

Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
Sept. 27, 2018	1:00 pm – 3:00 pm	Hearing Room 1D, Legislative Office Building 300 Capitol Avenue, Hartford CT

Council Members				
Allan Hackney, HITO (Co-Chair)	X	Mark Schaefer, SIM	X	Raj Chawla, AHCT
Joseph Quaranta (Co-Chair)	X	Bruce Metz, UCHC CIO	X	Lisa Stump
Joe Stanford, DSS	X	Ted Doolittle, OHA	X	Jake Star
Mary Kate Mason, DMHAS	X	Kathleen DeMatteo		Patrick Charmel
Cindy Butterfield, DCF		David Fusco		Alan Kaye, MD
Cheryl Cepelak, DOC		Nicolangelo Scibelli	X	Dina Berlyn
Vanessa Hinton, DPH	X	Patricia Checko	X	Prasad Srinivasan, MD
Dennis C. Mitchell, DDS	X	Robert Tessier	X	Tekisha Everette
Mark Raymond, CIO	X	Robert Rioux	X	Patrick Troy, MD
Sandra Czunas, OSC		Jeannette DeJesus		Stacy Beck
Supporting Leadership				
Victoria Veltri, OHS		Dr. Tom Agresta, UConn Health	X	Tim Pletcher, Velatura
Sarju Shah, OHS	X	Alan Fontes, UCONN AIMS	X	Rick Wilkening, Velatura
Jennifer Richmond, OHS	X	Kate Hayden, UConn Health	X	Lisa Moon, Velatura
Kelsey Lawlor, OHS	X	Michael Matthews, CedarBridge	X	Lauren Kosowski, Velatura
MJ Lamelin, OHS		Chris Robinson, CedarBridge	X	Courtney DelGoffe, Velatura
Open Appointments				
<i>Representative of the Connecticut State Medical Society (President Pro Tempore of Senate)</i>				
<i>Speaker of the House of Representatives or designee</i>				

Agenda			
	Topic	Responsible Party	Time
1.	Welcome & Call to Order	Allan Hackney	1:00 PM
	Allan Hackney welcomed the Council and called the meeting to order. Kelsey Lawlor gave an overview of the agenda.		
2.	Public Comment	Attendees	1:05 PM
	There was no public comment.		
3.	Updates	Allan Hackney	1:10 PM
	Allan introduced Mary Kate Mason who is representing the Department of Mental Health and Addiction Services. Mary Kate is currently the director of government affairs and the active chief of staff for the department, and is excited to learn more about what this Council is working on.		
	Allan then shared that the IAPD-U was recently approved by CMS and the team is very excited to move into implementation. Allan thanked the team from the Office of Health Strategy (OHS) and the Department of Social Services (DSS) that worked so hard to develop and submit the IAPD.		
4.	Review and Approval of the July 19, 2018 Minutes	Council Members	1:20 PM
	Once a quorum was established, Allan Hackney asked for a motion to approve the minutes from the July 19, 2018 meeting. Alan Kaye moved to approve the July 19 th minutes, Rob Rioux seconded the motion; all Council members voted to approve the minutes, with no oppositions and Pat Checko and Mary Kate Mason abstaining.		
5.	Dept. of Social Services Presentation	Dr. Minakshi Tikoo	1:15 PM
	Joe Stanford, Commissioner Bremby of DSS' designee on the Council, opened by stating that the department is excited to continue collaboration to get these activities in motion. DSS has had funding for a few years, which		

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has allowed them to move forward with a number of initiatives, and this council has stressed reusability and the goal of moving quickly. Dr. Minakshi Tikoo will be presenting on DSS' activities and initiatives.

Dr. Tikoo began by sharing DSS' mission and vision: to provide a healthy, secure, and thriving environment for everyone. Health IT ties in with DSS' goals to drive decision making through the enhanced use of data. DSS wants to be transparent in how they use their data and provide reporting in the public domain. Two weeks ago, they put some of their enrollment data in the public domain, which can be accessed via their online portal. As background, Dr. Tikoo stated that the population of Connecticut is 3.58 million and DSS serves over 1 million people per year. DSS has eligibility and enrollment data, lab tests, and the enterprise master person index (EMPI) to de-duplicate data. DSS also receives data from the health insurance exchange, claims data, the EHR incentive program, and provider data.

