Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
September 21, 2017	1:00 – 4:00 p.m.	Hearing Room 1D, Legislative Office Building 300 Capitol Avenue, Hartford CT 06106

Participant Name and Attendance

Council Members					
Allan Hackney, HITO	X	Robert Blundo, AHCT	X	Robert Rioux	
Joseph Quaranta (Co-Chair)	X	Mark Schaefer, SIM	X	Jeannette DeJesús	X
Joe Stanford, DSS	X	Robert Darby, UCHC		Lisa Stump	X
Michael Michaud, DMHAS		Ted Doolittle, OHA	X	Jake Star	X
Cindy Butterfield, DCF		Kathleen DeMatteo		Patrick Charmel	X
Cheryl Cepelak, DOC		David Fusco	X	Alan Kaye, MD	X
Vanessa Kapral, DPH	X	Nicolangelo Scibelli	X	Dina Berlyn	X
Dennis Mitchell, DDS	X	Patricia Checko	X	Jennifer Macierowski	X
Mark Raymond, CIO	X	Robert Tessier	X	Prasad Srinivasan, MD	
Supporting Leadership					
Victoria Veltri, (LGO)	X	Dino Puia, HIT PMO	X	Christina Coughlin, CedarBridge	
Sarju Shah, HIT PMO	X	Faina Dookh, SIM PMO	X	Michael Matthews, CedarBridge	X
Kelsey Lawlor, HIT PMO	X	Carol Robinson, CedarBridge	X	Chris Robinson, CedarBridge	X
To Be Appointed					
Representative of the Connecticut State Medical Society (President Pro Tempore of Senate)					
Health care consumer or a health care consumer advocate (Speaker of the House)					
Physician who provides services in a multispecialty group and who is not employed by a hospital (Majority Leader of House of Rep.)					
Speaker of the House of Representatives or designee					

Meeting Schedule 2017 Dates – October 19, November 16, December 21
Meeting Information is located at: http://portal.ct.gov/Office-of-the-Lt-Governor/Health-IT-Advisory-Council

	Agenda	Responsible Person
1.	**Welcome and Introductions**	**Kelsey Lawlor**
	Call to Order: The ninth regular meeting of the Health IT Advisory Council for 2017 was held on September 21, 2017 in Hearing Room 1D of the Legislative Office Building. The meeting convened at 1:00 p.m.	
2.	**Public Comment**	**Attendees**
	There was no public comment.	
3.	**Review and Approval of the July 20, 2017 Minutes**	**Council Members**
	• July 20, 2017 Council Minutes – Motion to approve minutes was passed unanimously. • August 17, 2017 Council Minutes – Motion to approve minutes was passed, Pat Checko abstained.	
4.	**Updates**	**Kelsey Lawlor**

Kelsey Lawlor and members of the HIT PMO welcomed Dino Puia, who is taking on a Program Manager role within the office and assist while Sarju is out on maternity leave.
Kelsey then introduced the HIT PMO branding efforts, which includes an updated PowerPoint template and Health Information Technology Office logo.

5. Review of the Immunization Design Group Recommendations — Carol Robinson

Carol Robinson provided an overview of the IIS Design Group recommendations:

- Implement priority use cases, including:
  - Ability for providers to bi-directionally send IIS data and be patient accessible;
  - Allow customization for school entities;
  - Allow vaccine forecasting for non-standard scheduling, chronic disease management, and high-risk patients; and
  - Support vaccine inventory tracking.
- Leverage and align efforts with HIE services
  - The IIS must have broader infrastructure needs for CT. A close linkage between the IIS and HIE will eliminate the need for duplicative services such as identity management.
  - Data transformation efforts should be aligned to support quality assurance.
  - The IIS should be interoperable with other states and IIS jurisdictions.
  - A group should be formed to govern interoperability of open application program interfaces to bolster Fast Healthcare Interoperability Resources (FHIR) standards.
- Maximize collaboration and planning across federal programs
  - Joint conversations between Connecticut agencies such as the Department of Public Health and Department of Social Services to support transparency with federal partners and foster alignment of IIS and HIE planning efforts in order to maximize federal funding efforts for Implementation Advanced Planning Documents (IAPDs).
- Provide stakeholder engagement
  - Foster ongoing stakeholder engagement during IIS planning phase to gather feedback on features to meet customization needs. A user group of stakeholders should be established to facilitate outreach and education of the new IIS platform.
- Provide necessary legislative updates
  - Establish a life-time registry that encompasses children and adults.
  - Legislation regarding the implementation of the IIS would be done through a graduated approach with special consideration for providers with inadequate EHRs that may have to enter data manually.
  - Legislation should be coordinated to identify issues between public health requirements and HIE needs for privacy and data access.
- Opportunities for financial sustainability
  - Follow the consortium model when procuring for a new IIS with shared HIE services across stakeholders. The need to prioritize the HIE infrastructure to support population health analytics and reduce health disparities was emphasized to promote financial stability.
- Need for technical assistance

