

# Environmental Scan Summary of Findings and Priority Recommendations

## Summary of Comments

The following is a compilation of feedback received from the Health IT Advisory Council members and the public for the Environmental Scan *Summary of Findings of Current State, Future Needs, and Recommendations for Action* developed by the CedarBridge Group. The environmental scan gathered qualitative data from group interviews, focus groups and surveys beginning on January 11, 2017 and continued through April 6, 2017 with over 130 organizations and almost 300 individuals providing input. CedarBridge Group applied subject matter expertise to develop the findings and recommendations described in this report.

As of May 17<sup>th</sup>, the Health IT Program Management Office (HIT PMO) received the following comments from council members and the public.

### Summary of Council Members Comments

- Couple of suggestions to an overall excellent document. Court Support Services Division (CSSD) part of the Judicial Branch don't seem represented or mentioned in the list of state agencies. They oversee probation, Behavioral Health (BH) providers submit a fair amount of data to them. They are often overlooked because they are not part of the executive branch but I believe they should be part of any HIT steering committee.

Finally, may be helpful to include in the glossary definitions for precision medicine and genomics. IMHO, **number 6** is arguably the most important consideration for the future of HIT.

- Interesting read. I agree with the overall recommendations. A few comments which may or may not be pertinent:
  - I did not see any mention of MACRA at all in this report (particularly pg. 20 which identifies reform initiatives). This strikes me as a concern as the HIE may be working off an outdated assessment scan right out the gates.
  - The references to other states HIEs is limited to just states in the region. If recommendations are being made, why not point to some model states at a national level? Seemed like a missed opportunity.
  - There is no mention of the CSMS and KAMMCO partnership to develop an Health Information Network (HIN). How would the HIE work together existing HIEs/HINs and newly emerging solutions?
  - The recommendations made are helpful, but detail items are extremely broad/generic. Will these be refined or made more actionable in the future?

- Before commenting on particular recommendations, I would like to acknowledge the hard work of CedarBridge in interviewing numerous stakeholders and thoughtfully preparing the report. The report provides nine recommendations, some of which are multifaceted. That said, we caution the Council that many of the recommended actions would require an active engagement of various stakeholders. In the current budget climate, where resources are scarce and strained, it may be difficult for stakeholders to provide the necessary level of commitment to ensure the success of all the recommended actions.
- Agrees with recommendation #1. We are in the initial stages of modernizing its information systems. The new information systems here will be built upon a shared-services architecture, where the consumer is the primary focus.
  - Agrees with the underlying theme in recommendation #2. We are working with Department of Social Services (DSS) to interoperate with existing and future shared services, including integrated eligibility and the master person index. We can appreciate the perceived benefit of building relationships with state-based HIEs and with organizations that promote interoperability outside of Connecticut.
  - Agrees with recommendation #3.
  - Agrees with recommendation #4.
  - Offers no comment on recommendation #5.
  - Agrees with the underlying theme in recommendation #6. It would be beneficial if all providers who are authorized to have access to health information for an individual could securely and electronically exchange this information with each other.
  - Agrees, in principle, with recommendation #7. We agree that the efficiency and effectiveness of healthcare delivery would be improved by tools that promote the flow of information among persons involved in healthcare delivery. We defer to the judgment of the Department Public Health regarding the need for bi-directional data sharing involving their information systems. We have already shared comments on the recommendations concerning electronic clinical quality measures. We offer no comment on the need for a single, integrated clinical encounter alerts service or on the need for expanded use of direct messaging.
  - Mostly agrees with recommendation #8; however, (a) we are concerned about the potential resource commitment for yet another committee and (b) assuming the proposed HIT Steering Committee is necessary, we suggest that the purview of the committee be limited to shared health IT assets (data or services shared across agencies), rather than all health IT assets. We see no benefit in having the HIT Steering Committee oversee health IT assets that are internal to a particular agency.
  - Neither agrees nor disagrees with recommendation #9, but it instead offers the following comment. In the next few years, we intend to move forward with a comprehensive modernization of its information systems. As part of this modernization effort, we intend to utilize, support, and contribute to the Shared Services architecture being developed at the DSS. We anticipate that the proposed statewide health information exchange services may require a significant resource commitment from us (planning and architecture input, governance and policy input, interface development ... etc.), even if a third-party organization assumes responsibility for much of the work. We offer no comment concerning the need for a neutral, trusted organization to operate the exchange services or on the governance-related recommendations.

