Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
November 16, 2017	1:00 pm – 3:00 pm	Legislative Office Building, Hearing Room 1D 300 Capitol Ave., Hartford

Council Members					
Allan Hackney, HITO	X	Jim Wadleigh, AHCT	X	Robert Rioux	
Joseph Quaranta, (Co-Chair)		Mark Schaefer, SIM	X	Jeannette DeJesus	
Joe Stanford, DSS	X	Bruce Metz, UCHC CIO	X	Lisa Stump	X
Michael Michaud, DMHAS	X	Ted Doolittle, OHA	X	Jake Star	X
Cindy Butterfield, DCF		Kathleen DeMatteo		Patrick Charmel	
Cheryl Cepelak, DOC		David Fusco	X	Alan Kaye, MD	X
Vanessa Hinton, DPH	X	Nicolangelo Scibelli	X	Dina Berlyn	X
Dennis C Mitchell, DDS	X	Patricia Checko	X	Jennifer Macierowski	X
Mark Raymond, CIO	X	Robert Tessier	X	Prasad Srinivasan, MD	
Supporting Leadership					
Victoria Veltri, LGO		Kelsey Lawlor, HIT PMO	X	Carol Robinson, CedarBridge	X
Jennifer Richmond, HIT PMO	X	Faina Dookh, SIM PMO	X	Michael Matthews, CedarBridge	X
Dino Puia, HIT PMO	X	Alan Fontes, UCONN AIMS	X	Chris Robinson, CedarBridge	X
To Be Appointed					
Representative of the Connecticut State Medical Society (President Pro Tempore of Senate)					
Health care consumer or a health care consumer advocate (Speaker of the House)					
Physician who provides services in a multispecialty group and who is not employed by a hospital (Majority Leader of House of Rep)					
Speaker of the House of Representatives or designee					

Agenda			
	Topic	**Responsible Party**	**Time**
1.	**Welcome & Call to Order**	**Allan Hackney**	**1:00 PM**
	Call to Order: the eleventh regular meeting of the Health IT Advisory Council for 2017 was held on November 16, 2017 in Hearing Room 1D of the Legislative Office Building. The meeting convened at 1:00 p.m.		
2.	**Public Comment**	**Attendees**	**1:05 PM**
	There was no public comment.		
3.	**Review and Approval of the October 19, 2017 Minutes**	**Council Members**	**1:07 PM**
	The motion to approve the October 19, 2017 minutes was passed unanimously, as amended.		
4.	**Updates**	**Kelsey Lawlor**	**1:10 PM**
	Kelsey Lawlor of the HIT PMO went over the meeting agenda and introduced the newest member of the Health IT Advisory Council, Dr. Bruce Metz. Dr. Metz is the newly-appointed CIO of the UConn Health Center.		
5.	**Legislative Update**	**Allan Hackney**	**1:15 PM**
	Allan Hackney provided the Council with a walk-through of the legislative changes that are a result of the newly-passed Connecticut State Biennium Budget for fiscal years 2018-2019. The changes that were discussed are as follows: - Section 164: Office of Health Strategy o Establishes the Office of health Strategy by combining the Health Information Technology Office, the State Innovation Model (SIM) Program Management Office, and the Office of Health Care Access o To be formed January 1, 2018; fully effective by July 1, 2018 o Charged with developing and implementing comprehensive and cohesive health care vision for the state including coordinated state health care cost containment strategy		