- Provide comprehensive technical assistance to EHR vendors when connecting to the IIS, whether is it offered through HIE services or not.
- Optimal functioning solutions require detailed collaboration between IIS technical staff, EHR staff, and HIE staff to allow for higher levels of data sharing.

- Need for ongoing education and training
  - Allocate enough resources to allow clinicians and staff to train under the new IIS to maximize its use. It was emphasized to allow the program staff to coordinate this effort and provide degrees of flexible training to meet the needs of various stakeholders.

Council Discussion:

Pat Checko thanked the Design Group members for their work, and asked for elaboration on how these recommendations provide value to the consumer, particularly how patients can gain access to their records. Dr. Agresta, a Design Group member and representative, answered that a focus of their work was the patient's ability to access their immunization and health records.

Pat Checko also asked about vaccines that are provided by the CDC and she did not see in the report – that need to be accounted for and tracked. It is important to draw attention to this fact, this will provide a level of accountability. Dr. Agresta answered that the recommendations included vaccine / immunization tracking. We recognize the important effort to prevent over-ordering, under-ordering, reduce waste, etc. DPH was an excellent partner and they believed this will continue to be an important component of any IIS.

Mark Raymond asked brought up the issue of financial sustainability. He feels that if we move forward, we must address this question. Dr. Agresta responded that this was something that was discussed during design group meetings. He stated that accepting these recommendations is a state priority in order to be in compliance with federal requirements. Additionally, the shared HIE services that are being investigated by another design group also have the potential to create cost savings. However, he acknowledged that the IIS design group did not get deep into the financial analysis as it was outside their scope of work. Carol Robinson added that the IIS design group recommendations would translate into business services that would add value to stakeholders, and this would create sustainability and cost savings. Mark Raymond stated that he appreciated the comment in the general sense, but wanted to more concretely define the financial parameters in which we must operate. Is the state going to pay for the implementation until something else is developed as a funding stream? Carol Robinson replied that if you look at other HIEs around the country, the initial funding is going to come from the federal government: 90% from the federal government and 10% from the state. Michael Mattews added that this use-case is a little different from an HIE perspective. Right now, many providers are completing a paper-based process. The operating cost of DPH managing a partially paper-based process could be reallocated. In terms of HIE, figuring out how to get the immunizations into the system is an HIE Use Case Design Group problem. The IIS is the catcher's mitt to be able to receive that data. Mark Raymond responded that he expects to be clear throughout the whole process who is benefiting, and who is paying the bill. Up front, there is a combination of federal and state funds, and we believe there are operations costs that will make up some portion. We should clearly communicate those assumptions. As we get the larger group of services identified, we should apply this same principle.

6.	Acceptance of the IIS Design Group Recommendations	Council Members

Dina Berlyn moved to accept the IIS Design Group recommendations. Robert Tessier seconded the motion. The Council voted to accept the IIS Design Group recommendations.

