Health IT Community Stakeholder Roundtables: Meeting Minutes

Summary of General Roundtable Presentation

Introduction	

Opening Remarks (Allan Hackney)	• Allan (The Health Information Technology Officer, or the "HITO") welcomes everyone and thanks them for attending
	• This may be an opportunity to get up-to-speed on what is happening at the state level, and the recent efforts that have been actively underway
	• We want to be open and transparent about the approach we are taking – want to involve as many stakeholders as possible
	• The HITO recognized those in the room who have been closely involved in the process so far:
	  ○ Middletown – Jake Star, Stacy Beck
	  ○ Danbury – Kathy DeMatteo
	  ○ North Haven – Lisa Stump, Dina Berlyn, Dr. Michael Hunt
	• This will start as a presentation of our efforts so far, and the current activities underway, which will then be followed by a group discussion
	• Introductions of State and CedarBridge staff

Opening Remarks (CedarBridge Group)	• What can health IT and data sharing do to advance the individual efforts of people and organizations around the state? • Connecticut has made several unsuccessful attempts at standing up an HIE in the past – this current initiative is building on those efforts and has learned from those efforts • Public Act 16-77 – passed in 2016 - requires the establishment of a new HIE in Connecticut, authorized the creation of a statewide health IT plan, as well as creating the roles/charges of the HITO and the Health IT Advisory Council • New approach for this initiative – let's ask the people what they want from health IT and HIE in the state, and engage people throughout the process
Report on Stakeholder Engagement Findings	
Stakeholder Engagement Approach	• Stakeholder Engagement Process consisted of 68 interviews, 4 focus groups, and 52 survey responses • 130 organizations; 282 individuals ○ The state recognized the omission of local Health Departments from the initial stakeholder engagement process and committed to engaging them in future, continuing stakeholder engagement activities • Findings were summarized and presented to the Health IT Advisory Council • This is seen as the "end of the beginning, rather than the beginning of the end" • The Council accepted the findings and encouraged planning to commence quickly

Stakeholder Engagement Themes	• We started the stakeholder engagement process with a blank slate – no preconceived notions – we wanted to hear directly from stakeholders and develop our themes, findings, and recommendations based on what we heard and learned during the discovery process.
	
	Stakeholder Engagement Themes:
	• The Patient is the "North Star"
	  ○ Privacy, security, and confidentiality
	  ○ Focus on health equity and the social determinants of health
	  ○ Consumer engagement and tools for better management of one's health and healthcare in partnership with care team
	  ○ Personal health records (PHRs) with integrated clinical data; not tethered to a single EHR
	  ○ Quality and price transparency
	• Embrace Existing Capabilities
	  ○ Statewide HIE shared services – Statewide Health Directory and patient attribution services; identify conformance, data validation, and data normalization services
	  ○ Networks of Networks – linking organizations that provide HIE services with "Rules of the Road"
	  ▪ Data use agreements
	  ▪ Data standards, security, and privacy protocols
	  ▪ Accreditation/certification or organizations delivering HIE services
	• Whole Person Care
	  ○ Includes all points of care engaging behavioral health, long term post-acute care (LTPAC), community health organizations, and others
	  ○ Level the playing field, incorporating information exchange beyond traditional EHR systems
	  ○ Enable care coordination with tools and support for care coordinators, providers, and patients
	• Focus on Workflow
	  ○ eCQMs – harmonize to support value-based payment and care delivery
	  ○ Connecticut Prescription Monitoring and Reporting System (CPMRS) – further integration with e-prescribing
	  ○ Public Health Reporting – improve bi-directional immunization, lab, and syndromic reporting
	  ○ Expand data exchange using Direct Messaging standards
	• Harness Accountable Care Organizations (ACOs)
	  ○ Align with organizations focused on value-based care models
	  ○ Inter-ACO and Intra-ACO opportunities – assist ACOs in exchanging data internally and externally
	  ○ Find and capture the value in ACOs to ensure sustainability
	• Meet Today's and Anticipate Tomorrow's Needs
	  ○ Advance precision medicine through expanded data sources – support consumer consent and enable sharing of genomic profiles
	  ○ Internet of Things – bring your own device, home monitoring
	  ○ Current and future data exchange needs – incorporate telehealth services, diagnostic images, structured lab results, etc.

Calls to Action: Priority Recommendations	• There were **9 Priority Recommendations** created for the State of Connecticut by CedarBridge, based on information gathered during the stakeholder engagement and research/analysis processes
	  ○ Connecticut must keep patients and consumers as a primary focus in all efforts to improve health IT or HIE, including addressing health equity and the social determinants of health
	  ○ Connecticut must leverage existing interoperability initiatives, including existing or planned private investments and relationships with state-based HIEs and the national initiatives
	  ○ Connecticut must implement core technology that complements and interoperates with systems currently in use by private sector organizations
	  ○ Connecticut must establish "Rules of the Road" to provide an appropriate governance framework – trust needs to be established
	  ○ Connecticut must support provider organizations and networks that have assumed accountability for quality and cost
	  ○ Connecticut must ensure that basic mechanisms are in place for all stakeholders to securely communicate health information with others involved in a patient's care and treatment
	  ○ Connecticut must implement workflow tools that will improve the efficiency and effectiveness of healthcare delivery
	  ○ State agencies must charter and implement a Health IT Steering Committee, chaired by the HITO, staffed by the HIT Program Management Office (PMO), and reporting to the legislative and executive branches
	  ○ Connecticut should establish, or designate, a neutral, trusted organization representing public and private interests to operate agreed-to statewide health information exchange services
	• Connecticut has a great opportunity with this effort – there is the opportunity to reboot, analyze market trends and move forward unhindered by existing infrastructure, and aided by a diverse group of passionate people

Report on Current Activities	
Current and Planned Activities	• Nothing is chiseled in stone – we want to continue to gather opinions and perspectives – example of local public health departments having been initially omitted from the process, but becoming engaged through these roundtables (continued stakeholder engagement) • You cannot do everything on day one – being overly ambitious has killed HIE efforts in other states • Ongoing/continued stakeholder engagement – this summer roundtable series is part of this process • Health IT is a means to an end
HIE Use Case Design Group	• What is the purpose? ○ Create a comprehensive list of very specific HIE services, establish value propositions to prioritize the services, validate functional requirements for prioritized services, and provide recommendations to the HITO and Health IT Advisory Council regarding shared infrastructural components. • What is the problem to be solved in Connecticut?

	○ Long list of HIE services that would benefit the population of Connecticut. The Design Group will help to prioritize these services and begin to create a path forward for implementation of HIE solutions. • How did this become a priority? ○ Through the stakeholder engagement process, many HIE services, data, and shared infrastructure components were discussed as possible priorities with stakeholders. A Design Group representing multiple stakeholders was convened to create and prioritize a comprehensive list of HIE services that Connecticut should implement. • Nine meetings will occur with appointed Health IT Advisory Council members and designees representing various stakeholder groups ○ Validate a curated "use case library" ○ Recommend 5-7 high priority use cases for HIE services ○ Recommend models for delivering HIE services to meet the business needs represented in each high-priority use case (such as: buy vs. build and/or federated vs. centralized
Immunization Information Systems Design Group (IIS)	• What is the purpose? ○ An immunization registry or Immunization Information System (IIS) is a confidential, population-based, computerized information system that collects vaccination data about all persons within a geographic area • What is the problem to be solved in Connecticut? ○ Providers of vaccinations, individuals who receive vaccinations, schools, pharmacies, employers, and other stakeholders currently do not have an efficient electronic system in which to comprehensively and accurately track vaccinations • How did this become a priority? ○ This was ranked as a high priority during the stakeholder engagement process – there are opportunities for the state to expand and improve its services, as well as to continue to address the need for streamlining public health reporting. • Five meetings of appointed Advisory Council members and designees ○ Recommend technical standards and functional requirements in alignment with the CDC ○ Recommend operational and financial sustainability strategies ○ Recommend strategies and timelines to create an implementation roadmap for a statewide bi-directional IIS systems to support provider and consumer needs ○ Membership included pediatricians, pharmacists, health department representatives ○ National pharmacy chains have provided some input in this process as well – they will be kept up-to-speed in the process
Electronic Clinical Quality Measures (eCQMs) Design Group	• What is the purpose? ○ eCQMs measure healthcare processes, observations, treatments, and outcomes. They quantify quality in our healthcare system; measuring and reporting CQMs help to ensure care is delivered in a safe, effective, equitable, and timely way.