  - To be governed by the Health Care Cabinet
  - The creation of this new office will bring together critical data sets and health information exchange efforts
- Sections 112-114: Transfer of the All-Payer Claims Database (APCD) to the HITO and the creation of a consumer health information internet website
  - HITO will seek funding for and oversee the planning, implementation, and development of policies and procedures for the administration of the all-payer claims database program
  - HITO will establish and maintain a consumer health information Internet web site
  - HITO may seek private and federal funds for staffing to support such initiatives
- Section 113: Updates to the APCD
  - HITO shall oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care
- Section 114: Consumer Health Information Website
  - The website will be developed and operated by the HITO to assist consumers in making informed decisions concerning their health care and informed choices among health care providers
  - Will define specific information regarding cost and frequency of procedures to be publicly available
- Section 125: Designation of the Health Information Exchange (HIE)
  - The HITO shall be responsible for designating, and posting on its Internet web site, the list of systems, technologies, entities and programs that shall constitute the State-wide Health Information Exchange
  - Systems, technologies, entities, and programs that have not been so designated shall not be considered part of said exchange
- Section 126: Establishes baseline connectivity requirements for the HIE
  - Upon commencement of HIE operations:
    - Within one year each hospital will connect and participate in the HIE
    - Within two years, each health care provider with an EHR will connect and participate in the HIE
    - (new) Each health care provider without an EHR shall be capable of sending and receiving Direct secure messages
- Section 127: Health IT Advisory Council changes
  - The Comptroller, or their designee, is added as an ex-officio member
  - The Health IT Co-Chairs may designate up to four additional members at their discretion
  - The Co-Chairs of the Council may establish sub-committees and working groups, and may appoint individuals other than members of the Council to serve as members of those groups.
  - The APCD Advisory Group becomes a working group of the Health IT Advisory Council
    - The HITO becomes Chair of the Advisory Group and may appoint new members
- Section 128: Creation of an HIE Entity
  - The HITO shall design, and the Secretary of the Office of Policy and Management, in collaboration with said officer, may establish or incorporate an entity to implement the HIE. Such entity shall, without limitation, be owned and governed, in whole or in part, by a party or parties other than the state and may be organized as a nonprofit entity.
  - Establishes the composition of a governing board to be as follows, with 2-year terms:
    - Advocate for consumer health care
    - Clinical medical doctor
    - Expert in hospital administration

- Expert in corporate law or finance
- Expert in group health insurance
- HITO (chair)
- Secretary of the Office of Policy and Management
- State Chief Information Officer

- Establishes the duties and authorities of the entity

Council Discussion

Dr. Alan Kaye complimented Allan Hackney on the quality of the presentation. Mark Raymond echoed the sentiment, and asked a question regarding section 128 of the budget implementer legislation. Specifically, Mr. Raymond stated that it seems to be rather ambiguous as to whether creation of the HIE entity is ultimately required. However, the legislation states that if you do decide to create the entity, then it needs to be a non-state entity. The "may" portion of the statute makes this optional. Mr. Raymond stated that he was trying to understand if there is a decision point here. Allan Hackney answered that yes, Mark is correct in his reading of the legislation. Allan emphasized that the statute states that they "may establish" an HIE because he personally advocated for this language. If the HITO moves forward with anything, it will be with the guidance of the Health IT Advisory Council, and the use of "may" gives flexibility to adjust plans based on the guidance that is received. With respect to the HIE being organized as a non-profit entity, the language in the stature anticipates that the entity "may" be a non-profit entity, but that the entity may need to change its organizational structure over time. For example, at some point we may want to do something that is for-profit in the future to do things like incubator work, or other revenue generating services. It leaves the door open to other options and opportunities.

6.	**Governance/Trust Agreement Discussion**	**Michael Matthews**	**1:45 PM**

Michael Matthews of the CedarBridge Group gave an introductory presentation on governance models as they pertain to the establishment of an HIE for Connecticut.

Michael explained the four key pillars of a successful governance framework: Organizational principles, trust principles, technical principles, and business principles.

Organizational principles require that the organization operates with transparency, establishes mechanisms to ensure the adherence to state and federal law, promotes inclusive participation and stakeholder representation, ensures that oversight is consistent and equitable, and provides due process to stakeholders.

The Trust principles require that the organization allows public access to the "notice of data practices," provides an explanation of privacy and security policies, provides meaningful choice as to whether personally identifiable information can be exchanged, requests data exchange limits based on data type/source, has the ability to access and request changes to personally identifiable information, and provides assurances that personally identifiable information is consistently and accurately matched when electronically exchanged.

Business principles set standards of participation that promote collaboration, provide open access to exchange services that would enable partners to identify with whom they can electronically share information, require the publishing of statistics describing their electronic exchange capacity, and would maintain and disseminate up-to-date information on compliance with statutory/regulatory requirements, available standards, potential security vulnerabilities, and best practices for the HIE.

