

# HIEPI Governance Workgroup Meeting AGENDA

Meeting Owners	Frank Nachman ( WG Lead) Micky Tripathi (WG Facilitator) Mark Belanger (WG Facilitator)
Minutes Author	Jackie Baldaro ( WG Business Analyst)
Version	1

Date	7/14/2010
Time	1pm-3pm
Location	Dial-in Meeting

## AGENDA

	Led By	Start	End
OPENING REMARKS –Welcome and catch up on new developments from last week	Micky Tripathi	1:00 PM	1:15 PM
Guided Discussion	Micky Tripathi	1:15PM	2:50 PM
<input type="checkbox"/> Phase 1 components under consideration by all workgroups and clarification of technical infrastructure <input type="checkbox"/> Coming to consensus on the Technical elements required for this first phase <input type="checkbox"/> Given time we will repeat this for later phase elements			
Wrap up & Next Steps – Prepare for Next Summit Meeting	Mark Belanger	2:50PM	3:00PM

## ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Cindy Rosenwald	Y	Kelly Clark	Y
Jackie Baldaro, WG Analyst	Y	Kirsten Platte	Y
Deanne Morrison	Y	Lisa Bujno	Y
Denise Purington	Y	Maggie Hassan	N
Dick LaFleur, MD	Y	Mary Beth Eldredge	Y
Janet Monahan	Y	Susan Taylor	N
Frank Nachman, WG Lead	Y	Vanessa Santarelli	N
Kathy Bizzaro	N	Mark Belanger, WG Facilitator	Y
Micky Tripathi, WG Facilitator	Y		

## GUESTS

Name	In Attendance (Y or N)

\* Via telephone

Meeting Summary

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## Meeting Summary

The meeting was called to order at 1:06pm and quickly moved through a summary of where the workgroup left off after the last meeting ending with an acknowledgement of the difficulty before us in trying to decide on a governance model without fully knowing “what” we are going to be governing. The focus of the meeting today is to move through models and try to move towards consensus.

The group was provided a brief recap of the other work group’s progress over the last week and a discussion of the current week’s focus and how it relates to the governance work for this meeting:

1. Finance WG: Working with the understanding that the current funding is seed money focused on trying to answer the questions of future funding and developing numbers around models and adding structure. The WG discussed how much money is available given that federal funding is ~\$5.5M + ~\$1.2M in matching funds from state – Once reporting overhead and planning are drawn down, ~\$4M is left to spend over three years- an important constraint to recognize as the WG’s lay out options.
2. Business & Tech Ops WG: This group looked at the phasing methodology in detail and came to a high-level degree of consensus about criteria and what would go into phase 1, 2, 3 was achieved with general agreement that we should spend time on the basic, concrete option to understand if what is created can “stand alone” after federal funding has been completed.
3. Legal & Policy WG: This group is meeting concurrently with the Governance WG and is trying to resolve cross work group issues related to the minimalist model. Looking in depth and under current NH Law, to describe what “opt-out” consent should look like and may essentially suggest that our minimalist approach is not as minimal as one would have to expose PHI in the transaction. The WG facilitator has had detailed discussions with state legislators to understand the issue in depth.
4. Technical Infrastructure WG: The Technical Infrastructure group met this morning to work toward consensus on what elements are needed to be able to support the minimalist approach.

The group moved to a discussion of the Straw man phasing slides with the understanding that these slides are intended to be hammered away at and to test, validate and inspire conversation. The workgroup facilitators and leads assumed four different criteria in constructing the straw men; level of difficulty and legality; any issues to resolve due to time constraints and is there demand/market options available right now.

Slide 12: The facilitator lead the group through the slide logic beginning with legality under current NH law as phase 1 criteria. More complex considerations, for example consent policy, are criteria for phase 2.

Slide 13: Characterized the HIE building blocks as mapped to infrastructure components and answers various questions such as what it means in terms of what each would provide for example, function, capability and what kind of organization is needed to run it.

Slide 14: A “push network” would allow access across hospital networks, for example allowing Dartmouth to maintain their value/investments, while allowing others who do not have this functionality, to push a record across organizations through secure messaging. This provides a more standardized, secure way, for this to happen. The group noted that this is already happening today, though not all hospitals have this capability. The group reiterated the goal of allowing options and access for those who do not have this ability while retaining, not replacing, functionality in places where this is working well.

In Phase 2, a Query capability- would enhance the push network and expand to have a community record to look up and pull down into their medical record. Persistent data is now stored and available through a query, involving a master patient index also adding to legal & operational complexity.

