North Carolina Health Information Exchange Authority
Advisory Board Meeting

MEETING MINUTES
Date: March 3, 2021
Time: 2:30 p.m. – 4:30 p.m.
Location: Virtual
Attendees:

Dr. Harriett Burns
Christie Burris (NC HIEA Exec. Director)
John Correllus
Dr. Jeff Ferranti (Chair)
Timothy Ferreira
Sam Gibbs (Sec. Cohen designee)
Donnette Herring
Dee Jones
Thomas Parrish (DIT Acting Secretary)
Richard Pro
Eric Snider (DIT Legal Counsel, NC HIEA)
Carolyn Spence
Dr. Donald Spencer
Dr. William G. Way

2:32 p.m. **Welcome and Call to Order** **All Members & NC HIEA Staff**

Meeting called to order by Chairman Ferranti at 2:32 p.m.

Housekeeping Items **Chairman Ferranti**

Chairman Ferranti reminded meeting attendees that only NC HIEA Advisory Board
members, support staff, and presenters should speak during Advisory Board meetings, and asked all on the call to mute their phone unless they are speaking.

Chairman Ferranti reviewed the draft meeting minutes from the January 2021 meeting. Tim Ferreira moved to approve the draft minutes; Dee Jones seconded the motion, which passed unanimously.

Chairman Ferranti welcomed Eric Snider to supply input needed to finalize HIE policies to accommodate Information Provisions in the 21st Century Cures Act.

2:34 p.m. **21st Century Cures Act Interoperability Rules Update Final Review and Discussion on Information Blocking Provisions and NC HIEA Policy Changes** **Eric Snider, NC HIEA**

Snider said that the Advisory Board plays a key role in guiding the HIEA's policies, operations,

strategies and mission, and on behalf of NC DIT and leadership within the HIEA he thanked the Advisory Board members for their significant engagement leading up to the meeting today. He indicated that following the opportunity to collect additional feedback from Board members, notice of changes will be provided to NC HealthConnex participants in order to fulfill a 30-day notice period before new policies go into effect.

Snider reminder the group of the April 5, 2021 applicability date for Information Blocking Rules and added that our timeline for release align nicely with that date. He also reminded the group of additional regulatory action with respect to enforcement of the Information Blocking Rules and the NC HIEA is staying tuned to that.

The NC HIEA conducted two informal office hour conversations attended by NC HIEA staffs and a small group of Advisory Board members as a forum for questions and feedback as well as discussion on priorities and strategies as we work to implement the Information Blocking Rules. Snider supplied a summary of the takeaways from these informal sessions to the group:

- Some of the most consistent and significant feedback obtained was around the HIE's role in providing North Carolina patients with access to electronic health information with a primary focus on issues of patient safety.
- What does it mean for the HIE to be implementing this new set of federal rules while it does not have existing provider/patient relationships? The small group discussed potential incongruencies between the HIE Act and a shift to the HIE becoming more patient facing, and related implications for that both to providers, stakeholders, and the patient.
- Discussion of potential avenues to address information blocking rules and regulations and how they interact with North Carolina State law while also preserving the HIE statutory mission.
- Issues around Privacy and Security implementation efforts in addition to resource challenges that the HIEA were discussed as well.

Snider briefly discussed revisions made to the NC HealthConnex User Access Policy:

- Updates with respect to access roles to help Participant Account Administrators (PAA) work through the platform to assign the proper amount of access to employees within their organizations.
- Technical revision with respect to the help desk are found in Section 3 of our policy and quarterly audit responsibilities in Section 4.

Snider briefly discussed revisions made to the NC HealthConnex Privacy & Security Policies:

- Revisions reflect updates from DURSA with respect to our eHealth Exchange participation.
- Revisions to Opt Out practices.
- Revisions to research protocols.

