UTAH DIGITAL HEALTH SERVICE COMMISSION MEETING

Thursday May 6, 2021, 10:00 AM – 12:00 PM MT

Room 125, Cannon Building
meet.google.com/mix-bhru-vhf
Phone Number: 559-419-0735
PIN: 367 573 773#

Members Present: Mark Dalley (Chair), Brian Chin, Ben Hiatt, Chris Klomp, Dallas Moore, Kenneth L. Schaecher, Matt Mccullough, Patricia Henrie-Barrus, Preston Marx, Randall Rupper, Seraphine Kapsandoy

Staff Members: Navina Forsythe, Kyle Lunt, Humaira Lewon, Valli Chidambaram, Robert Wilson, Huaizhong Pan

Guests: Heather Borski, Wu Xu, Micah Vorwaller, Joe Jackson, David Cook, Henry Gardner

1. Welcome and Introduction

Mark Dalley welcomed everyone. David Cook, the state director for Utah for Comagine Health formerly known as healthInsight and Kyle Lunt, the new Health Informatics Office director at the Utah Department of Health gave brief introductions for themselves.

2. Approve March Meeting's Minutes

Mark Dalley asked if somebody would be willing to make a motion for the acceptance of the March 2021 DHSC meeting minutes. Trish Henrie-Barrus made a motion and Matt McCullough seconded. All voted in favor.

3. Open and Public Meetings Act Annual Training

Micah Vorwaller gave an Open and Public Meetings Act (OPMA) annual training. The OPMA requires that members of a public body be "provided with annual training on the requirements of [the Open and Public Meetings Act]" (Section 52-4-104) to make sure that people know the whole goal of the OPMA. This training is also the opportunity to let people know about any big changes that happened to the Act from the most recent legislative sessions. There were some significant changes this year as well.

Micah said UDHSC is a public body created within the state statute, Utah Code 26-9f Utah Digital Health Service Commission Act. The OPMA does apply to the commission. The Act gives all the membership requirements. A public body is required to provide public notice of a meeting at least 24 hours before the meeting with, specify the date, time, and place of the meeting, include an agenda that specifies the topics, and be posted on the *Utah Public Notice Website*, etc. A public body may discuss an item raised by the public that is not listed on the agenda but may not take final action on the item at the meeting.

Micah pointed out some of the more recent changes. HB 27 modifies the process of publishing public notice and public information on the *Utah Public Notice Website*. There are new *Utah Open Records Portal Website* and *Utah Open Data Portal Website* to serve as a GRAMA (The Government Records Access and Management Act) request point of access.

SB 72 modifies the provision to prohibit a vote in a closed meeting except to end the closed portion of the meeting. SB 72 provides a majority vote to approve the ending of the closed portion of a meeting. It goes through what can be in a closed meeting and what cannot. People could discuss a person's character, litigation, property matters, criminal conduct, things like that, but they are not to be voted on.

Mark Dalley asked whether closed meeting discussions for topics voted on in the open meeting are available to the public. Micah said that usually the court must review the closed meeting recordings or minutes to determine whether they could be released to the public or whether some information discussed is protected as one of these statutory exceptions to open meetings. Micah and other AGs have discussed internally what needs to be discussed in close meetings, and how to make sure that there's nothing identifiable when it comes back to the open meeting portion and how to put this into effect practically.

SB 125 modifies the statute to require an "anchor location" if a public meeting is held virtually or electronically. So that any materials that were distributed at the meeting are also available to the public through the new data portal on websites.

A public body is required to keep written minutes and a recording of all meetings unless the meeting is a site visit or traveling tour where no vote or action is taken. A recording of the open portions of the meeting must be posted on the *Utah Public Notice Website*.

HB 293 modifies the statute to require a public body that is not a state or specified local public body to post and make available minutes and any public materials distributed at the meeting.

Any final action taken in an open meeting in violation of certain open-meeting provisions of the OPMA is voidable by a court. For closed meetings - it is a class B misdemeanor to knowingly or intentionally violate the closed meeting provisions of the OPMA. A person who willfully disrupts the meeting to the extent order is seriously compromised may be removed from the meeting.