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Q: Push Network, in Phase 2, public health accessing a CCD?

<The question was regarding two bullets under phase 2 – one was about public health being a new (different from phase 1) end point for a push record and the second was a CCD record being pushed to providers, in phase 2 public health would get push records that they already get (no expansion) but they would get them via HIE provided the law changes to allow it>.

A: With a change in the law public health ~~they~~ would receive the records they now receive, but they would get them through HIE. The other concept under phase 2, also requires a change in the law is to push to non-provider entities.

Next slides provide background and detail of the individual use cases. Slide 12, from a finance WG perspective, describes what importance this phasing will have on cumulative funding (depicted on the red line and “time” is on the x axis). In the finance WG the iteration that is happening currently, deals with the component pieces taking into consideration what the governance WG is discussing in this meeting and costing them out in an effort to understand if the WG is able to fit them into the red lines. The group was reminded that the phasing structure does not suggest that an item would not/should not be completed-phasing describes time <when>.

Q: Are there hardware considerations that each provider/organization would need to purchase?

A: This question is being posed to technical infrastructure to get us a list of options.

Slides 18 & 19, Governance Consideration for Phase 1 Building Blocks-

A discussion of Phase 1 may envision a multi-stakeholder steering committee <governance structure> to guide decision making past phase 1 and guide discussion into phase 2. The idea would be to broaden the stakeholder base in this committee past heavy state representation.

Slide 18 guided the group in discussion of:

- Source of Governance authority
- Organizational form considerations
- Governance structure/membership considerations
- Governance process considerations

Governance structure and membership:

Confirm that we have consensus on combining the following governance functions under a single governance body:

- Policy setting
- Fiduciary responsibility (financial management and control)
- Operational oversight

Bylaws may be determined in future planning –we should identify how this will occur in the ONC plan for August

Membership

Which stakeholders? Partial or full stakeholder representation?

- Staged with phasing and legislation?
- Link between financing and governance?
- Differential representation for those providing financial support?
- Organizational membership or individual membership?
- Process for determining who is included or excluded?
- Participation requirements?

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The workgroup discussed what kind of authority is needed with any with structure proposed. The information on slides 18 & 19 are intended to give the workgroup a range of opportunities or spectrum from state agencies to a completely independent entity to consider.

- Q: < *Are there* > considerations re: money following from the feds to the state- does this preclude options?  
A: There are federal restrictions on the grant- there has to be a fair process for determining who would receive funds and of course state funds now so there would be those considerations.  
Comment/A: Doesn't preclude the State bidding out the function?  
A: A State designated entity, once chosen, can be changed?  
A: No, it has to stay in place, however the state can contract with a state designated entity to do this work.  
Q: Does this mean phase 1 planning can be separated from the State? Can they back away and farm out the < *work*> balance?  
A: They can contract out very specific functions state could contract out and that's when you get into the question about the competitive process by the state.  
Comment/A: In general, it would go to a public bid and then be approved by Governor and Council.  
Q: What is a key "con"? How much of a barrier is it to pass funding to anything that is not a state agency.  
Comment: In the Healthy Kids model, state passes money to them- there is a fund which is a hybrid and a 501(c) (3)-a public instrumentality. The board has full authority by statute how funds and operations are directed. The legislature would have a check against rule making authority.

The group discussed funding in relation to governance/organizational structure proposing a flexible model to have the ability to function under a period of federal funding (which will end) and needing to understand model options post federal funding.

- Q: Is it beyond the possibility where we would transition to another model in the future  
Comment: I don't see this as being a state entity in the future, driven by private funds in the future  
Q < to the group>: Is a "Health Kids Model" attractive enough?  
A: Yes  
A/response: If it is just a pass through then another type of entity <not state>  
Comment: Healthy Kids Funds reflect a lot of flexibility and the gives the perception and shows up like a non-profit collaborative type structure- a nice balance.  
Comment: A Con <of *this model*>is that you would need to go through statute to create and to design <*rather than* > operate freely.  
Comment: the bigger job would be getting through the legislature, October at the earliest  
How do we set up in our plan pursuing what isn't legal already?  
All we are saying here is that the state can begin sending money and anticipate setting up an instrument.  
Molly Sims has indicated that Connecticut is doing these same things

The WG reached general consensus that a public instrumentality model for example, Healthy Kids, is a good model to pursue. The group discussed form in more detail and the pros/cons of the public instrumentality model and its acceptance of funds both public & private. Potential cons included: the fact that any changes to the model need to go through statute, and having bidding process in place due to using federal/state dollars.