Snider supplied an Information Blocking Review:

- Final Rule: 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (May 1, 2020)
- Interim Final Rule: Information Blocking and the ONC Health IT Certification Program: Extension of Compliance Dates and Timeframes in Response to the COVID-19 Public Health Emergency (November 4, 2020)
- 21st Century Cures Act
- ONC Fact Sheets
- ONC FAQs

NC HealthConnex Policy Revisions: Privacy & Security
New Safe Harbor Provisions Concerning Information Blocking and Interoperability
Section 15: Definitions (pp. 4-8)

- THE NC HIEA is building our in this policy a common set of terms, and language.

Section 15: Individuals' Access to Electronic Health Information (p. 37)

- Important to note that the kind of patient access facilitated for information blocking is not expressly outlined in our statute.
- Individuals can request copies of their health records in writing to the HIE,
- The HIE will support that work by supplying forms and materials for technical assistance,
- Transmit that information in a secure fashion,
- Guardrails for circumstances where there is no patient relationship, the HIE needs more information to respond or fulfill to requests, or where incorrect data exists.

During the informal sessions, Board members expressed broad support and enthusiasm for informed patients who are engaged in their care and who are seeking records. Members spent time observing the vital role that healthcare providers play

in helping patients obtain, understand and act on their medical data. There were considerable questions around this new relationship-patient to HIE.

Section 16: Requests to Access, Exchange, and Use Electronic Health Information; Prohibition Against Information Blocking; and Safe Harbors (pp. 38-46)

- State the HIEA's commitment to lawful and timely access, exchange and use of EHI,
- Opportunity to identify activities that are not information blocking due to applicable law,
- Staff training responsibilities, our team is ready to respond to these types of requests,
- Acknowledgement that on occasion the HIE cannot fulfill requests, and sets up safe harbor provisions,
- Instances where requests for information are denied, or fulfilled partially, etc.
    - Safe harbor allows for actors to deny requests when there is a concern for patient safety, or risk of harm. High threshold for providers but for our context the risk of harm is from bad data.
    - Privacy provision addresses how the HIE does not have to provide exchange of EHI data that is inconsistent with HIPPA.
    - Security safe harbor addresses fulling requests that may conflict with state security directives,
    - Infeasibility safe harbor in the event of a natural disaster or uncontrollable event and also data segmentation problems,
    - Health IT performance and system maintenance are addressed in our policy, participation agreements and other elements of our governance.
- Content and Manner policy track the regulation and allows for a back and forth between the HIE and the requestor to reach accommodation on how to fulfill the request,
    - Regulation does allow for actors to set fees, and in our state context we have more work to do when and if the time comes to consider fees.
    - Licensing agreements with third parties directed to receive information by patients are not considered information blocking.

Snider highlighted other policy revisions that do not concern information blocking but reflect desire to bring greater clarity to the program.
Housekeeping revisions consist of renumbering, updating site links and cites, new letterhead, and policy update table; Deletion of provision about qualifying organizations, update definition of participating entities, updates to permitted purpose language (updates to DURSA), and updates with respect to substance use disorder data; We have added provisions to our opt out policy to address the launch of the minor opt out process, removed language around authorization forms, and the removal of emergency access to records of opted out individuals; Language was added to permitted disclosures to government

agencies in Section 11, and also revisions to access to data for research in Section 12; A few provisions were deleted with respect to alternative dispute resolution requirements as a result of DURSA requirements.

Bill Way asked if there was opportunity to revisit the reimplementation of Section 7 if emergency access to the database for patients that have opted out is needed.

Christie Burris responded by saying that revisiting the provision both in statute and policy in addition to a work effort with our technical vendor partner to enable that capability can be initiated by the Board.

Bill Way asked for confirmation that the data are comprehensively there but access to this data is blocked.

Burris confirmed.

Chairman Ferranti asked if legislative changes were needed to solve for the issue where patients are primarily to get health data from providers and not from the HIE. What are next steps here?

Christie Burris indicated time for legislative discussion at the end of the agenda and NC DIT legislative liaisons are present on the call.