He stated emergency meetings are still possible and it is not required to give 24-hour notice.

The OPMA document should be available on the legislative website.

4. Telehealth Bill Updates

Matt McCullough provided telehealth bill updates. State level legislation was passed this year that impacted mental health access and telehealth. One from a federal legislation level, and two projects that are also related and tied into mental health access and telehealth.

The Digital Health Service Commission and a few of the committee members are part of a telehealth subcommittee, they have been meeting fairly regularly and the focus was on mental health access and telehealth. Federal and state changes during the pandemic allowed access to mental health services via telehealth including the ability to do audio only telehealth and be reimbursed for those services through Medicare And Medicaid. It is critical for access to care for certain populations, elderly populations, and also for geographic areas that have very poor or no internet connectivity or bandwidth.

SB 41 was sponsored by Senator Escamilla. This bill was related to mental health access amendments. It requires a health benefit plan to provide coverage for telemedicine services, including substance abuse treatment, that are covered by Medicare and reimbursed at a commercially reasonable rate. If the plan provides for mental health benefits in-person, then they also have to reimburse via telehealth. All services have to meet appropriate standards of care according to the insurer.

SB 161 was sponsored by Senator Weiler. It's called Mental Health Systems amendments. It would require a health plan to pay the same rate for a telehealth visit that they would pay for an in-person visit. It said that they must pay a commercially reasonable rate. Insurers can negotiate with the providers on what that rate would be as long as it is reasonable.

They are seeing this happen in a lot of other states. The bill also stated that a network provider that provides the telemedicine services may utilize any synchronous audiovisual technology for the telemedicine services that is compliant with HIPAA. This bill also says that DOPL may not refuse, revoke, suspend, or in any way restrict an applicant or licensee's license under this chapter solely because the applicant or licensee seeks or participates in

mental health or substance abuse treatment.

SB 27 and 28, sponsored by Senator Bramble, allow Physicians Assistants (PAs) under certain requirements to practice without the supervision of a physician. They have to meet certain experience, requirements and training. SB 28 allows PAs to independently offer mental health therapy after meeting certain training criteria. These bills expand access to mental health services and through different providers.

SB 53 creates a new license for behavioral emergency service technicians and advanced behavioral emergency service technicians. They have created a new licensing path for EMTs to become trained and certified to respond to mental health emergencies. That will be managed by the Department of Health in the BEMSP. They're also required to set up the training requirements for this new license. They're very interested in including specific training and education on telehealth and how to use telehealth technology in an emergency situation that involves mental or behavioral health needs.

New federal legislation was passed in December 2020, which states Medicare won't reimburse services for diagnosis, evaluation, or treatment of a mental health disorder unless such physician or practitioner furnishes an item or service in person, without the use of telehealth (i) within the 6-month period prior to the first time such physician or practitioner furnishes such a telehealth service to the eligible telehealth individual; and (ii) during subsequent periods in which such physician or practitioner furnishes such telehealth services to the eligible telehealth individual, at such times as the Secretary determines appropriate. This requirement goes into effect when the public health emergency ends.

Matt gave updates on two projects related to mental health access. (1) The Utah Education and Telehealth Network (UETN) did a school-based telehealth project, which included the following: Placeing telehealth kits in 170 schools in 20 rural school districts; Connecting students to school nurses when they can't be there in person; Working with DHS and county mental health authorities to provide mental health. (2) UETN is working with Sterling Petersen, the Department of Health with All Payer Claims Database (APCD), on building a Telehealth data dashboard. The top five data metrics that will be in the dashboard and will be public for anybody to see are: 1. Volume of Claims (in-person vs. telehealth); 2. Top 5 Procedure Codes (in-person vs. telehealth); 3. Top 5 Diagnoses (in-person vs. telehealth); 4. Payment (average in-person vs. telehealth visit); 5. Volume of claims by specialty type.

Mark Dalley clarified the PA law changes. There are certain hour requirements that they have to meet having worked under the direction of a physician. There's nothing in the law that says that an employer has to allow them to practice independently. He also mentioned the concern of the insurance companies on the reimbursement, and thought that still one of the things has to be worked out.