On slide 14 of her presentation, Dr. Tikoo showed a diagram of OHS's vision of a "network of networks" model for health information exchange. On the left-hand side of the diagram are the public and private HIEs, such as CTHealthLink and other state HIEs. In keeping with that picture, this is how DSS has worked on the Medicaid HIE Node to connect with the statewide utility. She added that the Medicaid HIE node is just one node. DSS already has an agreement in place with CTHealthLink and they are in the process of testing. DSS also has alert notifications/HISP services provided through Secure Exchange Solutions (SES). The Personal Health Record (PHR) went live on Monday 9/24, and is the platform that allows beneficiaries to be involved in their own care. Health Insight and the Zato Platform both exist in the spirit of business analysis; these systems have the ability for dashboarding, analysis, and more. The EMPI is a technology from NextGate, which is also the provider for the Provider Registry, and allows for relationships, such as provider-to-patient and provider-to-provider. The Medicaid HIE Node is an InterSystems platform, which is where data is aggregated. The Medicaid HIE Node is certified and uses various standards.

Dr. Tikoo then discussed identity challenges. The EMPI tries to solve for the identification of individuals across systems; each system uses their own unique identifier, and as systems talk to one another, the different identifiers create issues. The EMPI creates a unique identifier that links the identifiers from other systems. The EMPI is a centralized and trusted directory to manage and share patient information across healthcare settings, applications, and organizations. This technology comes with the ability to manage this workflow and keep the data clean. It also provides the ability to look up a person. The EMPI creates a common identifier which is used in the Medicaid HIE Node. This technology was set up in the Bureau of Enterprise Systems & Technology's (BEST) environment. Currently DSS and AccessHealth CT are using the system, and the Connecticut Office of Early Childhood (OEC) will begin using the system in October 2018. DSS is curating the data with addresses, phone numbers, and other data elements to provide more information. In the DSS data governance efforts, they have reached out to others who have expressed interest in the EMPI and the system may be updated to meet their needs. Today, there are 3.28 million individuals in the EMPI. Every morning, duplicates are identified and sent to the source system for clean-up. For example, DSS will clean up their own duplicates, AccessHealth CT will clean up their own duplicates, etc. On average, 60 duplicates are created per day.

At this point, Jake Star asked Dr. Tikoo for clarity on who has been involved in the development of their data elements. Dr. Tikoo responded that in 2014 and 2015 the department reached out to hospitals who did not have any interest in using this system. They did have interest in being able to ping the DSS EMPI in order to see if their individual were included in the EMPI.

Bob Tessier then asked Dr. Tikoo a question regarding the chart on slide 21. He asked for clarity as to which data the middle row was referring to. Dr. Tikoo answered that these numbers represent the individuals who

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have come to the Exchange to purchase health insurance, and includes the people who were re-routed for Medicaid eligibility.

Dr. Tikoo continued her presentation and discussed the Enterprise Provider Registry (EPR) previously mentioned. This system manages the identity of an organization. DSS captures data at the provider level and displays the single best record with the best information for any given individual. They also have data from the Medicaid Administrative Services Organization (ASO), the long-term support services ASO, federal data, and the MMIS data. DSS is also working with the dental and behavioral health ASOs to get this information curated and added to the EMPI. DSS wants to uniquely see who a person is. The technology is identical to the EMPI but is managed specifically for providers. On slide 27, Dr. Tikoo showed data on how many records are contained within the EPR. DSS publishes a provider directory for their beneficiaries, and is looking to have a public facing directory that is searchable as part of phase 2. She went on to state that relationship management is a phase 2 activity. Now that they have the EMPI and EPR, DSS can manage relationships between provider/patient, provider/facility, provider/provider, and patients/other people, as a few examples. If you want to alert a provider based on a person's admission to the emergency department, then the relationship management will alert providers; you need to be able to see attribution and have a mechanism to do this transparently and in an auditable way. Dr. Tikoo explained that their Data Quality Manager Tool provides DSS a way to manage their data and to allow their providers and data stewards to validate and compare data. They have different levels of people who are involved in the clean-up process. DSS has moved to a new eligibility and enrollment system and need specialists to review cases. They have many reporting capabilities in this tool; they do records counts, look at who is cleaning up data, and give people the ability to download data for clean-up. DSS has been very pleased with this technology.

In regards to the EMPI & EPR Onboarding Process, DSS has been working with state agencies on this technology. Now that they have had the EMPI for two years, this has become more nuanced and they believe it is in a good place.

