

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

July 15, 2013  
Meeting Minutes

**Location:** CT Valley Hospital, 1000 Silver Street, Middletown, CT 06457

**Members Present:** Mark Raymond (Chairman); Michael Michaud (Chairman); Daniel Carmody; John DeStefano; Alan Kaye; Bernadette Kelleher; Daniel Maloney; Mike Miller; Susan Niemitz; Chinedu Okeke; Dan Olshansky; Mark Schaefer; Barry Simon; Victor Villagra; Cheryl Wamuo; Joshua Wojcik

**Members Absent:** Bill Morico; Mark Root; Minakshi Tikoo; Jonathan Velez; James Wadleigh; April Wang

Meeting convened at 9:00 a.m.

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

The work of the other two work groups was reviewed. Care Delivery has aligned on a total cost of care accountability model. They are examining value levers, person centered medical homes, and state specific criteria for participation. Providers would self-report their information, which would be validated through audits or claims based process metrics. The bar will be set relatively low to encourage provider entry. The Department of Public Health also proposed the use of community based support entities that they would certify. Payment Reform is developing an initial scorecard. The goal will be to positively impact inequities in care, as well as the integration of behavioral health into clinical care. An additional goal is to create a more engaged patient base. The payment reform group is introducing a two track process where providers can participate either through adoption of a pay for performance structure or a total cost of care structure. There was a question as to how Medicare clients would be integrated into the model. CMMI is still navigating that issue. CMMI has been supportive of the ideas for change put forth and will sort out how Medicare clients will fit in.

The group reviewed the sources of distinctiveness that the work group supports: the need to address inequities, the concentration of health care leaders, strength in behavioral health, an engaged consumer base, cross-payer commitment, and inclusion of providers of all types. It was mentioned that it may be necessary to take an inventory of the analytics to include in the model, as the kinds of analytics needed may vary.

**Recap on how to make Connecticut's HIT infrastructure and capability development distinctive**

The work group reviewed the previous meeting discussion and vote on potentially distinctive infrastructure and capability. The group overwhelmingly supported sustainability. Also highly supported were clinical connectivity, care management technology, and consumer centrality. The vote did not impact the existing roadmap. The chairmen of each SIM work group will meet and review that information and determine how best to implement the recommendations.

### **Discuss assessment of implementation costs for required capabilities**

Members discussed the budget for SIM and examined how other states funded their efforts. The group looked at three types of investments: those funded by the SIM grant, other state funding sources, and required investments not funded by SIM or the state. The group also reviewed rules for SIM budgeting. The group also needed to consider policy and legal issues that could impact budgeting.

The group examined existing SIM testing grants to estimate the state's infrastructure investments. The various approaches have been approved by CMMI and could therefore work for Connecticut. The group reviewed preliminary estimates based on how testing states had budgeted for payer analytics, provider portal, patient portal, care management tools, and HIE.

Members discussed the budget estimate for a provider portal. There may be adoption challenges due to the high number of small providers in the state. There is a need to decide if a new system would be developed or if, instead, a system would be developed that points back to existing systems. It was mentioned that instead of focusing on providers, the group should look at vendors who could provide workable solutions.

Other states did not specify funding for a patient portal, so the estimate is based on the assumption that its cost would be similar to the provider portal. If it is for information transmission only, the cost may not be as high. With the patient and provider portals, they will need to define what both will do. That will impact both the cost and the kind of solutions that will be put into place. The group also discussed the importance of care management tools, connectivity between patients, providers, and state agencies.

### **Provide feedback and review strawman answers**

The group began a roundtable discussion regarding the list of infrastructure/technology design questions addressed for the model. Some questions are from CMMI; others were work group questions. Members were asked to think about their level of comfort with the answers to the questions. There was consensus that the group's work was heading in the right direction, however, they identified a need for additional information. There were requests for a more detailed timeline; increased specificity on measures; and improved connectivity between state agencies, as well as private entities. One question that needs to be answered is who will oversee the growth of the model. The need for flexibility and continued evaluation was also highlighted, as were concerns about the long term success of the model.

Members discussed care coordination. There was an example of an existing behavioral health model used in Middlesex County with the creation of community care teams. The team brings various players together weekly to address the needs of high utilizers and decrease emergency room usage. In other hospital systems, there is an inability to red flag high utilizers in their records systems. There is rudimentary information exchange through the telephone. The group examined a sample consumer-provider-coordinator collaboration portal.

### **Discuss work group's ongoing roles/involvement and next steps**

The group reviewed the next steps in the grant application and model design process. There are plans to establish monthly conference calls as the plan is formalized, providing members with the opportunity for review and comment. Members will continue to receive regular updates. There may be a need to better define phasing and practice standards as the model moves into the testing period. Members were encouraged to provide feedback and suggestions on engagement. They were also asked to consider providing letters of support from their agencies/organizations. There

was a concern about the sustainability of the initiative due to external factors. It was noted that there is voluntary agreement to go forward including payers, who have aligned on the need to address health care costs. Work group members were thanked for their participation and encouraged to remain engaged in the process.

Meeting adjourned at 11:00 a.m.