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Roy Cooper
Governor

James A. Weaver
Secretary and State Chief Information Officer

North Carolina Health Information Exchange Authority
Advisory Board Meeting

MEETING MINUTES

Date: January 13, 2022
Time: 2:00 p.m. – 5:00 p.m.
Location: Virtual

Attendees:

Dr. Harriett Burns
Dr. Cardra Burns (Sec. Cohen designee)
Christie Burris (NC HIEA Exec. Director)
Carol Burroughs (Interim GDAC Director)
Dr. Neal Chawla
Timothy Ferreira
Donette Herring
Dee Jones
James Weaver, NC DIT Secretary
Richard Pro
Eric Snider (DIT Legal Counsel, NC HIEA)
Carolyn Spence
Dr. Donald Spencer
Dr. William G. Way (Chairman)

2:00 p.m. **Welcome and Call to Order** **All Members & NC HIEA Staff**

Meeting called to order by Chairman Way at 2:03 p.m.

Housekeeping Items **Chairman Way**

Chairman Way reviewed the draft meeting minutes from the September 2021 meeting. Vice Chair Donette Herring moved to approve the draft minutes; Carolyn Spence seconded the motion, which passed unanimously.

Chairman Way welcomed new Board members and delegates:

- Dr. Neal Chawla, WakeMed CMIO (Representative of Health System/Integrated Delivery Network)
- Dr. Cardra Burns, DHHS Deputy Secretary for Operational Excellence (DHHS Delegate)
- Cherie Givens, NC DIT Chief Privacy Officer (DIT Delegate)

Chairman Way next welcomed Christie Burris to provide the NC HIEA update.

2:08 p.m. **NC HIEA Update** **Christie Burris**

HITECH Funding Closeout

Burris introduced Garrett Smith, the new NC HIEA Business and Provider Relations Manager.

She next supplied an overview of Federal Financial Participation (FFP) funds drawn down from the Centers for Medicare and Medicaid Services (CMS) via NC Medicaid for date range June 2017 through September 2021 to support approved NC HIEA activities funded via HITECH. Burris stated that the NC HIEA

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will continue to partner with CMS and NC Medicaid for long-term operations and maintenance funding for HIE infrastructure developed under HITECH that aligns to NC Medicaid Enterprise System goals.

Burris highlighted connections and outreach and training totals as of September 30, 2021, as memorialized in the presentation materials.

2021 Roadmap Wrap-Up

Burris provided an overview of the Roadmap 2021 Accomplishments.

Links:
Strategic Roadmap | NC HIEA
Roadmap 2021
https://vimeo.com/662346726/5cddfad9b2

Strategic Planning for Roadmap 2025

Burris shared Roadmap 2025 guiding principles with the group:

- Build upon a strong HIE foundation to support data quality and emerging data standards.
- Broaden exchange capabilities to promote data democratization and innovation to support patient-centric whole person care.
- Cultivate value and financial stability by providing a health data utility to support value-based care.
- Support population and public health priorities through surveillance and analytics as a service.

Use Case Updates

Burris provided a brief updated on NC HIEA use cases. NC HIEA has received State and Local Recovery funds through the NC General Assembly to partner with the Department of Public Health (DPH) on its syndromic surveillance program, NC DETECT, and to expand data sources to include outpatient clinics, local health departments, FQHCs non-emergency encounters, hospitals and health systems, and urgent care specialists. Key data extracts on encounters, procedures, diagnosis, observations, medications, and immunizations are sent to DPH on a recurring basis and are used to track COVID Like Illness (CLI) across the state. Burris reminded the group that providers' filtering of data sent to the HIE can create an incomplete analysis with statewide syndromic surveillance and the monitoring of disease trends.

Additionally, Burris informed the Advisory Board of a new use case underway with the Division of Public Health:

1. **Stroke Registry- The first phases of this project is planned to be completed in June 2022**
    - Stroke Registry is a project that NC HIEA is undertaking to support the Division of Public Health, which sought and received grant funds from the Paul Coverdell National Acute Stroke Program. The Stroke Registry will utilize patient demographic and clinical data received by NC HealthConnex concerning strokes and facilitate: (i)Division of Public Health (DPH)-led

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improvements in the quality and continuum of stroke care, and (ii) identification and reduction of disparities in stroke care.