Matt McCullough answered Trish's cross-state question. He said that at the federal level, there was a waiver in place that would allow providers to practice across state lines, but it came back to each state and what each state did. It still requires a temporary license for an out-of-state provider to see a patient in Utah. So, they always recommend checking with the state where the patient is located to see what the state requires.

5. Department of Human Services & Department of Health Consolidation Update

Heather Borski gave the Department of Human Services & Department of Health Consolidation Update. She said that during the 2021 legislative session, the legislature passed HB 365 at the request of the governor's office, and HB 365 state agency realignment authorizes the Department of Health and the Department of Human Services to merge into a uniform united agency the Department of Health and Human Services. The goals of this legislation are to more efficiently and effectively manage public health and human services that are under the state's control. To align health and human services policy for the state and also to promote health and quality of life for individuals accessing services across these two agencies. There's a hope and expectation that the combining of these agencies will improve service delivery for Utahans, and provide service delivery that occurs in a more holistic fashion. Considering both behavioral health, physical health and all of the other human service elements that impact health otherwise known as the social determinants of health. So this graphic shows a visual depiction of what's expected

to happen. Additionally, HB 365 pulls off a small component of Medicaid Eligibility Policy and moves that to Workforce Services. Workforce Services already does much of the eligibility to determination on behalf of Medicaid, but eligibility policy remains in the Department of Health. So, this would move that component eligibility policy, Medicaid eligibility, eligibility quality control and also eligibility adjudication to the Workforce Services. The rest of Medicaid will remain in the Health and Human Services Agency.

In terms of a timeline, the bill passed in March. The bill requires a report presented to the governor and to the legislature by December 1st, and that would outline what the new agency will look like. They will have the 2022 legislative session to make any additional legislative tweaks to make the merger function more effectively. July 1st would be the official start date for the new Health and Human Services Agency. Throughout this entire time, they will be gathering and working with stakeholders to gain input and involvement with their partners.

There's also a public website that's been developed. It's hhsplan.utah.gov. There is a really nice set of resources available about the merger. There's a weekly poll on the site. People can sign up using email, and then they will get regular updates. This site also has an update page that provides a running list of updates. Additionally, there's a feedback form on the site where people can provide input or ask questions which they will ensure are answered. Starting in the next few weeks, they will be having stakeholder Town Hall meetings and will be held every other week. The meetings will be open to any partner who would like to join. This planning effort is being led by a steering committee. The steering committee is made up of the executive directors of the Departments of Health, Human Services, and Workforce Services and includes Deputy Directors and other leadership from these three agencies, and the work groups that have been convened to carry out this work.

Heather thought one of the biggest challenges with this merger is that it is gigantic and they can't do it all at once. A huge challenge is tempering expectations and helping people understand that not everything will be done at once. They won't be a perfectly merged agency by July 1 of 2022. This is just the start and probably will be a three to five year process. That will be iterative over time. Questions about what are the most important things? Where can they make the biggest difference between now and July 1st? What are the most important things that they need to accomplish? So, they have work groups focused on Behavioral Health and Physical Health integration; a Communications work group; a work group that's focused on bringing the Department of Workforce Services and Medicaid Eligibility together, and executive operations work group, licensing and background checks, long-term services and supports, and early childhood coordination. Thinking about the scope of both of these huge agencies, these work groups just reflect a fraction of the work, but they feel that these are where the big gears are right now and the places where they can make the most important changes between now and July 1st.

IT is huge and daunting, and so that will be one of the first things that they are focusing on and under the executive operations team. Navina is helping to co-lead an IT coordination work group focused on many things.

Mark Dalley wanted to know what drove this. Heather said that the state is looking for a greater synergy between the two agencies, greater accountability, better coordination, better alignment. With time, they gained a greater understanding about things like the social determinants of health that impacts an entire person's well-being. Also considering the linkages between Behavioral Health and Physical Health, there are lots of overlaps. There's a huge benefit in integrating Behavioral Health and Physical Health treatment and healthcare to better serve people holistically, individuals holistically. So they have worked together, and this gives them an opportunity to accelerate that coordination and create a better one-stop shop for both individuals and communities to serve them more holistically.

