Health Information Technology Advisory Council
Meeting Notes

Meeting Date	Meeting Time	Location
March 16, 2017	1:00 – 3:00 p.m.	Legislative Office Building, Hearing Room 1A 300 Capitol Avenue, Hartford

Participant Name and Attendance

Council Members					
Victoria Veltri, (LGO)	X	James Wadleigh, AHCT	X	Jeannette DeJesús	
Allan Hackney, HITO	X	Mark Schaefer, SIM	X	Matthew Katz	X
Joseph Quaranta (Co-Chair)	X	Robert Darby, UCHC		Lisa Stump	X
Joe Stanford, DSS	X	Ted Doolittle, OHA	X	Jake Star	X
Michael Michaud, DMHAS	X	Kathleen DeMatteo		Patrick Charmel	X
Fernando Muñiz, DCF		David Fusco	X	Ken Yanagisawa, MD	
Cheryl Cepelak, DOC		Nicolangelo Scibelli	X	Alan Kaye, MD	
Vanessa Kapral, DPH		Patricia Checko	X	Dina Berlyn	X
Dennis Mitchell, DDS	X	Robert Tessier	X	Jennifer Macierowski	X
Mark Raymond, CIO	X	Robert Rioux	X	Prasad Srinivasan, MD	X
Supporting Leadership					
Sarju Shah, HIT PMO	X	Carol Robinson, CedarBridge	X	Chris Robinson, CedarBridge	x
Faina Dookh, SIM PMO		Michael Matthews, CedarBridge	X		
To Be Appointed					
Health care consumer or a health care consumer advocate (Speaker of the House)					

Meeting Schedule 2017 Dates –Apr. 20, May 18, June 15
Meeting Information is located at: http://portal.ct.gov/Office-of-the-Lt-Governor/Health-IT-Advisory-Council

	Agenda	Responsible Person	Time Allotted
1.	**Welcome and Introductions**	**Joseph Quaranta**	**5 min.**
	Call to Order: The third regular meeting of the Health IT Advisory Council for 2017 was held on March 16th at the Legislative Office Building in Hartford, CT. The meeting convened at 1:03 p.m., Joseph Quaranta presiding.		
2.	**Public Comment**	**Attendees**	**5 min.**
	There was no public comment.		
3.	**Review and Approval of the February 16, 2017 Minutes**	**Council Members**	**5 min.**
	The motion was made by Mark Raymond, and seconded by Jake Star to approve the minutes of the February 16, 2017 meeting. **Motion carried.**		
4.	**Review of Previous Action Items**	**Sarju Shah**	**5 min.**
	Sarju Shah reviewed and provided updates on previous action items.		

Action Items	Responsible Party	Follow-up Date
1. Revise & Circulate Guiding Principles (v.4)	CedarBridge	4/20/2017
2. Review eCQM Design Group Charter	Advisory Council	3/16/2017
3. Review eCQM Progress Report	Advisory Council	3/16/2017
4. Review SB-811/PA 15-146 requirements for APCD	APCD	TBD
5. Review SB-445 impact on APCD	Dina Berlyn	TBD

5.	**Updates**	**Sarju Shah**	**5 min.**
	Ms. Shah provided updates. The appointment of a consumer/advocate is the remaining outstanding item.		

6.	**Stakeholder Engagement Update**	**Michael Matthews**	**40 min.**

Michael Matthews of CedarBridge provided the update on stakeholder engagement stating at the time of the council meeting, his team has conducted over 50 interviews with more than 180 individuals interviewed. Key points discussed were:

- Interviewees reported that they had to make do without a statewide HIE; their needs have evolved over the past 3-5 years due to the changing landscape.
- The old-fashioned way (fax, phone, etc.) is still widely utilized and necessary.
- DIRECT messaging is in use, but not consistently in a standardized manner.
- Public health reporting is widely regarded as a high-priority need across the state.
- Clinical workflow is a top consideration for providers; "smart" care summaries would be valuable.
- Encounter alerts are valuable; however, there are concerns about functionality and potential duplication of efforts in the state.
- A statewide eCQM solution is viewed positively if measures and reporting can be harmonized and standardized.
- ACOs are emerging as an important part of the healthcare ecosystem in Connecticut, with implications for both HIE and value-based care.
- Community organizations are critical to coordinating systems of care and addressing health disparities.
- Some key stakeholders feel their needs have been neglected, such as behavioral health and long-term/post-acute care communities.
- Consumer engagement is critical for value-based care and HIE. Devices, patient portals, privacy, security and confidentiality are all of relevance to consumers.
- Patients should be viewed as the "north star" for decision making.
- Trust and confidence in planning and implementing technology are viewed as critical success factors. Trust has emerged as one of the most critical components of HIE planning and execution around the country.

