Health Information Technology Advisory Council
Meeting Minutes

Meeting Date	Meeting Time	Location
October 17, 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	X	Bruce Metz, UCHC CIO	X	Lisa Stump	
Mary Kate Mason, DMHAS		Ted Doolittle, OHA		Patrick Charmel	
Cindy Butterfield, DCF		David Fusco	X	Alan Kaye, MD	X
Cheryl Cepelak, DOC	X	Nicolangelo Scibelli	X	Dina Berlyn	X
Vanessa Hinton, DPH	X	Patricia Checko	X	Tekisha Everette	
Dennis C. Mitchell, DDS	X	Robert Tessier		Patrick Troy, MD	
Mark Raymond, CIO	X	Robert Rioux	X	Stacy Beck	X
William Petit, MD	X				
Supporting Leadership					
Victoria Veltri, OHS		Tom Agresta, MD, UConn Health	X	Sabina Sitaru, HIE Entity	X
Tina Kumar, OHS	X	Kate Hayden, UConn Health	X	Tim Pletcher, Velatura	
Sean Fogarty, OHS	X	Carol Robinson, CedarBridge	X	Lauren Kosowski, Velatura	X
Adrian Texidor, OHS	X	Terry Bequette	x		
Alan Fontes, UConn AIMS		Sheetal Shah, CedarBridge	X		

Minutes

	Topic	Responsible Party	Time
1.	**Welcome and Call to Order**	**Allan Hackney**	**1:00 PM**
	Allan Hackney welcomed the Health IT Advisory Council members and provided an overview of the agenda.		
2.	**Public Comment**	**Attendees**	**1:05 PM**
	Dr. Susan Israel, MD submitted the following public comment and asked for it to be read the Council: *"In discussion of the Best Possible Medication History – BPMH and the PDMP, I was wondering if the intention was for it to be a forced system like the PDMP which is done without patient consent? Another concern is the plan to send PDMP information to other states, because besides opioids, it also includes patient psychiatric medications which happen to be controlled*		

	substances. And right now, the ACLU is fighting to keep the DEA from accessing the PDMPs without a warrant! " Allan Hackney commented that these are questions opposed to a statement. With respect to the PDMP, there is not anyone present from Dept. of Consumer Protection (DCP) to answer this so it will be referred to them. In regard to the Best Possible Medication History (BPMH) for the Medication Reconciliation & Polypharmacy (MRP), Allan asked if any members of the MRP team would like to comment to the question. There were no questions or comments, the question will be referred back to the team for follow up. Sean Jefferies introduced himself as one of the individuals of a part of the MRP. Sean thanked the HIT Advisory Council for their continued work and for recognizing the importance of this issue. Sean commented that we have an opportunity to make an important difference in lives for residents and that it is important to make medication use safer across for all populations. The fact this can be done across all populations is tremendous. Allan Hackney thanked Sean Jefferies for his comment. There was no additional public comment.		
3.	**Review and Approval of August 15, 2019 and September 19, 2019 Minutes**	**Council Members**	**1:10 PM**
	Allan Hackney asked for a motion to approve the HIT Council meeting minutes from August 15, 2019. Patricia Checko moved the motion, Stacy Beck seconded this motion. All in favor. **The August minutes were approved without any abstentions or objections.** Allan Hackney asked for a motion to approve the September 19, 2019 minutes. Vanessa Hinton moved this motion, Mark Raymond seconded the motion. All in favor. **The September minutes were approved without any abstentions or objections.**		
4.	**Update on the HITECH Act APD**	**Allan Hackney**	**1:15 PM**
	Allan Hackney provided a brief update on the HITECH Act APD. • In the first week of October, CMS sent an approval letter to DSS approving the HITECH IAPD Funding request that the HIT Council affirmed in December 2019. • With respect to the specifics in Appendix D (related to activities in the HIE), everything that was asked for was approved. • Nuance to the approval: CMS rolled the funding request they put forward in federal fiscal year 2019 into 2020. • We had requested between the two years; under ~49 million, to focus on deployment of Health Information Exchange. • Good news is that they approved the entire amount; • Challenge is separating across the two-year period; because of the timing of approval and going to have to shift from 2019-2020 to funding 2021. • They will collaborate with Dept. of Social Services on this work. There were no questions or comments following the update.		

5.	**Review and Discussion of the Medication Reconciliation and Polypharmacy Work Group Project Charter**	**Dr. Tom Agresta, UCONN Health**	**1:50 PM**

Allan Hackney introduced Dr. Tom Agresta from UConn Health who reviewed and discussed the MRP Work Group project charter. This topic was raised to the HIT Council last month, and there was considerable discussion around the charter. The HIT Council had raised questions and advice to effectively set the precedent of the aspect of having a charter and a standing subcommittee.

