Vermont Health Care Innovation Project
HIE/HIT Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, January 20, 2016, 9:00am-11:00am, Ash Conference Room, Waterbury State Office Complex, 280 State Drive, Waterbury.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Simone Rueschemeyer called the meeting to order at 9:08am. A roll call attendance was taken and a quorum was present. Eileen Underwood moved to approve the December minutes by exception. Stefani Hartsfield seconded. The minutes were approved, with two abstentions (Kaili Kuiper and Brian Isham). Simone noted two major accomplishments at the end of 2015: • CHAC Gateway completed. • ACO Gap Remediation	
2. 2015 Year in Review and Workplan Review	Georgia Maheras presented on the project's work and accomplishments in 2015 (Attachment 2a). Sarah Kinsler presented the group's 2016 workplan (Attachment 2b), emphasizing that the workplan objectives are based on our project milestones, and focus on the HDI Work Group's tasks over the next year (rather than staff or contractors). • Mike Gagnon asked for more information about row 8, on building a cohesive strategy for data warehousing. Georgia noted that she and Craig Jones are leading this work, but have not yet developed a process or made significant progress. Georgia and Craig expect to bring this topic back to the group in late winter or early spring.	
3. Updates	*DocSite Clinical Registry:* Georgia Maheras announced that the acquisition and migration of the DocSite clinical registry is complete; more information to come from Craig and the Blueprint in future months. *VCN Data Repository:* Simone Rueschemeyer provided an update. VCN has contracted with NORC to complete this work, with kick-off meetings occurring this week.	

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	ACO Gap Remediation: Mike Gagnon announced that VITL has completed 64% as of the end of December. Recent accomplishments include collecting inpatient CCDs from UVMMC. Mike clarified 64% represents the percentage of beneficiaries of OneCare treated by organizations which VITL is connected to. Georgia noted that non-ACO providers can utilize this information if they have proper permissions in place. *ACO Integrated Informatics Proposal:* Georgia Maheras provided an update, and noted that this was also discussed at the 12/2 Steering Committee and 1/15 Core Team meeting. In December, the Steering voted to send this proposal, along with the VITL ACO Gap Remediation Proposal, back to the HDI Work Group for further review and prioritization. The ACO Integrated Informatics proposal is being reconsidered by the ACOs and a revised proposal will likely be brought back to this group in the coming months. The Steering Committee motion on this proposal will be clarified at their 1/27 meeting. • Dale Hackett commented that the Steering Committee motion clarification is mostly about wording. Susan Aranoff noted that the Steering Committee motion asked this group to prioritize projects in the event there is limited funding. • Dale Hackett reminded the group that data and data analytics need to be supporting improved care and outcomes for individuals. *Telehealth Pilots:* The bid review team has selected two apparent awardees at this point; the State is in contract negotiations with the apparent awardees. *New GMCB Staff Member:* Roger Tubby is the new GMCB Director of Data and Analytics. He will be a voting member for GMCB going forward.	
4. Data Utility/Data Governance	Georgia Maheras introduced this agenda item (Attachment 4). Lawrence Miller has requested this group discuss a statewide data utility and HIE governance structure, and provide comments and recommendations to him. Georgia provided some framing questions. • Brian Otley clarified that the utility is around health information, not data generally. Other areas of state government are off the table. Brian noted that he works for a regulated utility (Green Mountain Power), where regulation simulates a competitive market to avoid duplicative infrastructure. o VITL has been in the process of building out a data transport function across the state, and a lot of work has been done to get to a solution. A utility could mitigate some challenges VITL has been faced with so far (gaps in funding, varied focus, contracting challenges), but it would also constrain VITL in other areas. The group discussed the following: • Mike Gagnon noted that VITL identifies a significant portion of its work as "public good" – VITL wants anything they create or collect to be valuable to as much of the population as possible, but has had to	

