

Health Information Technology Advisory Council

Meeting Minutes

MEETING DATE	MEETING TIME	Location
February 21, 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, OSC	x	Jeanette DeJesus	
Joseph Quaranta (Co-Chair)	x	Mark Schaefer, SIM	x	Robert Blundo, AHCT	
Joe Stanford, DSS		Bruce Metz, UCHC CIO	x	Lisa Stump	T
Mary Kate Mason, DMHAS		Ted Doolittle, OHA		Patrick Charmel	x
Cindy Butterfield, DCF	T	David Fusco	T	Alan Kaye, MD	
Cheryl Cepelak, DOC		Nicolangelo Scibelli	T	Dina Berlyn	x
Vanessa Hinton, DPH	x	Patricia Checko	x	Tekisha Everette	x
Dennis C. Mitchell, DDS	x	Robert Tessier		Patrick Troy, MD	
Mark Raymond, CIO	x	Robert Rioux	x	Stacy Beck	x

SUPPORTING LEADERSHIP					
Victoria Veltri, OHS	x	Tom Agresta, MD, UConn Health	x	Chris Robinson, CedarBridge	x
Sarju Shah, OHS		Kate Hayden, UConn Health	x	Tim Pletcher, Velatura	x
Sabina Sitaru, HIE Entity	x	Carol Robinson, CedarBridge	x	Lauren Kosowski, Velatura	x
Alan Fontes, UConn AIMS		Michael Matthews, CedarBridge	x	Rick Wilkening, Velatura	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 and called the meeting to order. Allan took roll call of Council members and provided an overview of the meeting agenda.
2. Public Comment	Attendees	1:05 PM	There was no public comment.
3. Review and Approval of January 17, 2019 Minutes	Council Members	1:10 PM	Once a quorum was established, the Advisory Council voted to approve the meeting minutes from January 17, 2019. Vanessa Hinton created the 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 provided announcements on several topics. First, the IAPD-U and SMHP were submitted by the Department of Social Services (DSS) on January 28, 2019. The IAPD-U will provide additional funding to the HIE, particularly around technical assistance that will allow the HIE to scale across healthcare settings in the state. CMS typically takes 60 days. In addition, the 2019 Office of Health Strategy Annual Report was submitted to the Connecticut General Assembly on February 1, 2019. This report will be posted to the Health IT Advisory Council website.
5. Immunization Information System Update	Nancy Sharova	1:20 PM	Nancy Sharova, Health Program Supervisor for the Department of Public Health (DPH) Immunization Program provided an update on CT WiZ, the statewide immunization information system. CT WiZ went live in September 2018 after the transfer of 25 years of data from the old system, CIRTS. DPH had 11 months to

complete the migration and will be conducting user acceptance testing until late spring (2019). The goal of the IIS is to meet all functional standards, including electronic bi-directional information exchange. DPH has been communicating with stakeholders and is actively trying to obtain feedback and create engagement.

The IAPD-U submission included additional IIS funding for activities such as stakeholder outreach, onboarding, and collaboration/alignment with the HIE. DPH has also updated their IIS website – it is now a one-stop-shopping experience, including step-by-step instructions for bi-directional electronic data exchange and onboarding support for clinics. DPH is in constant communication with stakeholders and clients to ensure everyone understands roles and responsibilities and that data quality is being validated. Nancy presented several slides that outline the roles and responsibilities of DPH IIS staff, the EHR vendors, and the providers/clinics, both during and after onboarding. Communication throughout the entire process is critical.

At the last Advisory Council meeting, there were questions about evaluation. DPH is required to measure their data and report regularly to the CDC. As of February 7, 2019, there is real-time bi-directional data exchange between one EHR system and CT WiZ. Currently, there are 97 clinics in the EHR onboarding process with CT WiZ. The slide also presented a snap shot of one week of data exchange from one clinic, which included 425 vaccines and 184 patients.