Dr. Agresta shared that the group had a very engaged meeting a few weeks ago, and the work group participated through a webinar to work through the charter, which was shared with the HIT Advisory Council for feedback and approval.
Dr. Agresta highlighted the charter and commented on the goals. **This can be read in full on pages 7-15 here.**
The purpose statement of the MRPC is provide strategic guidance, and recommendations for support for HIT (for development and implementation. This builds upon the recommendations and areas of focused identified by MRP Work Group.

Dr. Agresta outlined the five project goals of the MRPC:

1) Go into greater depth on BPMH, engage patients in that process and longer-term options; including how to integrate them into health IT systems.
2) Provide an online directory and make it available as a public resource of tools and solutions
3) Serve as a resource – know that there will be a number of questions that arise form state agencies and organizations; create a brain trust of collaborations across the spectrum, they would be able to serve as a resource on how to approach something
4) Ensure that the recommendations that they made, develop an implementation plan; also develop real evaluation in are we making a difference? We recommended this and we started to implement, here's the data and what it starts to look like.
5) Support implementation Advance Planning Document (IAPD) and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (Support) Act funding initiatives.

Dr. Agresta highlighted the membership composition described in the charter.

Membership would include:

- broad representation; additional members with skill sets i.e. technical skills –good in clinical arena and other individuals that do care,
- need to do increased membership with payers involved and additional patient advocate
- annual review and then ensure people are staying actively engaged
- Officers/Subcommittees –The MRP work group thought it was important to pick Chairs and be able to represent the group to HIT Advisory Council
- member chosen chairperson;
- Opportunity to share leadership.
- Subcommittees could be formed.

Operating Procedures:

- The charter would last about two years due to funding in HITECH Act.
- Good time to reevaluate if group was effective, and goals were met.

Duties of OHS:

- helping with agenda setting, logistics, and federal/state changes to law

Duties of HITAC:

- approve the charter and any updates; agree to take action on recommendations as necessary, but that these are brought up to HIT Advisory Council; they will come up with resource requests and bring that here; as well OHS.

Dr. Agresta concluded his presentation by opening the floor for questions and further discussion.
Bruce Metz thanked the group for developing the charter.

Bruce had a detailed mechanical question, he asked if there should be mention of developing tools should be stated in the purpose? Since this is the first but as first subcommittee for this body and understand where boundaries begin.

Dr. Agresta wants to separate out the work products (online repository) and oversight of pilot projects (etc.). The MRPC doesn't have intention of developing a software solution, but maybe sponsoring pilot project. The work product they were thinking more about is a resource repository. For example, started with a literature review and as part of actual recommendations and that will continue about best practices, can be organized a bit more and that can be made publicly available and easy to find. They may also provide access to a number of different tools or resources, or open-source along with commentary on the features. But didn't envision the MRPC creating a solution, but defining what it may need to be, describing the features that may need to be present, and evaluation metrics. But actual development needed to be taken on elsewhere, that wouldn't preclude members of that committee.

Bruce Metz asked how does everything get coordinated? The implementation plan comes here and where does it go for execution and how does it get executed.

Dr. Agresta commented that we envisioned that it would come to HIT Advisory Council to Office of Health Strategy and wherever funding source exists.

The HIT Advisory Council would make recommendations about that.
Bruce Metz added that we don't want unfunded plans, so there needs to be some kind of coordination with these bodies.

Allan Hackney agreed with Bruce's comment to say that if they are recommending anything that would require resources, it will come to this (HIT) council. Subcommittees don't have the statutory authority ability to make decision on funding allocation.

Bruce Metz commented that we don't want work spent on things that are unfunded.
Dr Agresta suggested that this may be the role of the chairs and UConn to help support this.
They can go look at resource opportunities – other grants and opportunities and bring those forward as an option.
Bruce Metz agreed with this.

Mark Raymond thanked the group for putting in timeline around the Committee.

Mark asked how we think about funding and have we completed progress against our goals; as we went through the charter – couldn't get picture of what does "done" look like-could be vague so hard to articulate what this looks like. But the conditions of process in place, medications are fully reconciled, not sure what that looks like. But it might be helpful, when end of timeline comes, to start looking at to see at what point do we consider a sunset of the activities and do appreciate the initial steps. Have to make incremental progress and thinks that's what the charter entails.

Dr. Agresta commented that, "done is in eyes of beholder," but the group does want to think of criteria for success; it will look like not just % of folks covered or certain tasks, but will look like projects completed etc.

Nicolangelo Scibelli commented that was mention that the MRP group wouldn't have authority to do certain things because of statutory requirements. But asked if there were statutory requirements or regulations that guide the formation of this? In terms of how they start up, etc.

