



# Connecticut SIM: Health Information Technology

STATE OF CONNECTICUT

HIT work group discussion  
June 3, 2013

## Agenda for HIT work group meeting #2



### Agenda for today

- |  |               |
|--|---------------|
| <ul style="list-style-type: none"> <li>▪ 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</li> </ul> | <i>15 min</i> |
| <ul style="list-style-type: none"> <li>▪ 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</li> </ul>                  | <i>15 min</i> |
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| <ul style="list-style-type: none"> <li>▪ Align on next steps</li> </ul>  | <i>10 min</i> |

# Welcome to the second SIM design HIT work group

Michael Michaud  
SIM Associate Project Director

Daniel Carmody  
*CIGNA*

John Destefano  
*HITE-CT*

Bernadette Kelleher  
*Anthem Blue Cross Blue Shield*

Daniel G. Maloney  
*Dept. of Public Health (DPH)*

Dan Olshansky, LICSW  
*Dept. of Mental Health & Addiction Services*

Mark Root  
*Dept. of Children and Families (DCF)*

Barry Simon  
*Gilead Community Services*

Mark Raymond  
DAS Bureau of Enterprise Technology

Minakshi Tikoo, PhD  
*Dept. of Social Services (DSS)*

Jonathan Velez, MD  
*Hartford HealthCare ACO*

Victor Villagra, MD  
*Ethel Donaghue TRIPP Center (UCHC)*

James Wadleigh  
*Access Health CT*

Josh Wojcik  
*Office of the State Comptroller (OSC)*

Note: Representative from UnitedHealthcare/ OPTUM is being identified

## Today's points for review and discussion

### Review



- **Synthesis of first work group** discussion
  - Aspirations of the HIT work group, awareness of existing gaps in HIT infrastructure and barriers to the free flow of health information
  - First pass view of existing HIT assets and how they could play a role in the HIT infrastructure design
- **SHIP's vision** for care delivery, payment and HIT innovation
- **Initial hypothesis** of the care delivery work group

### Align



- **HIT capabilities across stakeholders** that will be critical to successfully enable the new care delivery model
- Early discussions on **level of standardization of capabilities across stakeholders** that will inform the development of a capability road map



# In the last meeting, discussions focused on existing assets and capabilities that could play a part in the HIT infrastructure design

**Data is critical to improving care delivery and outcomes**

**Existing assets could be leveraged in this effort**

**Need to be mindful of gaps in existing capabilities**

**Non-technological barriers also limit information flow**

## Takeaways

- Clinical, claims, and systemic data, when integrated and allowed to flow freely between patients, payers, and providers improves care delivery and outcomes
- Applying a 'whole-person' perspective to HIT infrastructure design will ensure collaboration between consumers, providers, and payers

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- State agency databases (e.g., APCD) could help inform system level decisions
- Private (payer/provider) databases, end-user interfaces, and data analytics tools could help operationalize the new care delivery and payment model

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- Existing assets tend to focus on subsets of the population and the data collected is not always at the level of quality/completeness that makes it actionable
- Lack of linkages between the different systems limits the flow of information

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- Consumer privacy concerns are material considerations that need to be addressed
- Legal & policy sensitivities constrain the level of sharing
- Business imperatives at times promote non-sharing
- Lack of overall ownership of the HIT infrastructure leads to poor coordination

**FOR TODAY: Review and discuss capabilities required for the new care delivery model**

## SHIP provided guidance on a vision for care delivery, payment, and HIT innovation



### **Establish a whole person-centered healthcare system that improves affordability, promotes value over volume, and reduces health inequities for all of Connecticut**

- Understanding and consideration of the needs of a whole-person that impact health
- Integration of primary care, behavioral health, population health, consumer engagement, and community support
- Shared accountability for the total cost and quality of healthcare
- Increased access to the right care in the right setting at the right time
- Migration to 21st-century healthcare workforce and health information technology that promotes usability at the point of care
- Supported by Medicaid, Medicare, and private health plans alike

## Agenda for HIT work group meeting #2

Identify existing HIT capabilities in CT

Evaluate HIT capabilities that will enable components of new care delivery model

Align on level of standardization necessary across these capabilities

Develop execution plan that builds off existing capabilities

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## The care delivery and payment work groups are beginning to form initial hypotheses for model design guided by the SHIP vision

 Details follow

### Care delivery work group

- **Convened on 5/28/2013 (Tuesday)**
  - Reviewed barriers along the stages of health for consumers across different payer groups (e.g. Privately insured, Medicare, Medicaid)
  - Identified which of these barriers were a priority to address so as to capture sources of value
  - Aligned on a 'Population health care delivery model' that would take a whole-person approach to care
- **Next meeting on 6/10/2013 (Monday)**

### Payment work group

- **Convened on 5/20/2013 (Monday)**
  - At its first meeting, the payment model work group aligned on the guiding principles and strategic design decisions that will inform the SIM effort's final recommendation on payment model reform
- **Next meeting on 6/3/2013 (Tonight)**



# The care delivery work group is proposing a population health model to capture sources of value along the stages of health

PRELIMINARY

## Sources of value

- Primary prevention (general population)
- Primary prevention (pregnant women/newborns)
- Secondary prevention/ early detection
- Selection of provider types and care setting
- Effective diagnosis and treatment selection
- Care coordination/ chronic disease
- Provider productivity

## Core components of a population health model

- 1 Understanding of ongoing needs of patient population
- 2 Enhanced access to care (structural and cultural)
- 3 Team-based, coordinated, comprehensive care
- 4 Patient engagement
- 5 Evidence-informed clinical decision making
- 6 Performance management



# Care delivery work group will be discussing a core set of components that will be implemented in the population health model (1 of 3)

PRELIMINARY

## Description

## Patient story from CT

### 1 Whole patient centered care and population health management

- Understand the **whole-person context**, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a patient's health
- Assess and document patient risk factors to **identify high risk patients**

- A 7 year old girl comes into the office for asthma
- Provider finds out she has been held back in school and has a history of anxiety, sadness, and anger
- She comes from a large family with prior incidents of disorderly conduct and domestic violence
- Her mother is unemployed, divorced and has no child support
- They are getting evicted from a mice and mold infested home

### 2 Enhanced access to care (structural and cultural)

- Provide patients **access to culturally and linguistically appropriate routine/urgent care** and clinical and mental health advice **during and after office hours**,
- Care should be **accessible in-person or remotely** (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

- A 27 year old 1st generation polish immigrant who is a self-employed house cleaner and for whom English is a second language, is in her second pregnancy
- She had a prior miscarriage and this places her in a high risk maternity situation
- She is not accustomed to or familiar with medical services and treatments that can help prevent a subsequent miscarriage or pre-term birth
- She is not likely to seek medical care unless something 'is wrong'



# Care delivery work group will be discussing a core set of components that will be implemented in the population health model (2 of 3)

PRELIMINARY

## Description

## Patient story from CT

### 3 Team-based, coordinated, comprehensive care

- Leverage **multi-disciplinary teams** and enhanced **data sharing** to improve care planning, diagnosis, treatment, and patient coaching
- This will ensure adherence to care plan and **successful care transitions** across care settings and care disciplines (e.g., medical, social, behavioral)

- A 67 years old male suffered a myocardial infarction, and is being discharged from the hospital to home
- Patient and his wife thought they understood the discharge orders, but the discharge process was overwhelming
- At home, they are confused about medications and follow-up
- Patient decides to resume all pre-hospitalization medications and most physical activities.
- He is waiting for his cardiologist to reach out with an appointment for rehab
- Patient is readmitted within the week

### 4 Patient engagement

- Appropriately **educate and encourage patients** to engage in healthy behaviors and reduce risky behaviors
- Encourage patients to partner with the provider to **follow-through on care plans**, and administer self-care as needed

