboriault called the meeting to order at 2:03 p.m.

October 25, 2017 MEETING MINUTES:

Bill Kirk moved to accept the January 24, 2018 meeting minutes as presented. Dr. Lawless seconded the motion. Minutes were unanimously approved.

State of Delaware: Office of the Governor Tribute to Delaware Health Information Network read by Dr. Jan Lee: See attached.

Randy Gaboriault congratulated Dr. Lee on her outstanding leadership throughout the past seven years.

COMMITTEE STATUS REPORTS:

Executive Committee:

The Executive Committee met on April 16, 2018, items discussed:

- PHR Work with MEDfx
- FY19 Strategic Planning & FY19 Goals
- 21st Century Cures Act / TEFCA
- Nominations for HCCD Sub-Committee

Finance Committee:

The Finance Committee met on April 12, 2018 to discuss the March 2018 Financial Package Review.

MANAGEMENT REPORTS:

Statement of Cash Flows: Mike Sims noted that DHIN's cash balance decreased in the third quarter due to planned negative net income and noted the offsetting swings in Accounts Receivable, Prepaid Expense and Accounts Payable. Also noted, that all Accounts Receivables are expected to be received and the invoices related to the Accounts Payable items had already been paid this month. DHIN's cash balance currently in the bank stands at \$5.7M.

ACTION ITEM:
January 24, 2018 meeting minutes were unanimously approved.

Profit & Loss: DHIN posted a net income of \$459K which was better than planned, largely due to the timing of the planned system conversion expenses and some identified expense opportunities. Overall revenue is on target, but DHIN has lost \$105K in revenue due to a delay in signing a contract with AmeriHealth Caritas for use of DHIN's services. However, this loss is offset by an unplanned favorable variance in billing to one of DHIN's data senders for Results Delivery due to higher than budgeted volumes.

On the expense side, DHIN was favorable in the Personnel and Administration lines, due to staff vacancy which resulted in absolute savings along with some delays in completing ITIL training by DHIN staff due to time needed for working on the system conversion. Also, DHIN received an unplanned credit for a Harvard Research study for the effectiveness of HIE's, which was started years ago. For the Ongoing License and Maintenance account, DHIN has seen savings due to lower than planned provider scorecard usage billings from our vendor. The Provider Scorecard in its current form is expected to be turned off at the end of this June. Lastly, the Technology Refresh line is favorable due to a delay in the project. Mike concluded this section noting that the financial strategy of accumulating reserves in order to pay for the new technology system is going as planned.

Balance Sheet: DHIN's balance sheet position remains strong, with \$5.7M in the bank that was discussed previously as well as an additional \$623K in Accounts Receivable (with \$200K received since March 31, 2018) for various Payer and Data Sender payments, all of which are expected to be collected. In all, DHIN's unrestricted Net Assets stands at \$6.3M equating to 295 days of operating expenses.

STATUS OF FY18 GOALS:

FINANCIALS:

Total annualized technology costs will be reduced by at least 5% beginning in FY19 through contracting activities occurring in FY18. In addition, securing new revenue-generating contracts(s) with an annualized value of at least \$175K:

As a result of our contract with MEDfx, we are anticipating an approximate reduction of \$1.7M in contracts related to the technical refresh. The net final will not be known until all components of the refresh contracting are completed. New contracts with an annualized value greater than \$82.3K which improves DHIN's financial position by \$98.3K.

However, we still have the loss of \$1M each year from Highmark's contribution. In addition, the lack of SIM support for the PHR totaling \$540K per year and the withdrawal of legal support in the amount of \$144K per year.

CUSTOMER:

Develop a business pro forma to inform a Board of Directors go/no-go decision regarding implementation of the HCCD:

DHIN's Board of Directors approved the formation of the HCCD Working Group Committee to work with Freedman Healthcare and DHIN management for both the Data Collection and the Data Access Regulations. Members selected for the HCCD Committee are: Meredith Stewart-Tweedie; Dr. Stephen Lawless; Brenda Lakeman and Jan Lee.