Allan Hackney answered that there is one standing committee of Health IT Advisory Council currently, the All Payers Claims Database (APCD). The APCD has statuary reference about its relationships to HIT Advisory Council and direction on types of skills that should be represented on the APCD and stopped short on that process. The statute goes on to give this body statutory to stand up any body that deem valuable and useful; it gives it discretion to Advisory Council to see how it works.
Effectively, this concept of having a charter is a precedent setting process to this group. If it's something that is agreed to, then it would be the model that what would be used moving forward for subcommittees.
Nicolangelo Scibelli responded that this answered his question. His concern was around how many times the design group could lead to form other groups and create a very complex subcommittee structure. Especially if it was time based.

Allan Hackney stated that there is a distinction with the design group it includes a set problem, a set number of meetings from a design group perspective. In this particular recommendation, it was brought to this group from MRP Work Group that this body consider a standing subcommittee and this group affirmed it. There is some control from the members.

Allan thanked Nicolangelo for the question and there were no additional questions/comments.

6.	**Approval of the Medication Reconciliation and Polypharmacy Work Group as a standing committee of the Advisory Council**	**Council Members**	**1:55 PM**
	Allan Hackney asked for motion to approve the Medication Reconciliation and Polypharmacy Committee as standing committee and its charter. Rob Rioux made a motion. Dina Berlyn seconded this motion. All in favor. **The motion is approved** without any abstentions or objection. Allan thanked Sean Jefferies, Dr. Agresta and team for their hard work on this.		
7.	**Review and Discuss SUPPORT Act APD**	**Terry Bequette, CedarBridge**	**2:00 PM**
	Terry Bequette from CedarBridge shared on update on preparation for the SUPPORT Act APD funding request to send to CMS. Terry shared that 100% of the funding opportunity with deadline of 9/30/2020 is urgent to get the request in to have the funds evaluated by CMS to have the funds released. In the January timeframe, it supports enhancement to PDMP system and makes it a qualified PDMP (which specific definition in legislature that makes funding available). It will also expand the footprint of PDMP, so they have access to Electronic Health Records; they want to include connections and HUBs through interstate data exchange; including CT HIE. Collaboration among DCP/DSS/OHS each with a stake in the game This process has a focused list of opportunities in funding request. Not included in list: outreach and education; (promoted idea of connecting PDMP) PULSE (open software system) patient unified lookup service for emergencies – it was employed during wildfires for emergencies; idea is that people evacuate and need for medication histories, if it was something CT were to deploy there is value in connecting it to PDMP; in addition to planning for New England regional solution. Two portions of funding: • Staffing and contracting. Most connections are done through Appriss and subscriptions. The rest of it is planning and making connections to the HIA and work that would go into that. Next Steps: • Over the past month: revisions and work were done on the document • A week and a half ago, a three-way joint review meeting to work through joint review list • Draft document submitted to HIT Council for review • There is still some work that DSS will have to do • No anticipated changes to the scope. Allan asked if there were any questions. No questions or comments. Allan asked for a motion to accept the recommendations for the support act scope and proposed funding, subject to final review by DSS for submission to DSS. Joe Stanford moved		

	this motion, William Petit seconded the motion. All in favor. **The motion was approved** without any abstentions or objections.		
8.	**Update on Consent Policy Design Group**	**Carol Robinson, CedarBridge**	**2:20 PM**
	Carol Robinson from CedarBridge introduced herself and participated in answering any questions. Carol acknowledged that there are Consent Policy Design Group members on the HIT Advisory Council and invited them to answer any questions and contribute to the discussion. Carol shared that in approaching meeting 12 of the Consent Policy Design Group, that this was a longer set of meetings than was originally planned for in the initial work plan from February 2019. This isn't surprising because of the complexity of the topic for any data exchange between two entities. Carol commented the progress of the Consent Design group is moving along and include thoughtful discussions and input from multiple sides of more restrictive consent policies and less restrictive policies. The group is developing guiding principles for those consent policies. A set of principles that outline recommendations for a variety of considerations to apply to any policy that is developed. The Consent Policy Design Group is currently at 18 guiding principles and reflects the thoughtfulness of the group and this work. Carol added that the group wants to have an overarching consent policy to help the Health Information Alliance and get data flowing. That was the original intent of the group; to look at HIPAA as the floor; and expand consent requirements as use cases would require or demand. Carol paused and asked if design group members wanted to comment on process. Pat Checko commented that when we all became involved, it was much more complex. The reality is that you need some type of process for each use case developed; so you can't have some universal consent for each use case. We understand the importance of privacy and sharing information to improve care. We will end up with situations where information is collected without consent and comes down to sharing. Mark Raymond added that in the context of these guiding principles, do they indicate who or where in the process they should be making those and finalized consent? So that there is clarity on where those decisions are being made and who is doing it? Carol Robinson answered that has been a discussion for the group for a few weeks. There may be some need for legislative action to codify policies into legislation. Carol believes the critical issue is whether the consent policies will be applied and reflective only for HIA or if they should be applied across the distributed networks across HIE entities; and if all entities need to use a common set of consent policies in CT. That is silent right now in CT legislation. Allan Hackney added that although he has not to all of the meetings but having listened to most meetings, he is familiar with the conversation. He continued, that with 18 principles headed towards 19; it's going to be multiple groups to answer Mark's question. Some of them are operational and some decisions lie within mechanisms in HIE Operating Committee; some are policy oriented and lie within this HIT group and some may be recommendations to legislature. Because there are statuary embodiments or challenges and when we see the final 19, we'll then "bucket them" depending on which one.		

