Health Information Technology Advisory Council

Meeting Notes

Meeting Date	Meeting Time	Location
November 17, 2016	1:00 – 3:00 p.m.	Legislative Office Building, Hearing Room 1D 300 Capitol Avenue, Hartford

Participant Name and Attendance

State HIT Advisory Council – Appointed Members/Designees			
Participant Name	**Attended**	**Participant Name**	**Attended**
Victoria Veltri, Chief Health Policy Advisor for the Lieutenant Governor	X	David Fusco Appointed by Governor	
Joseph Quaranta (Co-Chair) Appointed by Minority Leader of the Senate	X	Nicolangelo Scibelli Appointed by Governor	X
Kathy Brennan/ Sandra Ouellette For Comm. Roderick Bremby, DSS	X	Patricia Checko Appointed by Governor	X
Michael Michaud For Comm. Miriam Delphin-Rittmon, DMHAS	X	Robert Tessier Appointed by Governor	X
Fernando Muñiz For Comm. Joette Katz, DCF		Rob Rioux Appointed by President Pro Tempore of Senate	
Cheryl Cepelak For Comm. Scott Semple, DOC	X	Jeannette DeJesús Appointed by President Pro Tempore of Senate	X
Vanessa Kapral For Comm. Raul Pino, DPH	X	Matt Katz Appointed by President Pro Tempore of Senate	
Jordan Scheff For Comm. Morna Murray, DDS	X	Patrick Charmel Appointed by Majority Leader of Senate	X
Mark Raymond, BEST	X	Ken Yanagisawa Appointed by Majority Leader of the House	X
James Wadleigh, Access HealthCT		Alan Kaye Appointed by Minority Leader of the House	X
Mark Schaefer, SIM	X	Dina Berlyn Designee of Sen. Looney	X
Kathy Noel For Jon Carroll, UConn Health		Rep. Brendan Sharkey Speaker of the House of Representatives	
Demian Fontanella Acting Healthcare Advocate		Jennifer Macierowski Designee of Sen. Fasano	X
Kathleen DeMatteo Appointed by Governor		Prasad Srinivasan Designee of Rep. Klarides	
Supporting Leadership			
Sarju Shah, PMO	X	Carol Robinson, HIT Consultant	X
Faina Dookh, PMO	X	Teresa Younkin, HIT Consultant	X
Wayne Hauk, HIT Consultant	X	Minakshi Tikoo, DSS/UCONN	
TO BE APPOINTED			
Health Information Technology Officer (Lt. Gov)		*Technology expert who represents a hospital system (Speaker of the House)*	
Health care consumer or a health care consumer advocate (Speaker of the House)		*Provider of home health care services (Speaker of the House)*	

Meeting Schedule 2016 Dates – December 15

DRAFT

Health Information Technology Advisory Council

Meeting Notes

	Agenda	Responsible Person	Time Allotted
1.	**Welcome and Introductions**	**Council Members**	**5 min.**

Call to Order: The eighth meeting of the Health IT Advisory Council for 2016 was held on November 17th at the Legislative Office Building in Hartford, CT. The meeting convened at 1:05 p.m., Joseph Quaranta presiding.

2.	**Public Comment**	**Attendees**	**5 min.**

Written comment was provided by Susan Israel. A copy will be circulated to the Council members and posted on the Health IT Advisory Council website: http://portal.ct.gov/Office-of-the-Lt-Governor/Health-IT-Advisory-Council.

3.	**Review and Approval of the September 15, 2016 Minutes**	**Council Members**	**5 min.**

The motion was made by Ken Yanagisawa, and seconded by Vanessa Kapral to approve the minutes of the October 20, 2016 meeting. **Motion carried.**

4.	**Review of Previous Action Items**	**Joe Quaranta**	**5 min.**

Sarju Shah reviewed the previous action items:

Action Items	Responsible Party	Follow-up Date
1. SIM HIT Council Report	Sarju Shah	09/15/2016 – COMPLETED
2. Overview of MACRA	Faina Dookh	09/15/2016 – COMPLETED
3. Overview of Alert Notification Strategy	CedarBridge Group	10/20/2016 – COMPLETED
4. eCQM Learning Experience	CedarBridge Group	11/17/2016 – COMPLETED
5. eCQM RFI/RFP Process	CedarBridge Group	11/17/2016 – COMPLETED

5.	**Updates**	**Sarju Shah**	**10 min.**

There are three remaining appointments that will be made by the Speaker of the House which includes a technology expert who represents a hospital system, a provider of home health care services and a health care consumer or a health care consumer advocate. The expectation is that the appointments will be made shortly prior to the start of the next legislative session.

The interview process for the Health Information Technology Officer is now complete and recommendation have been sent to the Lieutenant Governor. The hope is to have the top candidate on board soon.

A prospective timeline for eCQM learning sessions were brought to the Council's attention including a webinar from Oregon and Rhode Island. The eCQM learning sessions will begin in January.

A draft timeline for the eCQM Measurement and Reporting System was also brought forth. Questions were raised if SIM should begin the RFI process before a HITO is on board.