In addition, Dr. Lee presented additional nominations for the remainder of the HCCD Committee to include: Dean Kathy Matt, DHIN Board Member representing the research community; Dr. Jonathan Kaufman, DHIN Board Member, Bayhealth, CMIO; Karen Kane, Highmark Privacy Officer, Liz Staber, Aetna, Senior Manager of Business Compliance; Bernadette Inskeep, APCD Program Director, United Healthcare; Dr. James Spellman, representing the Cancer Consortium.

Randy Gaboriault motioned for the approval of all HCCD Committee nominations. Brenda Lakeman seconded the motion. The above named HCCD Committee members were unanimously approved.

HCCD Progress to Date:

Go/No Go Implementation of HCCD:

- Data Collection and Data Access Rules: Published in October 2017 and March 2018 respectively
- HCCD Committee: Established in DHIN by-laws and a minimum membership selected
- Sub-Regulatory Guidance has been drafted and on DHIN’s web-site at www.dhin.org
- Medicare data from 2013 through 2016 has been received and in secure storage
- DSUAs have been executed with payers
- Proof of Concept using SEBC data to test suitability of NXT platform to house the HCCD – in progress and going very well
- Data Collection is scheduled to begin May 1, 2018

ACTION ITEM:
All nominations for the HCCD Committee members were unanimously approved.

Annualized Cost by Component	LOW END	HIGH END
Additional Couchbase licenses (nodes)	\$ 11,220	\$16,800
Hosting	\$144,000	\$300,000
Support	\$192,000	\$384,000
ETL tools	\$0	\$48,000
Anonymization tools	\$0	\$100,000
Grouper/Risk Adjustment	\$0	\$65,000
Statistical/analytics package	\$1,000	\$200,000
Additional Staff (fully loaded)	\$0	\$340,000
TOTAL:	\$218,620	\$1,450,800

The final numbers are expected to fall somewhere north of midway between lowest and highest estimates.

HCCD Moment of Truth: Will the State Commit Financial Support?

Though we only have estimates on pricing; DHIN is requesting 5 years of funding through the Capital Bond Bill at \$1M per year. We are currently working with Secretary Walker and Lt. Governor Hall-Long. DHIN does not have the financial reserves to do this without State

backing; and the SIM Grant does not have enough money left to cover implementation even for the first few months of operations. We are unlikely to know the outcome before June 30, 2018.

PROCESS:

Execute Year 2 of the Strategic Plan:

Implement ITIL/ITSM Framework tools and processes specific to the Strategy, Design, and Continuous Service Improvement stages of the ITSM life cycle: CSI processes have been implemented; Strategy and Design processes are nearing completion.

Perform competitive market analysis: Competitive market analysis is under way; expect completion by 6/30/2018

Normalize the clinical data per HL7 and CMS terminology standards: Clinical data normalization expected to be complete in May

Executing the Technology Refresh:

Mirth Results Implementation: Mirth results work is required with 30 different EHRs representing 2,068 result feeds; 256 practices and 1,447 providers. Currently, 25% are in production; 33% are production ready; and additional work has begun on 18%. Should we not be fully engaged by the end of June, we will work with Medicity for a short term extension.

Technology Refresh: Community Health Record

DHIN met with MEDfx executives on March 29th and we were told that they were six weeks behind schedule and they could not be ready for a go-live until July 15th. A go-live date of July 15th would force us to execute a minimum of a one-month extension with Medicity, and dropping us below the level of capital reserves the Board of Directors has asked us to maintain.

We discussed breaking the project up into phases; however, on April 2nd MEDfx reported that they would only be able to shave off one week of development and the earliest go-live would be July 9th. DHIN's technical staff expressed skepticism if MEDfx could even meet the July 9th deadline; and felt that we cannot wait until they fail to take action.