3:11 p.m. COVID Vaccine Management System Automated Reporting — Eric Meyers, SAS

Eric Myers supplied and overview of NC HealthConnex' s role in the COVID Vaccine Management System (CVMS) and the integrations being supported.

Integration Summary

- NC DHHS and NC HIEA are partnering to leverage the existing infrastructure in place at the NC HealthConnex health information exchange (HIE) to submit vaccine records to CVMS on behalf of Participants. Goal to increase vaccination rate by reducing dual documentation steps, improve user experience in CVMS by de-duplicating patient records using the NC HealthConnex MPI, and provide more timely and accurate reporting.

High-Level Roles of Partners

- NC DHHS – processing records into CVMS; reporting of errors; solution oversight and ownership
- NC HealthConnex – Data sharing (BAA) agreements; secures connectivity; patient matching from demographics feed; processing EHR extract; transmitting error reports
- Provider Organization – Data sharing (BAA) agreements, secure connectivity, sending patient demographics feed; creating EHR extract; error handling

Integration Requirements- Governance and Technical Components

- NC HealthConnex Data Sharing Agreement
  - Full Participation Agreement
  - Submission Only Amended Agreement with BAA
  - Retail Pharmacy Agreement
- Secure Connection to NC HealthConnex
  - Secure file transfer (SFTP)
  - Direct secure messaging (DSM)
- Submission of COVID-19 vaccine data to NC HealthConnex
  - NC COVID Vaccination Reporting (NCVR) file
  - CDC COVID Vaccine Reporting Specification (CVRS) file

CVMS Data Flows

- Option 1: Manual user entry to CVMS for patient registrations and vaccine administration details
- Option 2: Digital worker (RPA/BOT) solution for NCVR files. Will be replaced by the direct integration process
- Option 3: Direct integration process, which is the long-term solution for COVID vaccine files

RPA (BOT) Solution Overview

- Automate end-to-end workflow across data entry for patient look up and registration, appointment booking, vaccination, and communication of results back to hospital systems.
  - Retrieve and validate universal NCVR file
  - Processes patient look up, registration, appointment booking, and vaccination in CVMS
  - Output and communications

Vaccine Provider Groups

- Pharmacy Long Term Care (LTC)
- Health System health workers and general population
- Pharmacy general population

- Local Health Departments general population
- FQHC's general population
- Other general population

Steps for Completing Integration

- Prep:
  - Verify all necessary agreements, confirm HL7 patient demographics feed includes all ADT event types
- Build:
  - Send NCVR files for validation, NCVR validation/testing, error reporting
- Live:
  - Operationalizing and automation

Wave Approach for Onboarding

- Onboard 5-6 providers per wave
- Ramp up targets under review

Current Pilots

- UNC
- Duke
- Mission
- New Hanover Regional MC
- Vidant
- Atrium
- Cape Fear Valley MC
- WakeMed
- Wake Forest Baptist
- Columbus Regional
- UNC Health Southeastern
- First Health of the Carolinas

Outreach and Education

- January HIEA Update
- Onboarding packet and file specification distributed
- Webinars
- Recurring Meetings

Next Steps

- Continue to outreach to providers and recurring meetings
- Expand RPA/BOT footprint behind Atrium success
- Pilot direct integrations,
- Pilot stabilization

Chairman Ferranti asked when will CVMS Direct be generally available?

Meyers indicated that once stabilization occurs additional waves can begin establishing connectivity.

Chairman Ferranti asked if there are plans to expand the CVMS footprint or switch everyone to CVMS Direct?

Meyers stated that eventually the goal is to have everyone switch over to CVMS Direct.

Rick Pro asked about the access for health systems and local health departments that are interested in using more comprehensive vaccination data. Would that access occur through CVMS?

Meyers shared that CVMS would be the source of truth for vaccine data, and that the HIE is receiving and processing the data but, that the data is suppressed in the HIE. Any data back to the health system would need to come from CVMS directly.