Vanessa Kapral, on behalf of the Department of Public Health, has submitted the following comments in response to questions posed by the Council during this session:

Patricia Checko posed some questions/comments about the IIS current and future functionality. The DPH Immunization Program would like to include these comments:

- The current IIS does provide patients their immunization records. Parents can call to request their record. Providers can look up records online and print official immunization certificates. The new IIS will include a patient portal.
- The current and the new IIS are capable of capturing vaccines throughout the lifespan. In order to enroll the additional providers and patients, to ensure providers reports beyond school age and to ensure good data quality, the age range captured will be expanded in a phased approach.
- The current IIS has uni-directional EHR electronic data exchange, which was the standard when the current IIS went into production in 2012. The national IIS functional standards are revised every 5 years. The 2013-2017 standards include bi-directional exchange and the new IIS will include this.
- Both the DPH and the IIS Design Group Report include the use case to support vaccine inventory and tracking to support ordering and to ensure dose level accountability. Currently providers can order online using VTrckS. The new IIS will include this module within the IIS.

Mark Raymond asked about the sustainability of IIS funding, which is currently federal (and will hopefully include the 90/10 Medicaid Match if approved.) The DPH Immunization Program would like to include these comments:

- IIS federal partners are providing assisting (through webinars and conferences) to the IIS programs nationally on methods to secure additional funding to ensure sustainability. Beside the 90/10 Medicaid match and the 25/75 MMIS match, the IIS vendor Consortium works toward this goal of sustainability by sharing resources (SME and financial) to build new functionality into the IIS as new functional standards are released every 5 years.

Additionally, Vanessa clarified questions posed by Carol Robinson and Christina Coughlin in the 7/20/17 minutes under Topic 6: Update of IIS DG:

- The Design Group won't join the Consortium, it will be the IIS program who joins the IIS vendor consortium. We do plan to continue to collaborate with the IIS DG. The Consortium only includes the states who use the same IIS vendor, which does not include either of the NY IIS (the city and state IIS in NY are different vendors as well.) The new IIS will include bi-directional exchange.

7.	Update on the IIS/HIE Funding Request	Dino Puia, HIT PMO

Dino Puia updated the Council on the HIT PMO funding requests.

The annual IAPD Request was submitted to CMS on June 9, 2017 as a $4.97M request (Appendix D), and we are currently waiting for its approval. This request will be a continuation of planning funds that will further support the Health IT Design Group activities.

The IAPD Update (IAPD-U) is in development and will be submitted in the future, once we have received approval of the annual IAPD request. A further update will be provided to the council in November.

There were no questions or discussion.

8.	HIE Use Case Design Group Discussion	Michael Matthews

Michael Matthews of CedarBridge provided the Council with an update on the HIE Use Case Design Group activities.

The Design Group is comprised by a diverse group of individuals who have spent their summer developing these use cases.

Initially, the Design Group had said that they would be providing final recommendations during today's meeting, however the group decided that there was so much information and effort necessary to validate the work and give justice to the time commitment of the Design Group, that they needed to push back the delivery of recommendations until October. In the interim, CedarBridge will be working to conduct further analysis on certain use cases that were identified by the Design Group through discussion and prioritization/sequencing activities. The Design Group will reconvene on October 4th and October 11th to work on validating the preliminary findings and developing final recommendations.

Because "Health Information Exchange" can have such a diverse array of meanings, Michael felt it was important to establish a baseline understanding of each Use Case in detail. The full inventory of Use Cases was suggested for review with the Council.

Michael went through overviews on the 31 use cases that are have been, and continue to be, evaluated by the design group. They are as follows, not in any priority or rank order:

- eCQM and IIS were prioritized by the Council earlier in the year. It was decided to bring these use cases into the prioritization activities to validate their priority and perceived value.
- Advance Directives – this was recognized as an important use case from the consumer perspective. Very few people have advance directives in place, but even fewer have them electronically available.
- Opioid Monitoring and Support Services – important use case with a high level of public health and political importance.
- Wounded Warriors
- Longitudinal Health Record – seen as a foundational component to many other use cases by the Design Group. This use case describes the delivery of a complete health record, from many different disparate sources.
- Emergency Department Super-utilizers