6. American Rescue Plan & the Epidemiology and Laboratory Capacity (ELC) Data Modernization Grant

Navina Forsythe said that as part of the COVID response, a number of needs related to infrastructure were identified across the nation. A lot of the funding that has become available to build infrastructure. There are some American Rescue Plan Act fundings that can be utilized for investments and health data infrastructure. There was some guidance that it can be used to address economic impacts of COVID-19 crisis, support services affected by revenue

reductions, make investments and other things. There's a lot of ways the funding can be utilized. They submitted some ideas and there were a number of things that they had to put into place to help address the needs especially when the cases were high, including requests through the American Rescue Plan to update some systems that were out of date to help with scalability. As they look at goals and objectives later, they are going to be asking for feedback because they do have meetings with the legislature and the legislative fiscal analysts who will ultimately decide where funding should go. The executive directors and the governor are going to get into that and ask the UDHSC to help them and advise them on what they want to submit as their vision, where they want to get to, and where this funding can best be utilized and prioritized.

They will update on data modernization efforts. That comes from a lab grant that Joe oversees. The CDC is really interested in making sure that infrastructure and public health can be updated. So in the next round of funding in July, the CDC wants to fund personnel whose job is to do an assessment of applications within public health, to come up with recommendations and determine where their needs to be updated, and where modernization efforts need to focus. Those are some really good opportunities that they want to take advantage of to help with their IT infrastructure where resources have been really tight in the past.

Joe Jackson added that the second opportunity also includes workforce capabilities and ensuring that the public health workforce can actually utilize these systems, analyze the data and get the data out to the public and the other stakeholders that need it.

Navina also addressed Henry's question about efforts between the state coordinate efforts. She said there have been a number of forums and sharing for different technologies and the CDC is involved. She thought it's a multifaceted issue, it involves federal, state, local and private entities that need to report data. So it's one of those that involves multiple layers and multiple sectors involved in health, and coordination is going to be key.

7. COVID Technologies, Apps & Automated Contact Tracing

Joe Jackson had covered some of the things they had in place and where Utah was kind of a national leader or better off and he also talked about some of the things that they were able to put in place during the pandemic.

The system called Epitrax was developed in Utah with the Department of Technology Services (DTS) in coordination with a Consortium of a few other public health entities across the country. It did originate in Utah and several other states and local health departments use it as well. Epitrax is used by the Utah Department of Health and all 13 local health departments, five tribal public health agencies and the Hill Air Force Base public health office for all communicable diseases surveillance, as well as environmental conditions. They had this coordinated system before COVID, and during COVID they actually added three of those five tribal public health agencies as well as the Hill Air Force Base Public Health office to that group using it.

It was the system that they used for their COVID surveillance and contact tracing. They do have some reporting that comes in through faxes still, they have the vast majority of their surveillance happening for COVID has been done through electronic means. They have electronic laboratory reporting in place, and have had that for years. Over the last few years, they have been working with several health care partners to implement electronic case reporting. They all had syndromic surveillance available as well. A lot of these were stood up either through CDC grants or Meaningful Use and Promoting and Interoperability programs. Over 90% of the laboratories the laboratory data entered into Epitrax has been entered through Electronic Laboratory Reporting (ELR), and that continued to be above 90% during COVID as well. Electronic Case Reporting (eCR) has been a huge help. The labs typically don't have as good of demographic data and information about the visit, and then the eCR supplements that laboratory report when it comes in, and syndromic surveillance (SyS) allows them to follow trends in the community.

In Utah, they have also placed a high premium on automation of processing these data. Joe showed the chart on his slide that over the last week 93% of the ELR and eCR has gone from receipt of the electronic message at the Department of Health all the way into Epitrax and ready for an investigator to act on without a human touching it. They still have 7% roughly needed to either correct something in the data in order to process or have to do some

type of manual deduplication to ensure that they were not creating duplicate events. This system powers the coronavirus.utah.gov dashboard. It also powers a few dashboards as well that are used internally.

