North Carolina Health Information Exchange Authority

Advisory Board Meeting

MEETING MINUTES

Date: June 18, 2024

Time: 2:00 PM – 4:45 PM

Location: SAS Institute (100 SAS Campus Drive, Cary, NC 27513) – Executive Business Center 7

Attendees:

Chairman Richard Pro
Vice – Chairman Brent Lamm
Board Member Christie Burris
Board Member Ryan Craig
Board Member Cheri Givens (designee)
Board Member Tammy Kiger
Board Member John Meier
Board Member Greg Moore (designee)
Board Member Tanya Thompson
Board Member Ryan Wilkins
Board Member ClarLynda Williams-DeVane
Speaker Dylan Frick
Speaker Katie Horneffer
Speaker Sasi Nagarajan
Speaker Jenell Stewart
Speaker Tim Taylor
Speaker Anita Valiani
Executive Director Sam Thompson
NCDIT Deputy General Counsel, NC HIEA Regina Cucurullo

2:00 PM - Welcome and Call to Order **Chairman Pro**

Chairman Pro called the meeting to order and reviewed the draft meeting minutes from the March 28, 2024, board meeting. Vice Chairman Lamm motioned to approve the minutes. Board Member Craig seconded the motion, which passed unanimously.

2:15 PM - NC HIEA Operations Updates **Sam Thompson**

- **Metrics**
    - Service Enrollment as of April 30, 2024
    - Onboarding by Provider Type, April 2024 and YTD
    - Metrics Handout
- **Budget and Contract Update**

  In April and May, the NC HIEA amended MOUs to receive additional funding for services performed for NC Medicaid and NC DPH.
- **Staffing Update**

2:25 PM - Legislative Update **Dylan Frick**

Approved 2023 appropriations and Medical Freedom Acts, the NCDIT Agency Bill, and Jt Caucus for IDD/Omnibus

2:30 PM - Updated Research Policy **Jenell Stewart**

- Permitted research purposes set out in N.C. Gen. Stat 90-414(1) and N.C. Gen. Stat. 90-414.2
- Limited Scope – patient/provider organization relationship

Burris: The HIEA has proceeded with caution in relation to research as permitted in the HIE Act in order to establish governance, framework, and staffing capacity to respond to research requests.

Pro: There is research that requires identifiable data and some cases that require deidentified data. There are multiple factors involved in setting the research approach and strategy.

Thompson: After we implement a limited scope use case, we expect to take on more ambitious use cases.

Craig: Is the limited research use case in question related to patients opting in?

Stewart: Yes, the current scope involves patients opting in. The current use case is related to maternal health intervention in rural areas and determining the impact of the interventions.

Mier: What types of research projects are in the queue?

Stewart: See the above maternal health description.

Mier: Do any of these research projects complement research via NIH or CMS?

Stewart: AC4M is supported by PCORI.

2:35 PM - Update on Medicaid Workstreams **Katie Horneffer/Jenell Stewart**

- **HIE/Medicaid Partnership**
  - Network Adequacy Dashboard to support move to managed care
  - NC COVID Medicaid Dashboard
  - Using NC HealthConnex demographic data to enhanced Medicaid survey response rates
  - HIEA shares priority data elements with NC Medicaid's prepaid health plans to support quality measurement and population health analytics.

Thompson: Medicaid has a large amount of useful data, but they do not have clinical data which are essential to understanding health outcomes. The Priority

Data Elements complement claims data available in-house at Medicaid.

Lamm: When we discuss Medicaid, are we referring to the state agency or the health plans.

Stewart: We are talking about the state Medicaid agency.

Lamm: Can HIEA or DHHS purchase SDOH data from third parties?

Stewart: We have evaluated third-party options and explored options within the state. HIEA is not yet able to make a third-party purchase.

Burris: The DIT Data Division also has a service called NC-eLink which the HIEA is customer of and enables usage of data from other state agencies.

Lamm: Are there clear usage terms for this data?

Stewart: Yes, any data exchanged has a data governance component in collaboration with DHHS.

Burris: We have layers of governance in place. The Priority Data Elements are supplemental to the Medicaid that data has in-house.

Thompson: Some of the data is used for care management or risk stratification.

Stewart: Payers are currently going to each health system to collect data, and it is creating an administrative burden, so this effort seeks to reduce that burden.

- **SDOH-LOINC Data Exchange Pilot**. The goal is the support the exchange of SDOH screening data via NC HealthConnex by developing standards across participating hospitals.

- **NCQA's Data Aggregator Validation (DAV) Program.** Evaluates clinical data streams to help ensure the health plans, providers, government organizations and others can trust the accuracy of aggregated clinical data for use in Healthcare Effectiveness Data and Information Set (HEDIS) reporting and other quality programs.

  Burris: DAV is a very heavy lift by HIEA and SAS in collaboration with UNC and Duke.

  Thompson: Pre-paid health plans cannot use data from HIEA for HEDIS measurement without the DAV certification.

- **APD Project Goals**
  - Improve near-real time exchange of key data elements between providers and health plans
  - Improve accuracy, completeness, and timeliness of quality measurement and population health data available to the Division of Health Benefits (DHB)
  - Reduce administrative burden associated with duplicative reporting and disparate data systems

- **Use Cases Overview**
  - Digital Quality Measures (dQMs)
  - Health Related Resource Needs (HRRN)
  - Care Management Data Exchange

3:15 – 3:30 - Break

3:30 PM - Upgrade Update and Clinical Viewer Demo **Anita Valiani/Sasi Nagarajan**

HealthShare Upgrade 2023.1

- Platform/OS Upgrade
- Provider Clinical Portal Upgrade
- Testing & Remediation
- Go live – Mid August 2024

Thomspon: Since we have several staff out sick today, we will provide a slide-based demo, but if any board members are interested in a more detailed live demo, let us know. [*demo to be provided at 10/24/24 board meeting*]

Thompson: With this update, we expect to display claims/encounter data (not cost data). We also expect to expand access to data elements based on feedback from provider in the future. Fee-for-service claims are on the roadmap as well.