	○ The Connecticut SIM program served as a driver to move quickly on the development of an eCQM system • What is the problem to be solved in Connecticut? ○ Connecticut supports innovative programs that support the Triple Aim of improved patient experience, reduced costs, and improved population health. • How did this become a priority? ○ The Connecticut Health Innovation Steering Committee determined that eCQMs are necessary to drive statewide improvements in healthcare quality and enable payment and practice reforms. There is broad support for consistent eCQMs across provider, hospital, and insurer groups.
Statewide HIE Shared Services Entity Design Group	• Advisory Council members and designees representing diverse stakeholder groups will be appointed and tasked with the following goals: ○ Recommendations for operational and financial sustainability strategies for a statewide HIE Shared Services entity ○ Development of a high-level roadmap for the governance of a statewide HIE Shared Services entity, and for certification/accreditation of organizations providing federated HIE services in Connecticut ○ Neutral entity that has the confidence and trust of stakeholders ▪ Likely to be a non-profit entity – this is the optimal model to ensure that the entity is neutral ▪ This entity will not be an office of the government, and will not be part of one of the state agencies – in order to ensure that the entity remains neutral ○ Neutral entity means no actor has an unfair advantage over any other actor – services are not designed to benefit any one group specifically

Stamford, Connecticut

Logistics, Attendees, and Discussion

Meeting Date	Meeting Time	Location
July 18, 2017	8:00 am – 9:30 am ET	Stamford, Connecticut (UConn Health)

Stakeholder Attendees		
Kimberly Sage (SMC Partners)	Neil Vigdor (Hearst)	Jody Bishop Pullan (Stamford Department of Health)
Mike Pensiero (City of Stamford)	Maria Millan (City of Stamford)	Jim (Women's Health CT)
Jennifer Calder (Stamford Department of Health)	Arlene Murphy (Consumer Advisory Board)	Megan Dimeglio (City of Norwalk Health Department)
Todd Arnold (Sema4)	Lauren Rosato (Planned Parenthood)	Deborah Miller (Stamford Department of Health)

Eden Huang (Stamford Department of Health)		
SIM/HIT PMO and CedarBridge Attendees		
Michael Matthews, CedarBridge	Allan Hackney, HIT PMO	
Carol Robinson, CedarBridge	Sarju Shah, HIT PMO	
Chris Robinson, CedarBridge	Kelsey Lawlor, HIT PMO	
George Blair, CedarBridge		

Discussion / Q&A – *Feedback on Findings and Current Activities*

- **Participant Question** – "Form follows financing" – where do you get the money to accomplish this? Payers seem to be absent from discussion.
    - **CedarBridge Response** – Mark Raymond (State CIO, member of Health IT Advisory Council and HIE Use Case Design Group) is very focused on the sustainability of these efforts. Value does not necessarily equate to funding or revenue – we understand this and are actively working to address it.
- **Participant Question** – How do you engage the other players? This person really appreciates the focus on workflow, but they want to make sure we go beyond the traditional providers
    - **CedarBridge Response** –Through the recent stakeholder engagement process, we have engaged payers, reference labs, and other players.
- **Participant Comment** – Local health department representatives stated that have a lot of different software and technology tools that they are currently using. Some of their staff members need to go to five different screens or programs in order to complete their workflow. Insurance and billing is extremely cumbersome and daunting.
    - Example – they need to start looking at procuring a billing system, in addition to an EHR system that is designed for their specialty
    - Example – there are many different programs, and they would like to see enrollment and eligibility efficiency – example of having lead teams flagged due to other environmental concerns. Currently, different health departments, and even different programs will need to have memorandum of understandings (MOUs) in place in order to collaborate on a shared client
    - They believe that CIRTS (Connecticut Immunization Reporting and Tracking System) and WIC (Women, Infants, and Children) have an MOU in place at the state level – this has created some efficiency
    - People forget that many local health departments have clinics – they may not do everything that other clinics are doing, but they are still and important healthcare provider in the community – they would love to be able to access the local hospital's EHR systems and data sets – this is challenging currently
    - **CedarBridge Question** – Are you currently in the process of EHR procurement?
        - They have collaborated to look at each other's systems – they are very worried that whatever they procure will not meet the state's needs in the future
        - Most of the local health departments are in the same situation
        - They want guidance from the state – what they should be using, what works the best, how they should be using it, etc.
    - CIRTS is incompatible with what the physicians are using – now they have to send nurses to the doctor's office in order to manually key-in immunization information for young children
- **Participant Comment** – How will underserved populations be served or benefit from this program?
    - **HITO Response** - Until you see the data, you can't understand what is going on so it's hard to make predictions.
    - **CedarBridge Response** – If customers demanded interoperability, it would happen.
- **Participant Comment** – Consumers need information – the information that is transmitted back and forth either helps you get better, or it kills you. What is important right now is to have effective, accurate transmission of information – this does not exist right now, and the information is not accurate.

- The participant was very pleased to see us travelling around Connecticut to explain how this will work on the ground – example of using an ATM and how it will work regardless of the ATM or the owner of the ATM.
- It is the participant's hope that what we are building will plug people together effectively to ensure the accurate transmission of information
- Insurers won't accept measures that aren't collected properly

- **Participant Comment** – we have said "interoperability a couple of times" – it is not working on the local level. How do you get to a neutral and trusted organization? The big players have invested more than anybody else, they are not neutral, and they are probably not trusted.
  - **HITO Response** – it is a monstrous undertaking, that is for sure. The vendors have a role to play in this, and they may have a proprietary agenda. He sees a couple of interesting things happening with vendors, such as CommonWell, who was formed by the vendors because the vendors realized that the providers and healthcare organizations were hitting them from all sides – there needed to be an easier way to have information moving between systems. Getting the vendors behind this is powerful. Epic is another 800-pound gorilla – Care*e*Quality recently decided to join forces with CommonWell. This is an indicator that the vendors are coming to the table.
  - **HITO Response** – the people who can afford the big vendor systems have a lot of capital. There are a lot of organizations in the state that do not have this kind of capital, but are hungry to consume and exchange data. This may be perceived as a moonshot effort by some, but my philosophy is to start with use cases, find out what people need, and start to pick them off one-by-one. Otherwise you are just boiling the ocean.
  - **HITO Response** – More than 50% of HIEs across the country have admitted that they do not have a viable sustainability model and are likely to fail – that is just the ones that are willing to admit this. Despite the budget projects of the state, The HITO feels like he has more than enough capital to get the ball rolling. However, the real challenge will be to find a use case for exchange that will create enough value for stakeholders to drive sustainability.
  - **HITO Summary** – I do not think they will be able to solve everything, but they will begin to chip away and create value for stakeholders.
  - **Participant Follow-up Comment**– if you make those investments and it doesn't work, this is a big problem. We have all of this data that we want to use to benefit patients, this is why it is critical to have a neutral entity.
- **Participant Question** – How are the current providers participating in the shared saving program contributing their data currently? How is the quality measurement occurring today?
  - **CedarBridge Response** – this is being investigated as part of the procurement process for the eCQM system. We are trying to figure out the "what" – streamlined reporting processes has come up as a need over and over again. We have had long conversations with payers.
  - **HITO Response** – part of what we need to do is harmonize the measures – the first step has been accomplished through the work of SIM
  - **Participant Follow-up** – We need this eCQM system, it is a cumbersome process currently. Who is the recipient of the care? Everyone is going to have quality metrics – but how do you score the data? How do you weigh the data? Etc. – we need to get something cohesive. Quality metrics are a key driver – it needs to serve pretty much everyone.
    - **HITO Response** – we are touching on a public health dimension/domain in all of this – until you see the data, it is hard to know how to use it or what the real issues are. You can think the world is a certain way, but until you open up the data and see it in real-time, you cannot know how to act appropriately.

