

Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
January 16, 2020	1:00 pm – 3:00 pm	Hearing Room 1C Legislative Office Building 300 Capitol Avenue Hartford, CT 06106
	Web Conference:	Call-in: +1 646 876 9923 US (New York) or +1 669 900 6833 US (San Jose) Meeting ID: 915 903 919 https://zoom.us/j/915903919

Council Members

Allan Hackney, HITO (Co-Chair)	X	Ted Doolittle, OHA	X	Lisa Stump	
Joseph Quaranta (Co-Chair)	X	Stacy Beck	X	Patrick Charmel	
Joe Stanford, DSS	X	Robert Rioux	X	Alan Kaye, MD	X
Elizabeth Taylor, DMHAS		David Fusco	X	Dina Berlyn	X
Cindy Butterfield, DCF	X	Nicolangelo Scibelli	X	Tekisha Everette	X
Cheryl Cepelak, DOC		Patricia Checko	X	Patrick Troy, MD	
Vanessa Hinton, DPH	X	Robert Tessier			
Dennis C. Mitchell, DDS	X	William Petit, MD	X		
Mark Raymond, CIO		Jeanette DeJesus	X		
Sandra Czunas, OSC	X	Robert Blundo, AHCT			

Supporting Leadership

Victoria Veltri, OHS		Alan Fontes, UCONN AIMS	Carol Robinson, CedarBridge	X
Sean Fogarty, OHS	X	Tom Agresta, MD, UConn Health	Terry Bequette, CedarBridge	X
Adrian Texidor, OHS		Michael Matthews, CedarBridge	X	
Tina Kumar, OHS	X	Sheetal Shah, CedarBridge	X	

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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 at 1:05 pm. Tina Kumar took a roll call of the members and a quorum was established.		
2.	Public Comment	Attendees	1:05 PM
	SB Chatterjee announced that he will mail in a public comment as he is awaiting information.		
3.	Review and Approval of Minutes from December 19, 2019	Council Members	1:10 PM
	Allan asked for a motion to approve the December 19, 2019 meeting minutes. Vanessa Hinton created a motion to approve. Rob Rioux seconded the motion. No further discussion, all in favor. The motion passed.		
4.	Update on Consent Design Guiding Principles	Michael Matthews, CedarBridge	1:15 PM
	<p>Michael Matthews recapped from the last HIT Council meeting, to put final touches on Guiding Principles. There was discussion that extended around the priority and importance for getting data flowing for benefits of patients and treating physicians. He expressed concern for consent process to ensure it didn't prohibit getting data to flow. The goal today is to follow up with the Council today respond to Dr. Kaye's concerns. Michael Matthews reviewed the bullet points with the Council. This is consistent with Guiding Principle 8 and it will align with eConsent. There will be a mechanism for patients to align their preferences. No tool exists at this time, but this will be addressed as patients will have the binary ability to opt in or out. This is designed to be a simple solution for people who do not want their data to flow until more sophisticated tools are developed. This is also consistent with Guiding Principles 2,3, and 6.</p> <p>Dr. Allan Kaye spoke to his thoughts that "perfect" should not be the enemy of good. He related that the discussions within the design group involved concerns with types of encounters with providers would or would not be included and what entities would have access to the information, those would include research, OHS for policy development, would payers – in a more extensive/detailed way other than claims. If that was the case, why let this stand in the way of getting treating physicians and patients getting data? It would be approved by a use case basis and concerned that there would be confusion or delay. This accomplishes several things: it simplifies, if you are willing to have it serve a greater good of society – then please stay in, on the other hand – if that's your basis for opting-out then you can take it out for those reasons.</p>		

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Dr. William Petit commented that the language seems very good, but the second bullet talks about opting out for a binary way. If we're doing research on diabetes, do you envision someone could opt-in for just research?

Dr. Kaye doesn't think it will be a specific research by research basis, but once we open this up to researchers in general and then researchers can opt-in based on that.

