

**State of Connecticut
State Innovation Model Design
Health Information Technology Work Group**

**June 3, 2013
Meeting Minutes**

Location: Connecticut Valley Hospital, 1000 Silver Street, Middletown, CT

Members Present: Mr. Mark Raymond (Chairman); Mr. Michael Michaud (Co-Chairman); Mr. Daniel P. Carmody; Mr. John DeStefano; Dr. Alan Kaye; Ms. Bernadette Kelleher; Mr. Daniel G. Maloney; Mr. Mike Miller; Mr. Dan Olshansky; Mr. Barry Simon; Dr. Minakshi Tikoo; Dr. Jonathan Velez; Dr. Victor Villagra; Mr. James Wadleigh; Mr. Joshua Wojcik

Members Absent: Mr. Mark Root

Meeting convened at 9:00 a.m.

Welcome new additions to the work group, discuss goals for today's meeting, review synthesis from first work group meeting and SHIP's vision for care delivery, payment, and HIT innovation

There were new additions to the work group. There have also been ongoing one on one conversations with work group members. The group reviewed the meeting agenda and the discussion from the prior meeting. The overwhelming feedback has been that data is crucial to the success of the initiative and that there are existing assets that can be leveraged. There is also a need to understand current gaps and non-technology related issues in information flow.

Share current hypothesis of the care delivery work group: population health model that takes a whole-person centered approach to overcome barriers in the stage of health

There was a review of the structure of the work groups. The Care Delivery work group is developing a population health-based care model that builds on person centered medical homes and accountable care organizations. The goal is to expand pockets of care to a uniform delivery system that impacts 80% of Connecticut's population over a five year period and reaches across Medicare, Medicaid, the Children's Health Insurance Program, and private insurance. The work groups must be coordinated with one another and provide back and forth feedback. The goal of the Health Information Technology Group is to develop technological solutions that will enable also the care delivery and payment reform models to operate.

Discuss initial hypothesis for HIT infrastructure design that could support the components of the recommended care delivery model

The group further discussed how the care delivery group's decisions would impact their own decision making process. They reviewed four groups of capabilities: payer analytics, provider-payer-patient connectivity,; provider-patient care management tools, and provider-provider connectivity. They discussed putting claims data to greater use, integrating quality metrics, the development of work flow systems, how to change provider operations and get buy in. While there is work in developing the All Payer Claims Database, there is not an equivalent database for clinical data. Group members agreed it was important to integrate claims and clinical data, however, they would need to build clinical data capture capabilities. The group discussed creating an implementation strategy where they started small and built up capabilities over time. Stage One

would be the initial launch. Stage Two would focus on ways to accelerate impact. Stage Three would be long term solutions.

Break out to review the capability road map proposed by the initial hypothesis and refine based on CT specific considerations (e.g. existing HIT assets and capabilities)

Work group members broke out into four groups to review a list of capabilities and determine how to phase the roll out of those capabilities. The goal of the exercise was to determine what each stage of the roll out would look like. There was a question regarding the inclusion of governance structure. Group members were told they could make that determination.

Group One looked at the capabilities by exception and came up with several key questions/takeaways. One was whether there could be different paths for different people. For a smaller, less technologically advanced provider, could they start small and move forward? For example, if a provider implemented something basic, would they qualify for one benefit, but they moved to something more advanced they would qualify for a different benefit. The idea was to make it easier for some to begin but allow more advanced providers to move ahead more quickly. The group also discussed governance: if they move towards patient/provider portals, how would that operate? Would there be one portal? They also discussed patient consent barriers and how to get buy in from providers without forcing things on them.

Group Two focused on the Stage 1 roll out and began working on Stage 2. They discussed providing a foundational element that would be upfront in the first stage. They also talked about specialist facility analytics. Would that element need to be central? They talked about areas of distinctiveness with regards to a patient portal. The group felt there was a need for connection across different capabilities to provide a picture of who an individual patient is. If the connection is not made up front, it may be difficult to ever establish that capability. While the group liked this idea, they were unsure if it would be feasible to achieve this within the first year. They discussed the politics of implementing centralized analytics within a PCMH model. Different technologies may provide different answers. They also discussed tying incentives to the outcome.

Group Three looked at payer analytics as there are limits to what can be achieved by only using claims data. They discussed the need for integrated data, and what the minimum amount of clinical and claims data would be needed as a starting point. They also discussed provider/patient-care management tools. They discussed what was meant by care coordination, as it could mean different things to different people. In the first stage, they looked at integrated analytics, keeping a whole person focus, and introducing patient satisfaction tools. The Department of Mental Health and Addition Services has some of these technologies in place that can be leveraged.

Group Four discussed behavioral health and what was already being done in the system. They talked about statewide governance. The DMHAS system is broken into regions across the state. They could look at how governance already is happening. They talked about defining the data models that are going to be used and about tailoring health homes to specific populations. The DMHAS system is set up to account for high level users. Would a primary care system be able to deal with the complexities of the DMHAS population? They discussed whether it made sense to have separate models for certain populations. A primary care physician may be able to manage someone with low level depression, but not someone with greater behavioral health needs. There is a need to balance medical needs with mental health needs.

Introduce potential levels of standardization that would need to be applied to the infrastructure and capabilities across the different stakeholders

Due to a lack of time, the group decided to begin collecting information offline. It was noted that if the work group set a desired outcome without setting standards, providers would determine their own individual solutions, thus complicating the ability to conduct measurements.

Align on next steps

The July 1 work group meeting has been moved to July 8, and the group decided to hold the remaining meetings at Connecticut Valley Hospital.

Meeting adjourned at 11 a.m.