Dr. Harriett Burns asked who has access to the Stroke Registry.
Burris answered that DPH will have access for public health intervention.

Next, Burris highlighted the NC HIEA partnership activities with NC Medicaid.

1. **Delivered in 2021:**
   Network Adequacy Dashboard
   Medicaid COVID Dashboard Enhancements
   Phase 1 Data Extracts for Hybrid Quality Measures
   Ad-hoc Demographic Data Extracts
2. **In Process 2021-2022:**
   Phase 2 Data Extracts for Hybrid Quality Measures
   Priority Data Elements for Medicaid and PHPs
3. **Planned for 2022:**
   Data Quality Dashboard focused on Priority Data Elements
   NCQA Data Aggregator Validation Program (DAV)

Research Request Group Update
Burris revisited the proposed research request review framework and implementation. She emphasized the importance of meaningful resources and budget allocations to operationalize processes to support research and summarized recent efforts to build and refine a framework.

Operations & Key Metrics Update
Burris provided a summary of key operations and metrics which are memorialized in presentation materials:

Dr. Harriett Burns asked if there are similar statistics around outbound messages, either through portal queries or direct electronic queries for patient records that can be shared in a future meeting?

Burris answered that a standard report will be developed for future meetings.

Dr. Way asked if it is difficult to obtain these statistics.

Burris answered that there are ITI transactions that can measure these metrics and she will share for future meetings.

Dr. Way also asked if there was a budget estimate for 2022 and how will it be divided between various vendors to keep the HIE up and running?

Burris stated that the NC HIEA's single largest cost remains vendor output. The NC HIEA will continue to seek additional funding to complete the data connection work and to conduct new development work.

Dr. Way asked how other state HIE are addressing funding issues?

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Burris explained that many HIE peers have various funding streams (e.g., state funding; HITECH funding; partnering with Medicaid agencies to move into enhanced funding for operations and maintenance, and other grant opportunities.) Other HIEs are nonprofits and charge participation fees and/or fees for "data out" services. NC HealthConnex is one of the few HIEs that receives significant state funding support. Trends show that more and more states are investing in their HIEs to serve as a public utility that improves the delivery of health care.

Dr. Way reiterated to the group the importance of recognizing that North Carolina is limited by the intake of information through incomplete HIE participation.

Chairman Way next welcomed Carolyn Spence, Christy Revels and Eric Myers to provide the Legislative Workgroup update.

2:58 p.m. Legislative Report Workgroup Update Carolyn Spence

NCSL 2021-26 Review, Work Group Goals

Spence reviewed NCSL 2021-26 Directive:

- On or before March 1, 2022, the NC HIE Advisory Board shall submit to the Joint Legislative Oversight Committee on Health and Human Services recommendations regarding appropriate features or actions to support enforcement of the Statewide Health Information Exchange Act contained in Article 29B of Chapter 90 of the General Statutes and the results of the outreach efforts in subsection (b) of this section."
- The HIE Authority shall contact each entity or provider identified and ascertain the status of the entity's or provider's effort to connect to the HIE. The HIE Authority shall share information with each provider or entity about the Statewide Health Information Exchange Act and how to connect to the HIE Network.

Spence reviewed the goals and objectives of the informal workgroup assembled by the NC HIEA to assist it with addressing NCSL 2021-26

Spence described the Workgroup's review of available resources and explained that the work group coalesced on three major areas to explore further for possible recommendations for the Advisory Board's consideration:

a) Adjusting the HIE Act to Support its Enforcement
b) Pursuing an Aligned HIE Strategy Across Payers
c) Enhancing and Promoting Statewide HIE as a Tool

The work group examined data trends concerning provider types and their connection status to the NC HIEA.

The work group helped the NC HIEA formulate four possible recommendations for the Advisory Board to consider and evaluate in its public work to respond to NCSL 2021-26.

Finally, Spence reviewed the NCSL 2021-26 response timeline of activities.

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Barriers to Connect/Focus Group Feedback **Christy Revels**

Revels reported barriers to compliance for unconnected entities and providers which are recorded in the presentation slides.