In 2016, they went live with electronic case reporting with Planned Parenthood Association of Utah. It was their first electronic case reporting implementation for four conditions: chlamydia, gonorrhea, syphilis and HIV. In December 2019, they completed electronic case reporting with Intermountain Healthcare for pertussis, chlamydia, gonorrhea, salmonella and zika, and they were able to quickly add COVID to that. With the University of Utah clinics, there was a national push by Epic EHR system, which they use to stand up eCR for COVID. So, they were able to start receiving eCR from the University of Utah Clinic system and hospitals in June, and now they are working with the University of Utah to expand that to other reportable conditions.

The council of state and territorial epidemiologists reach out to them about a pilot to enable the use of technology to more easily and efficiently report point of care testing for COVID. They partnered with the council of state and territorial epidemiologists and Blue Mountain and Moab regional hospitals to pilot this technology, so that CSTE was made available. They worked with those two hospitals to give them a tablet. It synced up with the systems at the state in order to report the point of care test without a lot of manual data entry on both sides. It was successful but other approaches took over and they stopped expanding that to other hospitals. Another thing they have done in order to reduce the burden of reporting to public health was that they set up a reporting portal. They had a lot of laboratories that didn't even exist before COVID that didn't have an easy way to report their point of care tests. They can enter the results one by one, or they can do a CSV upload in order to report the results through the portal, and this has actually become the largest volume reporting mechanism for COVID results.

They also expanded into mobile technologies. The first technology was Healthy Together. They worked with the company called Twenty to implement their mobile technology. This was the first contract and it did symptom assessments, messaging, funneling to testing locations, and it was also a secondary mechanism for people to receive their test results. It was initially targeted at doing location tracking to help with contact tracing, but due to privacy concerns that was actually turned off before it fully rolled out. Now for the contact notification and exposure notification, the state is supporting the Apple, Google exposure notification express technology. This is a much more privacy preserving method of allowing citizens to notify each other about potential exposure to COVID. Because of the limitations on the data, they don't have actual good estimates of how widely adopted this is in Utah, but they are seeing people using the codes. One of the advantages to this option is it didn't require the state to build and maintain a separate app. It's just built into the iOS operating system or Google provides an app that people can download in order to use it on Android. This system is fully integrated with Epitrax. So as soon as they get a positive result notification, they actually will send out a key to that cell phone number and that email address if that was reported, and then the person is able to go into the app and tell the positive test results for COVID, and notify anybody that the person was around that meets the criteria over the last exposure period.

They partnered with TestUtah for online access for testing. There were several companies that were part of that, and they allowed system assessments especially during the period where they had constrained testing resources and helped to route people for testing. As the situation changed, as they learned about new symptoms, they were able to relax requirements for testing. They also implemented a system called REDCap. They use that for quite a few things. At the Department they use it for some initial testing triage at the public health lab earlier in the pandemic and then they have heavily utilizing it for the school testing, and their mobile testing teams scheduling and registration for patients. They also use it for a system that does automated contact tracing called ACTS.

They have reached out to communicate with the public in ways that people are more comfortable with nowadays that involves sending text messages. So, they have implemented text messaging capabilities using both Amazon Simple Notification Service (Amazon SNS) as well as texting from a company called Twilio for different aspects of notifications going out to people. This has allowed them to reach populations that they otherwise wouldn't have been able to reach, especially the younger populations. Because they weren't spending all of the time to enter data manually into the systems, they were able to implement these technologies.

They built Automated Contact Tracing System (ACTS) that allows case investigation, contact tracing, contact

notification, and testing referral. It is flexible and can be turned off. They did not use this for all of their cases. The technologies they were using include EpiTrax that integrated as part of the contact tracing process; REDCap for the public surveys; Nextgen connects integration engine and then Twilio for sending the text messages; they also use email for that. So they were able to quickly adapt the technologies available to meet the need.

They also had some internal Integration between different systems at the Department of Health that have been a benefit as well. They had EpiTrax links to the death registry system called Eden through the Department of Health Master Person Index (DOHMPI) via a FHIR API. They were able to connect between EpiTrax and USIIS, the immunization system through DOHMPI via the same API. It allows their case investigators to look up if one of their positive cases has been vaccinated already and to find vaccine breakthrough events without having to manually log into a separate system, and then they can import that data and report as part of the required reporting to the national stakeholders.

