

Health Information Technology Advisory Council

Meeting Minutes

MEETING DATE	MEETING TIME	Location
April 18, 2019	1:00PM – 3:00PM	Hearing Room 1C, Legislative Office Building 300 Capitol Ave, Hartford CT

COUNCIL MEMBERS

Allan Hackney, HITO (Co-Chair)	X	Sandra Czunas	X	Jeanette DeJesus	
Joseph Quaranta (Co-Chair)		Mark Schaefer		Robert Blundo	
Joe Stanford	X	Bruce Metz	X	Lisa Stump	
Mary Kate Mason		Ted Doolittle	X	Patrick Charmel	T
Cindy Butterfield	T	David Fusco		Alan Kaye, MD	X
Cheryl Cepelak		Nicolangelo Scibelli	T	Dina Berlyn	X
Vanessa Hinton	T	Patricia Checko	X	Tekisha Everette	X
Dennis C. Mitchell		Robert Tessier		Lewis Bower	X
Mark Raymond	X	Stacy Beck			
Robert Rioux	X	Patrick Troy, MD			

SUPPORTING LEADERSHIP

Victoria Veltri, OHS		Tom Agresta, MD, UConn Health	X	Chris Robinson, CedarBridge	X
Sabina Sitaru, HIE Entity	X	Kate Hayden, UConn Health	X	Tim Pletcher, Velatura	
Alan Fontes, UConn AIMS	X	Carol Robinson, CedarBridge	X	Rick Wilkening, Velatura	
		Michael Matthews, CedarBridge	X		

Minutes

	Topic	Responsible Party	Time
1.	Welcome and Call to Order	Allan Hackney	1:00 PM
	Allan Hackney welcomed the Health Information Technology (Health IT) Advisory Council members and called the meeting to order. Allan provided an overview of the meeting agenda and recorded attendance.		
2.	Public Comment	Attendees	1:05 PM
	There was no public comment.		
3.	Review and Approval of March 21, 2019 Minutes	Council Members	1:10 PM
	Once a quorum was established, the Council voted to approve the meeting minutes from March 21, 2019. Pat Checko created a motion to approve the minutes, and Mark Raymond seconded the motion. The motion to approve the meeting minutes was passed without objection or abstentions.		
4.	Announcements	Allan Hackney	1:15 PM
	Allan Hackney welcomed Lewis Bower to the Advisory Council. Lewis was recently appointed to the Council and will be taking the seat formerly held by Jake Star. Lewis provided an overview of his current role at Keep Me Home, and his experience in the home care and long-term post-acute care settings.		
5.	Outcomes of Medication Reconciliation Hackathon	Tom Agresta	1:20 PM
	Tom Agresta introduced the next topic, "Outcomes of the Medication Reconciliation Hackathon" which was an event hosted by UConn Health and funded by the Office of Health Strategy (OHS). Tom provided some background information to explain why they decided to host the Hackathon. Medication reconciliation is a complicated topic and Connecticut is in a good position to introduce creative change, utilizing the Medication		

Reconciliation and Polypharmacy Work Group, and take advantage of new guidance from the Centers for Medicaid and Medicare Services (CMS) and the Office of the National Coordinator for Health IT (ONC).

The Hackathon took place on April 5 and 6, 2019 and had more than 80 attendees from across the healthcare sector. Tom said that the diversity of the attendees helped to make the event successful. Attendees were separated into two workgroups (Clinical/Admin and Technical). The Clinical/Admin Workgroup aimed to define the problem, describe some functional requirements, describe components of the user interface, and detail requirements of a user-centered design. The Technical Workgroup aimed to discuss interoperability standards, such as FHIR, develop simple prototypes for different scenarios, meet several functional requirements, and gain experience working in multidisciplinary teams. Tom explained that the meeting materials and recorded presentations from the event are posted online and that a link will be distributed.

Next, Tom described several key points and lessons learned from the Hackathon, including:

- Agreed common elements across groups included: accessibility, confidence, indication, interoperability across sources, accountability, simple, timely, and relevant
- Interest and buy-in are high
- Limited prior experience using the FHIR protocol to gather data from multiple sources
- Unique opportunity for the statewide HIE to create messaging about the problems and potential opportunities for medication reconciliation solutions
- There were no major “ah-hah” moments regarding the best path forward

Tom said that this was a highly passionate and motivated group of people who are interested in staying engaged. Tom outlined the next steps, which included:

- Develop and publish a White Paper (UConn Health)
- Use business and functional requirements to build a use case for the HIE’s proposed statewide medication management service (HIE Entity)
- Structure the recommendations to help design technical infrastructure (UConn AIMS)
- Presentation to AMIA on May 2, 2019

Allan Hackney thanked Tom for his presentation and said the Hackathon was an excellent event. Allan asked the Council members if they had any questions regarding this topic.

