SustiNet Health Partnership

Health Information Technology Advisory Committee

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Health Information Technology Advisory Committee Regular Meeting
DRAFT - May 14, 2010 - DRAFT
Meeting Minutes

Participants: *Alex Hutchinson, Co-Chair; Jeffrey Asher; Enrique Juncadella; Bob Tessier; and Lynn Townshend*

Teleconference Participants: *Marie Smith, Co-chair; John Brady; Linda Green (SustiNet Consultant) and Ryan O'Connell*

Office of the Healthcare Advocate: *Africka S. Hinds-Ayala*

Absent: *Rob Aseltine; Jody Bishop-Pullan; Mark Boxer; Angelo Carraba; Joel Cruz; Pam Cucinelli; Judith Fifield; Meg Hooper; Darlene Kish-Thompson; Jeffrey Kramer; Jamie Mooney; Steve O'Neill; and Victor Villagra*

Marie Smith opened the meeting by welcoming all committee members and reviewed the agenda.

The April 30, 2010 meeting minutes were approved, with two corrections: (1) *Fourth Paragraph - Line 1:* Jeff Asher said that eHealth-CT recently received $5.3M in federal funding to serve as the regional extension center to provide training and technical assistance for physician practices around the state; (2) *Fourth Paragraph - Line 7:* change the word *players* to *payers.*

Marie provided an update from the May 12, 2010 Board of Directors Meeting stating that there was a presentation by and question/answer discussion with Stan Dorn of the Urban Institute regarding the 60-Day Report to be submitted to the Connecticut Legislature by May 31, 2010. Marie continued that the Board assessed the progress of the committees and taskforces to ensure that each group is on track for the template deliverables. Marie said that there was an introduction of consultants who are assigned to each group, with Linda Green being named as the consultant to work with the HIT Committee.

Linda Green provided personal background information with regard to expertise in the healthcare industry, to include the Massachusetts Healthcare Quality and Cost Council, Massachusetts Medicare Program, contact procurement, and rate setting for managed care. Linda also provided information for the other two consultants: Anya Rader Wallack and Katherine London. Linda said she is charged with assisting the HIT Committee with completing their template.

Lynn Townshend provided an update on the Gap Analysis Meeting at the Department of Information Technology on May 3, 2010. Lynn stated that the meeting was intense, but provided some insight on the technical infrastructure for governance of Connecticut's Health Information Exchange (HIE); the next meeting is scheduled for May 17, 2010, which will look at the alternative analysis prepared by Gartner, Inc. that was shared with the SustiNet HIT Committee via electronic mail. Lynn stated that the Department of Public Health (DPH) is seeking as much public participation as possible and inclusionary.

Lynn recently returned from a leadership conference conducted by the Office of the National Coordinator for Health Information Technology (ONC) in Washington, DC for those individuals who are assigned as the acting state Health

Information Exchange (HIE), the state designated entity, or both. This is a collaborative process. With regard to working with the eHealth-CT as the Regional Extension Center (REC) and the state CMS entity (Connecticut Department of Social Services), Lynn said that she has made some outreach to the two groups with great reception from each. There is a tentatively set public leadership meeting between these groups on June 10, 2010 at the Connecticut Hospital Association (Wallingford, CT) from 8:30am to 12:00pm; the purpose is to make certain that all involved parties interested in HIT / HIE are up-to-date as to what is occurring now, with presentations from eHealth-CT, DSS, and DPH and a public comment for the strategic plan (public comment period is from June 7 -14, 2010). The goal of the project is to be as inclusive as possible and come to a consensus about the direction of health information technology / exchange for Connecticut.

Jeff Asher inquired about the identified key questions about which decisions need to be made from the May 3, 2010 Gap Analysis Meeting; asked to identify the essence of the gaps, questions, etc. Lynn responded that the essence of the gaps were Gartner, Inc. presented all the information and now is the time for the involved entities to take the information back to the constituencies and determine the correct technical infrastructure with DOIT: Gartner, Inc. will present several infrastructure designs for government and the overall technical infrastructure architecture. The current gap is sustainability, with the question being: where is the money coming from to sustain this over time? Do you ask the providers to do transactions, since the state will be the beneficiary from the cost-savings?

Lynn provided an update on the legislation stating that the Senate Bill 428 (formerly SB 403), which passed the House and the Senate and awaiting Governor Rell's signature, creates the Health Information Technology Exchange of Connecticut (HITECT) Authority that will be the home of the Regional Health Information Organization (RHIO) with DPH being its fiduciary (overseeing the RHIO monies). HITECT should be in place by January 1, 2011; this is a transition period to hand everything over to HITECT which will have its own Executive Director, HIT Coordinator, Grants Master, Informatics Specialist, Technical Specialist, Accountant, Paralegal and Secretary.