Craig: Are medication reconciliations included?

Stewart: No, but we are receiving pharmacy data from retail pharmacies which may be used for reconciliation in the future.

Lamm: For participants who have been put on hold, have they expressed any concerns or pushback?

Eaker: No, I am not aware of major push back from participants who will not go live until after the upgrade.

Lamm: Are you seeking a security certification as part of this update?

Burris: The state has undergone a risk assessment based on NIST SP 800-53 and is pursuing HITRUST certification in the long term.

NC HealthConnex Upgrade

- Modernize the NC HealthConnex infrastructure to current health information exchange standards
- RHEL Upgrade
- HealthShare Upgrade
- Clinical Portal Upgrade

3:45 PM - New 42 CFR Part 2 Rule **Regina Cucurullo**

Confidentiality of SUD Patient Records: 42 U.S.C. § 290dd-2 Part 2 Rules

- Coronavirus Aid, Relief, and Economic Security (CARES) ACT: Required US DHHS to "make such revisions to [Part 2] regulations as may be necessary for implementing and enforcing the amendments made by this section.
- Patient Consent: Amended consent requirements in 42 U.S.C. § 290dd-2, 42 CFR § 2.12 Applicability, 42 CFR § 2.33 Uses and Disclosures Permitted with Written Consent
- Public Health Disclosures Without Consent: 42 U.S.C. § 290dd-2(b)Permitted disclosure, 42 CFR § 2.54 Disclosures for public health

Cucurullo: The HIEA does not currently accept Part 2 data, but with newly approved rules, this approach is being reconsidered. The compliance date for the new rules is in 2026.

Cucurullo: The HIEA currently utilizes a patient opt-out model, but under new rules, the HIEA will need to track patient consent and disclosure related to Part 2 Data.

Thompson: A consent provided at the point of care enables the support of sharing the data on an ongoing basis. The first step is to allow Part 2 providers to include Part 2 patients on their Notify patient panels and bidirectional exchange. Ingesting, storing, and exchanging Part 2 are a larger effort with a longer timeline to implement consent and data tagging as Part 2.

3:55 PM - Participation and Data Connections **Tim Taylor**

- Participant Engagement Overview: High touch approach, Accessibility, and Direct Access
- Education and Training: Many opportunities for 1 on 1 training,
- Virtual Training Modules, and groups lunch and learn sessions
- Proactive and Reactive Outreach: build and maintain relationships, provide stellar support and timely responses
- Specialty Outreach: Mass mailings of letters and brochures
- Data Collection: Feedback Is a Gift, participant surveys, outreach, coaches, and leadership calls

Burris: Unengaged providers were identified due to a legislative reporting requirement in 2021. We continue to identify unengaged providers as we are able.

Craig: Are you measuring the success rate of outreach efforts?

Taylor: Yes, one measurable outcome is keeping contact information up to date. Another is training registrations.

Burris: We have data on the number of participant agreements executed as a result of outreach efforts.

Webster: Office hours were implemented as result of survey feedback.

Burris: 2018 and 2019 had a large number of participation agreements signed. Since 2019, the numbers dropped, but due to outreach efforts, the numbers have increased since 2021.

Craig: These numbers represent organizations.

Burris: Yes.

Lamm: Is there more of a story to tell based on this graph?

Thompson: We would need to dig further. We do not have a denominator. We will take a closer look at the data and provide additional information. The bulk of the work occurs during the technical onboarding phase.

Burris: Onboarding can take anywhere from 6 weeks to 6 months to 1 year, depending on the EHR. We also have EHR migrations that occur, and we work to maintain and reestablish connections.

Thompson: We are working to improve the onboarding process at multiple levels (contractual, staffing, technical, etc.).

T. Thompson: Are the EHR migrations managed in a separate queue?

Burris: Yes, we maintain a separate queue.

Eaker: We prioritize maintenance and migrations to keep participants connected.

4:15 PM - Health Data Utility Update **Sam Thompson**

- What is a Health Data Utility (HDU)?
- Characteristics of an HDU
- What Differentiates a HDU from a HIE?
- Phases of Adoption
- Planning Workgroup

Thompson: The concept of an HDU helps us provide service beyond provider-to-provider use cases. An HDU would be a more sophisticated tool at many levels and ability to leverage existing policies.

Lamm: Is there a set of requirements that must be met to be designated as an HDU?

Burris: HDU is a framework and the HIE has been acting as such since the HIE Act based on our partnership with state agencies. We expect that there will be federal recognition of HDUs and policies for other state agencies that will require usage of the state HDU.

Thompson: We have opportunities to grow into a more robust HDU, we just need to define a plan with stakeholders.

Craig: Is there an example of an HDU we could model?

Burris: Yes, Maryland's HDU, CRISP. We could invite them to share at a future board meeting. TEFCA will support provide-to-provider exchange, but HDU will go beyond that specific use case.

Craig: Are there other drivers for HDU designation?

Thompson: It would open us up for additional funding.

4:30 PM - New Business **Chairman Pro**

Thompson: We are developing a 2030 roadmap which will include HDU but is not limited to HDU.

Burris: We expect to share a draft with the board this year.

4:47 PM - Adjourn **Chairman Pro**

Meeting adjourned by Chairman Pro; Vice Chairman Lamm seconded.

11/08/2024