Decision:

DHIN decided to implement the "CHR Lite" leveraging Mirth Results. Our go-live is planned for mid to late June. The CHR-Lite will be possible because it will be totally under DHN's control; and we already have approximately 70% of the solution in place because of our EMR integrations project.

The CHR Lite will have all methods of results delivery, the ability to search for a patient, and two years of clinical data. Full replacement of all current functionality will require implementing MEDfx.

Going Forward with MEDfx: DHIN will need to re-plan the project. Consideration of the data senders resources means we cannot have a major testing event again before November 2018. A new plan will incorporate all of Phase 1 and most of Phase 2 work to be tested in November and released in December 2018. DHIN is currently negotiating terms and conditions with MEDfx, to include prerogative to terminate without notice if we become convinced they cannot hit our dates. We are carefully investigating our grounds for invoking financial penalties for missing our required go-live date.

LEARNING:

Each staff member will take at least one ITIL/ITSM course at the intermediate level and at least 90% will achieve an intermediate level certification:

Twenty-five staff members are currently trained and certified in one ITIL/ITSM course at the intermediate level.

Legislative Update:

21st Century Cures Act and TEFCA

The **21st Century Cures Act**, signed December 13, 2016 by President Obama, promotes and funds the acceleration of research into preventing and curing serious illnesses; accelerates drug and medical device development; attempts to address the opioid abuse crisis; and tries to improve mental health service delivery.

The specific portions that will impact HITs/HIEs:

4006: Empowering patients and improving patient access to their data:

The Secretary shall...Use existing authorities to encourage partnerships between HIEs/HINs and providers, health plans, and other entities with the goal of offering to patient's access to their EHI in a single, longitudinal format that is easy to understand, secure and may be updated automatically.

Summary: Congress is very serious about empowering consumers to access their health data and share it with whomever they would like. Congress wants it to be easy for patients to do so in a single longitudinal format, easy to access and updated automatically; in addition to having patients be able to electronically share patient-generated information with their providers. Congress sees HIEs as a logical (but not exclusive) way to facilitate this goal.

4004: Information Blocking: The Secretary, through rulemaking, shall identify reasonable and necessary exceptions. There will be no enforcement before the exceptions are identified and providers may not be penalized for the failures of their vendors.

Summary: Congress is serious about eliminating information blocking. Civil penalties of up to \$1M per violation will be charged for validated cases of information blocking. Information blocking may apply to HIT developers/vendors, healthcare providers and HIEs/HINs.

Information Blocking may include all of the following:

- Refusal to share information that it is legal to share
- Deliberately making it hard to share information
- Not exporting complete data sets

4003: Interoperability: The statute defines Interoperability as an HIT that enables secure exchange with and use of information from other HITs: Without special effort on the part of the user; allows for complete access, exchange, and use for legal purposes and does not constitute information blocking.

The National Coordinator shall develop or support a trusted exchange framework, including a common agreement among health information networks nationally.

The Common Agreement may include:

- Common method for authenticating network participants
- Common set of rules for trusted exchange
- Organizational and operational policies to enable health information exchange among networks
- A process for filing and adjudicating noncompliance with terms of the Common Agreement

Participation in the TEFCA by HINs is voluntary; however, ONC is required to publish an annual directory of which HINs are participating and Federal agencies may require adoption of TEFCA by their exchange partners.

HINs are not required to adopt TEFCA for exchange of information within their own network, only for exchange across and between networks.

Financial Aspects:

QHINs **may** (not required) charge reasonable and non-discriminatory attributable costs to other QHINs. Reasonable Allowable Costs:

- Costs directly incurred or a reasonable allocation of indirect costs for attributable services
- Objective and verifiable
- Not variable depending on which QHIN is being charged

Attributable Services include:

- Developing or modifying APIs to enable exchange of data in the USCDI
- Developing or revising the Connectivity Broker required in TEFCA
- Employing legal services necessary to review the TEFCA and amend participation and BAAs to meet requirements of TEFCA

The draft TEFCA was open for public comment through February 20, 2018. ONC is currently processing all the comments they have received; the final framework has not yet been published. ONC is expecting to issue an RFP to select a Recognized Coordinating Entity (RCE); which is responsible for governance and operationalizing TEFCA.