Mark Dalley had a question about cybersecurity. It seems like the more technology they develop, the more ways that hackers can find ways to get into the systems. So he asked what to do from a cybersecurity standpoint to keep things safe. Joe answered that they spend a significant amount of time both on the IT aspects of securing the data as well as the policy and procedural aspects. There's a review process whenever they release data to make sure that it can't be identifiable. There are multiple layers of security for all of these systems. They worked with the Department of Technology Services to ensure that securities are in place and meeting all of the necessary requirements. They took the privacy of Utah citizens extremely seriously, and have multiple people who work on the security aspects of these systems. They used technologies that they were familiar with and knew how to secure rather than trying to introduce a lot of new technologies during the pandemic.

Randall Rupper wanted to know how to get the data. Joe answered that they were reporting in three different ways to the CDC. They provided download files for the other external groups, and also used IBIS to handle a lot of data requests. They have also got the data flowing into different dashboards and file downloads that are a little bit easier for people to get the data. They don't release identifiable data, the state code is very strict.

8. HIT Strategic Plan

Navina revisited and recalled some things that UDHSC had done. Part of what this commission has done is the development of a Utah Health Information Technology Strategic Plan for the state to guide direction and efforts and resource decisions and so on. The plan has been in place since 2016. It was set up to align with federal plans and then adapted for Utah with different guiding principles. It started before 2016 with the State Innovation Model, and they had a number of projects that they were tracking and updating then. They updated the plan in 2018 and 2019, and did not in 2020 because of COVID. It's time to look at the strategic plan again. She mentioned the projects that have been tracking (for detail, see https://hio.health.utah.gov/wp-content/uploads/2021/05/UDHSC-May-2021-DHSC-Project-Update_Master-Document.xlsx) including those that were closed or moved into maintenance stage and those that are open with a red yellow green status based on a decision of this Commission. They will go through in a future meeting

There was a new federal plan. Before going through the federal plan, Navina raised some questions and asked the committee to think. Where Utah's needs are? Where should they be focusing in as they are looking at those funds as they are deciding as part of the consolidation with the Department of Human Services, and the planning for that IT infrastructure as well as broader infrastructure? What do they want IT to look like in Utah? What and where are their biggest gaps in needs that they should be focusing efforts and funding on? She mentioned the Directors across Health and Human Services have talked about priorities of being able to track a client or a person that they interact with through the system and across time about what services have they gotten, what were the outcomes, What was the cost, Right now what different systems. There's some manual matching that would have to be done and pulling data together to be able to answer some of those questions. They are also interested in capabilities such as telehealth that no service has been delivered through before but recognizing the need because of COVID, and do they have some of those infrastructures in place?

Then she went through the new federal plan. She said that one of the focuses from the National Coordinator is looking at the patient's right to control their health and access and control their health information. She said that how information is utilized is important but it's also important to look at security and privacy, and finding balance between making data accessible, but respecting the privacy rights of the individual. There's been a lot of discussion related to that as they looked at things like the Social Determinants of Health efforts on how they can facilitate closed loop referrals but also give the patient empowerment and control over giving their consent for some information sharing.

The Federal Health IT plan is part of the Public Health Services Act and charged to the Office of the National Coordinator to do a federal plan to use for prioritization of resources, coordination of efforts to establish priorities for the private sector to look at and to set benchmarks and assess progress. A number of federal entities are tasked with giving input into this, as well as the Health Information Technology Advisory Committee, and then posted for public comments for several months to develop the plan.

The Federal Health IT vision is a health system that uses information to engage individuals, lower costs, deliver high quality care, improve individual and population health. The Federal Health IT mission is to improve the health and well-being of individuals and communities using technology and health information that is accessible when and where it matters most.

The Federal Health principles are: put individuals first; focus on value; build a culture of secure access to health information; put research into action; encourage Innovation and competition; be a responsible steward.

They recognize the challenges in healthcare and are looking at how they can work to overcome these challenges, such as increasing healthcare spending; poor health outcomes; increasing rates of mental illness and substance use disorders; access to care; access to technology; access to electronic health information.