- **CedarBridge Comment** – there is demand for providers for interoperability and HIE services. A lot of blame is cast on the vendors, who are out to make a profit and serve their customers. The customer voice will be critical in motivating vendors.
- **HITO Comment** to the local health department representatives: you have brought up the topic of MOUs – during the past 6 months. I have seen staff consumed by producing, editing, and working on MOUs. It is the clearest representation of a bureaucracy that I have ever seen. This is a huge impediment to moving forward with inter-agency collaboration.
    - **HITO comment** – one of the things that is key to creating an HIE entity is establishing a DURSA. The HITO believes that this is a key component that the HIE entity could bring to the state – a data use agreement that would clear up a huge amount of these bureaucratic issues. It also solves some of those HIPAA issues that public health often suffers from.
- **Participant Comment** – when you are talking about health information exchange it is purely limited to specific data elements. Public health goes beyond those data elements, we need to think about environmental components as well and have this linked with the health data.
    - **HITO Response –** health equity is a component of this effort – the vendors don't typically consider health equity, or it is an afterthought. There is something that this neutral entity and utility could do around this topic.

Middletown, Connecticut

Logistics, Attendees, and Discussion

Meeting Date	Meeting Time	Location
July 18, 2017	5:00 pm – 6:30 am ET	Middletown, Connecticut (Middlesex Community College)

Stakeholder Attendees		
Stacy Beck (Anthem)	Tracey Centola (CHNCT)	Raymond Connelly (CHNCT)
Alan Fontes (UConn SON, HIT-AIMS)	Louise Harmon (UConn School of Social Work)	Linda Langlais (Elim Park)
Mark Laudenberger (Middlesex Hospital)	Rachel Legg (Khmer Health Advocates)	James Glass (Rite Aid Pharmacy)
Yangzhou Li (UConn)	Joshua Longiaru (United Services, Inc.)	Neal Lustig (Pomperaug Health District)
Lynn MacLean (Elim Park)	Mark Masselli (Community Health Center, Inc.)	Amir Mohammad (Director of Health, Town of Orange)
Jim Monopoli (CT River Area Health District)	Ashley Reynolds (Saint Francis Hospital)	Brian Richard (Masonicare)
Annie Scully (United Way of CT)	Mary Scully (Khmer Health Advocates)	Jake Star (VNA Community Healthcare)
Penny Stefanski (Middlesex Hospital)	Connor Walker (UConn)	Maxwell Wilbour (UConn / Khmer Health Advocates)
Valerie Wyzykowski (Officer of the Healthcare Advocate)	Julia Werth (CT Mirror)	Tom Agresta, MD (UConn)

Theanvy Kuoch (Khmer Health Advocates)		
SIM/HIT PMO and CedarBridge Attendees		
Michael Matthews, CedarBridge	Allan Hackney, HIT PMO	
Carol Robinson, CedarBridge	Sarju Shah, HIT PMO	
Chris Robinson, CedarBridge	Kelsey Lawlor, HIT PMO	
George Blair, CedarBridge		

Discussion / Q&A – *Feedback on Findings and Current Activities*

- **Participant Comment (representative from local health department)** – the participant read his written comments aloud for the group – his expectation was for the 67 local health departments to be more closely involved in the process, as well as have representation on the Advisory Council. Local health departments provide a wide range of services. Local health departments were widely excluded from the Environmental Scan report, in the participant's opinion. The participant requests that the report be revised to include the input from local health departments.
    - **HITO Response** – The HITO agrees with the comments. A similar issue was raised in Stamford during the morning roundtable. There are insights that can be provided by local health departments and public health organizations. There was no intentional objective to exclude anybody. The exclusion was an oversight of a nuance. We also initially missed the hospice care, EMTs, fire departments, etc. We want to include people at every level as part of the continuing stakeholder engagement process.
- **Participant Comment** – one of the first thing that struck this participant is the fact that we were talking about building trust. Where does the consumer fit into this conversation? How are consumers going to benefit from this and take advantage of these services?
    - **CedarBridge Response** – Asks the participant to turn this into a statement – what would consumers like to see?
        - **Participant Response** – The consumers use health IT to improve the quality for everybody. It starts with the person, not the population. They need access to a culturally appropriate patient portal. Is "health equity" a word that we use or a principle for how we build?
        - **HITO Response** – those are all important comments. His philosophy – we have always operated with the primary principle that the patient/consumer is at the center of this effort. They are the "north star." The HITO's architectural premise in building an HIE is a continuous care map – we are beginning to map all of the points where patients are receiving care, while also incorporating social determinants and other important components. We are not starting with hospitals or doctors, we are starting with the person. The more data that you have, the more opportunity you have to use that data for opportunities.
    - **Participant Response** – will small populations be included?
        - **HITO Response** – all populations will be included – it is not too hard when your primary premise is built around "the person"
    - **Participant Response** – How long will it take?
        - **HITO Response** – it is a journey of years. Workgroups are currently determining priorities.
        - **CedarBridge Response** – in the eCQM Design Group we discussed how to build the trust of users, which included the ability or consumers to be able to see the price and quality measure results.
- **Participant Question** – How do you plan to provide transparency and access to consumers with limited English speaking abilities, or access to technology?
    - **CedarBridge Response** – provided an anecdote about example working in Oregon where a recommendation was for technology-limited individuals to use the library for computer access. You have to think about the needs of the users.

- **CedarBridge Response** – one discussion that needs to occur is determining what technology will be consumer-facing, and what will be provider facing.

- **Participant Question** – How will you identify what will be best practices and why is this a state-specific effort?
  - **CedarBridge Response** – there are a number of national initiatives that could be utilized at a higher level by providers in Connecticut.
  - **Participant Response** – is it fair to say that at some point this is either a hub or a spoke? There needs to be an accounting for plug-and-play.
    - **HITO Response** – we will need to parse this out between commodity services and necessary services. At this time, transacting capabilities of moving data from hospitals to doctors is a commodity. He personally thinks that we should not be building this, and should be looking for partners that can take advantage of the scale. Data is different – it is highly localized.
  - **Participant Question** – Where is this model working?
    - **CedarBridge Response** – it is happening successfully in certain states currently, such as Michigan and Maryland. You see pockets where this is happening successfully, not everything needs to be replicated.
- **Participant Question** – we are talking about health equity; how will this be achieved? How will we effectively engage consumers?
  - **CedarBridge Response** – nobody is really doing this well today. The Stewards of Change are looking at this topic very closely, they had to bring in people from Europe to show how this is being completed successfully.
  - **Participant Response** – we don't need to think about this as a complete solution, but maybe as the first domino in the process. We shouldn't say, "solve all of our problems" we should say "bring enough people around the table so that we can find the right solution for the right problems."
  - **CedarBridge Response** – it is important to make people comfortable that this is a system that is designed to benefit them, not put them at more risk or to monetize their health information.
- **Participant Comment** – we are here tonight because we love health IT and use health IT. We are the state's best partners. If you want to sell this in the community, and have us go out into the community and sell these services, you need our engagement. Health IT has the potential to open the doors for a lot of opportunities.
- **Participant Comment** – one of the things that their patients struggle with is the requirement to access numerous portals.
  - **CedarBridge Response** – if we are going to solve this for consumers, then there needs to be a single portal for patients. We can't rely on tethered patient portals that are connected to EHRs, or other systems
  - **HITO Response** – there is a lot of motivation behind the efforts to solve this problem. The answer, he thinks, for Connecticut will reveal itself when the HIE Use Case Design Group validates the approach for the HIE at a high level. Need to determine what is the appropriate solution for solving this kind of problem.
  - **HITO Question** – Do you think there should be a state portal?
    - **Participant Response** – I do think there should be a state portal, but I worry about adoption. We may be able to jump ahead and go where the technology is being developed because we don't have any baggage. There are steps to move forward.
      - **CedarBridge Response** – for the next four years, the federal government will be giving money to the states to develop this kind of technology, and to support Medicaid and the Meaningful Use program. Some states are moving towards a statewide personal health record.
- **Participant Question** – regarding quality measures, how are you determining and selection quality measures and solving the nightmare of having to report different levels of A1c to different payers?