Technical principles would ensure that the technology is implemented in support of the other key principles, would encourage the use of vocabulary, content, transport, and security standards, and associated

	implementation specifications developed by voluntary consensus standards organizations (VCSOs), would work with the VCSOs to develop standards for specific use cases, and would take an active role in the development and implementation of conformance assessment testing methods for HIE and would utilize testing methods developed to assess compliance with federal standards. Michael then went on to discuss the governing authority for the future HIE. Such a governing authority could fall into one of three models: centralized, decentralized, or a hybrid model. Michael gave the Council a number of examples as to what the governing body would be required to handle. These responsibilities could include setting strategic direction, establishing goals and vision for the entity, interpreting and applying standards of operation, fiduciary responsibilities, coordination the use and integration of HIE services amongst other organizations, recommending policies for adoption, contracting with venders, etc. Michael also shared with the Council a status update on the progress made towards establishing an entity for Connecticut. The HITO is working with the Lieutenant Governor's General Counsel to define the approach that will be taken, consulting with the Attorney General's office, conducting analysis on what has been done in other states, and looking into the use of Business Associate Agreements and single-purpose data agreements for early-implementation use cases. The HITO is looking to establish a Design Group within the Health IT Advisory Council to look into the best approach to be taken to develop a trust framework for Connecticut's HIE. Specifically, Michael outlined the recommendation for a 4-session Design Group to advise and recommend components of trust frameworks for Connecticut analytic and HIE services. This Design Group would be very focused, and would probably launch in early 2018. **Council Discussion** Dr. Alan Kaye asked how the trust framework relate to the trust principles discussed in the presentation. Michael explained that it goes from the principles to the framework, getting more specific with each step. Allan Hackney stated that he thinks Michael summed up the concept of the Design Group quite well. He has found that the work of these committees/Design Groups has been incredibly valuable. As we think about the complexity of how we are going to approach the structure of creating and deploying a trust framework, he is going to need help. We want to gather a small group of interested and knowledgeable Council members and other individuals. We will identify members of the Design Group between now and mid-December, and the group would start in January and last for 4-weeks, dove-tailing with the availability of the IAPD funding. Anybody who is interested, Allan wants to hear from them. Allan may also tap some people on the shoulder and ask them to participate. This is going to be very impactful and will really drive the construction of the shared utility services that we are all focused on creating. Pat Checko asked about where the two handouts passed out at the beginning of the meeting fit into the discussion. Allan Hackney stated that the diagrams would be discussed during the next topic, the SIM Operational Plan.		
7.	**SIM Ops Plan Update** - **High-level Roadmap Discussion**	**Faina Dookh / Alan Fontes**	**2:05 PM**
	Faina Dookh, a Program Manager for the State Innovation Model (SIM) Program Management Office gave the Health IT Advisory Council an update on the progress that has been made developing the SIM Operational Plan. The SIM PMO is getting ready to submit their operational plan to CMMI, and will be requesting health IT funding that will support the health IT strategy that this Council has been advising on. Faina is joined by Alan Fontes who will be giving a high-level overview of the solution architecture that is being proposed within the SIM Operational Plan.		

Faina explained the general charges of the SIM program: to achieve healthier people, better care, smarter spending, and health equity. Connecticut received a $45 million grant from the federal government for the period of 2015-2020 to aid in furthering these goals.

The Operational Plan is submitted annually and includes context, operational activities, timeline, risks, targets, and budget. The health IT section was drafted drawing from the recommendations of this Council, and is expanded with architectural designs and additional activities.

Faina discussed the many reasons why the SIM program is investing in Health IT, and highlighted that Health IT innovation is key to achieving SIM goals. An HIE in Connecticut would promote patient-centered care, expanded care teams, better care coordination, a reduction in duplicative care, more targeted interventions, and the ability to better track quality and cost effectiveness.

Next, Faina explained the different funding streams that will be drawn on the support Health IT initiatives. There will be state funds in the form of insurance assessment funds and bond funding; SIM grant funds that are time sensitive, federal matching funds in the form of the IAPD that come through the Medicaid EHR Incentive Program 90/10 funding and Medicaid Enterprise 90/10 funding, and finally from a sustainable financing model to support the HIE once it is in place. Faina focused her discussion on SIM funding, with amounts to a total of $10.6 million allocated for Health IT initiatives, with $8.7 million remaining. So far, they have received positive comments from the ONC that the Operational Plan is thorough and innovative.