Donnette Herring asked for an understanding on race and ethnicity data collection.

Sam Gibbs confirmed that the requirement for race and ethnicity comes from the CDC. States are required collect this information with a 99% target.

Harriett Burns asked is there a process for sending federal vaccine allocation data through the HIE?

Meyers confirmed that his understanding of the process is that federal vaccine allocation data is reported directly to the CDC.

3:57 p.m. NC HIEA Operations Update Christie Burris, NC HIEA

Christie Burris supplied a NC HealthConnex operations, metrics and legislative overview.

Operations Update- Quarter 1 2021 Activities

- Staffing: We are presently hiring for the HIE Implementation Project Manager. This position was vacated by Michael Crist in August 2020. We are also hiring for data quality and electronic lab reporting analysts to support public health.
- HITRUST Gap Analysis: The state is reviewing the gap analysis draft report and will report back findings.
- Public/Private Collaboration for Security Awareness/Threats: Burris has identified a few organizations and will report back to the board once more formal and finalized.
- Use Cases Update:
    - Colorectal Cancer Registry – Currently in UAT
    - Quality Measure Program is underway with stakeholder partners, ORH and DBH. Working with ORH to replace manual reporting with HIE data. Development has begun and legal agreements are in flight with a goal to deliver data to DBH to support annual Hybrid Measures on diabetes, hypertension, BMI, depression screening, and prenatal. CMS is currently reviewing an advanced planning document on Medicaid Quality Measure Initiatives. These activities will help achieve Medicaid's goal to build an innovative, coordinated, and whole-person-centered system that addresses both medical and non-medical drivers of health.
    - Advance Care Plan (ACP) document exchange. ACP documents in North Carolina are currently siloed, existing in health system EHRs, NC Secretary of State's database, private databases, and paper formats. Goals are to standardize the sharing and delivery of ACP documents at the point of care, improved access to advance care planning and end-of-life care planning documents, electronic integration of ACP documents, and the ability to share records without the need for scanning, copying and faxing from one location to another.
- NC*Notify: COVID alerts are now live withing NC*Notify both through the user interface through the clinical portal as well as through bi-directional interfaces. Additional alerts scheduled to go live at the end of March 2021 or April 2021 are dental alerts, care team change alerts, high utilizer alerts, diabetes registry and pre-diabetic alerts, place of service enhancements alerts, and chronic care management alerts.
- Provider Outreach: Considerable amount of outreach happening with the dental community as their mandated connection date is June 2021.

January 2021 Metrics Update
Burris supplied a NC HealthConnex metrics update highlighting a 47% increase in documents exchanged from December to January illustrating additional utilization and adoption of the HIE.

Legislative Discussion
Burris reminded the board that the HIE's goals for consideration and amending the HIE Act. Our mission is to connect healthcare providers to enhance their ability to safely secure health information and improve health care quality and outcomes in North Carolinians. We look to seek legislative changes to the HIE Act that will do no harm to patients. Currently, the HIE Act directs payers to withhold or deny claims or payments to providers who are not connected to the HIE by mandated deadlines. NC Medicaid is interpreting the HIE Act differently from the State Health Plan where state employees and retirees could be negatively affected if a provider claim is rejected. As a result, the HIEA has a strong belief that the cost of services could pass directly to the patient. We are also looking to incentivize connectivity, and this approach aligns with federal initiatives for interoperability and value-based payment arrangements. Finally, as a result of information blocking, we look to articulate that the HIE's role for patient access to health data in not an HIE to patient relations but an HIE to provider relationship. We want to maintain the HIE to provider relationship as opposed to stepping in between providers and patients. On February 25th, Representatives Lambeth and Goodwin introduced a piece of legislation to amend the enforcement mechanism for HIE participation. Two key provisions that are concerning to NC DIT are one, requirement of the HIE to assess civil monetary penalties to providers at $10.00 per claim or not to exceed, and two, within 30 days of receiving the notice a provider would be required to provide information thus, creating an administrative burden on the provider community. We hope to leverage HB 179 to get more collaborative language.