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	focus on clinical data first. Working on population health data and sending data to the Blueprint has not been the primary focus thus far. Funding is an ongoing challenge, and SIM has helped to fill in the gaps, but eventually we will need to figure out a funding model that makes sense and is sustainable. GMCB has approved interoperability criteria, but they aren't mandated or enforced yet. This could be an opportunity to institute some requirements for providers that would make data sharing easier and more useful. • Chris Smith provided written comment. He commented that the crux of the matter is how to fund this going forward. He is reluctant to embrace creating a utility because he believes this is too small at the moment, but this needs to last for the next few decades and we need to pay for the overhead for it. Georgia clarified that this is not just about funding, but is more about the concept, scope, and structure of a utility. • Susan Aranoff asked whether Lawrence has put time parameters around this. She noted that we'd asked Stone Environmental to look at what other states have done in this area, and whether any have utility models. Can Stone do a national review with pros and cons of different models? It would be good to learn from earlier adopters. o Mike Gagnon doesn't believe there is a lot to learn from other states – we're ahead of most, and trying something that is unique, and all states are still learning. VITL is trying to learn from other industries rather than other states, since other industries are closer to achieving what we're trying to do for health data. o Larry Sandage commented that the HDI leadership team is in touch with other states as well (through ONC technical assistance), and we can learn from them. Some other states have set up robust governance structures, including Colorado, and we do want to learn from their experience. There are comparable models in other states. • Georgia suggested talking about data utility and governance separately, and refocused the discussion on data utility. She noted that there are few states pursuing data utility in the way Vermont might, but we have a lot to learn from others on governance. Lawrence would have loved this feedback in late 2015, but there is no firm deadline – this will support ongoing state planning. • Dale Hackett commented that there is overlap between utility and public good – • Brian Otley suggested defining the scope of the utility. A utility will have a scope of work that is noncompetitive monopoly because it supports the public good and requires significant infrastructure; the state simulates a competitive market through tight regulation. We want the functions of the utility to be as tightly defined as they can be to encourage the competitive market outside of the utility scope. What are the functions of the utility? o Brian: Data transport, from provider organization to any other entity as appropriate. o Steve Maier: We want good data, so need a quality component to be part of scope. The utility would have the authority to identify the mechanisms they will use to clean data and to specify for data-producing organizations what they need to do to provide quality/clean data. o Mike Gagnon: Standards around collection, transport, and quality. Includes semantic capabilities of	

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	data. Might also consider creating something that would allow users to open up data ("service bus") with proper permissions and confidentiality protections to allow others to create applications to work with the data. "We should be developing the App Store without developing the apps." This would bring in the free market and make money to help fund the utility. Brian added that this describes a data platform that would be responsible for having high penetration, high quality, and high accessibility, and would allow others to use this platform to create other things. Having competing platforms for this would be really hard, and expensive. o Roger Tubby: Privacy and security. Entities that would use this utility would have different needs and would need data not available publically. Mike Gagnon agreed, and noted that we need to have a path for organizations to appropriately use identifiable data. o Steve Maier: Upstream work to develop the use cases that drive our need for data will be key. When we started work on the VHIE a decade ago, we were working to improve and support the clinical setting, and only later started talking about panel management and population health. Does this just include clinical data, or also VHCURES, VDH, Labor, Corrections? We need to clarify what we're trying to do and why we're trying to do it. We might want a single place where people can get all of that data in aggregate as we need it. The utility might not need to be the custodian of all of those datasets, but they would need the authority within their scope to receive datasets from other places to address the variety of use cases. Brian Otley commented that there is a difference between transport of data and warehousing/archiving of data. There are arguments for leaving those separate, or keeping them together. Brian also commented that we can't predict all future use cases, and it's the ease, quality, and accessibility of data that will support innovative and creative use cases. Mike Gagnon added that it should be relatively low-cost to solve individual problems, rather than create new, massive systems. o Chris Smith: If someone wants data from a data producer, do they have to go through the utility? Brian believes the utility would at the least enforce standards about how this data is collected (so it's done in a way that's additive to what's existing, not incompatible). This could be a next priority for the utility to create. Mike Gagnon commented that VITL has a process like this for organizations that want to be part of the VHIE, which a series of steps to connect fully – there are various levels of connection and data contribution. o Susan Aranoff: The role of a strong consumer advocate can't be underestimated. Vermont has regulations about patient access to information without an appeal process, and which consumers don't know about. She also commented that home- and community-based services providers need access to data. Payment for participation (and data submission vs. data viewing) will be a key issue for many providers. These are ongoing issues that have played out throughout the SIM grant. Simone Rueschemeyer added that consent management is a key issue. o Brian Isham: A key question will be who owns the data. We have data at UVM, at VITL, managed by Medicity, and it's not clear who would own it. What happens if Medicity stops operating, for example? Brian Otley agreed that this is a key question, though it may be a governance question.	