Following this portion of her presentation, Faina introduced Alan Fontes, Director of the UConn Analytics and Information Management Solutions team, also known as UConn AIMS. Alan is the Solutions Architect for Connecticut's HIE initiative, and gave the Council an overview of the project roadmap and milestones.

Alan stated that the architecture will focus on the following guiding principles:

- Open source software and tools
    - Allan Hackney interjected to say that he doesn't want to make the assumption that everyone understands this concept
    - Alan Fontes clarified that with open source software, you do not pay licensing fees, you pay for the maintenance and support of the code to configure the software for specific needs
- Commercial off the shelf software product (COTS)
- Modular, adaptable, and scalable of solution components – we need modularity going forward to avoid big customization expenses – this is the key to staying flexible and adaptable.
- Custom configuration of components – we do not want to custom code components, we want to create components that can be modified or configured to work within our state business functionality.
- No custom code – high risk and vendor dependencies – as soon as you start doing custom code, you introduce risk and get tied into the vendor that has developed the code for maintenance and support.
- Dynamic configuration of business logic – no hard coding – we want everything to be dynamically structured. Everything will be table-driven to ensure flexibility.
- Ease of use – self service capabilities – if it takes more than 3 or 4 clicks, then you need to go back and re-design it. More clicks mean that fewer providers will actually use the tool.
- Highly secure from data intake to user access – authorizations and access controls to encrypted file transfers.

Next, Alan discussed the Quality Measures Conceptual Model, one of the handouts provided at the start of the meeting. This diagram was presented at previous Council meetings and visualizes the various data sources,

transport mechanisms/methods, validation and organization components, and user access categories. The user access needs to be efficient and designed to best serve the end users.

Alan then moved on to discuss the High-Level Roadmap, the second handout provided to Council Members at the start of the meeting. Allan stated that since starting to work as the Solution Architect, he has been focusing on an Agile Development process. One the left-hand side of the diagram, it shows the system development lifecycle – you cannot put technology out there expecting people to come, you need to build based on identified business needs. The bottom of the roadmap (green) gets into data governance – everything that we do needs to keep data governance and trust in mind – we need a governing body that informs the structure of the system based on policies and procedures; data governance will be a key part of the entire process. On the diagram, the HIE (in blue) is listed on the top and the Core Data Analytics Services (CDAS) is below (in orange). In between the blue and orange lines are the Shared Services Components – master person index, data transports, SOA, Master Data Management, etc. Everything will follow an Agile Delivery process – we will be able to derive value faster, focused on business drivers. We will focus on various waves → stages (4-6 months) → releases → sprints (2-3 weeks). At the top of the diagram, there are the transactional use cases – longitudinal health record, clinical encounter alerts, public health reporting, image exchange; these functions will be supported by the HIE. At the bottom of the diagram are the persistent use cases – Quality measure reporting, population health analytics, social determinants; these functions will be supported by CDAS. At the end of the roadmap is the operations and maintenance section – this represents the process of maintaining the HIT Business Application(s) and supporting end users.

Council Discussion

Dr. Alan Kaye asked Allan Fontes if the portion of the diagram labeled "D2", which represents the rollout of the HIE, is drawn to scale. Alan Fontes answered that, no, it is not drawn to scale. Once there is more information on the use cases and what is required, then we can start looking at the systems. If we go with the services model and leverage something that already exists, it will be faster. One thing that could be done is to look at the priority use cases and identify where we can do something without any customization.