Alan Kaye thanked Tom for his presentation. From his experience, the main issue in this area is that the medical record becomes a dumping ground for information, without any kind of temporal relationship. Alan hopes the process involves some type of careful evaluation. Tom agreed with Alan’s comments and agreed that our ability to represent, track, and update medication is currently limited for a variety of reasons. Tom explained that all of this was considered during the Hack-a-thon. Alan said that it is promising that we are discussing interoperability with a variety of systems, including the APCD. Things like machine learning and big data could help to address this issue in the future. Tom completely agrees.

Lewis Bower said in the post-acute care world, medication reconciliation is the number one issue. This is part of the process for admitting or re-certifying patients, and medication reconciliation is one of the most time consuming and inaccurate things that they do, based on the information they receive. Medication records are often inaccurate, for a variety of reasons. Having some type of communication between providers and a central repository would be very beneficial; we need to start with an accurate list of medications. This is time consuming, costly, and results in a lot of readmissions. Tom agreed and said that people from the Hack-a-thon discussed the idea of a “best source of truth” and to not let the enemy of the good be the perfect.

Sandra Czunas said she participated in the event and was surprised to be discussing the same issues that she dealt with 20 years ago in her clinical and analytics background. Sandra is a caregiver at home, and in her experience, every time there is discharge, there is a disconnect. Medication reconciliation requires a huge amount of manual effort and manual processes. The Hack-a-thon was a jam-packed two days and was a very

	valuable event. Sandra hopes that we can keep the momentum going and she is excited about the fact that we have a technology today that can help to address this issue.		
6.	Use Case Factory™ Primer	Sabina Sitaru	1:35 PM
	<p>Allan Hackney provided an overview of the next topic, “Use Case Factory Primer” and introduced Sabina Sitaru, representing the HIE Entity, and Alan Fontes, representing UConn AIMS. Allan explained that Velatura has been engaged to support the HIE deployment. One of the concepts that is being adopted is the Use Case Factory™ (UCF). The concept of a UCF is used in Michigan and New Jersey. Allan said he thinks it would be valuable for the Council to understand this concept and the associated terminology.</p> <p>Sabina provided background on the UCF, explaining that it creates a standardized process for introducing and maturing different use case offerings of the HIE. The proposed UCF will follow the list of high-priority use cases that emerged from the Advisory Council’s HIE Use Case Design Group and the subsequent process of developing the Trust Framework. From a project management perspective, the UCF will be the process for which the HIE manages, prioritizes, pilots, and implements use cases. Sabina added that the currently submitted IAPD funding request includes adequate resources to support the adoption and implementation of the UCF.</p> <p>Next, Sabina provided an overview of the use case governance model. She explained the role of the HIE’s Board of Directors, management, and Operation Advisory Committee, which was described in greater detail at the March Advisory Council meeting. Sabina explained that use cases are data sharing scenarios with a defined purpose, type of data exchanged, and interactions between systems. Use cases include the business, technical, and legal framework for sharing the data, and are comprised of a business requirements document, implementation guide, use case summary, use case exhibit, and onboarding documentation.</p> <p>Sabina explained some benefits of the UCF approach, including an alignment of priorities, promotion of transparency, facilitation of consistency, and operationalization of use cases in order to demonstrate projects, test environments, and refine logistical, legal, and financial requirements.</p> <p>Next, Sabina provided an overview of the four stages of the UCF process: (1) Conceptual; (2) Demonstration; (3) Implementation; and (4) Production Implementation.</p> <p>The Conceptual phase aims to define and evaluate the concept. The HIE Use Case Design Group moved many use cases through the Conceptual phase and identified high-priority use cases that were ready to move into Demonstration. The Genomic Medicine Workshop and MRP Work Group are examples of use cases that are still in the Conceptual phase. This phase can include workshops, white papers, the development of personas, and the initial identification of pilot participants.</p> <p>The Demonstration phase aims to refine requirements and demonstrate projects. This phase can include Joint Application Design (JAD) or working groups to define requirements and resolve technical issues, technical demonstrations and evaluations, the development of implementation guides, and the development of use case exhibits to address data use constraints.</p> <p>The Implementation phase focuses on onboarding and conformance reporting. This phase can include incentives and policy levers to accelerate the adoption of use cases, onboarding packages to explain steps to legally and technically onboard, conformance reporting to monitor the quality and integrity of data sharing, and value assessments to illustrate the value proposition to participants.</p> <p>The Product Implementation phase focuses on critical mass adoption and ongoing evaluations. This phase can include cost recovery mechanisms to ensure the sustainability of the HIE entity, utilization reports to track and visualize participation and progress, trend analyses to confirm market needs, and ongoing evaluations to assess value and effectiveness.</p> <p>Alan Fontes explained that when the use case is received from the business side, they collaborate with stakeholders in order to understand the business and functional requirements and components. When they</p>		