Revels outlined areas of focus the informal work considered in order to help the NC HIEA provide draft recommendations for the Advisory Boards review and consideration. The informal work group set goals to examine the following:

- (1) Potential adjustments to the HIE Act to support its enforcement;
- (2) Pursuit of an aligned HIE strategy with payers to increase payer engagement; enlist their support to improve provider engagement, utilization, and data quality;
- (3) Enhancing and promoting NC HealthConnex as a tool for participants.

Dr. Harriett Burns expressed concern about feedback from dental providers and questioned how the state could expand its network of Medicaid dental providers.

Revels clarified that some dentists provided feedback that the costs to implement and maintain a connection to NC HealthConnex (including personnel and training costs) might prompt them to forgo providing care for Medicaid patients.

Dr. Burns stated that instead of focusing on reclassifying dental providers as "voluntary" under the Act, the State's focus should be on other ways to facilitate broader dental access for Medicaid patients.

Dr. Chawla stated that he recognized connection costs as a barrier for smaller practices and asked if there is a more efficient/less expensirve way for them to connect?

Revels answered that instead of a point-to-point integration with EHRs maybe a data aggregator solution could be obtained at a lower price point.

Donette Herring asked if there is a way to get records like a CCD through a public exchange like Care Quality instead of trying to connect at the individual practice level?

Eric Myers answered that platforms like CareQuality, the eHealth Exchange, and some other national networks would not be an easy substitute because they provide a query-based use case and may not be able to provide the level of data submission or usability enabled by point-to-point interfaces.

3:31 p.m. **Break**

3:40 p.m. **Analytics Overview/Findings** **Eric Myers**

Myers provided a summary of the connections analysis. The goal of the analysis is to identify the providers and entities required to connect to the HIE and determine which are (i) connected and (ii) unconnected. Reporting of entities and providers is based on

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National Provider Identifiers (NPIs) available to SAS and HIE from variety of data sources that were utilized in the analysis, including:

- JIRA - onboarding tracking for HIE at the organization level.
- SHP Provider information
- Dataset from DHHS to HIE of all active Medicaid Providers and Organizations with an "HIE indicator" to identify connected status.
- DHHS Provider Enrollment File

Based on these combined data sources, preliminary analysis (reported at the NPI level) yielded the following:

- 123,723 unique NPIs, comprised of 94,464 individual providers and 29,259 organizations
- 85,865* unique NPIs subject to the HIE Act or active participants
  - 67,668 individual providers
  - 18,197 organizations
  - *Note: This count includes certain "voluntary" providers and organizations that are not subject to the NC HIEA's statutory mandate
- Approximately 58,000 individuals and entities of the 86,000 subject to the HIE Act have completed connections. A majority of the unconnected have not engaged with the NC HIE.

Myers outlined additional considerations and limitations of the data analysis. First, the connectivity analysis is based on multiple data sets from multiple sources, rather than a single "source of truth." Provider affiliations represented in the data sets are fluid values. Second, in addition to NPI matching, the analysis required supplemental address matching which involved the creation and application of business rules and non-automated matching work. Third, NPIs in the data sets captured Veterans Affairs and Department of Defense facilities and practitioners. Connected facilities were included in counts, while unconnected facilities were removed from counts. Individual pharmacists (as opposed to pharmacy facilities subject to the act) were categorized as "voluntary."

Myers also reported on the connectivity rates and characteristics of specific provider types with lower connectivity rates, including behavioral health providers; dentists and orthodontists; chiropractors; residential facilities (including skilled nursing facilities); and pharmacies.

Donette Herring asked what percentage of those connected represent the spend of Medicaid covered lives? Myers answered that SAS and the NC HIEA do not have these statistics at this time.

Dee Jones asked if the licensing board validated denominators. Myers answered that the states multiple license boards did not validate denominators.

Dr. Chawla asked if the behavioral health providers were on electronic platforms or on paper?

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Myers answered that, based on understandings gleaned from interactions with behavioral health providers that have engaged with the NC HIEA, many of them do not have an EHR and did not benefit from HITECH funds to build out connectivity. Thus, for some behavioral health providers connecting to the HIE involves not only an integration but selecting, procuring, and implementing an EHR.