Next, Dr. Tikoo stated that DSS has talked to the Council previously about Project Notify. Through this program, DSS gets the admissions, discharge, transfer (ADT) alerts from the hospital systems. Based on these real-time alerts, they match them with the Medicaid beneficiary to see who has been admitted and tie them back to the care team. Based on what the provider has asked for, we deliver the report to them in the manner they have requested. To participate in these alerts, the key tasks on the provider side are straight forward - including signing an addendum, testing rosters, enrolling in Direct accounts, and training, among other tasks. Providers select valued alerts and desired format and then patients are registered/enrolled. Once the ADT comes in, the alert is triggered and sent to the individuals who are identified in the care team. Alerts are sent many different ways. Slide 35 shows the PDF and XML formats of the alerts. Today, DSS is live with Yale New Haven Health System and Hartford Healthcare System (who went live last week). This includes 12 hospitals across those two systems.

At this point, Dr. Joe Quaranta asked Dr. Tikoo if this process had to be followed and implemented by each provider who wants to access ADTs. He stated that it does not look like an easy process, and asked if it's been easy for providers to comply with. Dr. Tikoo answered that the department has not heard that this has been onerous on people. We have done this at small and large practices. We also have the option for providers to receive their alerts outside of their EHR, which does not require these steps. Dr. Quaranta asked Dr. Tikoo how many providers today have completed these required tasks. Dr. Tikoo answered that she did not have a complete unique count at this time. Dr. Quaranta asked how many participants are using a manual process. Dr. Tikoo answered that they do not know how many people are using the manual process. The ADTs are not tied to fax machines, so DSS cannot track this. No one has asked for DSS to deliver alerts manually, but they could accommodate this.

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Dr. Tikoo continued her presentation. She showed the Council a diagram outlining the notification process, found on slide 38. She stated that DSS is testing with many of the FQHCs in the state, and they are currently live with Beacon Health.

Jake Star stated that he is trying to understand what is currently up and running. Are alerts going back to the hospital and the folks who are connected? We learned about this system a few years ago, and he is concerned that we will have to build an interface for this and one for PatientPing. He asked if his organization is getting anything back out of this system. Dr. Tikoo answered that the hospitals don't want to receive an alert back at this time. If they did, DSS could accommodate this. This depends on whether or not the hospital wants to report back. Jake Star asked for Dr. Tikoo to clarify how this impacts providers beyond the hospital setting, home health care for example. Dr. Tikoo responded that these messages are targeted to the care team and the PCPs outside of the hospital; the alerts are coming from the hospitals to the care team, and it could be a care manager or navigator, or whoever was identified to receive the alerts. In the case of Beacon, they have been live since March. One day the system was down for two hours and Beacon did not know how they did care coordination before they were receiving alerts. Sometimes the ADTs have better contact information than what is in their system, which is very useful. Jake Star asked Dr. Tikoo if she understands that two ADT systems means duplicate work. Jake explained that he runs a small home care agency, and cannot afford to pay for multiple interfaces. He asked if DSS has looked at integrating. Dr. Tikoo answered that, yes, they have thought about this, but they aren't going into detail on this. As they have worked with the Connecticut Hospital Association (CHA), it was decided that they could not provide the feed to us which put our project behind by ten months. DSS had to go back and look at how we could get this ADT feed. The hospitals have not said this is a duplication of efforts. It would bear some evaluation to make sure it meets the use case for everyone who will use the ADT information to take better care of the people they are serving.

Mark Raymond stated that he had an observation of where the group was in the dialogue. He stated that it sounds like the focus is on the need for a broad HIE to connect and share. We are not trying to constrain innovation - we are looking to foster innovation. We should look to minimize overlap but recognize that it is still going to exist. He respects the question and thinks that is why this group is here; not to constrain DSS or anybody else in terms of their investments, but to create the connectivity that minimizes the long-term effects. He thinks the groups will have a lot of conversations like this moving forward.

Patrick Charmel stated that he was curious about the provider database itself. He asked if the service is exclusive to Medicaid-certified providers. Dr. Tikoo responded that that is correct. Patrick Charmel then asked what percentage of the whole Medicaid providers represent in CT. Dr. Tikoo answered that this is an interesting question. Some people say it represents 100% of the providers; this is the argument that was used to help secure the federal 90/10 match funding. Dr. Tikoo believes it represents a significant portion of the providers. In 2012, DSS did an assessment, which is in the public domain, which said about 30% of provider information changes every day. There is a huge amount of movement within a provider network. Everyone is working to keep the data clean which creates a lot of work for everyone else. She stated that she does not have an exact number of providers.