They want to do that and take advantage of some opportunities in a digital health system, like empowering patients; moving to value-based care; advancing Interoperability; promoting new technologies; reducing regulatory and administrative burden; protecting privacy of health information; and securing health information.

The strategic framework is under four goals. Within each goal, there's different objectives and strategies.

Goal 1: Promote Health and Wellness
- Objective 1a: Improve individual access to usable health information
- Objective 1b: Advance healthy and safe practices through health IT
- Objective 1c: Integrate health and human services information

Goal 2: Enhance the Delivery and Experience of Care
- Objective 2a: Leverage health IT to improve clinical practice and promote safe, high-quality care
- Objective 2b: Use health IT to expand access and connect patients to care
- Objective 2c: Foster competition, transparency, and affordability in healthcare
- Objective 2d: Reduce regulatory and administrative burden on providers
- Objective 2e: Enable efficient management of health IT resources and a nationwide workforce confidently using health IT

Goal 3: Build a Secure, Data-Driven Ecosystem to Accelerate Research and Innovation
- Objective 3a: Advance individual- and population-level transfer of health data
- Objective 3b: Support research and analysis using health IT and data at the individual and population levels

Goal 4: Connect Healthcare with Health Data
- Objective 4a: Advance the development and use of health IT capabilities
- Objective 4b: Establish expectations for data sharing
- Objective 4c: Enhance technology and communications infrastructure
- Objective 4d: Promote secure health information practices that protect individual privacy

For measuring progress, the plan including:

Areas Measured for Federal and Industry-Wide Progress

- Use secure, standards-based APIs to provide electronic access to health information
- Promote Fast Healthcare Interoperability Resources (FHIR®) across federal organizations and the populations they serve for a variety of use cases
- Implement and expand United States Core Data for Interoperability (USCDI) data classes and elements for a variety of federal use cases and the populations they serve
- Deter information blocking practices through federal authorities and investments
- Encourage data exchange across networks at national and community levels

They want this to be an outcome driven plan and in looking at the needs of multiple partners, including individuals, populations, caregivers, payers, etc. ONC is planning on tracking this and reporting it. They reported on measures previously such as adoption of certified EHRs, etc. (for detail, see https://hio.health.utah.gov/wp-content/uploads/2021/05/UDHSC-May-2021-FedHealthITStratPlan_WebinarSlides508.pdf https://hio.health.utah.gov/wp-content/uploads/2021/05/UDHSC-May-2021-Federal-Health-IT-Strategic-Plan_2020_2025-1.pdf).

There's a couple of different things that they need to look at. The immediate need right now is where do they see the greatest needs that they want them to think about for investment for the funding? which of these goals and strategies should they target? Can they provide more funding to UHIN and to bring more providers on board to expand some of the sharing or the connectivity? That's the immediate need.

Navina suggested that in future meetings they need to talk about how they update their state HIT plan, and do they align with these goals and objectives and strategies? She wanted people to be percolating on that in preparation for future meetings.

Brian Chin shared some thoughts. He said that the ONC director talked at their meeting the day before that related some interesting points. One of the things is that the 21st Century Cures Act is a component of that. They are very interested in pilot programs and innovation models that could work across the public health sector to innovate and to improve their infrastructure. One of the things he talked about with Dr. Ward is the interoperability. Brian thought it is the key aspect of focus on modernized APIs connectivity methods. He also mentioned having an overall state platform. He said the ONC coordinator answered “platforms” for the question about what most excites in the HIT space. Brian thought the key aspect that they should focus on is what is the state's platform; how are they interconnected; how they interoperate; how are they using modern cloud products; whether that's AWS, Google or Microsoft; and how are they leveraging those products to interoperate and connect the disparate data sources not only within their own state organizations, but with other community partners. Another key component is how they leverage the overall big data sets data fabric. He thought this committee would want to think about along with the idea of platform and interoperability.