Dee Jones mentioned that many of the behavioral health providers may be Clear Pricing Project (CPP) providers receiving a higher reimbursement than a Blue Options or Medicaid provider. Per contract, CCP providers are expected to be connected to the HIE; sometimes, however, connection costs are prohibitive or the provider refuses to send data to the HIE. Is there a technology provider or subscription service through which they can connect and begin sending the minimum data?

Myers answered that while there is some hesitation among many behavioral health providers to connect to the HIE, the data they are to provide has a huge benefit for both physical and behavioral health providers.

Legislative Report Goals/Outline **Christy Revels**

Revels shared plans for the NC HIEA's outreach initiative to ~27,000 unconnected providers and entities subject to connection/submission requirement, and as well as communications to related stakeholder groups. The timeline and methods for the outreach project, though subject to change, include (among other things): (i) different messages tailored to those with agreements with the NC HIEA and those without agreements in place; (ii) information about the HIE Act and the updated compliance deadline of January 1, 2023;(iii) providers need to engage in the process as soon as possible, due to expected high volume; (iv) concrete next steps with web links to resources; and (v) highlight NC HIEA contact information for questions or assistance.

Revels next summarized proposed preliminary recommendations for the Advisory Board's review and consideration, as outlined in presentation materials. These recommendations include:

- Recommendation 1: Establish Clear Enforcement Articles of the HIE Act and Assign Enforcement Authority to the NC HIEA.
    - Features of this recommendation include an annual State Health Data Assessment fee for unconnected entities subject to the Act. The proposed enforcement framework would not assess fees to those demonstrating an ongoing "good faith effort" in the connection process or those eligible for time-limited exceptions.
- Recommendation 2: Revise the Act to make dental and chiropractic providers "voluntary."
- Recommendation 3: Direct the Creation of a HIE Payer/Provider Council and Development of an Aligned Statewide HIE Payer Strategy to inform HIE development and incent broader connection and improved data quality submission among health care providers.
    - By aligning on specific clinical data needs, goals, and measures, payers would help shape HIE services to better respond to the health needs of

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North Carolinians, while improving the sustainability of statewide HIE infrastructure.
    - A representative of the HIE Payer/Provider Council could hold a newly created seat on the NC HIEA Advisory Board.
- Recommendation 4: Require Entities that Provide State-Funded Health Care to Submit the Same Clinical and Demographic or Claims Data for All Patients, Regardless of Payer.

Revels also forecast an outline of the draft report to be provided to the Board for review, consideration, and comment purposes.

A discussion of the draft recommendations followed. Dr. Harriet Burns asked what the proposed fee structure look like? Eric Snider answered that a possible proposal for a fee structure is still under development.

Dr. Cardra Burns asked how enforcement of a fee might be operationalized. Eric Snider answered that other fee-assessment models exist in the State for review, including some that allow address late payments and / or false statement.

Dr. Cardra Burns asked that the Board apply an "equity lens" while considering enforcement proposal and how they might impact providers and patients from historically marginalized and underserved communities. Snider responded that the hardship exception process would provide an avenue to address potential inequities. Revels stated that the workgroup wanted to focus on incentivizing providers rather than penalizing them.

Group Discussion **Carolyn Spence**

Donette Herring suggested that Recommendation 2 be expanded so that skilled nursing facilities be made "voluntary."

Dr. Harriet Burns stated that patient data from skilled nursing facilities can be extremely valuable and urged the Advisory Board to consider equity in its report. She thanked the informal work group and HIEA staff for their efforts.

With respect to proposed Recommendation 4, Donnette Herring stated that the expanded data mandate would give the State ownership of more data, as well as enhanced responsibilities for security, stewardship, privacy, and compliance.

Dr. Way commented that an expanded data mandate would be better addressed in a future iteration of the HIE Act after current challenges and opportunities are addressed. The Advisory Board should strive for a larger data set, but perhaps not through a legislative proposal at this time. Dr. Way next thanked the group for the presentation.

3:55 p.m. **New Business** **Chairman Way**

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Next regularly scheduled Advisory Board meeting will be held on March 21, 2022, at 2:00 p.m.

4:52 p.m. **Adjourn** **Chairman Way**

Chairman Way sought a motion to adjourn the meeting at 4:52 p.m. Dee Jones made the motion, with a second by Dr. Harriett Burns. The motion passed unanimously.

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Christie Burris 3/16/2022 | 2:17 PM EDT
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