In terms of next steps, DPH wants to fine-tune their training plan and they want to continue to onboard their clinics. DPH wants to have 700 clinics onboarded overall. DPH will continue to monitor data quality – they require 2 weeks of clean data before a clinic is moved into production from the QA environment. DPH will also be evaluating their progress and sharing their success via a newsletter. DPH is collaborating with the Connecticut chapter of the American Academy of Pediatrics (AAP), including two webinars that have been recorded and are posted online. DPH will be doing another webinar on April 24th.

Allan Hackney thanked Nancy for her presentation and asked the Council if there were any questions.

Dr. Joe Quaranta thanked Nancy and asked if Nancy could provide any detail on the process that provider groups are experiencing when they engage their EHR vendors for interfaces to CT WiZ, and the costs that they are being charged for these interfaces. Dr. Quaranta asked if Nancy had any idea of the scale of this issue, and if she had any insights into how this issue is being mitigated. Nancy said that it is free for clinics to work with DPH, however some clinics do have to pay their vendors. There is a wide range – some clinics are not charged at all, whereas other clinics have been charged \$4,000 for their interface. DPH is working with their national partners at CDC regarding this issue, and the fact that vendors are setting up interfaces using national standards that can be easily replicated. She understands that the vendors are running a business, but she is interested to see what the CDC can do to support the clinics. Dr. Quaranta thanked Nancy for evolving the dialogue. Dr. Quaranta said that if we assume the interfaces are standardized, then vendors have incurred the cost to develop the interface once, but are charging clinics over and over again each time the interface is deployed. In addition, these EHR systems are certified to provide this interoperability, yet when a clinic wants to exercise this interoperability to meet a public health need, they are being charged extra for this functionality. Nancy agreed and said they are hearing this from their national partners. There are some vendors who are not charging clinics anything; there is a wide range of business practices. Dr. Quaranta said that eventually we will have grapple with the issue that vendors are holding our interoperability hostage. This is worthwhile to keep track of and it would be great to know which vendors are doing this for free, and which ones are charging their clinics for this.

Allan Hackney said that the Office of the National Coordinator for Health IT (ONC) issued interoperability rules 10 days ago that include a requirement for EHR vendors to have application programming interfaces (APIs)

into immunization systems. These rules are currently out for public comment. This is a good sign that regulations are moving in the right direction.

Mark Raymond thanked Nancy and asked if there has been any other work done around business cases or participation in an effort to offset some of the additional costs. Mark said that the state or the clinics might be seeing some cost savings from the transfer to an electronic process. Nancy said that there are state regulations that mandate providers to report to the ISS, and that the electronic process is saving them time and effort in the administrative workflows, as compared to the paper-based process.

Pat Checko said "bravo" and thanked Nancy for her presentation. Pat said she remembers when the first \$20 million was allocated to try and complete this project. Pat is personally delighted and is excited to move forward and she is hoping that there is a long-term plan to utilize the portal for other types of public health reporting.

6.	Health Equity and Data Analytics Project Update	Tekisha Everette	1:40 PM
	<p>Tekisha Dwan Everette, Executive Director of Health Equity Solutions, provided an update on the Health Equity Data Analytics (HEDA) project, which has moved into its second phase. This project is being conducted collaboratively between Health Equity Solutions, DataHaven, and the Equity Research and Innovation Center (ERIC) at the Yale School of Medicine. The project goals are: (1) to identify vital few health equity data elements relevant to health equity issues in Connecticut and to advise UConn AIMS on incorporating elements into emerging HIE / CDAS architecture; and (2) to develop use case(s) utilizing health equity data elements to demonstrate potential for driving predictability of and progress towards better patient health outcomes at the population level.</p> <p>The HEDA project is currently in the second phase (discovery and analysis) of their work, which includes the identification of recommended health equity data elements to be incorporated into the HIE data architecture and the sources from which to obtain health equity data, and the development of a summary of the landscape analysis/literature review and provider/consumer outreach efforts.</p> <p>The literature review included an assessment of peer-reviewed journal articles and grey literature to highlight health equity and social determinant of health (SDOH) data elements collected and integrated by HIEs, and key performance indicators and outcomes measures for the collected data elements. The landscape analysis (national-level) included in-depth interviews with mature HIEs and healthcare data/informatics experts from across the country to learn more about the current efforts to utilize SDOH. The landscape analysis included 12 interviews, which will be summarized in the final report. The preliminary takeaways for the literature review and landscape analysis included the following:</p> <ul style="list-style-type: none">• Why integrate health equity / SDOH data into an HIE (value propositions)?<ul style="list-style-type: none">○ Risk prediction○ Population-level health management○ Care management and coordination between health and social service providers that aren't digitally connected• Where can we find health equity / SDOH data of usable quality (low-hanging fruit)?<ul style="list-style-type: none">○ Structured data from EHRs (though significant limitations exist)○ External sources with standardized/timely datasets (e.g. US Census Bureau – ACS)• Looking forward (considerations to frame prioritization of data elements and use cases):<ul style="list-style-type: none">○ What is the specific problem we are trying to solve?○ How much time/effort would it take to acquire the needed data?○ What data sources will HIEs have access to?○ Alignment with existing community/state/federal programs, initiatives, and resources		