start to prioritize use case, they bring them into the product back log and continue to grow the list of necessary functionalities across use cases. As the begin the development work, they continue to utilize review cycles and stakeholder engagement through activities such as the Joint Application Design or Working Group sessions. They take the requirements, build the use cases, identify necessary components, and then they pilot and delivery the service. Alan asked the group if there are any questions.

Bruce Metz asked that in this type of project, if something doesn't work, they typically want to fail fast. Bruce asked what kind of decision making goes into the back-end to ensure that a use case is ready to go into production. Alan said that they are utilizing an agile development process that relies on two-week sprints. Throughout the two weeks they have daily meetings and demonstrations. If there are things that need to be changed, it is worked into the next spring cycle. In agile, you want to fail fast so that you can either correct or change course, as needed. With medication reconciliation, you may go through 4 or 5 sprint cycles before you have a deployable component. Once ready, the use case or service will go to the governance body for a go or no-go decision.

Pat Checko thanked Alan for the presentation. She said Alan was using the medication reconciliation example but asked him to run us through a use case that the Council has been more involved with, such as eQMs. Alan said that with the eQMs they are on the seventh sprint cycle. In past sprint cycles they have been working on the deployment of software in the environment and looking at to calculate eQMs using the system. Alan said they have data coming in from external sources and are taking the bulk data and have a sprint to load the data into the right process and system. Another component of the cycle is the parsing of the data. Today, they have taken synthetic data and are able to calculate eCQM outputs based on providers. They have also been working on the dashboards and are refining these with JAD sessions. Today, they are able to take multiple C-CDAs, process them through the system, produce eQMs, and present the outputs in dashboards.

Allan said it was quite an achievement to get to the point where eQMs are now flowing out of the CDAs. He wanted to congratulate the team who has been working on this project. Allan asked if there were any questions for Sabina or Alan. The Council did not have any questions.

7.	Update on SUPPORT Act (HR6, Section 5042) Planning	Michael Matthews	1:55 PM
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Michael Mathews introduced the next topic related to the SUPPORT Act (HR 6, Section 5042) planning process. This is a recent opportunity for Connecticut from an omnibus funding bill passed at the federal level. This legislation presents a number of opportunities for Connecticut. The federal government will provide 100% funding for the integration and expansion of prescription drug monitoring programs (PDMPs) in order to address the opioid epidemic. There are a number of PDMP requirements associated with this legislation. There are also requirements associated with the IAPD funding process. Michael explained that this is a time-limited funding opportunity (through FFY 2020). OHS is working with DCP and DSS to identify a leadership group and move forward with the planning process and the development of a planning IAPD.

Michael provided an overview of the proposed opportunities and potential projects. Michael said that the initial funding request would be for planning funds that would be used to refine and validate the pursued projects and associated requirements. A subsequent IAPD will be developed for the implementation of any prioritized project or solution. The list of proposed projects includes topics such as: enhanced provider workflow, enhanced health system connectivity, integration with the statewide HIE, expansion of interstate data exchange, improved administrative efficiencies, interoperability with Medicaid, support for case management and care coordination, and policy alignment.

Michael provided an overview of the next steps, including defining and refining potential projects, the development of the funding proposal, discussion with NESCSO, and the integration with the MRP Work Group strategy and recommendations. Michael asked the Council if there were any questions.

Alan Kaye asked for clarification the connection between this group and the MRP Work Group. Alan sees a lot of synergies between the two work streams. Michael Matthews said he is spot on about the synergies. Michael said that SUPPORT funding is restricted to the opioid issues, however the outputs from the MRP Work Group will undergo additional planning and design work to ensure that there is alignment between the two work streams. These are different funding sources, but they will need to be in alignment.