6.	**Implementing HIE Services in Connecticut**	**Carol Robinson and Teresa Younkin**	**75 min**

Carol Robinson and Teresa Younkin presented on implementing HIE services in the state. The presentation is structured around eight principles to help steer the Council's role and build services with value.

Dina Berlyn noted that there is no mention of the patient in the principles. Ms. Berlyn mentioned that the language in PA 15-146 is centered on patients and the patient's control of their health information. She was concerned that this was not referenced. Ms. Robinson agreed that it wasn't mentioned and will elevate its importance.

Principle 1: Rapid Deployment - There are three time drivers that should be considered when deploying this principle, including availability of SIM funding (available until 2019) and 90/10 HITECH funds (available until 2021). We also need to factor in that 50% of Medicare payments is tied to value-based models by 2018. Alan Kaye had

DRAFT

questions related to funding and how it should be used. Ms. Younkin said his questions will be addressed at the end of the presentation.

Principle 2: Cost effective and Sustainable - It is essential that HIE services produce value for investors both in the near term and over time especially when federal funding ends. In addition to time of acquiring HIE services, a thorough evaluation of the solution needs to be taken account particularly if a solution is cost effective and adds value so that it can be sustainable.

Principle 3: A Comprehensive Set of Services with Full Functionality - Services can be acquired and built incrementally to provide valuable information for all participants. The federal government is looking towards agile implementation and tend to lean away from a "big bang" implementation.

Principle 4: Use of Latest Technology when possible – Health IT is evolving. In the past five years there has been an enormous increase in EHR adoption and use and there is a strong demand for tools that support care coordination as well as analytics. Organizations have moved through the stages of adoption and are now concentrating on new challenges such as interoperability. Organizations are moving away from expensive interfaces and customizations and looking towards inexpensive out-of-the-box solutions that will reduce customizations. FHIR is an open Application Programing Interface (API) which sends messages back and forth in a secure way and is vendor agnostic. Athena, Cerner and EPIC have released versions that are FHIR-enabled. FHIR resources are consumer facing. Additional information about FHIR can be found here: http://www.slideshare.net/ewoutkramer/hl7-fhir and http://smarthealthit.org/smart-on-fhir/

Dr. Kaye mentioned that the Commonwell Health Alliance is a vendor led interoperability initiative where a consortium of EHR vendors are working on a strategy for interoperability nationally. He did not know that they used FHIR, but it is good news since we know that interoperability is possible, and we [Connecticut] need a will to move it forward. Ms. Berlyn asked what FHIR does. Ms. Robinson related it to "apps" on a cell phone. These applications are essentially "plug and play". Ms. Berlyn then followed-up by asking if FHIR will help patients get their records from multiple providers. Ms. Robinson stated that is where the technology is going, but it isn't there yet. Dr. Yanagisawa asked if they could explain what data FHIR is able to access – is it demographics or the entire patient charts? Ms. Younkin replied that FHIR is currently working on care plans that includes information on medications, allergies, problem list that can be currently accessed. Jennifer Macierowski asked if EHRs will require FHIR. Ms. Younkin stated that Stage 3 of Meaningful Use does not call it out by name, but it mentions the requirements which are the same as the ones for FHIR. Ms. Robinson also added that major EHR companies will release their FHIR enabled platforms in the near future and we can expect to see a sea of change in the way that HIE continues to move. Connecticut is in a good position to move rapidly to that iteration.

Principle 5: Interoperable services – The modular approach allows assets to be built on one another in an incremental way like Legos. Both Michigan and Maine are example of states who have used the modular approach. MiHIN is Michigan's state-designated entity and acts as a "network of network" to connect regional HIEs. This is one of the best examples of modular services governed and managed as an independent nonprofit with direct ties to the state. Maine is one of the most successful statewide HIEs in the country and it too uses a modular approach.

Principle 6: Incorporate Lessons Learned and Best Practices – The NORC Evaluated six (6) HIEs that were operational for three (3) years and that had a good track record. One of the main lessons learned is that many of these states started off with a single vendor operator and as the market matured, newer more efficient technologies led these states to re-examine their solution and the states replaced their HIE with more modular services. One of the biggest lessons learned is that states were able to use the "best of breed" in software. Also, providers indicated that ADT alerts provided the most immediate value since they were able to receive actionable data to improve patient care. Alerts are a low cost way to begin exchanging data. In addition care

DRAFT

summaries/Continuity of Care Documents (CCD) also bring value when attached to the ADT. Ms. Berlyn commented that for Connecticut's plan clinical notes should be included. Ms. Robinson agreed to her point.

Principles 7 and 8: Streamlined Management and Operation of Services - The "Frankenstein" problem already exists in other states. There are a number of ways of managing HIE services and Connecticut will need to decide on the best way to manage and govern HIE services. The State has several assets including EMPI, Provider Registry, Alert Notification, Direct Secure Messaging, indexing clinical data repositories that will need to be considered as part of the operation of services in the State. Ms. Berlyn asked why Zato was on the list of vendors for services available in the state. Ms. Shah stated the vendors listed in the table (on slide 46) are existing assets that can be utilized or reused, if needed. Zato is being utilized by the Medicaid Agency. Additional assets might arise once an environmental scan is completed in the next few months.