Council members were receptive of the themes presented. Lisa Stump said she was surprised not to see issues around an enterprise master patient index (eMPI) reflected. Mr. Matthews said that it came up a couple of times but the nature of the discussion focused more on the "*if*" rather than on the "*how*." Mostly, the discussions have not been solely technical. Ms. Stump said that, when talking about a meaningful exchange of information, to not have the information in a master patient index would be a concern. Mr. Matthews said a number of potential solutions or functionality that might not inherently involve an eMPI or other identity management were discussed in the stakeholder interviews. It was highlighted that the eMPI will be very important in moving forward with any HIE planning efforts.

Dina Berlyn asked whether the state's reliance on ACOs and the discussions about social determinants of health came up more than in other states. Mr. Matthews said the penetration of ACOs was not a relative comparison but something to factor into an HIE strategy, which has to be reflective of the marketplace. Social determinants of health came up frequently and he said he didn't think he'd heard it referenced in other states as much as in Connecticut.

Jennifer Macierowski said she had heard there might be a direct messaging utility available but it can't be utilized. She asked whether a patient index would solve that. Mr. Matthews said most everyone wants to use the direct messaging feature within an EHR system. The key issue is knowing where the provider is, not the patient. A provider directory could provide the components she was taking about.

Ms. Macierowski asked whether the number of ACOs in the state could be a problem rather than a benefit. Mr. Matthews stated that changes happen organically and the state should look at ways to leverage what is

	desired, what is in place, and provide additional dimensions of support. He described it as an interesting state policy issue. **Corrected on 4/20/17:** Matthew Katz said that the CT Medical Society (CSMS) has a secure direct messaging application in place for several years. He sees that secure electronic messaging can be valuable if tied to workflows and integrated into the EHR. He mentioned that when the functionalities of secure messaging is outside of the EHR, it becomes challenging to fit into the workflows and allow the "digestion" into an EHR and usability of the received information to be tied to patient care. Fewer than 10% of CSMS members have used it and tied to patient care. Mr. Matthews said that secure messaging is a transport standard only. They can create their own content standards with secure messaging. If everyone agreed to a certain format, they can create some level of standardization beyond what the generic version would be. James Wadleigh noted that the state is creating an eMPI, a DSS initiative, and it is beginning to take shape. It was noted that if the eMPI at DSS is ready to be used it would be valuable to get this rolled out. Allan Hackney asked if there are other "table stakes" that should be mentioned – Analytics and Risk Stratification were noted and these tools can be powered by data outside of one's own database can create value and economies of scale. Another table stake is prescription drug monitoring - especially when thinking about the opioid epidemic. Any efforts to off-set the costs of getting data into the Prescription Drug Monitoring Program (PDMP) and utilizing the data within the PDMP will be beneficial and represents a great opportunity. Mr. Matthews noted that the PDMP program staff were interviewed. As background, the PDMP has a portal that providers can sign on to and look up opioids and other controlled drugs. They have made strides with EHR integration. It was noted that the Surescripts gateway makes a process for medication reconciliation very efficient and allows access to a wide range of information. Nationally there have been discussions about the benefit of creating a Surescripts-enabled PDMP database that combines these data sets. Many agree that the Surescripts-enabled PDMP database would be the ideal workflow; however, a business model to sustain this has not been determined. Prasad Srinivasan stated that it is very time consuming to review all available information when prescribing and having pop-up alerts would be easier. Mr. Matthews responded stating there is functionality available to fetch information before a patient visit so that searching is not necessary during the patient visit. He noted that the idea of scarce resources came up again and again. Potential solutions would need to bring increased value. Victoria Veltri asked if there was any prioritization made during the interviews. Mr. Matthews said that yes, they would sometimes say one area was most important. Mr. Hackney noted 15% of providers do not have electronic systems. The electronic system would allow them to manage their practice and be connected to other practices. Mr. Matthews said that close to 75% of providers have some kind of EHR or electronic practice management solution, but are not utilizing it to its fullest. Many physician practices aren't using the systems the way they were intended in which Rep. Srinivasan agreed and mentioned that his practice only uses it for billing. In addition, a large percentage providers have outdated legacy EHR systems. Mr. Katz complimented Mr. Matthews on his interview with the Medical Society members and described it as engaging and informative. He said members left with excitement that the state could do something. Mr. Matthews said Connecticut is on a journey; there are many initiatives and there are a lot of assets and stakeholders that are contributing. The challenge for the council and the HITO will be to determine how to leverage these assets and create a "multiplier effect".		
7.	**eCQM Design Group Update**	**Carol Robinson**	**40 min.**