Dr. Tikoo resumed her presentation at slide #43 on Electronic Clinical Quality Measures (eCQMs). She stated that when providers come to attest to Meaningful Use, DSS has the option for them to use QRDA 3 or 1 to allow them to qualify for eCQMs. DSS has tested with Yale and Hartford and they would like to use this in the future. Slide 44 shows a picture of the submission process results. The report tells you the program year, the CQM, the numerator and denominator, etc. Slide 45 shows an example of a processing results report from DSS for a QRDS Category 1 submission. DSS has used open source software, and has received certification from ONC. This allows for us to have better quality data and frees up the providers. Yale and Hartford are using Epic, along with

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many other providers and groups across CT. These individuals should have an ok-time connecting to DSS systems, and the department is testing with other EHRs as well to see if they can produce the desired results.

Dr. Tikoo then discussed the Personal Health Record (PHR). The PHR is an InterSystems platform. This has a simple and user-friendly interface that allows beneficiaries to look at their data. It allows for them to access their health data, care plan data, lab data, etc. as seen on slide 48. The platform allows people to create their own goals, manage their own budgets, and hire people to service their needs. We have the ability to create electronic care plans and this creates a budget which is sent to an intermediary. This allows them to see a timeline view and a category view where data can be viewed in terms of months or category, such as labs, allergies, etc. On slide 50, Dr. Tikoo showed that the care plan clinical care document (CCD) has been consumed by the PHR in this example. It is all coming in electronically and no one is hand-entering any data into their PHR.

Patrick Charmel asked Dr. Tikoo to talk about how clinical data is populating the PHR. Dr. Tikoo answered that Claims data is coming in as well as the ADTs. The third source of data is the care plan data. Patrick Charmel clarified that Dr. Tikoo was inferring that clinical data is not there yet. Dr. Tikoo responded that there is some clinical data in the ADT, and DSS is curating the data from the labs and they will receive information from CTHealthLink.

Dr. Tikoo continued that the PHR allows people to decide who they want to share data with. They can also look up information in the health dictionary (slide 53) and access their account history (slide 54). This functionality allows for the beneficiary to keep track of an individual.

Dr. Tikoo concluded her slide presentation and the floor was opened for Council discussion.

Dr. Alan Kaye stated that he was very surprised that he did not know any of these DSS activities were going on. He asked if the Council knew there was a completely parallel, state-run process to what the Council and the HITO have been spearheading. He reiterated that he was not aware, and noted that it was clear that a lot of work has gone on here on the part of DSS. It seemed to Dr. Kaye that DSS has been working in a parallel universe to what the Council has been doing. He has many more questions: why did the Council not know about this? Where does the funding go for these things and where does it come from? He stated that he knows there have been some funding issues in the past few years. Our success is going to be driven by lack of duplication. Before the merger of SIM and this Council, the question was how we are going to collaborate with SIM. Once the merger happened, we are still operating with cross-purposes. Should we buy or build? Dr. Kaye wanted to know if there are any other members of the Council who feel the same way. He said this feels like the wild west. Clearly discussions are going on with DSS and the hospitals whose representatives sit at this table. What is going on? Bob Tessier stated that he did not believe that Dr. Kaye's feelings and reactions were wrong. He added that he remembered that the Council was introduced to DSS's projects earlier this year, but it was fairly recently. He stated that he thinks those members of the Council who were made aware earlier had the same reaction. At this point, Bob Tessier stated that he is past that initial surprise, and was anxious for today's presentation. It was good to get a more detailed report on what's been happening, but he was unsure as to how DSS's activities fit into the broader Health IT efforts of this body. He asked how DSS envisions their Medicaid tool fitting into a broader interoperable system.

Dr. Kaye asked what the Council knew, and at what point did they know it. He referenced the past immunization discussions that took place, and said that this process is about how we work together – not about inheriting others' work. In regards to immunizations, he was told that the group had to pursue the project because there was federal funding at stake. He emphasized that this was a one-off situation, and not a model for future initiatives. He asked who the Council has to answer to regarding the federal funds. He stated that he believes this issue needs to be addressed for himself, the people he represents, and the legislators who pushed hard to get this Council established.

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Dina Berlyn asked what the federal government's response was to getting parallel funding requests from DSS and the HITO. Allan Hackney responded that the position of the feds on his portion of the funding request was that when we decided on our use cases and moved to implementation, we agreed to evaluate the tools that Minakshi has been describing. This was our response to the feds concerns, but he would have to defer to DSS for their positions relative to this question. Dina Berlyn asked if the feds express concern that they are funding the same thing twice. Joe Stanford answered that there were issues that slowed down the IAPD process, and this was part of the problem. They did not want to fund the same thing twice. The intent was to make these tools available statewide, which created problems with CMS in regard to funding.