- **HITO Response** – every program that is out there, whether it is a commercial carrier or a state program, they have different metrics and reporting requirements. First will be to get infrastructure in place where we can view the data. SIM has a standing working group that is focused on quality measures – one of their primary objectives is to harmonize these measures.
- **Participant Response** – a lot of the payers are at the table at these SIM standing meetings. Payers want to make sure that they are picking measures that are clinical efficacious. The participant's recommendation is to look at the HEDIS measures in this way, and to look at the measures nationally, not just at the Connecticut level.

Group Discussion – *Sustaining Broad Engagement and Support for Health Information Exchange Services*

- **HITO Question** – are roundtables a good mechanism for future engagement?
  - **Participant Response** – we cannot go to meetings where you are speaking in jargon about health IT. Everyone might not be appropriate for every meeting, but that is up to the state to determine. If consumers are involved in the process, we can make this work.
    - **HITO Response** – in the past 6 months, he has seen a lot of energy from consumers.
  - **CedarBridge Comment** – when eHealth Exchange was being formed 10 years ago, there were a lot of small companies attending a big conference. A woman was the spouse of a wounded warrior, who arrived with three boxes of her husband's medical records, and said "you have to make this stop."

Danbury, Connecticut

Logistics, Attendees, and Discussion

Meeting Date	Meeting Time	Location
July 19, 2017	8:00 am – 9:30 am ET	Danbury, Connecticut (Naugatuk Community College)

Stakeholder Attendees		
Lewis Berman (Western Connecticut Health Network)	Kathy DeMatteo (Western Connecticut Health Network)	Eric Jimenez, MD (Western Connecticut Health Network
Susan Israel, MD (Self)	Jenna Lupi (SIM PMO)	Mark Thompson (Fairfield County Medical Association)
Antonio Vas (Regional Hospice and Pallative Care)	Clark Woodruff (Cornell Scott Hill Health Center)	
SIM/HIT PMO and CedarBridge Attendees		
Michael Matthews, CedarBridge	Allan Hackney, HIT PMO	
Chris Robinson, CedarBridge	Sarju Shah, HIT PMO	
Carol Robinson, CedarBridge	Kelsey Lawlor, HIT PMO	
George Blair, CedarBridge		

Discussion / Q&A – *Feedback on Findings and Current Activities*

- **Participant Comment** – he commends everyone here for the work that we are doing, and he hopes this works. He is a little bit confused, not by the presentation, but by the actions of the Connecticut State Medical Society – who announced their effort to create a separate statewide HIE. CedarBridge mentioned that some areas have multiple HIEs, such as New York, but that does not seem to be the strategy here in Connecticut. His

understanding of CSMS is that they want to blanket the entire state – some newspaper articles have said that these two efforts will be competing.

- **HITO Response** – recognizes that some publications have focused on this – but it is important to understand the situation that CSMS currently finds themselves in – they have to serve as an advocate for their members and bring something of value to them. There is an issue of moving towards the reconstituted Meaningful Use Stage 3 (MACRA/MIPS) which requires things like bidirectional access to registries, etc. The genesis of the idea for CSMS is to do something for their membership that creates value. They ended up with their solution (Kansas) when there was nothing – so they created a doctor-friendly strategy. They created a centralized model – storing and curating all of the data in a central location. If you found yourself in the position of CSMS, with a possibly declining membership base, this is a great way to bring something forward that will serve the needs of the membership.
  - **HITO Response** – CSMS are very aggressive marketers. There is a subtly here – the Kansas solution is a for-profit entity and the reason they have a strong marketing pitch is because their affiliated insurance company (malpractice) wants access to the doctor's data. If you understand this subtly, you can understand their behavior in the marketplace.
  - **HITO Response** – At the state level, the Advisory Council has deliberated on all of this work and has decided that they need to focus on specific use cases that take advantage of existing infrastructure in the state, both public and private. We want to optimize this. The state's position is to wish CSMS good luck in capturing as many doctors as possible – there are a huge number of doctors who are not engaged electronically, and this could serve to improve this situation.
- **Participant Follow-up** – Is there room for two HIEs?
  - **CedarBridge Response** – We view HIE as certain services that will continue to evolve to meet the business needs. The centralized model is successful in very few locations around the country. The state's strategy will work well in concert with the CSMS solution, as long as there is a strong governance framework.
  - **HITO Response** – the other way to answer your question – there are other HIEs operating in the state currently. That is the reality. The Advisory Council is adamant that we should not try to supplant innovation that is occurring around the state, the strategy is to help innovation be successful through the identification of high priority use cases.

- **Participant Comment** – The concerns about immunizations were spot on – this makes it hard to care for patients. We all have a huge problem with medication reconciliation – this needs to bubble up to the surface. What we did not talk about is certain federal initiatives, such as CommonWell, it seems a little complicated and ambitious to create such a flexible solution
  - **HITO Response** – two buckets – one is the transport between two entities (transactional), and the other is data that can be aggregated and used for insight that will drive public health, public policy, inform care decisions, maybe economic development, etc. The longer-term vision is to have the state invest in both buckets, but in completely different ways. The CommonWells and the Care*e*Qualitys of the world are putting pressure on scalability, unit cost, and integration – he does not see a place where the state can play a role in the long term to serve the transactional needs. We have to be very focused on developing services that will deliver value very quickly and that people will use for the right purposes. On the data side, eCQMs might be the first example, should be invested in heavily. This is the big opportunity for Connecticut. There is a longer-term view here – get super-efficient on the transaction side, find ways to capture the scale, while getting "super deep" on the data in order to best serve the needs of the state. We have talked with CommonWell and Care*e*Quality, and we are ready to partner with them where appropriate.
  - **CedarBridge Response** – this may seem like a zero-sum game – but what you are also seeing is significant advancements in collaboration among these national interoperability approaches. For

example, CommonWell and Care*e*Quality have partnered recently. eHealth Exchange is also becoming a Care*e*Quality implementer. We are developing a lot of different "sockets" and people are focused on making it easier for the end user.
    - **HITO Response** – Connecticut is a state of 3.8 million people, which is not scalable. We need to borrow scale where we can find it and harness it.
- **Participant Comment** – We are an FQHC and we do a lot of work with big hospital systems and the VA – we are in the middle. The care coordination process is very difficult. We are a non-profit organization, and I cannot afford to have multiple interoperability approaches. They are getting offers from big hospital systems to move to a different EHR system. They have seen a number of past initiatives – now I am sitting here wondering "how is this different?"
    - **CedarBridge Response** – what is your idealized state?
        - **Participant Response** – One of patients will go to the ED at Yale, and we will have no idea this is happening. Then the patient will come in for a follow-up and we will have no idea. They will be given a log-in to the Epic system, which is not scalable or feasible for the providers in the 15-minute window that they are seeing the patient.
    - **CedarBridge Response** – What if the right information as delivered directly into your system every morning?
        - **Participant Response** – We want the right information at the right time. It is very difficult and these are very daunting conversations.
        - **Participant Response** – We have been trying to do this in Western Connecticut for 10 years. It is a private network that Western Connecticut owns and runs – which was intended to connect the community together. When you are dealing with 20-30 different vendors with different requirements, and nobody has the time or resources to reach the tipping point – we struggle with the same thing – I don't know what the answer is. It would be wonderful if the vendors were more proactive and collaborative. Even with CommonWell, it requires updates and other steps, it is not just plug and play. Even if you build it, how do you sustain it? There are realistic challenges. First of all, determining what makes sense from a cost and value perspective will be the key.
- **HITO Comment on Sustainability** – Participant just summed up his perspective on the HIE Use Case DG – if a service does not provide the tangible value that will create funding, then it will not work. In terms of a vision, the role the state could play irrespective of what the use cases end up being, there is a role for the state to solve the one problem that none of the actors can solve – creating a map of the care touch points that a patient receives, regardless of where that care was delivered. If you can determine that there were labs ordered, or care delivered, and then map that information and expose it to a care coordinator – then at least you have a clue about how to proceed with care planning. Then if you enrich this information with some social information – now you have something that is really useful. In terms of the vendors, they are all fighting each other for their little spot in the space – CommonWell is hopeful, but I recognize that this is tough.
    - **CedarBridge Response** – the demand side for interoperability has been missing. The legislature tried to mandate the demand, but that didn't work initially.
- **CedarBridge Question** – how does this presentation resonate from the hospice perspective?
    - **Participant Response** – we are in a very similar situation. A lot of our information comes in via fax machine. There is a lot of resistance to change, and the information that is received can be 200+ pages, it is not helpful. We sometimes find out later that we were supposed to use Direct Messaging, but there was some breakdown, so people try to transcribe information back into our system. Part of the state requirement is to have paper on site – if you can eliminate this requirement, then you may eliminate the attachment to this workflow. A lot of vendors have come to them with some solutions – such as scanning – however some of this functionality does not align with an existing vendor, like the EHR. It is a tough proposition.