Chairman Ferranti supports these efforts to promote the health of North Carolinians and promote connection to the HIE and believe the imposition of a civil penalty is not the best approach.

Dee Jones expressed excitement for ongoing dialog. And find a single source of truth. Currently no one knows who does and who does not have to connect to the HIE.

Burris will work with the Board on language that moves more towards the incentivizing providers as opposed to penalizing.

Harriett Burns asked where the idea of a penalty originated.

Burris clarified that as the HIE Act is currently written, a provider who is not connected by their mandated connection date will no longer be paid for services rendered. The penalty was thought of as a remedy to noncompliance.

Chairman Ferranti suggests that the cycles and efforts of this group should be spent on figuring our where obstacles to connection are and how to break them down. There is no question that we want all providers connected to the HIE.

Dee Jones reiterated the importance of identifying how many providers there are that are not connected and how to target those providers.

Chairman Ferranti asked how it is possible that we do not know how many providers are not connected that should be as these providers are billing for insurance, seeing patients, and are licensed to practice in the state.

Burris stated that there is a fundamental problem with understanding the provider universe. Providers enroll in networks that pay provider claims. The HIE works at an organization and facility level so there is a disconnect in data between individual providers and with whom they are affiliated. Providers also move from organization to organization or may report to more than one organization.

Chairman Ferranti asked if we honestly do not know who these providers are then how do we assess civil penalties.

Dee Jones said that initially Blue Cross will ask the HIE to pas along information as to who is connected. Jones suggested there will be gaps in how that information will be applied by Blue Cross. When a claim from a provider presents and it is flagged for noncompliance, then the claim will not come to the front door. The member will neve know when this happens until the moment that their claim is not processed. There is a flaw in the way the first legislation was written.

Christie Burris discussed the additional legislative recommendation to address the patient access rule. Where patients will request directly from the HIE for their health data versus going through their providers. Burris indicated that in the absence of legislative action, the HIE will find itself having to respond to patient requests per the information blocking regulations.

Chairman Ferranti asked Eric Snider what the process will be to endorse legislative changes.

Snider suggested to carry forward the general feeling of the Board to the General Assembly for consideration by resolution or vote.

Richard Pro asked if there is a potential role sitting somewhere in between. Is there a role for the HIE to play as an appeal mechanism if people are unable to get access to their records through a provider? Should we be a body through which they can appeal?

Burns responded that one thing to think about is that the HIE does not contain a full medical record but a subset of the medical record. If the HIE were to consider that type of role the data that the HIE has may not be relevant for the patient or any concerns they have about their care.

Chairman Ferranti brought up related point that if a patient were unable to get their record from a care organization then the care organization would be guilty of information blocking. We want to make sure patients are getting information from the providers who know them best and can provide the best records.

Donnette Herring suggested that when issues arise the HIE could instead help inform other organizations that the information should be shared by the folks that best know the patient.

Burris said that the HIE can supply educational materials pointing patients to the best sources for getting their health information.

Richard Pro asked to include information about information blocking that either the patient or the provider may not be familiar with.

Snider said that with added discussion we can move forward with a good plan.

Harriett Burns, in addition to the HIE not having a relationship with a patient, the HIE was designed to facilitate exchange of information between and among healthcare providers to provide optimal care to patients. The HIE was not designed for patient interaction.

Chairman Ferranti asked the group if they were in favor of the notion that patients should interact with healthcare providers to get health information and that the HIE should not be the source of that information.

Don Spencer strongly supports this action.

4:24 p.m. New Business **Chairman Ferranti**

4:36 p.m. **Adjourn** **Chairman Ferranti**

Chairman Ferranti moved to adjourn the meeting at 4:39 p.m.

DocuSigned by:
Christie Burris
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9/28/2021 | 11:47 AM EDT