

**Delaware Health Information Network
Executive Committee Meeting
Monday, April 16, 2018
1:00 p.m. – 2:30 p.m.**

In-Person

**Christiana Data Center
One Reads Way, New Castle, DE
Conference Room 205**

Meeting Minutes

I. CALL TO ORDER

Randy Gaboriault called the meeting to order at 1:08 p.m.

II. APPROVAL of December 8, 2017 MINUTES

Bill Kirk motioned for the minutes to be accepted as presented. Rich Heffron seconded the motion. Minutes were approved unanimously.

III. Management Reports

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

Currently twenty-four staff members have taken an ITIL/ITSM intermediate level course and all have been certified.

Technical Refresh / Community Health Record:

DHIN met with MEDfx executives on March 29, 2018; they informed us that they were six weeks behind and would not be ready for a go-live until July 15, 2018. The delay would force DHIN into a minimum of a one-month extension with Medicity; and would drop us below the level of capital reserves the board has asked us to maintain.

We discussed breaking up Phase 1 into two sections: 1A and 1B

- 1A: We would try to go-live not later than June 30, 2018, which is four weeks later than planned and it would be with partial functionality of the CHR
- 1B: We would go-live in September 2018, with all of Phase 1 and full functionality of the CHR

On April 2nd, MEDfx reported that they were only able to shave off one week of development with this approach; the earliest to go-live would be July 9, 2018. DHINs technical staff has expressed skepticism that MEDfx could even meet the July 9th deadline; we cannot wait until MEDfx fails to take action.

DHIN has decided to implement “CHR-Lite” leveraging Mirth results. Our go-live is planned for mid to late June. The CHR-Lite will be possible due to the fact that it will be

under DHINs control; in addition to already having 70% of the solution in place due to the 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.

DHINs cost will be the hire of more contractors and professional services from Audacious Inquiry (Ai) to strengthen our Mirth environment.

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.

Mirth Results Implementation: Twenty-five percent of Mirth Results are currently in production; 33% are ready to go into production; and work has been done on an additional 18%.

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

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

DHIN is requesting five years of funding through the Capital Bond Bill at \$1M per year. We are working with Secretary Walker and Lt. Governor Bethany Hall-Long. It is unlikely that we will know the outcome before the end of June 2018, possibly later. DHIN currently has pricing **estimates** only. The state of Colorado reports a five-year period to break even. In addition, the SIM Grant does not have enough money left to cover the implementation of the first few months of operations; and DHIN does not have the financial reserves to do this without State backing.

Financial:

Total annualized FY17 technology costs will be reduced by at least 5% beginning in FY19 through contracting activities occurring in FY18

DHIN anticipates a net savings in technology costs of \$1.7M; however, the net final will not be known until all components of technical refresh contracting have been completed.

The current negative aspects would be our loss of \$1M Highmark contribution; lack of SIM support for the PHR; withdrawal of legal support by the Attorney General's Office; and the refusal of AmeriHealth to execute a standard payer agreement.

HCCD Committee

The DHIN Board of Directors have selected Meredith Stewart-Tweedie, Dr. Stephen Lawless, Brenda Lakeman, Jan Lee and Dr. Jonathan Kaufman.

In addition, Kathleen Matt has agreed to serve on the Committee representing the research community, but will need Board ratification.

Dr. James Spellman will be representing the Cancer Consortium. Three payer nominations include; Karen Kane, Highmark; Bernadette M. Inskeep, United Health Care; E. Elizabeth Staber, AETNA.

Bill Kirk motioned for the approval of DHIN's HCCD nominations to be presented to DHIN's Board of Directors. Dr. Lawless seconded the motion. Representation for the HCCD Committee was unanimously approved to include: Meredith Stewart-Tweedie, Dr. Stephen Lawless, Brenda Lakeman, Jan Lee, Dr. Jonathan Kaufman, Kathleen Matt, Dr. James Spellman, Karen Kane, Bernadette Inskeep and E. Elizabeth Staber.

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>

FY19 Proposed Goals

Financial:

Introduce pricing structure that incentivizes sending us data

Customer:

Complete all phases of the tech refresh (CHR, Mirth Results)

Process:

Implement the Health Care Claims Database (assuming a financial commitment by the state).

Learning:

At least 30th of DHIN employees will become ITIL certified at intermediate level in at least one additional course and will produce process maps, RACI charts, CSFs and KPIs for at least 70% of defined ITIL processes

Other Business:

None

NEXT EXECUTIVE COMMITTEE MEETING:

The next Executive Committee Meeting will be held on May 18, 2018 @ 10:00 a.m. Christiana Data Center.

IV. Adjourn

The meeting adjourned at 2:36 a.m.

Attendance:

Executive Committee Members Present:

James Collins
Randy Gaboriault
Donna Goodman
Rich Heffron
Bill Kirk
Dr. Stephen Lawless
Meredith Stewart-Tweedie

DHIN

Jan Lee
Ali Charowsky
Scott Perkins
Tom Trezise