Carol Robinson presented an update on the eCQM Design Group (DG). The next meeting will include a discussion of the components of an eCQM system and the scope of the DG's future work, including the confirmation of business and functional requirements to meet the needs of the priority use cases and a discussion of future planning needs (i.e. governance, sustainability, etc.)

Ted Doolittle and Vicki Veltri mentioned that both the Department of Corrections and the judicial branch provide clinical care. Mr. Doolittle also asked if waste, fraud and abuse were included in the exercise. Mr. Doolittle said he would recommend that as fraud is often about low quality care. Ms. Robinson stated that looking for fraud is an important aspect of program integrity. CMS has started to think a lot more about new opportunities for waste, fraud, and abuse using new electronic systems. Ms. Robinson said they will add that as a use case.

Patrick Charmel asked about the patient generated data on slide 16 and whether this is a mechanism for transport or supporting the submission. Ms. Robinson said they are thinking that patient generated data will be available over time (from Fitbits, Apple Watches, or smart scales). The APIs connect to many different things and could plug into an EHR. The issue is not technology but developing policy over use of data, trustworthiness of the data, value of measuring the data, and method for collecting which will be part of future discussions.

Mr. Katz noted that the state has spent two years developing the SIM quality measures and if those fit within the model on slide 16. Mark Schaefer said the charter references the Quality Council recommended measures but is not limited to those. It was discussed that these are a high priority; claims-based measures are in the core measure set, as well as patient-level and EHR-based measures. Dr. Schaefer noted that EHR-based measures would be included is if those were included in payment methodology by payers. The SIM Quality Council made the recommendation for payers to have one reference standard and that SIM PMO would not look into implementing those EHR-based measures for just their own reporting purposes. Mr. Katz said he would hate to lose consistency and would not want that to be lost in the collection phase.

David Fusco said that is worth revisiting the conversation of value proposition and quality measure development with certain stakeholders. The HIT Council should take a step back and agree on a vision and what the Council is trying to accomplish. Slide 16 was primarily designed to detail how the eCQM design group fits together with the larger picture.

Dina Berlyn asked whether eCQM allows for different treatment options for patients, raises the question about the rigidity of the quality standards, and how this fits into clinical care delivery based on providers and specialties. Ms. Berlyn provided an example of how treatment plans differ from a provider versus a specialty provider. Dr. Schaefer stated that the quality measures are nationally specified measures. These measures have gone through rigorous testing and are consistent with evidence-based practice. The standards or specifications go with what has been proven through the national processes in place for testing and validation. Mr. Katz said in MACRA, there are 100s of options for some of the quality measures. The system should allow for specificity yet be flexible enough to meet multi-stakeholder needs. Patients will also need to see the information because they are the ones needing the care. The concern raised by Ms. Berlyn that beginning with a sub-set of measures could lead to not expanding to more measures. Mr. Charmel noted as process measures are being reviewed by the Design Group; outcomes measures will also need to be considered. Patricia Checko mentioned that the Design Group is discussing eCQMs as a payment system which is different from a patient system (outcome measures). Additional granularity is needed than just extracting measures from an EHR. Ms. Robinson said part of the discussion was around whether the system should be designed to just measure or to invest in data over time and scale to the types of use cases that are being described. There was unequivocal support for the latter.