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	In the utility model, the utility might own the pipes through which the data flows, but not the data itself. This requires more discussion. Steve Maier commented that he thinks the answer to this question will be very dynamic over the next decade. Generally, we believe records are owned by providers, not individuals, though individuals have a right to access their records. Steve commented that he believes that in 10 years, we will see data as patient-owned, at least in part. That makes providers and others uncomfortable. o Stefani Hartsfield: We're not going to decide today what the answer is – we need to talk about process. Warehousing is a key issue, as is aggregation and analysis. Mike is identifying apps as the key to analysis and aggregation, but many organizations at the table here are already doing this or building systems to do it, and many of us are doing our own analysis. We should consider that as a function of the utility. SASH is piloting VITLAccess for nurses, but is finding that it's not particularly useful because they have access to the data through another mechanism. It's also a challenging to get information to patients who request it, and that requires a considerable amount of consumer education. Simone commented that some of this is around ease of access. o Eileen Underwood: Likes the idea of scoping this at data transmission. What data goes in? VDH collects an enormous amount of information from providers now (immunizations come through the VHIE). VDH needs lab reports for reportable diseases, but in a different format than what comes through the VHIE. Would scope also include identity management? VDH has had to build its own identity management system to ensure data is attached to the correct individual when it comes to VDH. o Steve Maier: There's a lot we can learn from current utilities and how they're regulated, but would caution against assuming all of what we have set up for regulating power, for example, will be what we need for health data. He noted that the public service board has been around for a century, and has had a lot of evolution during that time. We may not want to start out with all of the regulatory infrastructure. Brian agreed and noted that some of the principles may be right, but structure might be wrong. • Brian Otley: Every time we put a function into place, we need funding to sustain and maintain it. There are a number of ways we could approach funding (State-funded, user-funded, value-funded). o Mike Gagnon: A hybrid model – core public good funded out of a State fund, but as the value proposition builds, that becomes user-funded. The core could be something everyone gains access to, but to build onto that, users will fund it. PatientPing is an example of how this plays out. o Stefani Hartsfield: We know EHRs' main strength is data collection, not aggregation and analysis. A lot of community-based providers' systems are not built to support this. Instead of building this infrastructure in provider settings, put this money into building a tool for everyone – this could also work for other places where providers are looking to improve their systems. Simone commented that timing, incentives, and requirements are key factors here. o Ben Watts: Dept. of Corrections now has VITLAccess with Centurion, its contracted health provider. DOC has nearly completed implementation of an EHR that meets 2014 MU standards. He	