Dr. Petit asked if there will be access to the whole record or just parts of the record?

Michael acknowledged that these are great questions and issues HIEs all over the country are dealing with. These are the issues that will have to be dealt with and are practical realities of how data is exchanged.

Pat Checko spoke to the need to have consumers understand the value and not just react to something they don't understand. The first thing that is concerning is a direct opt-in vs. opt-out, and many of us are uncomfortable with total opt-in vs. opt-out. She asked if it would be easy for people to come back if they change their mind. There are many other uses of data that are in between treatment and research. We're looking for a solution that allows us to move forward. Secondly, would hate to separate this into we can use your data for treatment vs. research and you can decide which? She is concerned about having sufficient time with communicating with the public. We would have a system, suggest another solution the original opt-in or opt-out would be for provider care only. Since the other things won't be ready and can create another system, perhaps that may be a resolution.

Dr. Kaye said he was not sure how that is different than what was proposed and asked if the opt-out would be for provider care only? Michael Matthews spoke to the other capabilities, which won't be ready on day one, and that the initial use case will be TPO – treatment, payment and operations.

Allan Hackney addressed the comment about losing people permanently by speaking to where eConsent fits in the Milestones (management system). The point being that if someone can opt-out between now and the date, and if they never come back. There is a tiny fraction of people who opt out in some states. In the case of Connecticut, it will take about two years to scale all of the 3.6 million residents into the system. His prediction is that it will be a small number and could turn to an outreach program to work with patients to take command of their consent. This is not to minimize the concern, just his perception.

Pat asked if we talked about who is doing the initial consent? Allan answered that the initial consent would be in the HIE. Tekisha Everette asked for clarification on that point. Allan responded that consent would have to be managed at the HIE level, it would be impractical to manage that at the provider level.

Dr. Kaye reported that he believes that a patient would have much less of a problem with the second bullet point compared to the 3rd bullet point. If that's the case, we won't have a lot of opting out in the beginning; but those who do may have periodic reminders of getting back in. There would be constant reminders about telling them to get it back in. Losing people in the beginning other than that they don't understand what HIE is.

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David Fusco said that during the December discussion, Dr. Kaye desired to have an additional guiding principle where priority would be around patient care as Use Cases develop. He is unsure how this relates to where we left off. Dr. Kaye responded that after the last meeting he believed it was a use case by provider. What he saw coming out of it was how data was going to be used. It's a different set of concerns and does not want that to get in the way of patients signing up for provider. The definition of use cases may be the issue in this conversation. David Fusco asked if these are specifications for consent design, and if it is a recommendation that will materialize into a Guiding Principle?

Michael said prioritizing treatment and data going to patients and treating providers, is not a guiding principle for a consent policy. That's a principle for overall delivery of data to the HIE. But it's not specific to consent policy itself. This becomes an additional context to the guiding principles while an eConsent management solution is being developed. It is crucial to not have consent stand in the way of data flowing.

Allan said by providing binary opt-out, we're not establishing policy in absence of process; we'll post the Guiding Principles' for public comment, organize the comments; bring that back to this body and bring it back to OHS who would then begin a regulatory process that is well defined for coming up with public policy around consent. In the absence of reaching end of that process, by providing simple binary opt-out, just defaulting to federal rules that are being codified in 21st Century Cures Act; and one of the principles is that patients control their data. We're simply aligning what to federal rules are until Connecticut comes up with something specific to the Connecticut environment.

Dr. Kaye questioned if this is an operable interim solution until a comprehensible solution is found? Allan said yes, in the infrastructure we're building; we have the consent abilities. We do not have the user interface for patients to express their desires, but by taking a simple yes or no; we can use infrastructure that is there pretty easily.

Dr. Kaye shared Tekisha's discomfort, as I saw this happening in day to day medical practice. Every time a patient comes to front desk, they handed a HIPAA PHI consent form. It would seem to me that it may be a reasonable way or primary way to express opt-in/opt-out of the system. Tekisha added that she does have concerns about consent not happening on the patient side.