Pat Checko said that given that this is IAPD funding, she wants to confirm that the money will need to come out of DSS. Michael said that this is correct. Pat asked for Allan to confirm the process. Allan Hackney said that the mechanism for requesting the funding uses the IAPD process. There are two paths for these funding requests, but they are always submitted to CMS by DSS. Once they arrive at the federal government, they bifurcate. The IAPD requests we have discussed previously use the path associated with the HITECH Act. The other path is the Medicaid Information Technology Architecture (MITA) path, which is a different set of funding to help DSS modularize their administrative functions. What is proposed for this IAPD, is that the funding will follow the MITA funding for a period of time. From our point-of-view, it looks the same until it gets to the federal government.

Ted Doolittle asked if there is a limit on the amount of funding that can be requested. Allan said he is not sure of the exact limit, but he knows that there is more available than we can ever spend. Ted asked if the state legislature is aware of this opportunity. Allan said that the people in the federal government who are responsible for this funding are aware of Connecticut’s interest in submitting a federal request. Ted wants to make sure that our delegation is aware of what is going on around this opportunity.

Allan Hackney said that Alan Kaye is spot on; the Venn diagram of medication reconciliation and the SUPPORT activities have a lot of overlap. When the SUPPORT Act first came out, Allan received a call from Tom Novak at CMS who said that Connecticut is in a good position because the MRP Work Group is already convened. Allan said that even the fact that we are having this conversation is in advance of other states. Allan added that if we think about the list of potential projects and opportunities, all of those things are great, and many are a requirement in the SUPPORT Act. However, time is out greatest challenge due to the funding limitations. Allan said that at some point we will need to do some prioritization and he is skeptical of whether or not it will be possible to address all of the projects.

Alan Kaye said that as he looks back on the initial prioritization of use cases, and in consideration of funding and timing, it would be good for us to get a feel of timelines for everything is going on and where we are on the prioritized use cases. Alan Kaye asked if there minutes of the HIE entity that could be provided to the Council. Allan Hackney said that he is also impatient with the process. Allan said we will have a takeaway to develop a timeline for next month’s meeting. With respect to the HIE, he is waiting to get the Articles of Incorporation signed before he can formally incorporate and launch the HIE entity. Allan said that we are working every day with OPM to make sure they are comfortable with signing the Articles. Once this happens, the entity will be formed, and there will be board meetings. Allan said that we want to be transparent with what work is going on. Alan Kaye said he didn’t mean to imply that there is something hidden, but it would be helpful to know what is going on.

8.	Health Equity Data Analytics Project Update	HEDA Project Team	2:05 PM
<p>Tekisha thanked the Advisory Council and handed over the microphone to Mark Abraham and Dr. Karen Wang. Mark Abraham introduced the agenda item of the Health Equity Data Analytics (HEDA) project update. Mark provided an overview of the HEDA project, including the project goals to (1) identify vital few equity data elements relevant to health equity issues in Connecticut and advise UConn AIMS on incorporating elements into the emerging HIE/CDAS architecture; and (2) develop proposed use cases utilizing health equity data elements to demonstrate potential for driving predictability of and progress towards better patient health outcomes at the population level.</p>			

Mark provided an overview of the HEDA report deliverable, which will be released in June 2019, and the various sections of the report. Mark explained that the vital few recommended health equity data elements, including race/ethnicity, address and zip code (and corresponding census tract-level neighborhood measures), and insurance status. Mark introduced Dr. Karen Wang who provided an overview of the process for determining the data recommendations. Karen explained that the landscape analysis was conducted between November 2018 and February 2019 and included in-depth interviews with HIEs and healthcare data/informatics experts across the U.S. to learn more about current efforts to utilize social determinant of health data in HIEs. Karen also provided an overview of the data sources and elements that were included.

Next, Karen described how the data is being used by the HIEs, including who is using the data (patient/individual care, practice/system level case management, population health), and how it is being used (predictive analytics and the identification of health and human service needs). Next, Karen provided an overview of example use cases, including use cases for health systems, providers, community-based organizations, human service agencies, and academic partners. Next, Karen explained the opportunities and challenges that were identified during the landscape analysis, including drivers, data challenges, and operational challenges.