**ACTION ITEM:** WG Legislator will request a legislative history of the Healthy Kids program to understand reasons for choosing this model, contracting process and to understand the history any changes to the model.

Comment: If in the history the special provisions are importance to us as we think about HHIE oversight then we should think about that model but if none of them really apply to HIW then why use that model

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Response: It may be that the legislature wanted to have some solid oversight,  
Comment: Would be helpful to understand why they thought the statute was required not just set up a regular 501c3?  
Response: Seems like a logically connection kids covered by insurance and rule making authority/state oversight

Request: define Rule Making Authority

A: Administrative rules have the full force and effect of law. The legislature grants rulemaking authority to a state agency and the agency can then adopt rules within the framework contained in the legislation. Rules are used to fill in the detail that is not in the statute. For example, DHHS has rules for how to apply for public assistance benefits – the forms that are used, information that needs to be provided, etc.

Comment: it seems like in principle having that kind of rule making authority can allow a bit more “nimbleness”

Response: A caution here- the process is not really nimble.

The group discussed specifics that will need to be addressed in the governance model and how it may change over time; understanding that the model launched as a product of this planning process may contain a multi-stakeholder committee at the decision making point until such a time where funding is expanded and a decision may be made to continue with the 501(c) (3) approach. They considered having a potentially different stakeholder group steering and advising DHHS. The workgroup wishes to flesh this out a little more and pass ideas under the eyes of Molly< Sims> from ONC to get a “sanity check”.

The group discussed closing rapidly on organizational form within the next week and moved to try to converge and understand if there is consensus on any issues beginning with a single governing body for fiduciary responsibility, operational oversight, and policy making keeping these elements unified into a single unit.

Comment: Regarding membership, I feel we need consumer representation regardless of what come up with.

Response: Agreed.

Comment: Everyone needs to have an equal vote regardless of organizational size or money spent (e.g. no additional votes as related to amount of money spent)

Q: What types of stakeholders do we want to consider in each phase?

Comment: I would like to see it broader than just clinicians

A: Two ways to view this: start with a clinical board for phase 1 and a statute that says so, or we know that it is going to eventually be a multi-stake holder board so let's represent them now.

Comment: I want to see patients represented from the get go.

A: What about Public Health?

A: We should be involved because of what we do.

A: ONC requires state agencies.

C: We need to include policy makers

Q: Do we know if the Healthy Kids Board has always been configured as it is know?

A: I don't know

Comment: I will try to find out from the legislative history.

Comment: a representative from a clinical care organization should suffice- doesn't necessarily have to be individuals

Comment: Hospitals should talk <among themselves>about how they want to be represented.

Comment:Healthy kids membership appointed by different bodies appointing, organizational representation vs. individual,

Q: Possible to get an understanding on what Tennessee is doing-about how they are configured?

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Comment: Vermont may be a good model to look at.

Response: Agreed there are many models available to look at.

The Group moved to consensus on the following points: organizational form, governance body & functions, initial stakeholder representation and involvement.

Work group consensus was achieved on the following points:

1. Organizational form of choice so far is a “Public Instrumentality” modeled after NH Healthy Kids ([http://www.nhhealthykids.com/about\\_us.php](http://www.nhhealthykids.com/about_us.php)) which is a 501(c)3 with ability to pass through state funding, authority to make administrative rules, and with the operational and funding model flexibility of an independent entity. WG members are doing further investigation to see if this is a good fit.
2. All governance functions under a single governance body: Policy setting, Fiduciary responsibility (financial management and control), Operational oversight
3. Inclusive stakeholder involvement from the start (as opposed to aligning governance participants with those who are allowed to exchange information at each stage) Stakeholders include consumers, care givers, policymakers, payers, public health, and others. No agreement yet on where to draw the line (e.g., Long Term Care?). Want to ensure there is a mix of clinical and functional (e.g., IT) expertise represented.
4. No differential representation. Equal voice for all stakeholders regardless of financial contribution.
5. Representation by stakeholder group (where there is an obvious aggregation point e.g., NHHA, Medical Society, Patient Advocacy group) as opposed to representation by individual

Wrap Up & Closing Remarks:

The group expressed pleasure regarding the amount of work accomplished during this session.

The goals of next Summit on July 20<sup>th</sup> are 1. Lock down ideas & move to consensus, 2. Finish researching other models and 3. Begin putting pen to paper for cross workgroup circulation.

The meeting ended 15 minutes early at 2:45pm