

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

**July 8, 2013
Meeting Minutes**

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

Members Present: Mr. Mark Raymond (Co-Chair); Mr. Michael Michaud (Co-Chair); Mr. Daniel Carmody; Dr. Alan Kaye; Ms. Bernadette Kelleher; Mr. Mike Miller; Ms. Susan Niemitz; Dr. Chinedu Okeke; Mr. Ron Preston; Dr. Mark Schaefer; Mr. Barry Simon; Dr. Minakshi Tikoo; Dr. Jonathan Velez; Dr. Victor Villagra; Ms. Cheryl Wamuo; Ms. April Wang; Mr. Joshua Wocjik

Members Absent: Mr. John DeStefano; Mr. Bill Morico; Mr. Mark Root; Mr. James Wadleigh

Meeting convened at 9 a.m.

Discuss goals for today's meeting, share progress from other work groups, review synthesis from third work group meeting

The goal for the day's meeting was for group members to align on a level of standardization and develop necessary capabilities. They reviewed the work of the care delivery and payment reform work groups. Neither group has changed its general direction since the previous update. The care delivery group has looked at provider fragmentation and ways to pool providers into groups. Group members mentioned setting tiered performance standards, performing a baseline capabilities assessment across payers, and mandating providers to register their EHR capabilities. It may also be important to look at sustainability and to better invest savings.

Align on model for standardization/consolidation of HIT capabilities across stakeholders refined based on discussions during the last work group

The group reviewed past discussions on the need for consolidation/standardization of HIT capabilities. The members discussed the development of a single provider portal that would incorporate both public and private payers. Commercial payers have access to a common portal that checks patient eligibility and can go to a deeper level of detail. On analytics, there would be standard reports across payers. There may be a need for payers to build upon existing data in order to allow for the standardization of reports. There may be a need for a connectivity infrastructure to support regional HIE systems. There may also be a need to incent the change, particularly with smaller providers.

Consider aspects of HIT infrastructure and capability development where Connecticut could strive to be distinctive

In the first round of SIM grants, states tended to focus on common HIT areas: building/expanding health information exchanges and unified patient portal. That may not be innovative enough for this round of funding. The application will need to highlight state specific solutions at a higher standard. Group members discussed four areas where Connecticut HIT could be distinctive: consumer centricity; provider care management technology; integrating public health data; and clinical connectivity.

The group discussed consumer centric technology, and researching specialized vendors. They discussed Castlight Health, a start-up aimed at helping people to understand the cost and quality impact of different health choices. The group could also look at other states' solutions that could be built upon. CMS may look favorably upon partnerships with other states. One of the state's efforts could be to more easily enable small providers to adopt care management solutions. This could be done through provider education, the establishment of a technology marketplace, or the development of a shared service.

One of the goals should be to integrate public health into primary care in order to more effectively manage population health. There is some public health data that is available. The Department of Public Health is currently examining all of its databases to see what data could be useful to providers.

The group reviewed the four areas where Connecticut could be distinctive. One suggested addition (added as a 5th option) was to develop an evolving evaluation component that focuses on continuing quality improvement. Another suggested addition (added as a 6th option) was to develop a model that allows for savings to be reinvested into technology. Group members were asked to vote for the areas the state should focus on in the three year timeline.

1. Consumer centricity: 9 votes
2. Provider care management technology: 9 votes
3. Integrating public health data: 6 votes
4. Clinical connectivity: 10 votes
5. Quality evaluation and improvement: 1 vote
6. Reinvestment: 13 votes

Early assessment of implementation cost

The group had some discussion regarding what HIT investments should cost. That cost should only include direct SIM related infrastructure and not all HIT in the state. HITE-CT, for example, would be considered a parallel process. There are many unknown factors that may impact the cost. The group will need to finalize a roadmap for the first three years of the model implementation (Stage 1 and Stage 2). There are various ways the group could approach this. They could look at the other testing grants as a starting point. The group reviewed Arkansas's approach to funding HIT. It was noted that Arkansas is very county-centric and relies on public providers. In New England there are fewer public providers; the reliance tends to be on non-profit providers. It was mentioned that one of the issues is that while the group is looking to be innovative; however, they are also trying to level the field between the private and public sectors.

First review of answers to key HIT questions

Group members received a draft of key questions and answers for the design of a supportive HIT infrastructure for care delivery and payment innovation (see Strawman Answers: Discussion Document). Members were asked to spend some time reviewing the document and provide feedback to the co-chairs by Wednesday, July 10.

Align on next steps

The group's last meeting will be July 15.

Meeting adjourned at 11 a.m.