Jake Star asked two questions on the Agile approach. Typically, Agile will end with a better result in terms of acceptance by stakeholders; however, there are often challenges that lead to longer development cycles and less-predictable expenses. He asked if Alan Fontes is worried about this. With such a large group of stakeholders, the feedback loop and sprints in an Agile process are concerning as well. Alan Fontes responded that these are both valid risks and concerns. When a challenge arises with the Agile approach, a decision needs to be made: can it be changed, can it continue to be used as it is, or does the problematic function need to be disposed of entirely? It is a management process and you have to stay on top of it very closely to make sure it doesn't take off. We have to take a look at the stakeholders' abilities, as well. One example would be to have a discussion every other day for a half hour. We have a scrum – a meeting of the minds – for 30 minutes every morning. This will be dependent on getting the stakeholders involved. Jake Star stated that there are things that they're working on that have 30+ stakeholders; how can we get them to respond that quickly? Alan Fontes responded that in terms of a delivery process, we will have consultants, such as Tom Agresta, who will be doing the bulk of this. This will be a process, and when we talk about the delivery, it is not just the technology, it is the business process/decisions as well. Allan Hackney stated that, coming in from a different flight path on this – with the concept of Agile, the recipients of the service/output will be involved in the development of the system. He is less concerned about including the stakeholders along the way, and is more concerned about the big picture deployment. We are working with the Office of the State Comptroller because it is a clean place to start, but what is the next step – do we go to DSS and PCMH+, do we go to FQHCs? This is where the Advisory Council will come into play and help to determine the sequence.

Pat Checko stated that it was an amazing presentation, and the diagram was extremely helpful. She is looking at the final product as more of an entity than an end. When she looks at the operations & maintenance and knowing there will be training and outreach, etc., does this become a permanent structure? Does it live with the contractors? Is this something that will live at UConn or is this something that will live on its own? Allan Hackney responded that the objective would be to have this reside in an entity, as discussed during the legislative update. How the end product will be shaped and informed by the Design Group and Advisory Council. The HIE services need to live in a neutral and trusted container, for lack of a better word. UConn is just helping to build this.

Dr. Alan Kaye stated that he understood this presentation to mean that the HIE entity that was described earlier will be a driving force. He asked if Alan could elaborate on the role of Health IT Advisory Council – where in this roadmap does the HIE entity take over the decision-making process? It seems like it would need to be prior to "D2." Allan Hackney responded that the Design Group that he was describing is part and parcel to this question. The entity that was proposed can in fact have affiliates, so the overarching board may decide to build an entity for the HIE and install a board with people from the Council. There are different ways to answer the question that you are asking.

Mark Raymond had two questions. The first question is that we seem to be proposing a set of relationships and we appear to have decomposed health IT into two components, HIE and data/analytics; if we are not really sure how we are organized, does this constrain how we think about this downstream? Are we going to be making decisions based on the separation of these components before we get any further? The second question is in regard to the shared services components. The state is already making significant investments in some of these areas, such as EMPI, what is the process of analyzing these components and technologies? Allan Hackney answered that with respect to the first question, part of the premise of divergence has to do with advice that we have gotten from this Council in terms of how the HIE will be comprised vs. what will be desired in terms of analytics. There is a feeling amongst many people that in terms of HIE the services are increasingly commoditized and available through a contract or partnership. The analytics is the "crown jewel" to drive the state's decision making and less readily available as a commodity. As such, these functions will be developed. For the second question, we are at the point where we are trying to finish the SIM Operational Plan and we are moving immediately towards the IAPD-U which will be brought to the Council next month. As long as the activities you see here can pass muster, then we need to get to the details of how we execute on the shared services, such as developing a requirements list and analyzing various technical services. Michael Matthews added that, to take it back to the language used during the HIE Use Case Design Group: 8 of the 10 use cases are transactional, where data is moving from point A to point B. Two of the ten use cases have data that persists (eCQM and Data Analytics) – the divergence is all based on the selected HIE Use Cases. The middle piece, the shared services, would support both the HIE and the data analytics. Mark Raymond responded that he doesn't see the full mapping, especially around something like the longitudinal health record. He does not know how we got from the high-level concepts to the bifurcation of these two different directions. Maybe there is more detail that needs to get flushed out. Perhaps we are making a decision by going with two directions that pre-suppose outcomes.

8.	**IAPD-U Status Report**	**Carol Robinson**	**2:35 PM**

Carol Robinson, Principal of the CedarBridge Group, gave the Council an update on the IAPD Update submission process.