- Overall, I believe the process this document embodies is important. Gathering perspective, summarizing, feeding it back to the group. All really important items to crafting a common vision. However, after reading the document, I believe that summary recommendations are premature. Specifically, while we've collected all this feedback, it represents the individual perspectives of a wide variety of groups. We've had limited opportunity to consider what this means holistically. Perhaps we should collect individual feedback around each of the specific recommendations and stratify it by constituent group. (Providers value this, government values that... I agree with 1, but not 7 etc.). That may help to understand why groups value specific recommendations and others do not.
  - The document suggests in its text that it's only a starting point for conversation. Is a vote on the recommendations a conversation?
  - As I stated in a previous meeting, I struggle with the differences between the "community" of Connecticut and the "government" of Connecticut as they appear in the document. The most successful exchanges that we previously heard from were not creations of government. I'd recommend a much more clear and definitive definition of what is intended. If a stakeholder is using the word Connecticut – they may be referring to the government or the collective of the payers, providers and government in our state.
  - I am not sure we have alignment on goals – much less recommendations. Do we have commitment from stakeholders that we will all work towards an agreed upon set of goals? Where is the recognition that some stakeholder goals are actually competing?
  - What specifically do we want to accomplish, by when, is everyone on board with that. Then make recommendations on how to get there. We are not being specific enough to gain support or understand lack thereof.
  - There is no treatment of the concept of what defines an acceptable floor for engagement, technology or skills. If we do not definitively state what we believe those items should be, we will underestimate the costs and efforts to actually implement change. (Further lowering confidence). There is an undercurrent of technology haves and have-nots in the provider space. Do we believe we need to have a basic set of capabilities in the state to be successful with this initiative?
  - I've heard much discussion around the "failing" of exchanges across the country. Shouldn't this document be delivered in that context? Are they really closing, failing? If so, why. Regardless of the "idea" of HIT, what are we doing that's different enough to deliver sustainability and success (or even just incremental improvement)?
  - I find the discussion around lack of information about DSS initiatives particularly troubling in its perspective. Every single one of the stakeholders has made and continues to make investments in technology. That stakeholders feel it is important for DSS not to make progress and investments unless aligned with a strategy that is not yet developed is both unfair and unsound. It would be the equivalent of telling the Medical Society to not launch a new initiative because we don't have more information.
- I question **build (re-invent the wheel) vs buy (enemy of good is perfect)**.
- On slide 31 of the presentation, ELR is described as "based on the NIST all-purpose HL7 v2.x message validation tool".

That is incorrect. ELR is part of a larger DPH built and based system (that we describe as the DPH ELR/EDX System) that allows us to securely receive electronic laboratory messages in HL7 or non-HL7 formats, validate structure and content, map the content to standard codes and values used in the end user systems (such as CTEDSS), and generate an output file that can be uploaded into those end user systems. The DPH ELR/EDX system will also be modified to take output files from CTEDSS and transform them into HL7 messages for case notification to the CDC. The core of the DPH ELR/EDX system is built using the PilotFish Technologies i.e. console and engine, but that is not the only component.

A better short description for ELR would be: “DPH based system for processing state reportable laboratory results sent electronically”. If your main focus is MU, you could say “DPH based system for processing HL7 messages of state reportable laboratory results”.

I’m not sure if this also should be corrected in the Draft Summary.

Second, in your email, there was listed the following as one of the recommendations:

“the ability to share data bi-directionally (report and query) with the Connecticut Department of Public Health on the Electronic Laboratory Reporting (ELR) system; the Hospital Emergency Department Syndromic Surveillance system and Hospital Admissions Syndromic Surveillance system; and the Connecticut Immunization Registry and Tracking System (CIRTS), with CIRTS as a first step;”

One of the goals of CDC for state Immunization Information Systems (IIS) is to ultimately allow bi-directional exchange between the IIS and provider EHRs for report and query. However, that is not the goal of ELR or Syndromic Surveillance – there is no report back out of the DPH system to the sending facility/lab other than standard message acknowledgments.

I would mention that the new EpiCenter system is supposed to replace the 2 Syndromic Systems you describe above into one system. Also, ELR and Syndromic surveillance for public health purposes is not really about “the efficiency and effectiveness of healthcare delivery” but more about being used as a means to receive data that will allow us to confirm the presence of disease for public health case confirmation (ELR) and/or public health action or monitoring (for example, detection of increase in respiratory infections in persons seen in EDs in CT).

## Public Comment

- On pg. 42 there is floating quote mark in red “

- When the HIT meetings first started, patients' right to opt-out was discussed. It seems that there is a tsunami of intentions of the uses of everyone's EHR and claims data that may drown out patient rights over their medical data. CedarBridge writes of patient privacy concerns and does give examples of states that have an opt-in or out, but I saw no mention of recommendations for patients to be able to control who sees their medical information. Patients should not have to pray that their data remains truly private as it was prior to 2000 and now be forced to trade privacy for the hope for lower health care costs and higher quality, as the intentions of uses of an Exchange have gone way past getting data to all one's physicians and for patients to access their own data. If patients are the North Star, then they truly need to be empowered by having the right to opt-out of any Health Information Exchange. This also would ensure that the Exchange answer directly to the patient/consumer and would help ensure that the most stringent privacy provisions are maintained.

Again, if patients are the North Star, why is there no discussion of establishing a mechanism for the citizen/patient to contest the findings of what treatments will or will not be provided to them by the results of the "value and quality" studies? The state will present data from our records and claims to support what our providers can or cannot give us to comply with being cost and quality effective. We are effectively creating a single payer state system, where patients may lose choice over what health care treatments will be available to them. Once that happens and there is no real competition or ability for providers to act freely, we will be like the VA patients subject to the government bureaucracy. There are a lot of people around the country who understand this scenario but just are not vocal in CT.