- Medication Reconciliation – this use case was investigated and it was determined that the process is broken. We are investigating further to make sure that we are considering a process re-design so that technology is not placed over a broken process.
- Care Coordination: Referral Management
- Care Coordination: Transitions of Care
- Care Coordination: Clinical Encounter Alerts – this use case was also seen as foundational to a number of other use cases, including ED Super Utilizers and Transitions of Care.
- Care Coordination: Care Plan Sharing – patients with chronic conditions may or may not have a care plan that is synched across their providers, but it is unlikely as there are no standards or required format for this.
- POLST / MOLST – Physician / Medical Orders for Life Sustaining Treatment – medical orders from a physician that are most relevant in the case of a life-threatening emergency situation.
- Disability Determination – this is a cumbersome process for Social Security and the state office to determine if someone qualifies for benefits. There are mechanisms to automate this process by sending discrete data to the SSA.
- Life Insurance Underwriting – similar to disability determination, creates efficiency in this process.
- Image Exchange – this is a new and emerging capability within HIEs across the country. There are various approaches for this process, and many considerations, such as how to connect PACS systems, association of radiology reports, etc.
- Population Health Analytics – this is one of the use cases that is not a transactional exchange of health information, this involves compiling large amounts of information for the purpose of conducting analysis.
- Public Health Reporting – this can be viewed in parallel to the IIS use case. Some states have stood up pathways or gateways that support data from various public health disciplines.
- Lab Results Delivery – providers need to receive labs in a discrete format so they can be integrated into the larger EHR. This has been stood up by some of the large reference labs already.
- Social Determinants of Health – if we are looking holistically at a patient's needs, the social determinants can be bigger than the health needs in some cases, or in many cases directly connected with health issues.
- Research / Clinical Trials – this use case has some sensitive issues with patient permissions, this use case focused on connecting patients with relevant clinical trials or investigators with data to support research.
- Patient Portal / Personal Health Record – aggregated, longitudinal access to health records by patient.
- Patient-generated Data – includes data from wearables, in-home monitors, etc. This use case is still developing rapidly in the market.
- Medical Orders / Order Management – important use case in the long-term, post-acute care sector.
- CHA Dose Registry – registry to track exposure to radiation.
- Bundle Management – this is alive and well in organizations such as orthopedics, where providers are being paid for a bundle of services.

- Emergency Medical Services – Exchange of information between EMS professionals and hospitals or other providers, as well as the ability for EMS companies to run outcome reports.
- Lab Orders
- Genomics – how can this information inform treatment decisions, diagnoses, etc.
- eConsult – electronic consultation of specialists

Council Questions:

Ted Doolittle asked why there are no use cases pertaining to waste, fraud, abuse, billing irregularities, or consumer protection. Michael Matthews responded that there is not a lot of discussion around this issue across the country, but it is an important topic and he and the team will do some follow up research.

Bob Tessier agreed that the issue of waste/abuse/fraud/etc. is important. Added that he was not certain as to what Use Case #9: Medication Reconciliation is; aware that physicians' offices overwhelmingly use fax machines, and that pharmacies and doctors are not effectively communicating. Does MedRec address this? Michael Matthews responded that doctors and pharmacies are connected. Fax machines are dwindling in terms of ePrescribing. SureScripts was stood up to address this issue, as well as communicating with PBMs. When a provider on a SureScripts enabled system sends a prescription to the pharmacy, it passes through the SureScripts gateway and is then populated into the pharmacy's information system. Pharmacies can send refill requests via this same gateway. There is an additional broken process. SureScripts works well on the front end. If a physician discontinues a prescription, mail order prescriptions keep coming, or they get pinged by pharmacies, because this is not communicated. The Design Group will wrestle with the broken process, and figure out a recommendation for solution.

Victoria Veltri asked if, under the Medication Reconciliation use case, was there a discussion about pharmacy-to-pharmacy communication? Michael Matthews responded that theoretically the pharmacies would have access to prescription information from other pharmacies, but he does not know who takes advantage of that capability for each prescription.

Mark Schaefer stated that he was captivated by the discussion in the HIE Use Case Design Group. Things will emerge where we see new, important use cases that we had not considered. Providers and consumers were recognized as primary beneficiaries, a health plan CEO reminded him about the importance of risk scoring for managed care plans and participating in the healthcare exchange. They pay handsomely for this kind of data capture today.