Patrick Charmel stated that he had a question about process. Whether it is the legislation or the spirit of what the Council has been engaged in, he thinks everyone agrees that this should be an inclusive process where all of the stakeholders are around the table describing what we want to build and agreeing on components and use cases. DSS has done this in isolation against the spirit of what the Council wanted. This is the most troubling. He has seen this happen three times. Now that the money shows up, people then fund something that was built in isolation. There are components presented today that we have been made aware of, that we objected to, which apparently still exist. He also found this troubling.

Dina Berlyn asked under what authority DSS went forward with these activities. She noted that it was not under the authority of PA 15-146. Joe Stanford responded that these activities go back to 2007, and they are not something DSS did in isolation. This process has been going on for some time. Dr. Tikoo added that in terms of funding, these programs are funded under the same vehicle as the IAPD which has been reviewed by the Committee and was originally approved in 2010. The funding is coming from CMS, and if you go back to the SIM Health IT portion of the grant, these technologies are outlined in that document from that time. The logic model is included in that grant as well. DSS has shared this publicly and the way they describe this has been in the IAPD. The EMPI and Provider Registry are the leftovers from first effort of HITE-CT which are good tools that the state had already paid for and wanted to continue to use. DSS has a purposeful vision for how to use these technologies and always wants the work to be standards-based.

Patricia Checko stated that she believes the group needs to get beyond some of this, and move towards what they want to do now. She asked if DSS is offering their tools to the Council to use and integrate as they see fit? She also stated that, after sitting on the Health IT Advisory Council for the past 18 months, she had to disagree that these activities have been occurring in a good-faith basis around the OHS SIM project. She feels that it is clear to herself and many of the Council members that DSS has another vision in mind, and was pushing Zato down the Council's throats. She believes it is disingenuous to suggest this direction and information was out there. A lot of money and time have been spent on a system that is expensive to sustain and that is similar to other HIEs in the country that are now failing. The most important question at this time is, given the lack of data, what DSS has that this group should take on. Or, is it DSS's desire that Medicaid itself should become the node when we are clearly talking about becoming the HIE node? Dr. Tikoo answered that Allan Hackney stated that his team would evaluate DSS's tools for use by this Council for the use cases that get identified. This is what was articulated to CMS. These technologies are available to everybody at a fair cost basis, which is CMS' ruling. She stated that they would be evaluating each of these pieces for usefulness and the Council's vision for the HIE. Dr. Tikoo was not sure of the "node of the node", but thought the Council would be standing up the service utility and that everyone who is playing in this ethos or ecology is connecting to whoever they want to connect with, which is kind of the model that she thought the Council put forward.

Dr. Alan Kaye stated that he wanted to reinforce Patricia Checko's comments, and extended them further. He reiterated the Council's need to decide what to do with this information from DSS and how to go forward. This should be the next order of business – the Council needs to learn from its history. He stated that when the original SIM Council merged to create this current body, everyone's assumption was that this would be great

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and there would be adequate coordination. After a few meetings, it became clear that there was no merger of thought, but at least there would be an opportunity to hash the issues out transparently. This has not been transparent. The Council needs assurance that they are not spinning their wheels. Two state-organized entities need to be able to talk to one another. As a taxpayer as well, Dr. Kaye does not like this kind of duplication. He expressed the need for honest conversations about how the group moves forward and what the process will be.

Dina Berlyn stated that she feels like it is a bit off that DSS continued to purchase these tools when they knew there was a state-wide entity that was in the works. They should have been more cooperative, and this is not consistent with the way the HIE was designed in PA 15-146. There was supposed to be one thing – there was not supposed to be DSS doing one HIE for itself and the state doing another. She stated that she does not believe this behavior is consistent with the legislative intent.

Allan Hackney noted that the discussion was running over time, and thanked Dr. Tikoo for her presentation.

Patricia Checko asked if it would be appropriate to request that DSS respond to the Council's questions in writing. They brought this presentation to the Council, and it is unclear what they were looking for in response. Joe Stanford answered that he did not think it was unreasonable to ask for a written response from DSS. He stated that they have been working with Allan Hackney, and the intent was that as this Council moves forward, DSS would present their tools for the Council to evaluate and make decisions about whether they want to incorporate the use of those tools or not. He added that DSS would share what was shared with CMS.