Mark provided an overview of the provider outreach process, which included targeted outreach with the goal of gathering information regarding:

- EHRs in use and their potential for interoperability and data sharing
- Social determinant of health data elements that are collected, and mechanisms used to collect
- Ability of provider to extract and analyze social determinants of health data
- Value of social determinants of health data to the provider (potential value proposition of HIE)

Mark provided an overview of the lessons learned from the provider outreach process. Mark highlighted the lesson learned that HIEs have a key role to play in providing a more holistic picture of an individual beyond just their medical history. Mark explained the preliminary proposed use cases using health equity data integrated within the HIE. Next, Mark provided an overview of the next steps (May to September 2019) and key considerations. They will continue to work with UConn AIMs to test completeness and accuracy of recommended health equity data elements and posit proxy sources or additional data sources, if needed. They will also work with OHS and the HITO to refine, establish, and socialize potential use cases. They will also determine the feasibility of incorporating an aggregator or risk indicator index rooted in health equity.

Mark said he has a few questions for the Council: (1) how do you see health equity data being important for your health care organizations in terms of specific uses and outcomes? And, (2) Is there anything specific that you want to see from the report that is currently being developed?

Pat Checko said that the elements that we are starting with are critical, however they will require us to change admission forms. Pat asked how we can get past the stigma of asking for race/ethnicity/language information and how many of the HIEs are creating a population database similar to what is being suggested for Connecticut. Pat also said that Mark and Karen should talk to the Association for Directors of Health in regard to their health index and risk indicators. Pat also said that we need to go beyond these three elements and consider whether or not the sources we have now are sufficient to be able to give us the data that we need and address the identified issues. Dr. Karen Yang said that almost all of the HIEs that were interviewed are trying to build this type of population database. They are working to address some of the legal issues, develop trust arrangements, and normalize and standardize data capture. They have had a great conversation with Maine – they have a mandate to collect everything at a state level and they have been a great resource. Tekisha Everette said that based on their data elements and recommendations, they are not specifying a level of race/ethnicity data that should be included. They understand that clinical and claims will be available from CDAS as a starting place. Tekisha said they could spend much more time on this project and identify more elements, however they were tasked with identifying the elements that are immediately actionable and

scalable. The gap is the community data, and the best route to get this data is the neighborhood-level data. The project is intended to be focused on the vital few data elements, but we need to make sure we frame this as a starting point.

Ted Doolittle said that his office helps those who are fighting with insurance companies. Connecticut has one of the highest average insurance deductibles and he believes there are SDoH impacts on deductible levels and premiums. Mark Abraham said that there are multiple layers here. We need to look at community-level disparities. It is promising that the HIEs are looking at areas such as treatment gaps – you may be able to apply a layer of claims data to identify possible inequities in the future. Without combining the two data sets, this will be very difficult to accomplish.

Allan Hackney said he was interested to see that Pequot Health was one of the provider groups that was interviewed. Allan was interested to know if there anything unique that emerged from this group of providers. Dr. yang said that Tekisha was the one who interviewed Pequot Health, and she is no longer present at the meeting. They wanted to talk to them because Indian Health Service data is commonly missing from HIEs.

Alan Kate said he has always viewed HIE as a huge opportunity for health equity, on the macro level. Alan asked where they see the largest area of opportunity for the HIEs in terms of health equity. Karen agreed with Alan’s comments and said that the biggest thing, in terms of use cases, is understanding the basics of how disparities exist. Karen said that if we do not have a central repository, then we cannot take advantage of these potential opportunities. There are some geographically isolated providers and there are many opportunities to help – there are many areas that can be considered low-hanging fruit. Alan said that the HIE is more of a data aggregator that can be used to guide public policy. Mark said the DPH has release granular maps on certain conditions or use cases. The HIE can provide a lot of value for this type of data mapping. Karen said that on the other side is asset framing, as there are populations that are doing extremely well, despite disparities. We can learn from these populations.

Nic Scibelli said that as an organization that is capturing SDoH data, they are using it on an individual level in an encounter with patients and for risk scoring. The challenge is standardization. However, some health centers are coming to an agreement around this standardization. They are learning a lot from the PCMH+ initiative, particularly in the technical assistance they are receiving for implementing best practices in the workflow. They may be able to get valuable information from the PCMH+ team.

Pat Checko, in response to Alan Kaye, said that one of the most important things this group did was to decide to develop a population database. This will allow us to really look at disparities and determine if our transformation efforts are actually having an impact. Pat thanked everyone for deciding to go to Zip+4. This is an incredible limitation for other data sets, and this is something that we should consider expanding for other data sets.

9.	Wrap up and Meeting Adjournment	Allan Hackney	2:55 PM
Allan Hackney asked for a motion to adjourn the meeting. Vanessa Hinton created the motion, and Alan Kaye seconded the motion. The motion to adjourn was approved without opposition or abstentions.			

Upcoming Meeting Schedule: May 17, 2019; June 20, 2019; July 18, 2019

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