- **Participant Comment** – can you get the vendors in a room and make them talk?
    - **HITO Response** – One thing he has in his current position is the ability to pull certain legislative levers. This can be useful in certain circumstances. There was a recent piece of legislation that passed regarding bi-directional exchange. This is useful because it forces an issue where there are actors feeling disadvantaged. The problem is dealing with the vendors – it is very hard to legislate commerce. There are some things we can do through consumer perspective.
    - **Participant Response** – I would much prefer dialogue to regulation.
        - **HITO Response** – once we get the entity established, one of the roles they can play is the "convener" – at that point we can bring some of the key vendors in the state into the room and have a focused session to work through some of these issues.

North Haven, Connecticut

Logistics, Attendees, and Discussion

Meeting Date	Meeting Time	Location
July 19, 2017	5:00 pm – 6:30 pm ET	North Haven, Connecticut (Quinnipiac University)

Stakeholder Attendees		
Eileen Andrews (CT Health Policy Project)	John Brady (Connecticut Hospital Association)	Jennifer Cox (Connecticut Hospital Association)
Brian Evans (Milford Hospital)	Lauren Hoffman (Quest Diagnostics)	Mikaela Honhongva (Clifford Beers Clinic)
Michael Hunt (St Vincent's Health Partners, Inc.)	Leslie Krumholz (Hugo)	John McCreight (McCreight and Company)
Jane McNichol (Partnership for Strong Communities)	Joe Parkes (Southwest Community Health Center)	Jennifer Richmond (Clifford Beers Guidance Clinic)
David Sones (Hamden Health Care Center)	Jonathan Steinberg (State Rep. – CT General Assembly)	Lisa Stump (Yale New Haven Health System)
Sten Vermund (Yale School of Public Health)	Frank Wang (Sacred Heart University)	Tracie Wizda (Boehringer Ingelheim)
Dina Berlyn (CT General Assembly)	Kyra Ray (Quinnipiac Medical Student)	Gillian Vanderbilt
SIM/HIT PMO and CedarBridge Attendees		
Michael Matthews, CedarBridge	Allan Hackney, HIT PMO	
Carol Robinson, CedarBridge	Sarju Shah, HIT PMO	
Chris Robinson, CedarBridge	Kelsey Lawlor, HIT PMO	
George Blair, CedarBridge		

Discussion / Q&A – *Feedback on Findings and Current Activities*

- **Participant Comment** – every state, or most states, are trying to do this. He was struck by the specific states that were highlighted as being ahead of Connecticut. What kind of lessons can be learned so we don't need to start from scratch?

- **CedarBridge Response** – many states would trade places with Connecticut in order to have a blank slate, and not being hindered by the baggage of having outdated or antiquated infrastructure. Another big question is how you create a sustainable business model for HIEs or health IT services. Sustainability and a clear value proposition needs to be determined before implementation can occur
- **CedarBridge Response** – we have borrowed some information from states like Michigan, who are ahead of the curve, or who have gone through the growing pains and found a model that is working.

- **Participant Question** – what is in process, or will be put in process to identify data across all of the different providers and stakeholders that will have utility for these services?
  - **HITO Response** – the amount of data is incredible, but the problem is that it is siloed. Our objective is to tease out the data that will meet the recommendations that were presented. You will hear in a second the process that one Design Group is going through in order to analyze activities / use cases. Our intention here is to prioritize use cases. This will be a process that will take some time. In the broader vision of things, what I am concerned about is being able to capture social determinant data. It is very challenging to get certain data fields, such as race, ethnicity, housing, etc. We will need thoughtful ideas from the community on how to approach this issue. It will be a journey.
- **Participant Comment** – this was a good 30,000-foot process presentation, but there is so much data involved. He is surprised that one of the use cases was vaccinations. It is my understanding that vaccination rates in Connecticut are quite high and I could probably pick 10-12 items that would be more important.
  - **HITO Response** – the state has the only immunization system in the country that cannot accept electronic submission of immunization information and cannot be queried for information. There were a number of reasons why the immunization use case served as a nice starting point.
  - **CedarBridge Response** – the electronic submission of immunization information is also a requirement under meaningful use for provider incentive payment.
  - **HITO Response** – a lot of the other items that were listed are also on the list, including opioids, wounded warriors, disability determinations, etc.
  - **CedarBridge Response** – just because one of the services or use cases does not make the initial implementation, that does not mean it is not important. It is because of timing – you can't implement everything at one time. We need to start with early, quick wins that establish a value proposition and create a return on investment for stakeholders. In addition, the services that are implemented might ultimately support 3 or 4 additional use cases. Over time, who knows, maybe all 30 use cases can be implemented.
  - **CedarBridge Response** – for each of these use cases, there might be a few technical solutions that are feasible. We need an education process.
- **Participant Comment** – first they thank us for including them in this whole process. The 9 priority recommendations cannot be argued with, we got them "exactly right." Given their members, and the lack of a budget and the state's budget situation, how can we pay for all of this? How will this be funded?
  - **HITO Response** – I have a lot of thoughts. He looks at the funding in two buckets – one is the initial risk capital and the other is the funding for the maintenance and service. In regard to the risk capital, what we are talking about here is largely funded by federal funds in a number of ways – one is SIM, currently a $45 million grant, with $10 million allocated to health IT, and the other is HITECH funds through 90/10. This HITECH funding comes through DSS to drive changes in the environment. This is the IAPD process, which is provided at a 90/10 rate ($9 federal dollars for every $1 the state contributes).
  - **Participant Response** – what kind of commitment do you have for the 10%?
    - **HITO Response** – we have a small grant in place already. If we do a larger project, you need to demonstrate that the state is allocating its fair share against the federal funds. They are working with OPM through this process. I should also mention that there is previously appropriated Bond Funds available to the HITO to execute this health IT plan. This has not been tapped yet, but could be taken advantage of if needed. I do not feel constrained in terms

of capital to move forward. What I worry about is the sustainability. That is why we are creating these Design Groups that will find real, genuine, tangible value for stakeholders. The HITO's objective would be a failure if a use case is implemented that has no sustainability model.

        - **CedarBridge Response** – a lot of states start to panic regarding the 10% match, however CMS has recently loosened the rules regarding how this 10% can be calculated. Also, a lot of providers who were left out of Meaningful Use Incentive Payments are now available for funding to connect with MU eligible providers.