Michael Matthews continued with the HIE Use Case presentation:

Michael explained the Prioritization Activities and Criteria. Two activities were employed – a matrix and a more subjective survey. The scores were equalized and blended to create a rank-order top 10, which was discussed at length by the Design Group. The top 10 that came out of the activities did not necessarily align with the final top 10 recommendations for use cases that need additional analysis. It provided a starting point and reference point for an in-depth discussion by the Design Group. Criteria elements were validated by the Design Group and included a variety of topics that we determined to be of critical importance to stakeholders in Connecticut.

The Use Cases that have been identified for further analysis are as follows:

1. **IIS** – Affirmed by the HIE Use Case Design Group as a priority
2. **eCQM** – Affirmed by the HIE Use Case Design Group as a priority
3. **Longitudinal Health Record** – Foundational element for other use cases
4. **Clinical Encounter Alerts** – Foundational element for other use cases
5. **Public Health Reporting** – Complementary to, and supportive of the IIS use case
6. **Population Health Analytics** – Potential to leverage technology supporting the eCQM use case
7. **Patient Portal / PHR** – Consistent with the concept of the patient as the "North Star"
8. **Image Exchange** – Validated by the HIE Use Case Design Group for further analysis
    a. CedarBridge will be having a conversation with stakeholders in New York who are doing this currently.
9. **Medication Reconciliation** – Validated by the HIE Use Case Design Group for further analysis
10. **Advance Directives / MOLST** – Consistent with the concept of the patient as the "North Star"

Additional analysis is being conducted around the top 10 use cases – including business, financial, legal, policy and technical considerations. CedarBridge, HIT PMO, and UConn are building a Technology Matrix to ensure there is careful consideration of technical requirements. Michael Matthews stated that they need to make sure the group of use cases that is identified makes sense – which use cases can be supported by shared infrastructure, and which use cases requires specialized, unique technical infrastructure. CedarBridge will also be working to socialize and validate these use cases with targeted stakeholders to ensure we have adequate input.

Council Questions:

Pat Checko wanted to clarify that just because a use case is not listed in the top 10, this does not mean it that it is gone forever. Michael responded that yes, this is correct. The Health IT Advisory Council needs to be an ambassador of this message. At some point in the future, all of these use cases may be addressed, this is an effort to create a pragmatic, realistic, and viable first wave of use cases for implementation.

Dennis Mitchell asked if we are thinking about a long-term prospect of using artificial intelligence to support image exchange? Dr. Alan Kaye (via conference call, poor connection) stated that he is not sure what we are thinking about on this, and does not see how this would relate to the exchange of images. Dennis Mitchell clarified that he was referring to using the image repository to strengthen artificial intelligence in terms of radiological assessments. Michael Matthews stated that he would like to take this back to the design group and do some more research on the topic.

Dr. Quaranta stated that one topic he did not see brought up is the concept of clinical decision support – this is an important concept. How can we make sure a provider has relevant information in real-time that will support their decision making? Thinking of these use cases with a backdrop of clinical decision support – this is a concept he thinks should be considered in regard to each of these use cases by the Design Group. Michael Matthews stated that there are discussions around clinical

decision support happening around the country. Genomics is a great example – you are not just providing genomics data, you are providing clinical recommendations based on that data. Dr. Alan Kaye does not see how this is necessarily associated with the HIE. Lisa Stump agrees, stated that she feels that the decision support functionality typically lives within the EHR workflow, rather than the HIE. Michael Matthews responded that there was a KLAS study that confirmed most decision support is embedded within an EHR, but our goal could be to provide as much data as possible to ensure that decisions support is as effective as possible with the most data that is available. Lisa Stump clarified that this could be thought of more as population analytics, as opposed to decision support.

Dina Berlyn added that she was not sure that this is something that the HIE could help with this – but let's say you have a physician who is prescribed infusion, but does not want to use the hospital. Most hospitals do not make it easy to order infusions, as they say that it is technically impossible and must be faxed. Ordering infusions could be something that is considered.