Implications for DHIN:

- We need to position ourselves as the HIN of choice for Delaware data senders
- We will need new participation agreements that mirror the Common Agreement
- Should we seek to become a QHIN or join one?
- We must re-invent ourselves

For more information on TEFCA:

<https://www.healthit.gov/sites/default/files/draft-trusted-exchange-framework.pdf>

PUBLIC COMMENT:

No one from the public offered comments.

NEXT BOARD MEETING:

The next DHIN Board of Directors Meeting will be held on July 25, 2018 from 2:00 p.m. to 4:00 p.m. at the DHIN Office.

ADJOURN:

The meeting adjourned at 3:58 p.m.

Attendance:

Board Members Present

Randy Gaboriault
Jeffrey Hawtof
Rich Heffron
Jonathan Kauffman
Ann Kempfski
Bill Kirk
Brenda Lakeman
Dr. Stephen Lawless
Kathleen Matt
Troy McDaniel
Remy Richman

Board Members Absent

Sheila Grant
Randeep Kahlon
Nathan Merriman

Phone

James Collins
Donna Goodman
Stephen Saville
Meredith Stewart-Tweedie

DHIN Staff Present

Dr. Jan Lee
Ali Charowsky
Jeff Reger
Stacey Schiller
Mike Sims
Randy Wise

Guests Present

John Dodd
Scott Perkins
Tom Trezise



SPONSOR: Sen. Bushweller & Rep. Bentz & Rep. Heffernan

DELAWARE STATE SENATE
149th GENERAL ASSEMBLY

SENATE JOINT RESOLUTION

RECOGNIZING THE DELAWARE HEALTH INFORMATION NETWORK AS AN EXEMPLARY MODEL FOR PUBLIC-PRIVATE PARTNERSHIPS AND AS A GROWING HEALTH INFORMATION TECHNOLOGY ORGANIZATION BASED IN KENT COUNTY.

1 WHEREAS, the State of Delaware is committed to improving the health of Delawareans and improving access to
2 quality, timely healthcare data; and

3 WHEREAS, healthcare spending in Delaware is higher than the national average and the State is pursuing efforts
4 to control costs; and

5 WHEREAS, the Delaware Health Information Network (DHIN) grew out of a private-public partnership begun in
6 1997, with the State partially financially supporting the effort to develop a statewide health information exchange (HIE);
7 and

8 WHEREAS, the DHIN's enabling statute was amended in 2011 designating DHIN as a non-profit, state-related
9 organization, not a State agency; and

10 WHEREAS, the DHIN was the first statewide HIE in the nation and among the first to have 100% participation
11 among acute care hospitals in its home state; and

12 WHEREAS, the DHIN achieved full financial self-sustainability in 2012 and operates completely independent of
13 any direct government financial support; and

14 WHEREAS, the DHIN has grown its regional footprint to all or parts of 6 states and the District of Columbia,
15 helping Delawareans who receive care throughout the Mid-Atlantic region experience better transitions of care; and

16 WHEREAS, the DHIN's Community Health Record now includes over 2.5 million total unique patient records
17 from all 50 states and is a valued resource among Delaware's medical providers and public health officials; and

18 WHEREAS, the DHIN has established a national reputation as a model organization for public HIEs; and

19 WHEREAS, the DHIN has honored its statutory mission of launching services for consumers to help better engage
20 Delawareans with their healthcare; and

21 WHEREAS, the DHIN is playing an active role in the State's efforts to reduce the total cost of health care for all
22 Delawareans.

23 NOW, THEREFORE: