

STATE OF CONNECTICUT
State Innovation Model
Health Information Technology (HIT) Council
Meeting Summary
Friday, November 20, 2015
10:00-12:00p.m.

Location: Room 1B of the Legislative Office Building, 300 Capitol Avenue Hartford, CT

Members Present: Thomas Agresta; Roderick Bremby; Anne Camp; Patricia Checko; Jessica DeFlumer-Trapp; Anthony Dias; Tiffany Donelson; Michael Hunt; Vanessa Kapral (Phone); Matthew Katz; Mike Miller; Philip Renda (Phone); Victor Villagra (Phone); Josh Wojcik

Members Absent: Ludwig Johnson; Alan Kaye; Mark Raymond; Amanda Skinner; Sheryl Turney; Moh Zaman

Other Participants: Faina Dookh; Ian Goldsweig; Michelle Moratti; Minakshi Tikoo; Vicki Veltri

The meeting was called to order at 10:05am. Commissioner Roderick Bremby chaired the meeting.

1. Introductions

Commissioner Bremby initiated roll call. Council members introduced themselves.

2. Public Comment

There was no public comment.

3. Minutes

Commissioner Bremby requested a motion to approve the October 16th meeting minutes. Matthew Katz motioned to approve the minutes. The motion was seconded by Thomas Agresta. Commissioner Bremby opened the floor to discussion. The minutes were approved. Anne Camp abstained and remarked that it was difficult to hear the last meeting as a phone participant.

4. HIT Relevant Updates

Michelle Moratti of The Chartis Group facilitated a discussion around SIM HIT relevant updates. Ms. Moratti said the work the HIT Council is dependent on receiving sufficient detail on programmatic designs created by the other Councils and Taskforces. Ms. Moratti reviewed the objective of the HIT relevant update discussion which was to inform a discussion of the HIT Council's path forward and how best to act on the other SIM related inputs.

Ms. Moratti briefed the Council on updates related to the SIM's Advanced Medical Home (AMH) work stream, summarized on slide four of the meeting [presentation](#) created by the UConn team which describes how the quality metrics might flow and what the implications of those metrics might be for the technology requirements. Ms. Moratti defined "advanced networks" as a conceptual term meant to represent a collection of AMH practices, hospitals, and other providers that exist or operate as a network for the purpose of value based

contracting. AMH practices are part of that larger network. Ms. Moratti stated that the Quality Council (QC) has defined a set of quality measures that are under consideration to serve as the basis for value based payment for use by advanced networks. There are two types of the quality based measures: claims data (historically used by the industry) and through the collection of clinical data from presumably EMRs, EHRs, and other practice based technology supports. This is where the use of the edge server technology was contemplated as a technology that could go into a variety of clinical systems, index data, and allow for the calculation of quality measures. The HIT role relative to quality measures is to demonstrate the use of technology by programs that collect clinical data to support the calculation of clinical quality measures as defined by the Quality Council. Mr. Katz asked if the approach includes a consideration of an earlier discussion of using the edge server technology to validate other methods of collection such as the claims collection. Mr. Katz asked if the Council is collecting and analyzing as outlined in the presentation tied to the quality measures and if the Council will validate the other approach of computing payer measures based on claims. Ms. Moratti said the HIT Council's role is to provide the HIT support required for the quality measures but the degree to which the design of a validation approach will be required is still unclear. Dr. Agresta said there is a number of places where validation will need to occur based on the different EHRs and systems that even one ACO may have within it. The Council will need to be cognizant of all of those things if providers are being judged on the quality of care they are delivering and the value of care. Ms. Moratti said independent of payment, as an industry healthcare has had difficulty agreeing on the terms of data validation so one can imagine if that discussion is framed in the context of payment, alignment will become key. Dr. Tikoo said that using edge server indexing to validate claims measures is currently out of scope for the HIT Council and that the validation piece was not part of the earlier discussion for the claims based measures because the assumption was everyone was already comfortable with the way claims based measures were coming in and that clinical measures was where the problem of collection was. To Mr. Katz and Dr. Agresta's point, Dr. Tikoo said validation of data will be important because you are assigning a payment based on value. This notion is part of the ongoing discussions. The HIT Council's work is to deliver the metrics. Other work groups will need to provide guidance on what they are going to base the payments on and what is the metric that they want validated or collected. The HIT Council has not heard validation requests yet, but the Quality Council or PMO could consider and ask for validation of the data that is being produced, even at the ACO level. At this point in time the PMO will have discussions with the payers that will help determine if the work flow is doable in the timespan prescribed. Dr. Tikoo said in terms of the edge server technology, disparate systems, and the variety of systems, the UConn team has worked with the PMO to call the measures "clinical measures" instead of EHR measures to support the notion that they could come from various systems.

Vicki Veltri said the subject of payer alignment is an ongoing conversation. Therefore the left side of the chart on page four of the presentation is a work in progress. With respect to the quality measure alignment, Ms. Veltri said that is a statewide initiative. While AMH practices in an advanced network may have some kind of shared saving contract, the PMO is looking at a statewide quality measure alignment with AMH as a subset. Mike Miller commented that step two on slide four of the presentation could take many paths regarding how the interaction will happen with the payers. It could be through contracting or through third party aggregation. The technology piece will be important because their infrastructure is determined.

The specific validation request has not been made. The HIT Council is anticipating a series of iterations with other Councils and Taskforces where further clarity over the specifics of their request is gained and will likely include validation. Mr. Katz said physicians do have issues with claims-based measures with insurers, even if they are using consistent platforms that look at aggregation of data and analysis. Each insurer interprets it differently so the scores or ratings are different and that relates to the payment. The HIT Council must make sure they have definitive validation of the payer claims measures and information or there will be challenges. This needs to be built into the system the Council creates so there is consistency over what the data means. Dr. Tikoo said interpretation is referred to as normalization of the data which has been part of the discussion. Validation and normalization interpretation and rendering of the data has to be consistent, but the data and agreements need to be in place prior to that calculation. What is the criteria for success? The rendering of the data might be different than how it is rendered today, otherwise the Council risks mismatch. These conversations need to occur before so people understand what they are agreeing to. Ms. Moratti said building payer and provider alignment around how you are calculating the metrics and how you are collecting and normalizing the data is as significant a challenge as the technology because the industry has struggled to build consistency around methodology of data collection. The left side of the chart on slide four of the meeting presentation outlines a potential strategy for building payer alignment to the approach and collection and normalization of the data and use of the technology. Ms. Moratti pointed out the “chicken and egg” scenario faced by SIM where support and agreement for participation needs to be secured from the payers, but the parameters of the program need to be defined in order to secure that agreement. What is the degree to which the Council seeks to secure payer support prior to proceeding on the pilot design and testing? Anne Camp remarked that for the uninsured, the payer is the patient. How are they represented in this system? Dr. Camp said claims data will not capture any information for uninsured. She asked if the SIM will represent the uninsured as payers. Ms. Veltri said the issue was discussed during the model design grant phase and it was concluded that it would be difficult to track the uninsured through these arrangements. The original intent was for SIM to cover 80% of the population. The uninsured are not considered “payers” for purposes of HIT solutions. However, there are initiatives in the SIM beyond the HIT piece that touch upon the uninsured such as health enhancement communities and organizations that would be affected by the technologies in the test grant. Additionally, there may be an opportunity to measure the impact of CCIP on the uninsured but that is not currently part of the scope of SIM. Dr. Camp said the issue is measuring and validating the improvement in care, quality, and disparities for this [the uninsured] population. Ms. Veltri said that she does not disagree and that there are many things contributing to the disparities in healthcare even among the covered population. Michael Hunt said it depends on how you sample the population, which should be defined in the data use agreement. At a secondary level you could determine how the care was financed whether personal or otherwise. Self-insured means a number of different things including those who pay out of pocket, those who are economically challenged, and the Medicaid population. Dr. Hunt said healthcare facilities are giving a lot of care to support that per their mission. The answer is in the model and how the group pulls from the population. If you pull data from pop health, the sample will be from all patients regardless of their financial capabilities. Josh Wojcik asked in terms of the “chicken and egg” problem regarding edge server technology, what is being asked of the payers? What is the feedback? What do they need to move forward? Ms. Moratti suggested the question be deferred as it would be addressed later in the presentation.

Ms. Moratti reviewed the Advanced Medical Home (AMH) program, summarized on slide five and six of the presentation. She said the medical homes sit within an advanced network and the program plans to support both the claims and clinical based measures pulled from the advanced networks.

Ms. Moratti reviewed the Clinical and Community Integration Program (CCIP) HIT relevant update detailed on slide seven of the presentation. CCIP facilitates horizontal integration in terms of interaction and coordination of providers in the provision of care and the connection of that clinical care continuum with non-clinical community providers who play an important role in the health of the population. The notion is to build connective tissue along the continuum of care for clinical delivery with both traditional or historical clinical care providers in a network as well as other clinical care providers who sometimes sit outside the network such as behavioral health, dentistry, etc. In addition, it is meant to build connective tissue between that clinical care delivery continuum and non-clinical community care providers who provide important support to the health of the population. Ms. Moratti reviewed the updates related to routine questions the PMO receives regarding CCIP detailed on slide seven of the presentation. Mr. Katz asked for clarification regarding FQHC requirements around standards. Ms. Moratti clarified that question one on slide seven references the general criteria of the MQISSP RFP and question two referenced the degree to which those who meet the general criteria and participate will be required to meet the specific CCIP criteria. Faina Dookh of the SIM PMO gave further context to the second question on slide seven of the presentation by explaining that Connecticut was a recipient of a new Transforming Clinical Practices Initiative (TCPI), Practice Transformation Networks (PTN) federal grant. CHCAT is one of the recipients so they have a program for all FQHCs under that umbrella to provide them with transformation services. As the CCIP program for the SIM grant is developed, the PMO will determine which of the transformation services are duplicative with those offered by CHCAT. The PMO is undertaking an analysis to ensure they are optimizing the resources of the grants and not duplicating services. Dr. Agresta said UMASS and UConn are also recipients of TCPI and there may be an opportunity where programs could be synergized but not duplicated. Mr. Katz said his concern is that some people could get two-times the support while others get nothing. Ms. Veltri said a lot of work still needs to be done in terms of reconciling between Medicaid, the Practice Transformation Taskforce (PTTF), and the PTN grant.

Ms. Moratti reviewed HIT relevant updates related to the Quality Council's measure set. She reviewed the framework for the quality measures detailed on slide eight of the presentation. Ms. Moratti referred Council members to a [handout](#) detailing the draft core provisional quality measures. Ms. Moratti reviewed the results of the interviews conducted by the PMO to understand how payers are currently using quality measures, collecting that data, and reporting and building those measures into their contracts detailed on slides nine and ten of the presentation. Mr. Katz asked if the contracts referenced were those the payers had with other physicians and providers of service. Ms. Moratti confirmed. Mr. Katz said the description simplified the contracts as there are lots of different contracts and contracting entities; some are through ACOs and other groups, some are "evergreen", and some have standard provisions that from a statutory perspective require even longer time to change because they would be a material change to the contract. Some of the timeframes presented would have to be adjusted based on what constitutes a material change in the contract. Ms. Moratti said the information provided are generalizations across a very wide variable data set in terms of ability to modify contracts. Mr. Miller asked if there has been any reconciliation of the provisional quality measure set with what payers and others are

currently using. Ms. Dookh said yes, the Quality Council started with an analysis of all of the quality measures being used in Connecticut by the commercial payers and Medicaid. From that starting point, there was a massive misalignment which made it difficult for providers to focus on quality improvement. Following that assessment the Quality Council took several months to determine a core set which is now nearing an alignment process to get the payers to narrow down their sets and create a focus. Dr. Agresta added that the ability to extract and compute the clinical quality measures out of the EHRs is still being worked on in many ways in the research settings. Some would require people to go in and change what they do in their workflow and how they record data. Some of the presented measures may not be as easy to extract as they appear and some will be standard. At least 6-7 of the measures in the measure set would not be able to be extracted from an EHR. Ms. Veltri said that is why more discussion needs to be had around the measures and alignment and ensuring practicality of the measures. Ms. Moratti reviewed the recommended alignment process detailed on slide eleven of the presentation. Ms. Moratti reiterated the need for further discussion on the contract period portion of alignment and the issues for the HIT Council in moving forward given these uncertainties. Ms. Moratti reviewed the draft timeline for alignment detailed on slide twelve of the presentation. She noted that given the different sources of the data (consumer experience, claims, and clinical), the projected timeframe and implications for technology development are very different and all progress over the next couple of years. Ms. Veltri said that the Quality Council report is still in draft and that the timeline presented is just a projection. Ms. Moratti continued the review of the draft measure set implementation timeline, further detailed on slide thirteen of the presentation. Mr. Katz asked if the MQISSP timeline presented on slide 15 was the most up to date timeline including the delay discussed during the October 16th meeting of the HIT Council. Commissioner Bremby confirmed that the MQISSP timeline presented is the delayed timeline, referenced at the last HIT Council meeting. Ms. Moratti noted that the CCIP is tied to this delayed timeline and that quality measurement is tied to payer contracting cycles and the new effort to accept and validate clinical measures.

5. Review of Overall SIM Logic Model

Ms. Moratti reviewed the SIM Logic Model which was created to review how the SIM initiatives attach to the projected outcomes of the overall initiative detailed on slides seventeen through twenty one of the presentation. Ms. Moratti oriented Council members to the Logic Model components. The Logic Model is meant to give Council members a full synergistic view of the SIM initiatives. Mr. Katz noted that the Logic Model included integration of primary care with behavioral health and that the Council hasn't talked about how we would collect behavioral health data which is very different from collecting medical information. Mr. Miller said the Council should consider the operational environment of the technology in reference to I.A.3, of the Logic Model, especially if the technology is new to a provider environment. He remarked that the less burden that can be put on providers as well as other parts of the system, the more beneficial it will be to move the initiative along quicker. Dr. Tikoo said once the SIM Logic Model is finalized, we will develop the HIT Logic Model that speaks to the elements asked for by the PTF and QC that call for HIT assistance. The Logic Model details what the program plans to undertake to impact the outcome. That clarity has to come from the design itself. In the case of those pieces where the HIT Council is asked to deliberate they will need an understanding of what the provider has to do. That will depend on which elements they ask the HIT Council for help with. When the other Work Groups put out their reports it's a question, where are the opportunities and initiatives where help is being sought from the HIT Council. Ms. Moratti said the intention is to leverage what is already in place to minimize the burden on providers and that an inventory

must be collected to inform design. Ms. Veltri said the HIT Council is the first workgroup to see the Logic Model. The Logic Model will be viewed by the other Work Groups and then by the HISC so it may be modified. Ms. Moratti added that the Logic Model will be an evolving document that represents the current state of thinking as that thinking evolves.

Mr. Katz said the Logic Model discusses payer alignment but not provider alignment. He said, for example, there could be two large provider systems that see 400,000 recipients without community physician and provider alignment resulting in only two systems providing care to 88% of this population. This narrows the access point by narrowing who could provide that care creating more problems with not just outcomes but access. Something in the model needs to discuss provider alignment and not just beneficiary and payer alignment. Ms. Dookh said the program has goals and statistics related to beneficiaries and providers, including a target number of providers SIM wants to involve. Outside of Medicaid, SIM has a goal of 88% of the Connecticut population goes to a primary care provider that is responsible for the quality and cost of their care. That is a multi-payer goal that is aligned with a national goal for value based payment both in the public and commercial sectors. For example, Medicare's goal is to have 85% of their payments be tied to value-based payment arrangements by next year. Beneficiaries' choice of providers is not constrictive on whether the payer is doing a value based payment model or not. Ms. Moratti clarified the question asked as similar to the payer alignment, we need a provider alignment strategy to build support for the implementation of the measures. We are too focused on the payer alignment and need to also strategize around provider alignment and potentially the patients in some way to Dr. Camp's earlier point. Commissioner Bremby reiterated that the HIT Council is the first group to view the SIM Logic Model and it is important that the group has a shared understanding of what the goals are and what the hypothesis is. He suggested the Council stay "in the tech box" and that Mr. Katz's comment regarding the critical question of where the providers are and should be is something that needs to be sent back upstream.

Commissioner Bremby said the [HIT Council] executive team took a lot of time determining what would be included in the presentation. The Council is fortunate that many members wear multiple hats and understand different factions of the programs.

Dr. Agresta said that in terms of provider strategy, you should be thinking in terms of helping providers achieve something. He asked what the best process is for Council members to provide feedback and input on the Logic Model offline. Dr. Tikoo suggested the PMO decide on a process that members could use to send inputs on the model. Ms. Veltri said the members could send their comments to the PMO or the PMO could hold a webinar to walk through the model. Dr. Checko asked if the PMO had considered the use of Dropbox technology as a means of collaborative software to read or comment. Ms. Veltri said the PMO has collaborative software that they use for the initiative. There are state restrictions on certain kinds of software. Ms. Veltri suggested the PMO would decide on the process to receive feedback from the members on the Logic Model.

Dr. Hunt said from a technology perspective there is definite measureable technology to look at preventative services and chronic care services, but behavioral health has both restrictions on sharing that information of diagnosis and more complication with obtaining the risk assessment component. He expressed concern with goal of looking at those behavioral health outcomes. Mr. Katz commented that the behavioral health information will be difficult to capture, model, and report from an outcome and income perspective

because some systems don't collect data and even what can be extracted is problematic. From a HIT perspective tied to the pilot, how much has to be built tied to the measures? While the draft core provisional measure set does not reference behavioral health, if the Council wishes to include behavioral health measurements in the long term technology, it should be included in the pilot. Ms. Moratti said the best solution will be based on the determination of what the Council wants to do and what is possible. The Logic Model is meant to be a bidirectional conversation where the other Work Groups provide insight into what they would like, and the HIT Council provides insight into what is possible thus comprising the best possible outcome. Commissioner Bremby said for example, if you reference page two, Outcomes/Impact, Output Outcomes bullet three, "reduction in number of mental health days," that is currently captured in the Behavioral Risk Factors Surveillance Survey (BRFSS), so that is a survey that is already built for population perspective but it doesn't get at the iterative, individual level that people are hoping for, but that may not be doable in the pilot, for several years, or until there is a major policy change. What is important is that the information is laid out in the Logic Model and the Council can determine what can be solved for. Mr. Katz said the pilot will need to ensure it includes how that [behavioral health] information is captured, which is outside EMR technology for most clinical practices. Dr. Hunt said the Council may have to acknowledge that that may not be a measure for the pilot. Dr. Camp said if you look at the clinical measures, Fair Haven Community Health Center is measuring them and has been for ten years in their EHR which is Epic, and widely used. Practices may not have implemented PHQ screening for depression across the board but it is certainly measurable and extractable.

Ms. Moratti said the PMO will communicate the manner in which they seek to iterate with input and comments on the Logic Model. Commissioner Bremby thanked the team for the investment of time in developing the Logic Model. Dr. Hunt asked if technology will be used to identify and create the CCIP care plan that will be visible throughout the continuum as part of the pilot. Ms. Moratti said the care management challenge is both from a clinical perspective attempting to link in other clinical providers who aren't part of your direct system and trying to share information with non-clinical providers which is a new frontier in terms of breadth. Dr. Tikoo said in the proposal, care coordination was identified as one of the activities that the HIT Council would try to solve for should it be asked for.

6. Design Team Updates

Ms. Moratti facilitated a discussion regarding the relevance of the Design Teams as currently structured for the Pilot and Long-Term group meetings given the information that surfaced. She reviewed the timeline that was initially proposed and the steps that have been taken, detailed on slide twenty-three of the presentation. She said given the state of the programmatic designs and altered timelines, the Council is at a decision point about whether they potentially alter their path forward. Dr. Checko asked if given the timeline and uncertainty around the initiatives, does it make sense to continue with two Design Groups. She suggested that perhaps the groups would become one large Design Group as they were to begin with. Additionally she asked how the work of the HIE will impact what the HIT Council is doing and would it provide avenues and technology that would be beneficial to the Council in determining their solutions.

Commissioner Bremby said the Council is not working in isolation but is affected by a number of innovations around HHS. The day before the HIT Council Ms. Veltri and Commissioner Bremby learned that state insurance exchanges are expected to partner with payers who are placing QHP products on the exchange to report some forty-three quality

measures. The Council will have to work with HHS to determine how the programs will be implemented. Additionally, the State has Senate Bill 811 which asks Connecticut to stand up an HIE. The HIE can provide some clinical information and measures for this work. The HealthIT Advisory Council discussed bringing vendors in for demos during the first quarter of 2016, release an RFP in the third quarter of 2016, so a vendor may not be available until 2017 at best given state procurement processes. Commissioner Bremby advised the Council not to rely on the HIE for the SIM pilot. Mr. Miller agreed with the notion of one Design Group and suggested the Council take the functionality that Zato allows and apply the technology to the programmatic requirements and create the Design and then determine where the opportunities or challenges lie. Mr. Katz said given the timeframe it makes sense to have one workgroup and asked if the Council should ask other vendors besides Zato to demonstrate as the Council is looking toward the long term solution and no longer the pilot. He asked where the initiative is in the process with Zato and has a contract been signed. The Commissioner agreed with the notion of one large Design Group now that there is a long term and no longer an immediate solution. He said nothing has been signed with Zato regarding a pilot, but there is an agreement with Zato and Zato is in the State's data center and they are being used in the state and at UConn. He said the demo could occur early next year. He said the first order of business is do we design specs and push them out in an RFI? Have a demo/vendor fair, then an RFP? Dr. Agresta said the Council has to start with seeing if the vendor can match the design requests. The demo moves from theory into a concrete example. He said the information exchange presents such a large opportunity their objective will not be getting at the data SIM will use, their objective will be to share information on grander scale which may not be discrete in the short term. Mr. Miller said we have to start somewhere and Zato is a good start. Waiting for the HIE would be problematic. Commissioner Bremby said it was the intent of the sponsors of the legislation, Senator Fasano and Senator Looney, that the State not build an HIE but look to procure HIE services from states or organizations that are already operational and effective in their space.

Mr. Miller said the two factors with Zato are time and leveraging of existing assets. If Zato is already deployed in the data center, to get anyone else engaged at this point would take two or three months. At minimum the Council will learn and at best the solution fits the need. Mr. Miller said the information presented today starts becoming actionable. Anthony Dias said the Council has done a lot of thinking and work around what the Zato technology means and he would hate to see that work laid aside at this point, but rather build on it. He suggested a spec document be created to inform an RFI process for Zato and others. The struggle with Zato has been that their presentations and information to date has been around all of their capabilities, instead of information regarding the specific needs of the Council. If the Council is able to create a spec and try an RFI process with Zato as well it may help with the escalation of understanding of how Zato can solve for the Council's technology requests. Mr. Katz agreed and said his concern is that he does not feel comfortable enough with what Zato has shown the Council to understand the health care area in a way that the Council needs. He agreed with Dr. Dias in presenting a spec to Zato and seeing what they respond with. Mr. Katz said that the challenge will be if Zato responds unfavorably, there is not a lot of time to go somewhere else. Tiffany Donelson agreed and said the original intent of the two Design Groups was to have a focus on the Zato pilot and look at long term solutions. In the creation of one large group, she urged the Council not to lose sight of the original intent of the two design groups. Commissioner Bremby said we need to run in parallel, bring requests to Zato to view the technology in January 2016, while simultaneously developing an RFI so the Council can ask Zato to reflect their response

based on what is actually needed and be prepared to issue that for someone else should the need arise long term. Dr. Agresta remarked that the space of interoperability is evolving. He said it may be helpful to create educational material to help members understand how fast the space is evolving and to understand what may be solvable in a year or two that isn't solvable now. The EHR vendors are opening up their applications such that you can get at certain data layers which may provide more quality measures than originally anticipated.