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	suggested casting a broad net to catch DOC, HCBS, and other populations that are at-risk and complex. Simone commented that Part 2 data plays into this significantly. o Mike Gagnon: Recent meeting with IBM Watson Health – this is exactly what they're trying to do, and it includes social data, genomics, and much more. They're building this infrastructure – we're not inventing this from scratch. o Chris Smith: Size is a key factor, as is stability. Utilities are often highly stable and not particularly innovative – it's hard to get both. Brian noted that we need to strike a balance there, and a good regulatory structure with incentives or directives will support this. o Roger Tubby: The model might be closer to the internet – it's lightly regulated, we can direct and control the flow of data, it doesn't involve as much widespread physical infrastructure (wires and poles), and it encourages people to want to use the data. o Richard Terricciano: Is there opportunity for a company to exist as both operators of the utility structure and operating in the private space as well? Brian commented that there can be mandated functions and also market opportunities. o Susan Aranoff: There's a public/private dynamic here that is very different from the internet. We've already put millions of dollars into creating the ACO structure and supporting this, and we have a responsibility to ensure this structure supports the public good. There are large areas of Vermont without access to the internet, and large sectors of providers that don't have access to the HIE structure.	
5. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	There was no additional public comment. **Next Meeting:** Wednesday, February 17, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury.	

VHCIP Health Data Infrastructure Work Group Member List

1° Eileen. Underwood
2° Stefani Hartsfield

Member			Member Alternate			Minutes	20-Jan-16
First Name	Last Name		First Name	Last Name			Organization
Nancy	Marinelli	✓	Susan	Aranoff	✓		AHS - DAIL
			Gabe	Epstein			
Joel	Benware	✓	Dennis	Boucher			Northwestern Medical Center
			Jodi	Frei			Northwestern Medical Center
			Chris	Giroux			Northwestern Medical Center
Eileen	Underwood	✓	Peggy	Brozicevic	✓		AHS - VDH
Amy	Cooper						HealthFirst/Accountable Care Coalition of the Green Mountains
Steven	Cummings						Brattleboro Memorial Hopsital
Mike	DelTrecco						Vermont Association of Hospital and Health Systems
Chris	Dussault	✓	Angela	Smith-Dieng			V4A
			Mike	Hall			Champlain Valley Area Agency on Aging / COVE
Leah	Fullem	✓	Greg	Robinson			OneCare Vermont
Michael	Gagnon	✓	Kristina	Choquete			Vermont Information Technology Leaders
Ken	Gingras						Vermont Care Partners
Eileen	Girling						AHS - DVHA
Dale	Hackett	✓					Consumer Representative
Emma	Harrigan	✓	Tyler	Blouin			AHS - DMH
			Kathleen	Hentcy			AHS - DMH
			Brian	Isham	✓	A	AHS - DMH
Paul	Harrington						Vermont Medical Society
Stefani	Hartsfield	✓	Molly	Dugan			Cathedral Square

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20-Jan-16

Member		Member Alternate		Minutes	
First Name	Last Name	First Name	Last Name		Organization
		Kim	Fitzgerald		Cathedral Square and SASH Program
Kaili	Kuiper ✓	Trinka	Kerr	A	VLA/Health Care Advocate Project
MaryKate	Mohlman ✓				AHS - DVHA - Blueprint
Brian	Otley ✓				Green Mountain Power
Kate	Pierce ✓				North Country Hospital
Amy	Putnam	Todd	Bauman		DA - Northwest Counseling and Support Services
		Kim	McClellan		DA - Northwest Counseling and Support Services
~~Ken~~	~~Gingras~~	Amy	Putnam		VCP - Northwest Counseling and Support Services
		Russ	Stratton		
Sandy	Rousse ✓	Arsi	Namdar ✓		Central Vermont Home Health and Hospice
Julia	Shaw	Lila	Richardson		VLA/Health Care Advocate Project
Heather	Skeels	Kate	Simmons Laurie Scharf		Bi-State Primary Care Laurie Scharf
Richard	Slusky	~~Kelly~~	~~Macnee~~		GMCB
		~~Spenser~~	~~Weppler~~		GMCB
Chris	Smith ✓	Lou	McLaren		MVP Health Care
Kelly	Lange	James	Mauro		Blue Cross Blue Shield of Vermont
	27		27		

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VHCIP Health Data Infrastructure Work Group
Attendance Sheet 1/20/2016

	First Name	Last Name			Organization	Health Data Infrastructure
1	Susan	Aranoff	✓		AHS - DAIL	M
2	Joanne	Arey			White River Family Practice	A
3	Ena	Backus			GMCB	X
4	Susan	Barrett			GMCB	X
5	Todd	Bauman			DA - Northwest Counseling and Support Se	MA
6	Joel	Benware	✓		Northwestern Medical Center	M
7	Tyler	Blouin			AHS - DMH	MA
8	Richard	Boes			DII	X
9	Dennis	Boucher			Northwestern Medical Center	MA
10	Jonathan	Bowley			Community Health Center of Burlington	X
11	Jon	Brown	✓	JAB	HSE Program	X
12	Peggy	Brozicevic	✓		AHS - VDH	M
13	Martha	Buck			Vermont Association of Hospital and Healt	A
14	Shelia	Burnham	✓		Vermont Health Care Association	X
15	Narath	Carlile				X
16	Kristina	Choquette			Vermont Information Technology Leaders	MA
17	Peter	Cobb			VNAs of Vermont	X
18	Amy	Coonradt			AHS - DVHA	S
19	Amy	Cooper			HealthFirst/Accountable Care Coalition of t	M
20	Diane	Cummings	✓	dcc	AHS - Central Office	S
21	Steven	Cummings			Brattleboro Memorial Hopsital	M
22	Becky-Jo	Cyr			AHS - Central Office - IFS	X
23	Mike	DelTrecco			Vermont Association of Hospital and Healt	M
24	Molly	Dugan			Cathedral Square and SASH Program	MA
25	Chris	Dussault	✓		V4A	M
26	Jennifer	Egelhof	✓		AHS - DVHA	X
27	Nick	Emlen			DA - Vermont Council of Developmental an	X
28	Gabe	Epstein			AHS - DAIL	MA
29	Karl	Finison			OnPoint	X

30	Jamie	Fisher			GMCB	X
31	KIm	Fitzgerald			Cathedral Square and SASH Program	MA
32	Erin	Flynn			AHS - DVHA	S
33	Paul	Forlenza			Centerboard Consultingt, LLC	X
34	Jodi	Frei			Northwestern Medical Center	MA
35	Leah	Fullem	✓		OneCare Vermont	M
36	Michael	Gagnon	✓		Vermont Information Technology Leaders	M
37	Daniel	Galdenzi			Blue Cross Blue Shield of Vermont	X
38	Joyce	Gallimore			Bi-State Primary Care/CHAC	X
39	Lucie	Garand			Downs Rachlin Martin PLLC	X
40	Christine	Geiler			GMCB	S
41	Ken	Gingras			Vermont Care Partners	M
42	Eileen	Girling	✓		AHS - DVHA	M
43	Chris	Giroux			Northwestern Medical Center	MA
44	Al	Gobeille			GMCB	X
45	Stuart	Graves			WCMHS	X
46	Dale	Hackett	✓		Consumer Representative	M
47	Mike	Hall			Champlain Valley Area Agency on Aging / C	MA
48	Emma	Harrigan	✓		AHS - DMH	M
49	Paul	Harrington			Vermont Medical Society	M
50	Stefani	Hartsfield	✓		Cathedral Square	M
51	Kathleen	Hentcy			AHS - DMH	MA
52	Lucas	Herring			AHS - DOC	X
53	Jay	Hughes			Medicity	X
54	Brian	Isham	✓		AHS - DMH	MA
55	Craig	Jones			AHS - DVHA - Blueprint	X
56	Pat	Jones			GMCB	S
57	Joelle	Judge			UMASS	S
58	Kevin	Kelley			CHSLV	X
59	Trinka	Kerr			VLA/Health Care Advocate Project	MA
60	Sarah	Kinsler	✓		AHS - DVHA	S
61	Kaili	Kuiper	✓		VLA/Health Care Advocate Project	M
62	Kelly	Lange			Blue Cross Blue Shield of Vermont	MA
63	Charlie	Leadbetter			BerryDunn	X
64	~~Kelly~~	~~Machee~~			GMCB	MA
65	Carole	Magoffin	✓		AHS - DVHA	S
66	Georgia	Maheras	✓		AOA	S
67	Steven	Maier	✓		AHS - DVHA	S