- **Participant Comment** – I represent a community hospital and have spent years sending out data. I have not yet seen the return on these investments. Can you talk about how some of these existing systems and organizations will receive value? We send out quality data, which is mined in some cases, but must meet certain format requirements.
    - **CedarBridge Response** – one slide we have used in the past has the quote "skate to where the puck is going to be, not to where it was." Some of the data that you are doing a heavy lift for currently, we may be able to layer some infrastructure that can address these burdens.
    - **HITO Response** – can I have more details about what kind of data you are sending and to who?
        - **Participant Response** – Meaningful Use reporting data to CMS
        - **HITO Response** – CMS is a tough one. I understand that. We need to control the things that we are able to control, and unfortunately CMS is outside of that. There are a number of databases within the state, such as the APCD, which have not made much progress in recent years. My view is that those issues need to be addressed. If we are going to contribute data for the betterment of public health or population health reporting, we need to see the output. One thing that struck me initially, from the stakeholder engagement process, was the questions about what are we going to do with the state databases. These are completely under-utilized resources. This will become a higher priority.
        - **CedarBridge Response** – this is not just technology, it is also a process issue. If you put technology on a broken process, it will also be broken and may even make things worse. We have been in touch with AHIP and other groups about the harmonization of quality measures.
- **Participant Comment** – I work with a housing organization, and just saying "social determinant" broadly is not helpful.
    - **CedarBridge Response** - What information would be helpful?
        - **Participant Response** - If you are going to measure actual outcomes, not just process outcomes, you need to have some idea of the person's housing situation, not just their healthcare situation.
        - **HITO Response** – it is hard to get the social determinant data. I stand by that statement. However, once you have this data you have really enriched the understanding we have about how to treat conditions and provide medical care and social services. My view on that is that it is probably not going to be the first thing that we do – we don't have the type of data we need to form a basic understanding about a person. One of the things that is implicit in what we have heard is that we need to start mapping the points of care that people in Connecticut are receiving so that it can be appropriately exposed and inform the way that we are providing care. This is the molecular component of what we are talking about. Then we can talk about which types of care, and what types of data we can add in on top of this base. I view this as something that might follow the first round. I would love to have a conversation with the team about where we can go get housing information – doctors and nurses are not going to make clinical decisions based on data that they do not know is correct.
        - **CedarBridge Response** – Connecticut's homeless registry is a powerful data set. One thing that came up during the eCQM Design Group discussion is different data sets that could be brought

in and measured in the future. There is another place where all of these organizations could gain great value – that is from a healthcare directory. A directory that could be utilized at a provider level, with linkages to social service organizations and community organizations, including things like bed space. This is powerful.

- **Participant Comment** – one of the things that I wanted to raise is that we hear a lot of discussion around the Meaningful Use program – I was involved in getting this started with our BH program – we still struggle with critical things like getting information passed from one facility to another. When you think about the amount of resources and cost that go into vetting EHR systems and getting up to speed with MU and if the systems are certified. Personally, what I found, is that we have a language disconnect between the EHR vendors understanding of what is required, and what healthcare organizations believe is required. It is difficult to navigate. One key thing that could be beneficial are things like CCDs and portals, but a lot of these things are broken, or speak different languages. You worry about oversight and accountability.
    - **HITO Response** – you are right. Different interpretation of standards is one aspect. Some of it is also procedural inside the organizations. The providers who are entering the data have different attitudes about how that data should be entered. When it is exposed outside of the organization, is it a standards problem or a culture problem or that the mechanisms for data entry are not as robust as they should be.
    - **Participant Response** – there are certain standards, and the CCD is a very limited data set. It can only solve so many problems. Most HIE data exchange happening in other states is the CCD-level of data. What people really want is so much broader than a CCD, which can come from portals. There is no standards way to document things like homelessness, which seems like a simple process. As a community of providers, we can start to do a lot more by working together. The vendors are going to follow the national standards. They are also marketing their products as being flexible, and they are giving healthcare organizations and providers too many options. Connecticut is a small state and we can really start to move the needle through the leadership of The HITO.
    - **Participant Response** – there is a lot of pressure from the flexibility that is allowed by vendors. The market-leading systems are very expensive. There is a pressure from some providers to go with the systems that most people are using.
        - **CedarBridge Response** – you have seen a very recent settlement against EHR vendors because they are not delivering what they have been promised or what they are certified for.
- **Participant Comment** – I just want to understand; a provider organization is blocking data form the hospital because of crappy data? (Yes). My other question – I have 3 accounts under the same EHR system (Epic) and the patient portals are so different in terms of what you have access to, in Connecticut you don't have access to clinic notes, you have delayed access to lab results, CCDs, etc. I think that it is a decision by the hospital.
    - **Participant Response** – Epic is rolling out something called HappyTogether that will allow patients to link profiles from various patient portals. Yale New Haven is beginning to show their clinic notes, as part of the Open Notes movement. Password and user names are managed at the local level, this is not cross referenced in the cloud across health systems.
- **Participant Comment** – where does lab data fit into this conversation? I have doctors coming to me every day, all day, asking for access to lab data. Where is this on the roadmap?
    - **CedarBridge Response** – this came up a lot in the process. A lot of people have trouble receiving lab information, as well as sending orders.
    - **Participant Response** – physicians don't have time to reach out to Quest to get this data on a patient-by-patient basis. We are feeding data into a number of different registries. I don't know how this information is being matched, or being used. Patient matching is a huge problem.
    - **CedarBridge Response** – it came up in the most recent Advisory Council meeting – we need a longitudinal health record. This is the cake, and everything else is the icing. The other comment is that a lot of people are venturing down this road are primarily focused on getting the labs and getting the

medications. Everything else is a "nice to have" whereas these two items are "must haves." Lab orders and results are on the list of use cases.

- **Participant Comment** – we would love electronic lab orders and results delivery.

Group Discussion – *Sustaining Broad Engagement and Support for Health Information Exchange Services*

- **HITO Comment** – is this a good format for delivering updates?
  - About half the room said they would like to see this format again.
  - **Participant Comment** – Webinar would be great for those that have to travel.
  - **Participant Comment** – Newsletters, websites, etc. are great because you can go get this information on your own time.
  - **Participant Comment** – it is always nice to have presentation materials in advance.

Farmington, Connecticut

Logistics, Attendees, and Discussion

Meeting Date	Meeting Time	Location
July 20, 2017	8:00 am – 9:30 am ET	Farmington, Connecticut (UConn Health)

Stakeholder Attendees		
Jan Marie Andersen (UConn Health PTN)	Tanya Barrett (United Way of CT)	Supriyo SB Chatterjee (Conslt)
Matthew Cook (UConn/UConn Health)	Donna Damon (DCP Prescription Monitoring Program)	Kevin Dionne (Connecticut Community Care, Inc.)
Tiffany Donelson (CT Health Foundation)	Gina Federico (Community Solutions / Saint Francis Hospital)	Erica Garcia-Young (CT Dept. of Social Services)
Lynne Garner (Donaghue Foundation)	Bruce Gould (University of CT School of Medicine)	Karin Haberlin (DMHAS)
Miu Miu Hin-McCormick (Commission on Equity and Opportunity)	Phil Hopkins (CCMC)	Amy Justice (Yale University)
Todd Kawecki (VA Connecticut Healthcare System)	Tracy King (Starling Physicians)	Beata Labunko (UConn Health)
Eileen McMurrer (CT Office of Early Childhood, CT Birth to Three)	Eric Mortensen (UConn Health)	Marie Mormile-Mehler (Community Mental Health Affiliates, Inc.)
Sebastian Motta (ProHealth Physicians)	Jeanne O'Brien (Value Care Alliance)	Susan O'Connell (Community Health Resources)
Sarah Oravecz (UConn Health)	William A Petit, Jr. (State Rep, 22nd District)	Ronald Preston (UConn Health)
Steve Ruth (SMC Partners)	Russell Schwartz (Avon & West Hartford Health Centers)	Kathryn Steckowych (UConn School of Pharmacy)
Victor Villagra (UConn Health Disparities Institute)	Catherine Wagner (Connecticut State Medical Society)	Sara Wakai (Uconn Health)
Tom Woodruff (OSC)	Sandra Czunas (OSC)	Rochelle deMayo (CCMC)
Stephen Bernier (Marcum LLP)	Tyler Phillips (CHC)	Peggy
Natasha	Sudeep	Jeanna