	Carol Robinson commented that there is some sort of technical review in how consent management is being done now or in the future; and HIA role may; may be a group that comes out of council as well. Allan Hackney added that getting back to HITECH IAPD; that IAPD included considerable funding – close 1.5 million across 2 years to develop a consent management solution for HIE. This group in its principles will include some recommendations for direction that would inform that program. It's just about the time where we would land with Consent Management System. Mark Raymond says it raises the question; if there's a couple more meetings; are we running the risk of having them not vetted when HIE is implemented? Allan Hackney said the approach that we settled on for HIE launch is to focus on primarily on standard based HIPAA TPO based activity. The vast majority HIPAA BA's deal with those transactions all the time; our goal connect as many standard EHR's as possible before the HITECH IAPD funding ends of September 2021. We expect to do that by limiting the data to very standard clinical data, so avoiding the nuance of incorporating data around SUD, behavioral health and other sensitive data that require extra rules and consent. For example, with Wheeler Clinic, we talked about policy sharing clinical data into Wheeler but not accepting data from Wheeler without a consent management system so that they can make progress on making the connections. Nicolangelo Scibelli commented to the point that Allan is making which is integral to our work. Using the foundation of the use cases; talking about the use case factory – what are particular requirements for sharing information and if factory takes on; sharing of behavioral health information is under specific state regulations and federal regulations. It doesn't need to be that complicated. Allan Hackney thanked the committee members and added that this has been a long road for these members.		
9.	**Announcement of the Health Information Alliance, Inc. Board Meeting**	**Allan Hackney**	**2:40 PM**
	Allan Hackney shared that the Health Information Alliance, Inc, the entity that will house health information exchange, had its first board meeting on October 1st, 2019. This is a huge milestone for the State of CT. The HIA, Inc. Board is targeted to have eight (8) members; five (5) members are appointed; three (3) are ex-officio; there is overlap with this committee and Mark Raymond and Allan sit on the board. The meeting was largely administerial, meeting to consider types of activities-accepting bylaws, conflict of interest and getting briefed on what we have been working on. Allan shared his observations from the meeting that the Board is very engaged and interested, and they view their fiduciary responsibility keenly. In terms of engagement; the first meeting was three hours and kindly hosted by pro-health physicians. The Board asked for the next meeting to be four hours. The next HIA, Inc. Board Meeting will be November 6th. To discuss strategy of the exchange and onboarding processes, types of use cases and all the other kinds of things to be focused on. Allan commented that this is a great start and it is a group of really impressive people. Mark Raymond was asked to share any updates or observations from the first meeting. Mark echoed		

	Allan's comments and added that the Board has a tremendous work to do, during the meeting the executive search committee for lead of organization is formed; process of how to go about that difficult activity; get right board of directors in place. The group recognized the role and volunteered to do more to ensure that group is successful. Pat Checko asked if we will we find out who is on the board and if there will be a public facing website. Allan Hackney responded that on the members on HIA Board are: Mark Raymond, Dr. Allen Davis, John Vittner, Lisa Stump, Jill Hummel; and three nominees who are awaiting appointment. On the Office of Health Strategy website, under the Health IT Advisory Council section, there is a section for the Health Information Alliance, Inc. which will reference Board meetings.		
10.	**Wrap up and Meeting Adjournment**	**Allan Hackney**	**2:20 PM**
	Allan Hackney announced that Lewis Bower who was appointed to HIT Advisory Council earlier this year resigned from the Council as of this morning (10/17). Lewis Bower represented the Skilled Nursing Facilities and Home Health Care Domain. Allan acknowledged and thanked Lewis for his contributions and being a part of the council, and that his participation was a very valuable contribution to our efforts. Allan shared that we will proceed to find another candidate to fill that role (appointed position) and begin process of replacing his position on the Council. Allan asked for a motion to adjourn the meeting. Mark Raymond made a motion to adjourn. **All in favor to adjourn the meeting at 2:20 pm.**		