Mr. Katz recommended Commissioner Bremby's suggested next steps of requesting the Zato demo for January 2016 and in parallel develop an RFI for Zato to respond and others to respond to if necessary, and to move forward with one Design Group, as a motion. Dr. Checko seconded the motion. Dr. Hunt remarked that whatever tool the HIT Council decides to move forward with should be easily adaptable into the HIE. Dr. Camp asked what the pilot oversight group is asking Zato to demo in January. Dr. Tikoo said the group met only once. She said the question is, who are the people we will pilot test with? Where is the data coming from? What are we collecting it? Are there agreements? First we have to determine criteria before we do the pilot. The providers will be paid based on what the technology captures and computes, will the groups agree to the number the technology comes up with? She said as a group, the HIT Council needs to define what they are asking Zato to do and what will comprise a successful pilot. Victor Villagra asked if and how the data will be parsed, organized and integrated? Claims data have been used as proxies for clinical data, there is a clinical metric that comes out of claims with time lag that is 6 months etc. Clinical data can be more real time or batched in quarters, and then there is lab and pharmacy data and encounters. These processes are complex and require intimate knowledge. Who is in charge of mapping out this integration of claims and clinical data? Commissioner Bremby said as of now there is no one in charge of mapping the integration of clinical and claims data, however the solution that will be demoed in January will speak to that integration. Commissioner Bremby commented on the notion of Zato's lack of experience in the health care setting, which is patently incorrect. Zato is in the medical space, for example, the medical facility in Springfield, Massachusetts. Commissioner Bremby reviewed the motion on the table, which was to consolidate the two Design Groups into one and complete a parallel process with the Zato demonstration and iteratively develop an RFI so the Council can issue that back to Zato to respond to and then issue the RFI to other vendors. All Council members were in favor.

7. Q&A

Ms. Moratti reviewed the frequently asked questions detail on slide twenty-five of the presentation. In reference to question number one on that slide, Ms. Moratti opened the floor to discussion. Commissioner Bremby said he thinks the Council risks losing the expertise and the knowledge if people are recused from Design Teams because of the company they represent. The Council can benefit from all the information they can receive. Dr. Checko recapped an earlier discussion involving Amanda Skinner's participation in the pilot group. The Council's notion was that sometimes you need input from the best source. She said perhaps the issue could be taken to a higher level because with the pilot the Council will need to address the types of people out there that are capable in executing what the Council is solving for. Mr. Miller commented that Optum is the largest healthcare company in the country serving payers, providers, and government entities with a variety of things. In one sense, Mr. Miller said, the HIT Council is to establish the guidelines of what a solution could entail that would be successful. Mr. Miller said he has raised the issue of participation several times because he wants to avoid any perceived or actual conflict issues around how he participates in regards to potential technological solutions. Mr. Miller has

not participated in any Design Teams to date, and will not if a conflict is perceived. He will recuse himself upfront if there is a conflict. Dr. Agresta said there are two levels of participation in the groups. The first is expertise and knowledge to educate participants in what is possible and what is deployed and not represent their own technology. To a large extent given the range of knowledge and skills that are represented in the Council the education that is possible is really important for that group to understand how these things work. Dr. Tikoo said the Council should get clarity based on the state procurement process. Ms. Veltri said participation is allowed except in regards to the RFP where if the company will be bidding on an RFP, the Council member cannot serve in designing the RFP. For example, the PMO drafted the PTTF's RFP for the AMH program to allow medical homes to be at the table without being in conflict. Ms. Veltri said the PMO delegates each Council to determine their own interpretation of their Conflict of Interest protocol. Commissioner Bremby said the parameters are moving from no involvement to what manner of involvement is appropriate. There was a suggestion that the PMO check in on the legality and restrictions and that will inform how the Council moves forward. Commissioner Bremby said it is the intent to advise the Council on the matter before the Design Group is stood up. Mr. Miller said there is no intent for Optum to bid on SIM HIT initiatives but it is still unclear how it will evolve.

8. Next Steps

Ms. Moratti reviewed next steps. The Council confirmed a motion on the path forward and the PMO will send out a summary of that path forward in terms of one Design Group and pursuing on parallel paths the RFI. The PMO will communicate back to committee the process by which they will receive ongoing feedback on the Logic Model. The PMO and procurement department will determine where to draw the line in terms of participation in the Design Group and report back.

The meeting adjourned at 12:00pm.