Marie question of the Connecticut EHealth Authority have a new name. Lynn responded that affirmatively that the new name is the Health Information Technology Exchange of Connecticut (HITECT) Authority, as to not have confusion with eHealth-CT and for branding/marketing purposes. Marie asked if HITECT is a quasi-public agency; Lynn responded to the affirmative and included that everything is available, except trade secrets, through the Freedom of Information Act. Lynn said the current advisory committee will cease to exist by January 1, 2011 and be replaced by a Board of Directors for the Authority; the Board of Directors will retain all appoints as stated in the legislative language and there will be two additional positions designated for a consumer advocate and a small practice physician (defined as less than 10 physicians in a practice and no hospital affiliation). HITECT can create subsidiaries that will be considered quasi-public and subject to the same FOI requirements.

Marie asked Lynn to clarify in sections of Senate Bill 428 that mentions the purpose of the authority as "…promoting, planning, designing, developing, assisting, acquiring, constructing, maintaining, equipping, reconstructing, and improving Healthcare Information Technology…", whereas another section of the bill designates "…the authority to serve as the statewide Health Information Exchange..."; the basic clarification between HIT and HIE. Lynn responded that HIE can be an exchange or data warehouse, which serves a gateway through which information passes; whereas HIT is the technology infrastructure of that exchange. There are state agencies that have health exchange information for their own respective systems. Lynn will ask that the DPH / HITECT glossary will have these definitions and more for individual clarification.

There was discussion amongst the group that included having HIT at a lower-case for provider level to include durable medical equipment, prescribing, etc.; will the authority detail specific for physician offices, facilities, hospitals, etc.; input and standard setting from federal agencies such as the FDA, ONC, HHS, CMS, etc.; the stringency levels of the ONC; and health data security issues.

Marie moved the discussion towards completing the template by stating that she, Linda, and Alex discussed how they wanted to frame the work with identification of "principal items" / "guidance recommendations", as follows:

1. Define HIE and HIT *(e-prescribing, disease registry, EHR/EMR, clinical decision support, etc.)* to determine scope of duties;
2. Recognize that SustiNet HIT recommendations are in congruence with new legislative body;
3. Multiple HIE / HIT stakeholders *(Sustinet, eHealth-CT, Patients, Providers, DSS, DPH, etc. with Patient-, Provider-, Hospital-centric Models)*;
4. Design Utilization of HIE/HIT inclusive of multiple Healthcare Providers, not just physicians;
5. Promotion of national standards of HIE and HIT via the ONC *(privacy/security, interoperability, continuity-of-care, testing, screening, etc.)*; and
6. Sustainability of the HIE for years to come.

Jeff stressed the importance of following the work development DPH and sub-workgroups because the SustiNet HIT Committee will complete the majority of the discussions and work with regard to system development, patient privacy, etc.

Marie agreed and said that it is not necessary to re-create work and recognize the work of others and refrain from working in parallel.

Alex Hutchinson mentioned that each workgroup should have begun to flush out key components, ideas and recommendations regarding the template as reviewed. Alex asked each workgroup to give a brief summary of work, ideas, recommendations complete thus with regard to the template far:

- **FINANCE (Jeff Asher):** The group has not been very active. There has been an exchange of e-mails. The group is having difficulty completing their portion of the template because they are unsure of the subscriber base. From the perspective from financing, there is a question around sustainability being a charge or a mechanism to maintain the HIT system. A conversation included how to collect revenue for the sustainability of a HIT system through eHealth-CT, which could include subscriber fees charged to pharmacies, physician practices, etc. or charging a nominal fee for per transaction that flow through the HIT, which would potentially be a small enough dollar amount that it would not be considered offensive, but the volume of the transactions would be enough to finance a HIT delivery system. The financing side for acquisition of technology (software), the group is working with the CT Hospital Association; eHealth-CT is seeking out ways to assist physician practices. The Finance Workgroup needs to know who and what they are dealing with before being able to complete the template; subscribers to a HIT system could range from individual insurance companies, pharmacies, radiology, facilities, walk-in clinics, state employees/retirees, community health centers, etc. This will determine how to place the financial pieces in relation to HITECT Authority. Jeff said that he had conversations with three hospitals with Waterbury Hospital not purchase their own equipment/software, but will do everything on a fee-for-service basis through an external source; the other hospitals will do capital acquisitions (i.e., Yale New Haven Hospital) with the purchase their own soft-/hard-ware with financing through CHEFA. Enrique Juncadella provided some background history with regard to how some physician practices have possession of expensive soft-/hard-ware that is useful and interoperable. Jeff described various forms of federal funding and mechanisms currently available to hospitals, community health centers, etc. Alex questioned if there are limitations to the type of provider; Jeff responded it depends on who SustiNet will be marketed towards. Alex questioned the sustainability with regard to what SustiNet need to think about changing the basic reimbursement rate/process and answering the age-old question of "what is in it for me?"; the response was the reimbursement will not come from SustiNet but from Medicare/Medicaid when physicians institute a requirement that meet federal governmental standards. The additional fee is an incentive up and through calendar year 2014 and thereafter it becomes a penalty. This will create a greater efficiency. Enrique said there is potential for practice revenue through CPT-Codes. Bob Tessier stated that SustiNet may have envisioned provider reimbursement at a higher level for SustiNet participating providers for various things such as, HIT, care management, etc. Lynn said in the totality of healthcare reform, financial incentives will move physicians closer to where they need to be with regard to federal health care reform.