Only one Health IT IAPD can be submitted at a time to CMS, and states must wait for approval of one IAPD before submitting another. These requests account for 2-year budgets, but must be updated once per year at

minimum. The first draft of the IAPD Update has been reviewed by the HIT PMO, and the team is currently working out the budget determinations. This process is being conducted through collaboration between the Department of Public Health and the Department of Social Services, and the overall request must align with Medicaid Meaningful Use requirements, as well as the processes laid out in the SIM Operational Plan. Ultimately, the IAPD-U will describe a Health IT infrastructure that will enable health information exchange.

Carol described the format of the IAPD-U as being comprised of eight sections, including an executive summary, results of activities in Appendix D of the IAPD-U, a statement of needs, a statement of alternative considerations, a personnel resource statement, a proposed activity schedule, a proposed budget and a cost allocation plan for implementation activities.

The budget for the IAPD-U funding is set up in eight categories, as well. The categories are as follows: governance of HIE services, HIE shared services technologies, HIE use case technologies, state agency personnel and fringe, contractor services, onboarding (including interfaces for Medicaid MU-eligible providers), technical assistance/education and stakeholder engagement.

Review of future IAPDs will be cyclical, and will encompass the following components:

- Year One: Shared Services implementation, Support Services implementation, "Wave 1" Use Case planning and implementation, "Wave 2" Use Case planning, Continued assessment of business/functional requirements
- Year Two: "Wave 2" Use Case implementation, "Wave 3+" Use Case planning, Continued assessment of business/functional requirements
- Year Three: "Wave 3" Use Case implementation, "Wave 4+" planning, Continued assessment of business/functional requirements

Next steps for the IAPD-U is to continue development of the draft to align with the final SIM and HIT operation plan. It will then be completed for review by state agency partners by December 1st, and submitted to the Council for their review by December 15th. The Council will vote to approve the draft at the Council meeting on December 21st before the final draft is submitted to CMS.

Council Discussion

Dr. Alan Kaye stated that this is very valuable background information. With respect to the budget that was discussed earlier, Dr. Kaye stated that he assumes there is more interlocking. Will the budget seen earlier constrain this request? What can we expect to get? Carol Robinson responded that because of the flexibility of IAPD submissions, you never really have to get out with your head over your skis, you can go back to the well and make sure that the funding request is accurate as you are implementing.

Lisa Stump asked how, as an Advisory Council, members can hold themselves accountable to a cost-efficient budget to get this work done? She wants to make sure that there is a good cost estimation for each phase. Carol Robinson responded that they have a way in which they are doing cost estimates for the various states in which CedarBridge works. There are a couple of approaches; one is to identify a scope of services that a state aims to do between today and the end of the funding window and go for all of all of the funding up front, in other states they take a more incremental approach. In the incremental approach, the governance entity and decision-making body is involved along the way. Allan Hackney stated that he has been beating a drum on value since he got here, and Mark Raymond is beating the sustainability drum. Through that lens, when Carol started this conversation she mentioned that the IAPD for FY 2018/2019 was approved two weeks ago. In that request was funding for the HIT PMO office to get help and drive out several activities, including sufficient resources to do

	detailed financial planning for the activities overall. It is his expectation that they are going to launch those activities as soon as the HITO gets through the RFP process. Whoever the winner is will engage this body on the questions that are being asked today. Jake Star stated that a number of months ago, the Council Members reviewed an IAPD that included a significant level of funding for DSS. He asked if this the same IAPD, and he wanted to be clear on what the process will be with for the Health IT Advisory Council with this IAPD. Allan Hackney responded that the statute states "review and comment" and that approach has been taken quite literally in the past. Allan is going to take a broader view. He does not want to implement things in this state that the Council does not agree with.		
9.	**Wrap up, Action Items and Next Steps**	**Dino Puia/Kelsey Lawlor**	**2:50 PM**
	Allan made a final comment regarding the December 2017 meeting. He stated that the next meeting is an important one – he knows that this falls in the middle of the holiday season, and he thanked members for all of their work, and thanked them in advance for their attendance next month. On the agenda will be an update from Medicaid, in addition to a number of other items. Allan Hackney concluded the meeting at 3:03 p.m. after a motion to adjourn was passed unanimously.		

Meeting Schedule 2017 Dates – Dec. 21

Meeting information is located at: http://portal.ct.gov/office-of-the-lt-governor/health-it-advisory-council