Bill Vallee	Giuseppe Macin	
SIM/HIT PMO and CedarBridge Attendees		
Michael Matthews, CedarBridge	Allan Hackney, HIT PMO	
Carol Robinson, CedarBridge	Sarju Shah, HIT PMO	
Chris Robinson, CedarBridge	Kelsey Lawlor, HIT PMO	
George Blair, CedarBridge	Christine Nguyen-Matos, SIM PMO	

Discussion / Q&A – *Feedback on Findings and Current Activities*

- **Participant Comment** – In this day in 1969, Neil Armstrong landed on the moon and here we are discussing health IT. I work in healthcare startups where we really strive to solve problems as entrepreneurs. One way to do this is by going up-stream, such as the social determinants of health. We need the entrepreneurs in this realm – I am not sure how they would be engaged, but there seems to be a gap.
    - **HITO Response** – I couldn't agree with you more. If you can enrich this data set with the social determinants of health you can reshape the way the people provide cares. There are a couple of issues from a tactical perspective. One is that I don't know doctors that are willing to incorporate data that they don't trust into their clinical decision making, and getting reliably accurate social determinant data is difficult. In some cases, the clinical data, or other data that the state has available that are living in silos, such as the APCD, is difficult to extract, but having the discussion about how to collaborate is the first step.
- **Participant Comment** – I don't have an idea about a timeline for actually having an HIE. Can you also address the efforts by the CSMS and how you are going to reconcile the efforts?
    - **HITO Response** – In respect to the first question, regarding the timeline, my approach on all of these projects is to parse it down into chunks of work that you can put definitive timelines on and that you can deliver value quickly. I have never seen a "Big Bang" effort work in technology – you need to get specific. The eCQM project should wrap up in the late 3rd quarter, and then the RFP will take 60-90 days and a contract will be awarded late first quarter of 2018. For the Use Case Design Group, we need to decide on the Use Cases, which will likely be some contracted services, compared to something that the state would build. There are a lot of successful service providers that have these capabilities. Connecticut is a state of 3.8 million people and that is not scale when you talk about a transaction system. The economies that will support a sustainability is to have a partner that can bring the numbers up to 10 million or more. Some use cases can be quicker than others.
    - **HITO Response** – As it relates to CSMS, they have a membership to serve who have expressed issues or concerns. As a membership trade organization, they are rightfully focused on doing something to serve their members. My view, and the Advisory Council's view, is that we wish them luck and hope they are successful. They are one more opportunity for innovation. We have existing HIEs in the state, such as Western Connecticut. There are also integrated hospital systems that are working to integrate their ACOs, etc. We are in a "Network of Networks" environment. If CSMS can reel in some of the small practice doctors (into the digital age, and into health information exchange) that would be very helpful.
- **Participant Comment** – A theme that emerged was that we need community investment and collaboration. How much of an investment priority are we willing to make related to community investment? Will they be able to be at the table on their own terms?
    - **HITO Response** – I am not going to be someone who dictates. The investment will be a key component of how we go forward. I have worked with large systems and operational rollouts for many years. As I look at the HIE activities around the country, a surprising number of them are at risk of collapse – one reason is that they overbuilt their model and don't have a viable sustainability model. They also don't have the engagement, they didn't plan on how to engage the actors who will be using the system. We do not want to make this mistake. I feel like I have enough risk capital available to me to do the job

right. Most of the funding is coming from 2 different federal programs, and I do have some state funds. I expect to use a lot of this funding for community collaboration and investment.

- **Participant Comment** – Has anybody reached out to the US Department of Veteran Affairs (VA)?
    - **CedarBridge Response** – Collaboration with the VA is something that is personally important to our company. We have experience with VA collaboration around health information exchange. There are some 70 organizations nationally that are able to interoperate with the VA through the eHealth Exchange. There is only one entity in Connecticut that is onboarded with eHX. They have not yet been on any design groups, and we have not yet had a direct conversation in the context of Connecticut, but we have uses cases that are being prioritized, and this will happen in the future, and the timeline is dependent on the prioritization of these use cases.
    - **HITO Response** – if you have ideas about how the VA should engage, then we are very interested in hearing about this. When I arrived 6 months ago, there were conversations about how to build adequate representation. This continues to happen, so if you have ideas.
- **Participant Comment** – One thing that I would ask you to speak about a little more – information technology takes a lot of time to mature, and it takes significant investment. The incremental approach is appropriate, but organizations will need to evaluate what will be leveraged, what initiatives will work, what can be relied on. Have we talked about the sustainability models?
    - **HITO Response** – When I came into this role, I had a lot of learning to do, and what stuck out to me is that of the 105 HIEs around the country, there is a failure rate of 5-6% per year. They are failing because they did not address the sustainability model question adequately. I do not want Connecticut to get into this situation. The HIE Use Case Design Group is all about tangible use cases – they have 30 really solid use cases, but they are not all solving for issues that people will broadly get behind and support financially. This is one of the most significant factors for me. You put it perfectly when you said "you are going to depend on this for years to come and you need to rely on the infrastructure." I would appreciate everyone in the room who touches any of this to continue to beat the drum.
    - **CedarBridge Response** – when you think about the use cases, a lot of them will be enabled by the same technology services. We talk about HIE more as a verb than a noun, and when we talk about HIE to support these use cases, you can see some successful models around the country. You can look at this as a building block of sustainability – it is built by identifying the services that have broad and effective
- **Participant Comment** – I am a veteran of previous HIE efforts – when you talk about 2 attributes of the HIE entity, neutrality and trust, I think those are right on. If you can talk about the sustainability model for a neutral and trusted entity that is operating in an industry predicated on competition. Is the value for the patient or for the institution? For example, the large systems are creating their own HIE, for example through EHR systems, and they can share information internally, however, if 40% of the care is outside of a specific system, and there is not incentive for that system to collaborate, then the neutrality concept becomes very difficult – there is no neutral stakeholder in a competitive environment. You want to prevent leakage. How do you conceive of a neutral entity in this competitive environment?
    - **HITO Response** – What you are describing is a systemic, organizational aspect of the way people focus on the delivery of care – it is human nature. Outload thinking – what we have been talking about this morning is around information exchange and loosening up the gates of the data flow. If you step back for second you are talking about largely transactional activities. The data is a different thing than the transactional component of health information exchange – down the road there will possibly be two entities, one for transactions, and one that is focused on the data that is flowing through the network, that can be retained for various purposes. There is a lot of things you can do with the data. If you have a repository of data, that has a long history of clinical quality measures, sitting next to the cost and claims data, with layers of social determinants, the access to that data is power. Data is power. I