Marie said that at this point each work-group should be submitting initial high-level, draft recommendations with identification of major issues that need to be worked out. Linda supported the statement and said that the template is a working document.

- **MARKET RESEARCH/OUTREACH ENROLLMENT (Enrique Juncadella):** The general discussions are based on complimenting the stimulus and federal funding relative to the incentives that practices would benefit from adopting any kind of HIT capability. The incentives are limited, transitional, and temporary to create a critical mass early in the game. There is a focus on the up-front incentives and medical home and primary care management (through HUSKY) could serve as the platform to begin the process because of the number of providers already available. Alex said to what extent does SustiNet needs to structure in financial incentives to get providers to implement/adopt HIT; there are multiple initiatives/efforts available to start things not the least of which are associated with the funding. The perspective is that it may not be necessary for SustiNet to be concerned with brining additional funding and incentives into the market because so much funding and opportunity exists now; simply reinforcing that HIT is a requirement to be a provider with SustiNet is enough of an enforcement because of the population that SustiNet will serve (state employees/retirees, HUSKY, etc.). Enrique said the transition creates the danger of a digital divide; therefore, we need to set-up a system that is not so punitive in nature, but user/provider friendly. Enrique continued that a demand pool should be created from the members of SustiNet that give direction to the provider of patient needs, which will be a patient-driven outreach method. Alex said outreach needs to be designed around the healthcare delivery community to include others than the physician, especially e-prescribing. Lynn stated that doctors listen to doctors and do not see the patient as a potential outreach resource; it is important to have a small group of providers having a peer-to-peer discussion about healthcare. Enrique said there is controversy over death panels and there is certain protocol overseeing chronic disease management. Lynn said that data will help

drive the healthcare access / delivery. Alex asked if there has been discussion about reducing malpractice if the provider is operating within a defined standard of care; Lynn guessed yes and that someone maybe looking at this issue. Alex asked if this is a state or federal issue; Bob said it can be addressed at the federal level. Ryan O'Connell said that he has heard of some malpractice carriers do offer a discount if provider institute some type of HIT. Marie said that at the on-set of e-prescribing that there were some malpractice carriers who did provide discounts on the premiums. Bob said Hartford and St. Francis Hospitals were working together to develop the best healthcare practices within certain disease groups. Lynn said insurance companies have begun to do the same thing; she continued to state that there are three entities that the ONC / CMS are looking at within the state (DSS, DPH, and eHealth-CT) that need to have communication plans in place as to be consistent across all the stakeholders involved. Enrique suggested a branding logo around SustiNet.

- **LOGISTICS (Ryan O'Connell):** The key points/principals are not recommending a specific vendor, but the vendor does have to be certified by a certifying organization for quality, insurability, and operations; the RHIO should facilitate the consulting work for providers; HITECT may will administer the HIE with DPH as the fiduciary; and survey data from the CT State Medical Society – IPA. John Brady conducted a survey showing the systems that hospitals are dealing with within communities, as well as the level of penetration that these systems have. There are three to four vendors who are predominant within the state. Ryan said there are concepts of meaningful use, no single vendor system, and community health center funding for HIT development. Attempted to gather information from the underserved. Alex said that Enrique is involved in granular activities to ensure that EHR/EMR is capturing specific demographic traits (race, ethnicity, income, educational levels, electronic access, etc.). Africka S. Hinds-Ayala said that the SustiNet Health Disparities and Equity Committee is looking at developing individualized patient-care plans that is tailored based on family medical history, ethnic preventative screenings, etc.; upon receiving services the patient will complete a patient-survey at the physician's office or pharmacy with staff assistance where needed, thus, with every completed survey that office or pharmacy receives a financial incentive.

- **ORGANIZATINAL TASKS:** No Report

Alex began to outline the next steps for the SustiNet HIT Committee according to the established timeline. Linda said the group is going in the correct direction and the real focus should be the recommendations. Alex outlined for the group who is serving on what sub-committee and encourages everyone to submit recommendations as soon as possible to be compiled and formatted by Linda. Linda said it is best to add items on and do not leave things off because it does not fit at this point in the process. Ryan will coordinate with Meg Hooper (DPH) to coordinate recommendations from the Organizational Tasks and Federal Health Reform workgroups and attempt to extract information/recommendations at one-time. Linda will assist as a resource and facilitate the discussion among the various workgroups; the workgroup members coordinated times, meeting places, and communication methods to complete the template.

There was no unfinished business.

Meeting was adjourned.

Next meeting will be June 11, 2010 from 1:00 pm – 3:00 pm at CHEFA