6.	HIE Entity Planning	Michael Matthews, CedarBridge Jennifer Richmond, OHS	
	Michael Matthews gave the Council an overview of a framework for how to think about this work now that we are moving into implementation mode. The framework is found on slide 63. He emphasized that this is not a linear process, and there will be planning periods occurring simultaneously along the way. Jennifer Richmond then gave an update on the HIE Entity. She referenced the work of the Governance Design Group, whose recommendations laid the foundation for how the entity should take shape. In addition, the Design Group's work to develop key characteristics of a successful trust agreement and trust framework for the entity allowed the OHS team to be able to respond quickly once the IAPD-U funding was approved. Jennifer stated that they are working to secure additional legal support from Bill Roberts of Shipman & Goodwin, and a participant in the Governance Design Group. They also have a draft charter under way and are developing staffing models.		
7.	OHS Data Sharing Activities - Updates	Alan Fontes, UConn AIMS Tim Pletcher, Velatura Mark Abraham, DataHaven	
	Alan Fontes gave an update on the CDAS eCQM Model. The goal of the eCQM Model is to enhance and broaden the Office of the State Comptroller (OSC)'s visibility into quality outcomes by capturing person-centric data and calculating individual and aggregated quality and utilization measures. OSC has been doing some of this work already, and this Model will build the next layer of value for OSC by adding clinical data. As was mentioned before, this is all at the person-centric level. They are looking at a standard set of eCQMs that go across all organizations and are working with the different organizations about what measures they use, what they want to see, and to validate our current list of measures. This project is supported by the eCQM Design Group from a year ago. OHS put out a Request for Agreement (RFA) for the eCQM Model to look at early adopters and to take a look at how to get clinical data to calculate eCQMs. QRDA 1 and QRDA 3 are usually inaccurate - they want to remove false positives that emerge from EHR systems, which are tracking data as it is entered, but need to have the data cleaned in order to calculate denominators effectively. Through the RFA, there were eight qualified		

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respondents, including one FQHC, three ACOs, and three hospital-anchored organizations. The respondents have been divided into 2 different waves, and work will begin with the teams on the ground to figure out what data can be used to start calculating the measures and do a comparative analysis. There are also two health insurance payers who are very interested in the Model, thanks to Tom Woodruff. Initially, there was only going to be a focus on the OSC population, but the insurers wanted to broaden this scope. This will enable the analysis to look back historically to develop trends. Work has already begun with the participants on the agreement and budget sides to begin the process of releasing funds from CMS and CMMI. Alan stated that they are targeting contract execution for wave 1 by November 1st, and wave 2 by December 20th.

Patrick Charmel asked what the process is for determining the quality measures and who agrees to this. He asked who is making the determinations about what will be looked at, noting that he thinks providers will be concerned. Alan Fontes answered that he believes the initial list of quality measures was put together by OSC, and that the technical team will also assess what data they can actually get from each system. He stated that they want participant input. Mark Schaefer added that, as a point of clarification, the list was taken from the core measure set that was recommended by the SIM Quality Council. CHA is part of this body. This is a carefully curated list that is updated annually to make sure NQF endorsements are in-tact. This is the starting point for the core measure set that they are trying to get payers and providers to align on.

Jake Star asked, given the presentation that the Council viewed earlier in the meeting, if Alan could provide a comparison of the eCQM work he is doing to the eCQM work that DSS is doing. Alan answered that they are looking to get the base data from the systems and the clinical value from the EHRs to calculate their eCQMs. This is different than the EHR calculating the QRDAs directly. Alan's process will take the clinical data and calculate the eCQMs and then compare it to what the EHR system actually produces to see the differences. Understanding these discrepancies is key. For Meaningful Use, we know the denominators being produced are not accurate. This is why getting the base data is important; you don't want to use just the QRDA 1 and 3 because those are not accurate. Alan Kaye commented that this is very telling; this is supposed to be a statewide measure that everyone adheres to, whereas the DSS process is dependent on whichever EHR is being used. He asked Alan if it were possible to have 20 different sets of data, where only 2 or three are in common. Alan answered that yes, this is correct. That is why it is so crucial to get the lowered level of data to calculate the measure, which allows for apples to apples comparison. With the QRDAs, it's difficult to make comparisons because the basis is unknown and often inaccurate.