The provider outreach effort includes eleven total interviews. Some of these interviews have been conducted already, and others have been scheduled. The targeted outreach will try to gather information related to the EHRs in use and their potential interoperability and data sharing, the SDOH data elements collected and mechanisms used to collect, the ability of providers to extract and analyze SDOH data, and the value of SDOH data to providers. The preliminary takeaways from the provider outreach effort include:

- There is an interest in SDOH among providers
- There is a large degree of variation in the collection and use of SDOH data by providers
- Most providers are collecting some basic SDOH data elements, but the use is inconsistent
- The utility of SDOH data elements in clinical context has yet to be established
- The value of SDOH integration in HIE – giving providers access to numerous “touch points” of patients; the HIEs have a key role to play in providing a more holistic picture of an individual beyond just their medical history
- Short-term value at population/health system management level; potential long-term value at provider level
- Data curation and workflow optimization are critical – “data overload” / “EHR burnout” are common

The goal of the consumer outreach effort is to learn more about both potential value propositions and potential concerns regarding the use of health equity/SDOH data in the forthcoming statewide HIE. The HEDA team targeted the SIM Consumer Advisory Board, the Connecticut Hospital Association, the Mental Health Board, Clifford Beers Clinic, and several local public health departments.

The preliminary recommendations for data elements are as follows:

- Race, ethnicity, and country of origin
 - Location/source: EHR
 - Ideal transmission method: C-CDA
- Address and zip code
 - Location/source: EHR
 - Ideal transmission method: C-CDA
- Insurance status
 - Location/source: claims data and EHR
 - Ideal transmission method: XML and C-CDA
- Census tract neighborhood measures (e.g. racial residential segregation, concentrated wealth/poverty, % of adults with no high-speed internet, % of adults without cars, educational attainment, home ownership rate, and additional indicators corresponding to areas with concentrated populations of recent immigrants)
 - Location/source: US Census Bureau and additional sources with timely/standardized datasets
 - Ideal transmission method: APL or XML

Phases 3 and 4 of the HEDA project will be completed concurrently by the end of April 2019. Based on the recommended data elements, they will develop use cases and will think of a possible pilot opportunity.

Allan Hackney said that Tekisha mentioned EHR data and country of origin data elements. Allan said that some organizations have been opposed to entering country of origin data, as it may increase the risk of exposing illegal immigrants. Allan asked if this issue has surfaced during the conversations. Tekisha said that there were four mature HIEs that have been collecting country of origin data in a usable way. On one side, she is not necessarily supportive of this data element, as it can be more problematic from an immigration standpoint. The HEDA team strongly supports the use of race and ethnicity data and they know that several

groups are employing different ways of using and accessing this data and they want to be as inclusive as possible when considering possible data elements.