Dr. Quaranta opened the discussion up to the council for their reactions to the presentation. There are pros and cons when we look at the Health Information Exchange "in-a-box" solution versus an incremental approach. Nicolangelo Scibelli asked if we should start now or do we continue to wait. He stated he was the opinion that we start working on things now. Mr. Scibelli stated he does not believe the issue is about the technology, but about how and when information is shared.

Patrick Charmel asked about what architectural needs are foundational to build a statewide HIE. If we are talking about existing HIE architecture that is antiquated but proven, we may not be able to take advantage of new technology like FHIR. So in terms of the eCQM solution, is procuring a solution premature if we don't know what the HIE architecture is going to be? Dr. Schaefer responded that at this time we are trying to educate ourselves through an RFI process. This may reveal standalone solutions or solutions that tie into our existing assets. Having this information in hand by the time the HITO is on board will inform the council's ability to provide a recommendation.

Patricia Checko asked if there are certain check-points with the legislature that need to happen in order to move forward. Is the RFP within the council's purview or does it need to be authorized by the legislature? Ms. Berlyn responded that the legislation directs that there be an RFP and that the council advises. The RFI/RFP process is consistent with the statute.

Dr. Kaye is optimistic about FHIR and he has seen similar technologies emerge in radiology. We are on the threshold of having a HITO on board whose main focus is to bring an HIE into the state. So the question is do we recommend that the Council sit back and allow the HITO to make the decision regarding procuring an "out-of-the-box" solution or working on an incremental solution. The HITO's responsibility is to evaluate all the opportunities out there and the eCQM timeline may be completely changed once the HITO is on board. Ms. Macierowski asked if the eCQM solution a product or a service. Dr. Schaefer said it is similar to an HIE and that it could be either. Ms. Macierowski and Ms. Berlyn both agree that they do not feel comfortable making a decision without the HITO on board. Dr. Quaranta then posed a question to Mark Raymond about his past experiences using an incremental approach. Mark Raymond responded that in his experience with large technology projects he has seen the business requirements continually change during implementation and that the incremental approach can be seen in the tech space. Dr. Kaye stated that he doesn't have a problem moving forward with the incremental approach but he is less inclined to support a solution that works in isolation. Dr. Checko commented if there was a legacy system that we could use, it would be in place. She further elaborated that based on the way technology is moving forward and the way the legislation is written, solutions need to be interoperable.

Mr. Raymond wanted to discuss and confirm whether the principles were correct and complete. There was a question about the definition of patient-centered. Ms. Berlyn stated that patient-centered meant health information was patient-controlled and the patient could determine which providers had access to see PHI. Dr. Checko then mentioned that the concept of confidentiality and privacy are missing from the principles and needs

DRAFT

to be addressed. Ms. Berlyn also mentioned that the idea of de-identified data is also missing. Mr. Charmel mentioned that this is an opportunity to engage the consumer around these principles. Dr. Quaranta also cautioned against losing sight in our role as stewards to patient data. Ms. Robinson stated she will synthesize these statements into a document for review and approval at the next meeting.			
8.	**Federal Financing Information**	**Carol Robinson**	**10 min.**
Ms. Robinson reviewed the slides around federal financing. Originally the 90/10 HITECH funds were only to support Meaningful Use. In February, this was broadened to include other organizations that would support Medicaid providers in meeting meaningful use (i.e. Skilled nursing facilities, long term care & post-acute facilities, labs among others). At this time, the SIM PMO is working with the Medicaid agency to develop a funding request so that the state can utilize funding to support planning activities, where the state will need to come up with a 10% match. Vicki Veltri informed the council members under the current state fiscal climate, coming up with a state 10% contribution may be very difficult and we may need to look at other creative approaches for the contribution.			
9.	**Wrap Up and Next Steps**	**Joe Quaranta**	**5 min.**
Dr. Quaranta summarized next steps: update the guiding principles with additional principles, circulate FHIR, other references, and the written public comment. The meeting was adjourned at 3:00 pm			

Action Items	Responsible Party	Follow-up Date
1. Circulate FHIR and other Health IT References	Sarju Shah	12/15/2016
2. Circulate written public comment	Sarju Shah	12/15/2016
3. Update Guiding Principles with “Patient-Centered”; “Privacy and security”; and “data stewardship” for circulation before next meeting	CedarBridge	12/15/2016

REFERENCES:

Office Of The National Coordinator For Health IT

- Interoperability Standards Advisory
  https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf

NORC Evaluation Of The State HIE Cooperative Agreement Program

- Case study report
  https://www.healthit.gov/sites/default/files/CaseStudySynthesisGranteeExperienceFinal_121014.pdf
- Provider experiences with HIE
  https://www.healthit.gov/sites/default/files/reports/provider_experiences_with_hie_june_2015.pdf

Fast Healthcare Interoperability Resources (FHIR):

- FHIR High-Level Overview
  http://www.slideshare.net/ewoutkramer/hl7-fhir
- SMART Health IT Platform
  http://smarthealthit.org/smart-on-fhir/

DRAFT