Stacey Beck asked if we could ask a physician's office to add that information to a HIPAA form, and if it would be legal. Michael shared that Guiding Principle 6 outlines that there should not be an undue burden on providers to collect consent. Certainly, the administration of that would be through the HIE with some tool, but as Dr. Kaye said there will be policies, procedures, education and processes around that – every provider and patient will be well informed on this.

Pat added there's another guiding principle that patient will have the opportunity to understand and make that decision. Pat feels strongly that there needs to be an education mechanism for the consumer to understand.

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Dr. Kaye stated that he's okay with the guiding principles and have expressed his thoughts on this.

Michael said this item does not require action. Sean Fogarty in OHS will work on developing a plan and space for the Guiding Principles to provide public comment. OHS will be assimilating the comments and bringing back to the Council for additional discussion.

Michael shared his continued appreciation for the Council's active engagement and thanked the Consent Design group who laid the foundation for this quality of conversation. Allan echoed his comments and shared his appreciation for this group and the importance of this topic. appreciates this group and importance of the topic.

5.	Review of The Health Information Alliance, Inc. Milestones	Allan Hackney	2:15 PM
	<p>Allan reviewed the Health Information Alliance, Inc. Milestones with the council. The two main purposes for sharing the milestones is for the advisors to have an understanding of where commitments have been made with regards to funding. The second to give the advisors the ability to understand the order of magnitude of work that has to happen in the next 21 months. Allan noted that these dates are aggressive and that they'll miss some, but the goal is to take advantage of all the HITECH Act funding. The ability to draw funds down and disperse them into the health ecosystem and offset their costs will end September 30, 2021.</p> <p>Allan reviewed the milestones and provided in depth detail of the document. Milestones are organized to meet several overlapping objectives: 1) DSS/OHS milestones are required for DSS to exercise its fiduciary responsibilities related to drawing HITECH Act funds from CMS, 2) Investment Committee milestones are achievement-oriented markers required before additional bond funds may be requested, 3) HIE Board milestones are required board actions, 4) HIE Team milestones are necessary achievements to reach overall goals, and 5) Advisor milestones are necessary actions of the HIT Advisory Council and other relevant advisory boards. Allan provided further explanatory comments on several milestones. Allan also noted that an extensive master plan supports the proposed milestones.</p> <p>The Technical Assistance program has been modeled after the milestone-based NJ program. It has been reviewed by the HIA, Inc. board. Next step will be with DSS.</p> <p>Pat Checko asked regarding Immunization if any of these requirements with labs fit in with the larger picture. Allan answered that with The Department of Public Health, there's thoughts on a gateway concept; it's more like a Hub where you could interface with Department of Public Health on one end and then it goes to Immunizations, tumor registry, disease registry and that it is consistent.</p> <p>David Fusco commented that this review of the milestones is great and helps to see put the pieces together and hopes that the Council will revisit this from periodically.</p>		
6.	Overview of the Health IT Advisory Council 2020 Calendar	Allan Hackney	2:20 PM

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	Allan shared a proposed calendar with topics for discussion for the Council meetings. This calendar can be viewed here: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/Presentations/OHS_HealthIT_Advisory_Council_Mtg-Presentation_01162020.pdf .		
7.	Announcements and General Discussion	Allan Hackney	2:30 PM
Allan announced that with enormous regret, Michael Matthews will be retiring from CedarBridge. Michael has been instrumental in driving the design groups, among other projects and we do not where how we could have got to where we are without his tremendous support. Michael Matthews thanked Allan for his comments.			
8.	Wrap up and Meeting Adjournment	Allan Hackney	2:30 PM
Allan asked for a motion to adjourn. Pat Checko created a motion. None were opposed. The meeting was adjourned at 2:30 pm.			

Upcoming Meeting Schedule: February 20, 2020 | **Meeting information is located at:**

<https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council>

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