Pat Charmel thanked Tekisha for her presentation. Pat asked how Tekisha ended up with some of the data elements that they selected, given the existing initiatives around the state. Tekisha said that based on the existing programs, they determined that food security, transportation, and housing issues were identified consistently. They believe that including this information in census-tract neighborhood aggregate data is the easiest way to understand risk, rather than looking at variables individually. At the clinical encounter, they think census-track neighborhood information may be very valuable. Tekisha said that the challenge is that not all information is housed in the HIE, and that their project is limited to recommending 2-4 data elements. They are trying to find the best indicators that will bring the most valuable information forward and determine the best indicators.

Pat Charmel asked why the HEDA project is being limited to 2-4 data elements, given that this is such a fertile area. Allan Hackney said that this is a good question. OHS is trying to make this program actionable. Allan said there is nothing in Tekisha's grant that would preclude us from taking all of the other data. Tekisha said that the report will recognize all other SDOH data elements that are available, but the recommendations will be limited to 2-4 specific elements.

Pat Checko said that the magic word motioned by Pat Charmel is "siloes." She is impressed by the presentation and said "bravo." There was a wide variety of groups that were interviewed; Pat asked if the HEDA team looked at all of the different clinical perspectives. Tekisha said that during all of her interviews, there were a variety of individuals involved in each discussion. Each group had a different network of players that were involved. Many provider groups deferred their interviews to the larger hospital systems. The department where this data is being collected, and the workflows involved were very variant, and they found this very interesting.

Lisa Stump said that hospitals are working to craft a plan, through CHA, to collect SDOH in an organized, standardized way and utilize this data in a collaborative way with community partners. They think this effort will be very complementary to the efforts discussed today by Tekisha.

Dina Berlyn asked if they looked at the possibility of using region of origin data, instead of country of origin data. Tekisha said that the issue with country of origin data is that it overlooks many groups of people – such as people who were born in America, but identify with a different, specific ethnicity. Country of origin data is only relevant to immigrants. In other countries, the term "ethnicity" has a different definition. The group has no way of testing or validating regionality data to know whether or not this will be useful. Pat Checko said she thinks the group can look at the CDC model for determining ethnicity and culture.

Mark Schaefer said that the SIM Program has been wrestling with this question for a while and they have recently learned that Medicare is struggling with basic OMB categories, and their data has such low reliability that they had to limit their race/ethnicity analyses to black vs. non-black. The SIM program is trying to get to a greater level of reliability. Mark was talking with someone from the federal health insurance exchange who identified similar challenges. Even if one has accurate ethnicity data, it does not tell you much about meaningful considerations in terms of healthcare engagement and outcomes; one needs to get to a certain level of granularity, but Mark is not sure this data makes sense for quality improvement activities. Some people are uncomfortable with too much information sharing. There are ways that culture, ethnicity, faith, religious affiliation, etc. actually influence one's lifestyle. Effective consumer segmentation could be a viable approach.

7.	Medication Reconciliation and Polypharmacy Work Group	Tom Agresta	2:00 PM
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Dr. Tom Agresta provided an update of the Medication Reconciliation and Polypharmacy (MRP) Work Group. The MRP Work Group was a legislatively mandated group to determine how the state can utilize HIE services to improve medication reconciliation and reduce polypharmacy, where appropriate. There have been five monthly meetings to date and the group has seen good attendance thus far. The group has worked to identify a definition for "medication reconciliation" and has developed an organizational structure that allows the group to do work in parallel to the monthly meetings. The group has begun an analysis of tools and resources that currently exist in the environment, as well as best practices.

The Work Group has developed a high-level timeline. The group began meeting in September 2018. The meetings are highly engaged and people have very good ideas and are motivated to solve problems. The group developed a project charter and have created topic-specific subcommittees. A recommendation report will be delivered to the Advisory Council in July 2019. The subcommittees include Technology & Innovation, Medication Reconciliation & Deprescribing, Engagement & safety, and Policy. Tom provided an overview of the charge and scope of each subcommittee, and where there is overlap and opportunities for collaboration.

Tom provided an overview of the recommendations and key findings that emerged from the CancelRx Work Group, which was convened prior to the MRP Work Group. The executive summary of findings was submitted to the Connecticut General Assembly on February 1, 2019. Key findings of the Work Group included:

- There is a significant opportunity to enhance patient safety if the CancelRx standard is adopted in a manner that is workflow-friendly for prescribers, pharmacists, and patients.
- There are a number of stakeholders who would benefit financially from a reduction in inadvertent prescribing that would occur as a result of CancelRx adoption.
- There are a number of challenges that need to be overcome for widespread adoption and effective use to occur.