He thought three pillars or a couple pillars that this committee could rally around would be great as a starting point and then get more detailed around what that looks like. They have also been discussing with UHIN partners and with Comagine their data analytic shop and how they could possibly assist in semantic normalization, data interoperability, etc.
Navina thought that discussion of platforms is really interesting. With the Social Determinants of Health efforts, this has been a challenge with multiple states. The discussion of do they adopt a platform and try to get everybody to use it versus do they allow for multiple platforms and just focus on the interoperability in the modernized APIs. There's been a presentation on that by Greg Bloom who said that interoperability is the way to go because there hasn't been success getting folks on a platform. That is something that the Social Determinants of Health Group is looking at. She will send a link to that video to the committee members.

Regarding the platforms, Ben Hiatt mentioned the possibility of a third way, called a DHT or a distributed hash table. It's opposite of a hub and a central source and it's very decentralized, very closely related to a blockchain.

9. Discussion

The committee members discussed the vision for the new integrated Health and Human Services and Brian's idea of the pillars. Where are the key pillars? What's your vision of things will look like in the future that can be infrastructure or functionality? Where the biggest gaps are to reach that vision?

For the vision, Navina thought is getting the data that you need at the time you need it.

Trish Henrie-Barrus said that she always thinks about collaboration. She would like to know things that are going on in other committees or state agencies so that this committee could help and supplement what they're doing, especially for mental health. Huntsman Mental Health Institute is doing huge mental health. What are they doing, how can they help the Institute and how can the Institute help them. That is huge going forward.

Navina said that they are facilitating those collaborations as they move forward.

David Cook thought of a couple of things that are important in Utah for the value based medicine and burden. He thought about how they create the IT platforms and infrastructure to help support providers, showcase their outcomes and their strengths, and at the same time, not make it in a burdensome fashion.

Randall Rupper thought another goal or pillar may be allowing information to be available for research and learning health systems. He thought one of the key things about having Interoperable data is that it allows for better research and decision-making that he thought should be kept in mind.

Preston Marx thought about the consolidation. For the underlying data, can they consolidate platforms? There are a lot of opinions about whether they ought to promote a singular platform. He added something like a common communication method to promote interoperability.

Mark Dalley mentioned that there are a lot of dollars associated with interoperability with getting systems to talk to one another and being able to share. A single platform would be wonderful, but he thought that they missed that opportunity when they spent all the money on the EMRs and nobody talked about how to make sure that they all cooperated or went for a single EMR, which probably would have been impossible. One of the concerns he had as a small hospital was that every time they write an interface with a larger system, it costs money. If they are truly going to be interoperable, they have to make it affordable for everybody to be able to participate.

Navina Forsythe thought that it doesn't have to be a platform, they can work to minimize platforms. They have multiple applications in the Health Department and some efforts have been done to reduce them to help with efficiency, and with the interfaces. She wondered if there is a way through standardization of format and APIs where you don't have to do as much customization of all these individual interfaces but you can build something that is consumable and could be reused with different partners.

Brian agreed that standardization is important, whether that's for technological standardization or a data standardized data model. Those are all sorts of ways you can do. The challenge there is sort of getting everyone rallied around a common standard and adhere to it. That had been the challenge at least for UHIN in the past.

Navina summarized the discussion which included looking at data as a core; collaboration and communication; value-based medicine; and supporting that in a way that's not overly burdensome. Making sure that the data is available for research, learning health systems, decision trees to support clinical work. Looking at where they can consolidate and reduce platforms, which may reduce burden and cost-related to interfaces; where they are looking to interoperability and as much as they can look at standardization; and if there's a way for funding to help some of the systems who need to build that interoperability but don't have as many resources themselves; and common communication method.

Navina asked that in a future meeting that the group think about how they want to update the state HIT plan, and do they just align and adopt what is in the federal plan and then spell out how it applies to Utah. She will work with Mark, Preston and Rand, either in July or September. And what they might want to target and track. How much of the individual project tracking that you want to do? They had about 40 projects on the list. if you want to keep

tracking to that level. They will work on what they want to do at one of those future meetings, and that would be very helpful.

10. Wrap Up

Mark Dalley thanked everyone and thanked Navina and her staff for helping run this meeting. There were no further comments or questions, the meeting moved to adjourn at 12:00 PM.