	Dr. Quaranta mentioned the Good Hearts Law where once a measure is identified for measurement, then it loses its value because people figure out how to "cook" the data. When thinking of quality, there is a need to move towards a more complex way of measuring data. In the short-run, these metrics are needed and providers are being measured on them. Ultimately, the system will need to be scalable, flexible, and able to adjust over time to meet expanded use cases in the future. This is a stop gap in the journey. Mark Raymond expressed gratitude for the Design Group members work and then noted that the charter calls for the engagement of all payers, including Medicaid, yet they were not part of the discussion. Mr. Hackney stated that Commissioner Roderick Bremby or his designee had been invited to the eCQM Design Group, and he declined to participate since DSS is focusing on eCQM internally. Mr. Raymond mentioned that the DSS perspective is a critical one to have. Nicolangelo Scibelli said the focus has been to be more inclusive with the data. As a behavioral health provider, they see tremendous value in participating. They track things like social determinants and they have outcomes that are valuable to the process. The Design Group is continuing to seek ways to include data and measures that support other providers. Dr. Checko said consumers should be the north star. To evaluate outcome, from day one, currently existing measures with the HER needs to be utilized to allow for the state to determine health equity, disease management, population health, and social determinants of health. Measurement needs to be granular enough to get to inequities in the state. That is critical.		
8.	**Wrap Up and Next Steps**	**Sarju Shah**	**15 min.**
	Mr. Katz made the announcement that the State Medical Society launched a health information exchange for the state, earlier that day. With MACRA and MIPS rolling out, CSMS made the decision, at the request of their members, to provide interconnectivity that would allow them to meet the federal requirements. CSMS has model the HIE after Kansas. South Carolina and Georgia also use the same system and several other states are considering rolling out this model in the next few months. CSMS is not asking for funding or support, but recognize both would be helpful in the future. CSMS is setting up the HIE as a 501(C)3 public utility. Mr. Scibelli said he was unfamiliar with the model. Mr. Katz said they are partnering with the Kansas HIE which has 4 million patients in the system and 100% of hospitals. There are federal and state grants to include FQHCs and behavioral health centers into the system for free. It has been in place for two years and is a "plug and play" type of system. The HIE also has the ability to collect and measure eCQMs and will be utilizing a Connecticut vendor – DiameterHealth to support this functionality. There are nine fully functional eCQMs and thirteen being finalized. Patients also have full access to their records in this system. Since this system was developed by Kansas Health Information, the system already is connected to 43 EMRs and are and 12 are embedded within. Robert Tessier asked how patients access it. Mr. Katz said there is a statewide portal where patients can review, update, and question information in their record. Ms. Berlyn said it sounds like an opt-out system. She asked if clinical notes are available. Mr. Katz said the state will need to decide whether it is opt-out or opt-in. Clinical notes are available. The model is a pay and play with an initial set up fee followed by a monthly service fee. They will front the cost for providers and they can pay over time. Ms. Stump asked whether it will be managed and adjudicated in CT. Mr. Katz said three states are going through it already and the lessons learned are valuable. They have not made decisions regarding opt-in or opt-out. The board will consist of other entities. They have a licensing agreement to get the technology and CSMS is responsible for the agreements. The idea is to get as many involved as possible to move forward. CSMS leadership made the decision that they can't leave funding on the table. There are no disease or immunization registries and they were told to build it. For many of the physicians, they are spending a little bit of money to see a 4-8% bonus. They see others jumping in so they can get points within MACRA. He has		

	seen HIEs fail because they don't have provider engagement. If they can get doctors on something that allows them to connect with each other, it is a step in the right direction. It as a core set of eCQMs; labs and pharmacy data will populate. They need to work on signing up hospitals and social service providers. The meeting adjourned at 3:03 p.m.

Action Items	Responsible Party	Follow-up Date
1. Revise Guiding Principles based on discussions	CedarBridge	TBD
2. Review SB-811 requirements for APCD	HIT PMO	TBD
3. Review SB-445 impact on APCD	HIT PMO	TBD
4. Distribute the KHIN slide deck that was referenced during the Council meeting	Matt Katz	ASAP