The CancelRx Work Group and MRP Work Group have received some national attention and Tom will be providing a presentation at the AMIA conference in May 2019. Connecticut will be able to collaborate with, and learn from other states.

Next, Tom Agresta provided an update on the University of Connecticut (UConn) Health Medication Reconciliation Hackathon. The Hackathon will take place on April 5th and 6th of this year and will provide the opportunity to collaborative problem solve. The event will take place at UConn Health and an invitation has been distributed to Advisory Council members.

Allan Hackney said that he has attended a number of MRP Work Group and he was impressed with how involved and engaged members were.

8. Update on Subcommittees and Design Groups	Michael Matthews	2:25 PM
Michael Matthews provided an overview on the OHS subcommittees and design groups that are actively underway. The first group is meeting to discuss SUPPORT Act (HR 6, Section 5042) opportunities, which is federal legislation that was passed in October 2018 to try and combat the opioid epidemic. Section 5042 provides 100% federal funding to address how the state can better utilize the prescription drug program (PMP). The federal government thinks Connecticut is in a great position to utilize this funding. The federal funding is available at 100% rate, and the state will want to act quickly. Pat Checko said that there are a lot of opioid bills in the hopper, and asked if this can be assisted by state legislation. Michael said he think this will be part of the discovery process and they may have relevance to the SUPPORT Act. Dina Berlyn said it is hard to say which bills will land at this point in the process.		

Michael then provided an update on the All-Payer Claims Database (APCD) Data Security and Privacy Subcommittee. This group will be re-convened to analyze the APCD policy framework to determine how the data release process can be restructured to support the needs and objectives of OHS. This group will meet for five meetings and will develop recommendations that will be adopted by the APCD Advisory Group.

Michael then provided an update on the Consent Policy Design Group. This design group was introduced at the last Advisory Council meeting. This group will kick off at the end of March, or the beginning of April. We need to make sure we have the statutory and regulatory frameworks identified and analyzed. This group will cover a lot of territory and will aim to meet every other week for eight meetings. This group will provide interim reports the Advisory Council.

Michael then provided an update on the Statewide Health IT Plan Design Group. The Statewide Health IT Plan is forthcoming and will be delivered to the Advisory Council in March or April. One of the main areas of this document will address the potential state collaboration and engagement opportunities. The state agency representatives and business/technical owners will begin meeting to identify and expand on potential state agency collaboration opportunities.

9.	Wrap up and Meeting Adjournment	Allan Hackney	2:55 PM
	<p>Allan Hackney introduced several other topics that are actively underway:</p> <ul style="list-style-type: none">• The Genomic Medicine Workshop (March 8th) – OHS, in partnership with Yale School of Medicine's Genomic Center, will analyze the use case for connecting genomics into the statewide HIE. The group look at an initial use case for connecting genomics into the HIE.• HIE Trust Framework – this is a reminder that the legal structure for how entities will connect to the HIE entity is under active development, with help from Velatura. This document will be shared for feedback in the near future. This is the most critical step associated with the launch of the HIE entity. <p>Next, Allan Hackney introduced Sabina Sitaru, the Interim Chief Operating Officer for the HIE entity. Allan will be distributing a survey that will look for the Council's input on: (1) the name of the HIE entity, and (2) the logo of the HIE entity.</p> <p>Mark Raymond said that the agenda today was full of good content and was reflective of a lot of good work that is going on. This is a demonstration of the leadership and commitment and Mark thinks we are making good progress.</p> <p>Allan Hackney asked for a motion to adjourn the meeting. Mark Raymond created the motion to adjourn the meeting, and Vanessa Hinton seconded the motion. The motion was approved without objections or abstentions.</p>		

Upcoming Meeting Schedule: March 21, 2019; April 18, 2019, May 17, 2019

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