Jennifer Macierowski stated that, in terms of waste, fraud, and abuse – the HIE is promoting efficiency and giving patients and providers the right information at the right time, but if we use it for law enforcement purposes, will that dissuade people from using the system? Also, can you elaborate on a longitudinal health record? Michael Matthews responded that the feeling of the group is that longitudinal health records are the ability to aggregate clinical data in one spot in order to inform clinical activities and treatment decisions is foundational to many other use cases.

Pat Charmel stated that from an operational standpoint, there are providers that need to be part of the HIE and they are feeling anxious about needing to be connected. Should that influence our decisions in order to make this competitive? I have a concern that people will be rushing to meet an immediate need. Michael Matthews responded that that point is not lost on the Design Group. The track record of standing up HIEs in Connecticut is not great, and we think quick wins will be important. We are trying to be realistic in terms of what is happening in the marketplace. Pat Charmel reiterated that we have to set a realistic timeline. Carol Robinson stated that it is great to be working in Connecticut because there is a compelling and fast driver of this process. The HITO is ensuring that we are moving quickly to try and plan for procurements that will meet the use cases. The communication of this is important in addressing the concerns you are raising. It is a dynamic balance – you do not want to get ahead of this process. Most of the technology components that you need to procure will be very similar across these use cases, therefore it is really more about the roll out of the services, rather than the specific technology components. Allan Hackney added that as the Design Group is finishing up these recommendations, there are numerous people beating the drum on sustainability. We are going to do something that is going to drive tangible value in the market. There is no debate about this issue. Time is not our friend here in Connecticut. The entity planning will be very important, it will provide speed and latitude.

Ted Doolittle stated that regarding of waste, fraud, and abuse, this does not mean that you are solely pro law enforcement – one example is using HIE to detect drug seeking behavior. This can be very consumer and provider friendly. I do think that not including waste, fraud, and abuse would be a clear miss.

	Allan Hackney stated that CedarBridge wanted everyone to understand what has gone into these discussions, it has been an endurance test. There is work product behind all of these slides that is very impressive. I am excited to see the final recommendations.	
9.	**HIE Entity Update**	**Allan Hackney**
	Allan Hackney gave an update on the HIE Entity development process. He stated that much of this work is happening behind the scenes. From our stakeholder engagement process from earlier this year, there were recommendations made for a neutral and trusted and trusted entity. Neutral means that you ensure the entity does not provide advantage to certain stakeholder groups over others. Trust means that you have oversight of the entity by the participants. From this input, we are looking to incorporate a nonprofit entity, pending the passage of the state budget implementer bill. Consistent with precedent from other states, 68% of HIEs are nonprofits, including the ones that have been most successful. Our goal is to establish this entity by January 2018. The timing of this is critical; in terms of competitiveness, the Allan Hackney has had many conversations with Commissioner Curry (DAS) about how to procure for these types of services. Their advice has been to identify a different process than the one DAS employs; it is rule-driven, time-boxed, prescriptive, and has been estimated to take as long as 12 to 15 months to complete. Allan Hackney has been researching other procurement avenues that can meet market speed, and the statutory language has been drafted and approved. It is sitting in draft form in the implementer bill and once approved, the HITO can start working almost immediately.	
10.	**Wrap Up and Next Steps**	**Kelsey Lawlor**
	Kelsey Lawlor thanked the Council for their attendance and reviewed the action items: 1. Michael Matthews will take feedback from the Council back to the HIE Use Case Design Group to look further into the topics of waste/fraud/abuse, pharmacy-to-pharmacy interactions, and artificial intelligence. 2. Allan will provide examples of 501(c)3 organizations that have been established by the State of Connecticut or other states Allan Hackney asked for a motion to adjourn the meeting. A motion was made and seconded. All in favor unanimously to adjourn at 3:54 PM.	

Key Deliverables/Action Items

Action Item	Responsible Party	Date Due
Michael Matthews will take feedback from the Council back to the HIE Use Case Design Group to look further into the topics of waste/fraud/abuse, pharmacy-to-pharmacy interactions, and artificial intelligence.	CedarBridge	October 19, 2017
Allan will provide examples of 501(c)3 organizations that have been established by the State of Connecticut or other states	Allan Hackney	October 19, 2017