Next, Tim Pletcher of Velatura gave an update on their work this summer on workgroups and stakeholder engagement. After catching up on the work done by CedarBridge in their environmental scan last year, and then conducting their own series of meetings with a diverse array of stakeholders this summer, Tim explained that a set of themes had emerged. First, he stated that much of the data that is or will be shared as a part of this work will be based on attributed populations. They will be establishing connection points for patients around the state, which will serve as the basis of decision making – starting with who is and isn't entitled to receive such data. This will help improve patient matching and calculation of quality measures. Next, there was a common theme of the patient being the “north star” of this work, as well as opportunity for mutually beneficial solutions for providers and consumers. People are also anxious for signs of momentum, and a lot of enthusiasm for these efforts to be successful. Additionally, it is clear that we need to learn from past mistakes, including the importance of consulting stakeholders throughout the process. Tim added that, as part of the focused momentum, some of the things that are bubbling up as action items are to:

- Prioritize use cases based on stakeholder feedback
- Do not let anything slow down our CDAS eCQM model that has already been started. Quality Measure Information (QMI), which may surface as a new acronym, is a general bucket for the quality information sharing that is really important to how evaluate thing moving forward.

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- The encounter notification use case, which has already been prioritized very high and has progress around the state.
- Sharing clinical summaries is another. This is something that has recently generated more focus at the national level use case. This includes pushing these documents, which can be a good source of information and can begin to solve a lot of problems.
- Immunizations and public health are a really important part to include in the HIE.
- The second big area is to initiate legal signoff and data flow for use cases, such as payers sending claims. Alan did not mention this as a difference between CDAS and what we saw from DSS. The CDAS model is also getting claims, in addition to clinical information. This is a powerful way to do standardized quality measurement.
- Providers sending clinical summaries and patient panels. You need accurate rosters to calculate measures. Providers sending clinical summaries based on the patient panels.

Dr. Quaranta asked Tim to provide more detail on what they are considering a clinical summary. Tim answered that they are using C-CDAs (consolidated clinical document architecture). A CCD is a handful of documents that adhere to the C-CDA format.

Tim then discussed upcoming workgroups. The first workgroup will be the QMI Work Group, which will be focused on defining data sharing as it relates to QMI, specifications, implementation concerns, how we standardize things and provide feedback to Alan Fontes team. The second workgroup is the Data Governance / Stewardship Work Group. These are the technology, data wonk equivalents who want to improve the content and quality of the data and work towards the golden record opportunities. Tim noted that there are several items to watch for in the next few months, including the legal connectivity process that is going to happen prior to the entity forming (but that will accelerate after the entity is created), as well as starting to see data flow through the eCQM model. They will also begin to launch some operational engagement opportunities.

Mark Abraham of DataHaven then discussed work being done around health equity and social determinants of health. Specifically, his team and colleagues at Health Equity Solutions and the Yale School of Medicine Equity Research Innovation Center are working with the Office of Health Strategy to integrate health equity components into the architecture and then will be developing a pilot case study. He explained that the goal of the project is to identify within the early stage of this initiative, some health equity data elements that are most relevant, most meaningful, and that are statistically sound. One possible use case is a prototype for how health equity data elements can inform clinical outcomes. This is the example that has been found in other HIEs around the country. The project has already begun and goes through April 2019. They will be doing some stakeholder engagement to identify the data elements and work from the informatics side to see how to plan for the architecture of the HIE to analyze those elements. He also noted that they are using the Healthy People 2020 definitions of Health Equity. It is very important to ensure the structure can anticipate changes and provide a model that can test and prove the importance of this type of analysis and how this can inform state health policy moving forward.

Patricia Checko stated that those who do not know Mark, he is a well-hidden secret, and this is an incredible use of public health and epidemiology and ways to get at what people do and don't have. She and the Council are looking forward to the outcomes of this work.

8.	Medication Reconciliation & Polypharmacy Workgroup	Dr. Tom Agresta, UConn Health	
	Dr. Tom Agresta of UConn Health gave an update on the work of the Medication Reconciliation and Polypharmacy (MRP) Work Group. They held their first official meeting on September 24 th , and there will be a number of updates over the course of the year as the group has its meetings. He stated that it was an energetic first meeting, with nearly all members in attendance. During the meeting, they established some key goals for the initial time frame. One, they want to think about the patient as the north star, and want the right thing to do to be the easiest thing to do. They discussed the idea of a "single source of truth" for medications. They also		

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recognized a need to come to agreement on how to define medication reconciliation and polypharmacy in the context of this group, as well as conduct a survey or scan of existing technology to leverage (ex. The Prescription Drug Monitoring Program). They also want to construct a success framework, and agree that there will likely be subgroups taking up these different activities.