68	Nancy	Marinelli	✓		AHS - DAIL	M
69	Mike	Maslack				X
70	James	Mauro			Blue Cross Blue Shield of Vermont	MA
71	Kim	McClellan			DA - Northwest Counseling and Support Se	MA
72	Lou	McLaren			MVP Health Care	MA
73	~~Jessica~~	~~Mendizabal~~			AHS - DVHA	S
74	MaryKate	Mohlman	✓		AHS - DVHA - Blueprint	M
75	Todd	Moore			OneCare Vermont	X
76	Stacey	Murdock			GMCB	X
77	Arsi	Namdar	✓		VNA of Chittenden and Grand Isle Counties	MA
78	Mark	Nunlist			White River Family Practice	X
79	Miki	Olszewski			AHS - DVHA - Blueprint	X
80	Brian	Otley	✓		Green Mountain Power	C/M
81	Annie	Paumgarten	✓		GMCB	S
82	Kate	Pierce	✓		North Country Hospital	M?
83	Darin	Prail	✓✓		AHS - Central Office	X
84	Amy	Putnam			DA - Northwest Counseling and Support Se	M
85	Amy	Putnam			VCP - Northwest Counseling and Support Se	M
86	David	Regan			GMCB	X
87	Paul	Reiss			HealthFirst/Accountable Care Coalition of t	X
88	Lila	Richardson			VLA/Health Care Advocate Project	MA
89	Laurie	Riley-Hayes			OneCare Vermont	A
90	~~Greg~~	~~Robinson~~			OneCare Vermont	MA
91	Sandy	Rousse			Central Vermont Home Health and Hospice	M
92	Beth	Rowley			AHS - DCF	X
93	Simone	Rueschemeyer	✓		Vermont Care Network	C/M
94	Tawnya	Safer			OneCare Vermont	X
95	Larry	Sandage	✓	LS	AHS - DVHA	S
96	Julia	Shaw			VLA/Health Care Advocate Project	M
97	Kate	Simmons			Bi-State Primary Care/CHAC	MA
98	Heather	Skeels			Bi-State Primary Care	M
99	Richard	Slusky			GMCB	M
100	Chris	Smith	✓		MVP Health Care	M
101	Angela	Smith-Dieng			V4A	MA
102	Russ	Stratton			VCP - HowardCenter for Mental Health	M
103	Richard	Terricciano	✓	RT	HSE Program	X
104	Julie	Tessler			VCP - Vermont Council of Developmental a	X
105	Bob	Thorn			DA - Counseling Services of Addison County	X

106	Tela	Torrey		AHS - DAIL	X
107	Matt	Tryhorne		Northern Tier Center for Health	X
108	Win	Turner			X
109	Sean	Uiterwyk		White River Family Practice	X
110	Eileen	Underwood ✓		AHS - VDH	M
111	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
112	Julie	Wasserman ✓		AHS - Central Office	S
113	Richard	Wasserman, MD, MPH		University of Vermont - College of Medicine	X
114	David	Wennberg		New England Accountable Care Collaborati	X
115	Spenser	Weppler		GMCB	MA
116	Bob	West		Blue Cross Blue Shield of Vermont	M
117	Kendall	West		Bi-State Primary Care/CHAC	X
118	James	Westrich ✓		AHS - DVHA	S
119	Bradley	Wilhelm		AHS - DVHA	S
120	Cecelia	Wu		AHS - DVHA	S
121	Gary	Zigmann		Vermont Association of Hospital and Health	X
					121

Mary Byrne Smith ✓ AHS

Ben Watts ✓

Logee Tubby ✓

Rachel Block

Steve Kappel

Lauri Scharf

Doc - Centurion

AHS - DOC - Health Services

GMCB

Stone Environmental

Policy Integrity

Bi-State