struggle with this question, because this is an immense resource that can be used or misused. I don't have a specific answer to this question – and am open to input from anyone in the room.
    - **Participant Response** – I completely agree that the possibilities of data are huge. The point I am making is the divorced from existing laws for data sharing, transparency, consumer information – thinking only about the data is falling short of the reason why HIEs are failing. They are failing because of business and political issues. How much are you investing on the political and business issues that will drive the success of this next HIE iteration? Of all of your resources, how much is being invested in enforcing laws of transparency so that this can succeed.
        - **HITO Response** – I lean very heavily on my Health IT Advisory Council, which is made up of a broad subsection of the health ecosystem. When these issues of enforcement come up, the Advisory Council's advice to me, and my encouragement to them, is to have an appropriate role for the state. The role that has surfaced is that the state has the role as a convener, the state can set standards for engagement including the degree to which participation is going to happen, there are statutes that this entity will need to adhere to (bidirectional, data blocking, etc.) The statute gives me the authority. On the political front, we need to have the right relationships with key actors around the state. We also have to have the right resources in the legislature. So far, we do, and we will see when the new budget comes out. This is the role that I believe I have taken on – it is not just the technical issues.
        - **CedarBridge Response** – we have to get to the point where the incentives to share information are greater than the incentives to not share information. That is not the case currently. What is missing from other HIEs is the demand.
- **Participant Question** – Thank you for this forum and transparency around the process. I work for a collaborative of healthcare organizations. Where in the 30 use cases does the idea of understanding the population level, and social determinants of data – begin to access insights?
    - **CedarBridge Response** – one aspect that The HITO shared is for these very insights you are talking about. We are discussing permitted purposes of data use. These very well may be what you are talking about around population health. Other decisions need to be made, but part of the early work will be informed by the eCQM effort. Harmonizing the quality metrics is an important access. If you collect this data it will beg for different uses and different applications.
- **Participant Comment** – children spend a lot of time in the home, child care, and school. Have you thought about how to fold in this data?
    - **HITO Response** – I cannot say that we have a comprehensive view of the data set you mentioned, but it is very clear that if you are dealing with children you need to look beyond the traditional care settings. As part of the IIS Design Group, we have reached into the school nursing realm with one of the DG members. The folks in the Department of Public Health were hesitant at first, but now that the collaboration has begun they are working well together. We need to do more in this area. I would personally invite a conversation for how we can better understand.
- **Participant Comment** – state funded insurance makes up a large portion of the state population, we have all failed to recognize the non-clinical services. Will there be an effort to attach these to the HIE?
    - **HITO Response** – one recommendation was to bring together the state agencies to create a Steering Committee to bring these issues to the surface. I also have most state agencies on the Advisory Council, a few still need to be added. I have spoken with all of the state agencies – when we get some of the infrastructure in place, then we can start to have conversations about how to proceed. Early in 2018 this work will be in full swing.
- **Participant Comment** – Many of us who are working in BH organizations are under contract and state law required to submit to various databases around the state. Reporting is not always rationalized. Is there any chance that this HIE might be able to replace or rationalize the reporting processes?

- **HITO Response** – I am not sure the HIE will solve for everything that you mentioned, but it may solve for some of it. Given my background, I have never seen so many contracts that exist between employees of the state, there are so many MOUs and MOAs floating around, and all of the data is locked. The HIE will be an opportunity to break down these barriers. The bigger opportunity is the other half of my remit in this role – which is to look across the state agencies and coordinate health IT and information exchange activities.

Group Discussion – *Sustaining Broad Engagement and Support for Health Information Exchange Services*

- **HITO Comment** – is this a good format for delivering updates?
  - **Participant Comment** – Webinars are a good way to engage people without travel. It would be good to post the presentation online. About half of the people in the room felt that the roundtables are a good forum for disseminating information.

Norwich, Connecticut

Logistics, Attendees, and Discussion

Meeting Date	Meeting Time	Location
July 20, 2017	5:00 pm – 6:30 pm ET	Norwich, Connecticut (Three Rivers Community College)

Stakeholder Attendees		
Anne Kenny (Generations Health Center)	Patricia Pia (Independent Consultant)	Reinaldo Torres (Generations Health Center)
Frank Maletz (HEALTHSPITAL Foundation)	Pamela Duffy (Pfizer)	
SIM/HIT PMO and CedarBridge Attendees		
Michael Matthews, CedarBridge	Allan Hackney, HIT PMO	
Carol Robinson, CedarBridge	Kelsey Lawlor, HIT PMO	
Chris Robinson, CedarBridge		
George Blair, CedarBridge		

Discussion / Q&A – *Feedback on Findings and Current Activities*

- **Participant Question** - Did not realize the complexity of this effort and what is being considered, how is this being balanced?
  - **HITO Response** – it is ridiculously complex. When I look at it from the high level, and look at other states' experiences, one way to simplify the situation is to not re-invent the wheel – use systems and infrastructure that has already been built. This has two advantages – one is speed and the other is the fact that Connecticut is a small state. When I look at the organizations that are doing well, they all have more than 10 million people in their system. I believe there is a path that we know we want to take.
- **Participant Question** – is there an opportunity to join a HIE from another state?
  - **HITO Response** – forces in Connecticut are making this an imperative. Yale New Haven is already across the border in Rhode Island. If you look at the population, say Fairfield County has 125,000 people to get on the train and go into New York every morning – you have to believe people are receiving care across the border. There are 2 or 3 service organizations that are viable options for joining, but they need to have 10 million or more people in their system.

- **Participant Comment** – we are part of a group of FQHCs and we put together a population health effort. Some of the vendors were charging $50,000 to build an interface. It is a very limiting factor for our participation in information exchange.
    - **HITO Response** – the is a big issue. There is some grant money and federal funding available to help organizations join HIEs and participate in information exchange. It is also possible to join entities that have already built interfaces to the vendors so you don't have to start from scratch. Ultimately, scale is the game. When you have scale, you have clout and it is easier for you to influence the direction that vendors take.
- **Participant Comment** – I believe everybody at the table is right and I thank you for the amazing amount of work that has gone into this. From my world, Connecticut is a very manageable entity. We have a contained state, and we have two major medical systems – both have spent hundreds of millions for their Epic EHR systems, which is a lot of sunk costs, and they are not interoperable. As a healthcare provider, this state is uniquely pre-positioned to co-create an experiment where we put the two major healthcare entities together, we put the medical chairs of universities together, and we put the leaders of Epic all in a room. On this issue of privacy, I may have some unique perspectives – I asked every patient at my practice if they had any objection sharing data for the purposes of care and every single person said they trust him to make the right decision and share the information at the right time.
    - **Participant Continued** - I appreciate that you were recruited from the 100,000-foot view and don't get into the nitty gritty, but healthcare is a little weird and a little chaotic. It needs a fresh perspective and special treatment to be able to integrate all players.
    - **HITO Response** – paint a picture for how this will work?
        - **Participant Response** – there is a moment in time when somebody has to take the bull by the horn and tell the vendors, it is time for you to give us a product we can actually use.
- **Participant Comment** – we have support from our vendors, but they have to keep up with the requirements from the federal government. It is this constant challenge – which creates this huge project to clean up provider notes.
    - **HITO Response** – The quality of the data, the timeliness, the standards, etc. there are decisions about how this will look. I like Michigan's model because they have gotten very precise on a number of things I just listed. The data is flowing in and it is getting scored, and then it is sent back. There is process improvement occurring through a feedback loop – which is forcing the participants to deal with the issues that they have with their vendors, and they have fact based evidence. Some of the problem is the providers are entering data through one of the processes incorrectly, among other reasons. There are some models to take – I would be interested in learning about what levers we might look at pulling with the vendors. What lever does the state have to pull?
        - **Participant Response** – the levers are already in existence. I deeply respect Nancy Wymen. These vendors are using the fragments to make complex problems even more complicated and they are fragmenting all of the data. I wouldn't want to go head-to-head with Epic either, we need to gang up on them. Everything on the slides is dead-on right, but it is not going to solve the problem. We need to embrace the complexity. We could be the state that flips it.
    - **Participant Comment** – I think there should be a way to create incentives and influence the SMEs at the different health systems and organizations. The Epics of the world are making their customers happy – they have a framework that they can highly configure to make their customers happy.
- **Participant Comment** – we are at a point where more and more care can happen at home, and more people expect care to occur differently – connected medical devices for example. Big tech is positioning themselves to upset the healthcare ecosystem. I didn't hear a lot today from the patient perspective – if we could enable the patient, then there is a push/pull concept.
- **Participant Comment** – Blockchain will conceptually put all of the vendors out of business in the future.

- **CedarBridge Response** – a lot of providers are still on the edge, but if you look at incrementalism – you can't do everything at once – you have to meet the white space, or the have-not providers.
- Participant Response – we have smaller healthcare providers who are technology poor – maybe this is the right place to look because they haven't spent millions on an Epic field. They don't have the sunk costs.

- **Participant Comment** – rural hospital conversation – how are you going to integrate the rural providers? We aren't, we are just going to buy them out.

Group Discussion – *Sustaining Broad Engagement and Support for Health Information Exchange Services*

- **HITO Comment** – is this a good format for delivering updates?
  - **Participant Comment** – Some participants in the room believe that email communications would be a good method for ongoing stakeholder engagement
  - **Participant Comment** – The participants were generally glad to see that we came "across the river" and held a session in the Eastern part of the state