Bruce Metz, a member of the work group, thanked Dr. Agresta for the overview and stated that it was an excellent meeting, and it was clear that there is a lot of expertise in the group. He noted that they will need to prioritize what they want to tackle, and having input from the larger Health IT Advisory Council members would be beneficial in helping to create boundaries and scope.

9. Final Discussion	Council Members
	<p>Mark Raymond commented that someone once told him, "when something went wrong, you told me, but you didn't tell me in a way that I really understood." He said that this was a very important piece of feedback for him, and he felt it was applicable to today's discussion. In the earlier conversation with DSS, the Council knew about these things. In the Environmental Scan from 2017, these things were identified and funded. Knowing the group, he can only attribute it to the Council not fully understanding what they were being told. To get the level of collaboration that is needed is a once per month time commitment sufficient to get the collaboration that everyone wants? There is a lot going on, not just at the state, but in the private sector as well. There are investments being made. As a group, how do we get to this level of collaboration and understanding? He thinks good communication requires both sharing and listening, and group is missing some of this. A part-time group like this cannot treat this topic in the depth it requires. This is an observation, he does not have any answers for today.</p> <p>Alan Kaye answered that he agrees about the part-time nature of this group. Under Allan Hackney's leadership, he feels that they've made significant progress. Part of this success was the small design groups that have come up with universally accepted (by the Council) processes. To Mark Raymond's first point, he feels that there was a compact here when the two Councils were merged that there would be collaboration and open discussion amongst stakeholders, and this has not happened on the part of DSS. Open collaboration and communication is critical. Some people brought this up previously, including himself, as a concern and it was ignored. There has to be a compact that we are working on this together and are not going to move in a parallel universe and something won't be sprung on us in the eleventh hour. If there is a way to put this in a resolution, he would like to hear some suggestions.</p> <p>Patrick Charmel stated that maybe he was not as direct as he should have been earlier in the conversation. What he stated was that there were components of what was described today that were presented previously. The Council went on record as opposing these efforts. There is no recognition of this from DSS. DSS went on and continued to develop what we opposed. If we are going to collaborate, there has to be a mutual respect and trust. This seems to be missing. Otherwise, why is the Council here?</p> <p>Dina Berlyn stated that she does not understand under what authority DSS went forward. It certainly wasn't the authority under 15-146. She does not understand how they did what they did.</p> <p>Jake Star stated that he agrees with both Mark and Alan Kaye. He does believe part of this was presented to the Council – he remembers Commissioner Bremby describing ProjectNotify and their need to move forward. They also reviewed the IAPD on a call and Commissioner Bremby clarified what the Council's role is in reviewing the IAPD and yes, we expressed concerns about it, but were not in the position to approve the IAPD. He also agreed that there has not been collaboration since then. There is a history of a lack of trust, which was discussed in the Governance group, and as part of the charter, we are required to review the systems that the state has in place as we build out an HIE. It</p>

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becomes difficult for the Council to consider adopting these systems without establishing trust and getting more stakeholders involved.

Bruce Metz commented that while he may not fully know all of the history behind this discussion, he has seen other areas of the state that are doing parallel initiatives that are valuable in their own right for their organizations. In order to really collaborate, there needs to be some formal mechanism to collaborate. He doesn't know if the Council can formally charter a work group to help coordinate and integrate similar activities across the state, but he thinks the potential value would be huge. He would be happy to work with others and with Allan Hackney on a work group to integrate these other efforts effectively. There needs to be some orchestrated plan and approach to do this and some regular outreach. For example, he recently received an offer to participate on a work group with CHA on SDOH. That would be a nice fit here. When Alan Fontes came and talked at UConn Health Center regarding the eCQM Model, a number of questions came up. There will be questions, but he thinks we have to structure this and take ownership of it and he would be happy to support this.

10.	Wrap up and Meeting Adjournment	Allan Hackney	3:00 PM
Allan thanked the Council for their attendance and asked for a motion to adjourn. Vanessa Hinton moved to adjourn, and Rob Rioux seconded the motion. The membership voted unanimously to adjourn.			

Upcoming Meeting Schedule: 2018 Dates –October 18th, November 15th, December 20th

Meeting information is located at: <https://portal.ct.gov/OHS/Services/Health-Information-Technology>