- A 57 year old divorced executive, has a very stressful job and works on average 60 hours a week
- He is overweight, a smoker, lives alone, has family history of cancer, suffers from frequent headaches and has minimal physical activity
- Patient is at risk for Type 2 Diabetes, hypertension, stroke, colorectal cancer and depression
- Patient needs an annual physical, colorectal screening, physical activity, and down time



# Care delivery work group will be discussing a core set of components that will be implemented in the population health model (3 of 3)

PRELIMINARY

## Description

## Patient story from CT

### 5 Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of **evidenced-based care** reflecting clinical outcomes and cost-effectiveness

- A 52 year female, is a new patient to the local PCP's practice
- Her past history is significant for type 2 diabetes and hyperlipidemia for which she is on Medformine and Lipitor
- She is also on 40mg of Omeprazole which she has been taking for years despite no current symptoms of acid reflux
- Her new provider continues the current medications including the Omeprazole since Carmen is convinced the medication is critical for her wellbeing despite no evidence of renewed symptoms

### 6 Performance management

- Collect, integrate, and **disseminate data for care management and performance reporting** on cost and quality effectiveness of care
- Use performance and patient experience data to identify opportunities to **improve and compare performance** with other providers

- A 65 year old male with history of high blood pressure and high cholesterol
- He is prescribed a new anti-hypertensive for his uncontrolled hypertension which he does not fill-out because the copay for the medication was beyond his means
- Equivalent care could have been provided via medications that were tailored to Vega's current insurance plan
- Lack of provider performance metrics on cost of care meant this did not occur

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## Illustrative example of a potential state HIT strategy

- Given the limited time we have to develop and gain broad alignment on an HIT vision, plan and budget, we thought it helpful to review what a PCMH-focused state HIT strategy could look like
- This is not the answer for CT, but a starting point for us to tailor to the unique needs of our state
- We will spend the next hour reviewing the example, then break into groups to
  - Change it based on our collective views of the end-state and the best path to achieve it
  - Integrate the Connecticut state assets that we identified in our last workgroup



## Categories of HIT capabilities across stakeholders that are required for care delivery and payment innovation

Category	Description	Typical tech pathway
<b>A</b> Payer analytics	<ul style="list-style-type: none"> <li>Tools for payers to analyze claims and produce payment-related analytics, quality/outcome/ performance metrics and make actual payment for episodes and population health</li> </ul>	<ul style="list-style-type: none"> <li>Heavy <b>upfront development/ sourcing</b> followed by incremental enhancement</li> </ul>
<b>B</b> Provider - payer - patient connectivity	<ul style="list-style-type: none"> <li>Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models</li> </ul>	<ul style="list-style-type: none"> <li>Start <b>with basic or low tech solutions</b> to allow time for development or sourcing of tech-enabled enhancement</li> </ul>
<b>C</b> Provider – patient care mgmt.	<ul style="list-style-type: none"> <li>Provider tools (e.g., workflow, event management) and analytics to e.g., physicians, care managers) coordinate the medical services for a patient (focus on highest risk)</li> </ul>	<ul style="list-style-type: none"> <li>Highly dependent on state-specific <b>starting point</b></li> </ul>
<b>D</b> Provider-provider connectivity	<ul style="list-style-type: none"> <li>Integrated clinical data exchange among healthcare stakeholders, including the longitudinal patient registry that can be enabled by HIE</li> </ul>	

# Capability to business need map

■ High: Most relevant business need

		Business needs					
		1	2	3	4	5	6
Categories	Capabilities	Whole patient centered care and population health mgmt.	Enhanced access to care (structural and cultural)	Team-based, coordinated, comprehensive care	Patient engagement	Evidence informed clin. decision making	Performance management
A Payer analytics	Population attribution and adjustment	Foundational requirement					
	Population stratification	■					
	Pooling analytics	Foundational requirement					
	Claims patient registry			■		■	
	Performance reporting						■
	Specialist/facility analytics						■
	Care gap analysis	■		■		■	
	Event management based on claims (e.g. alerts)	■					
Payment		Foundational requirement					
B Provider-payer – patient connectivity	PCMH enrollment	Foundational requirement					
	Provider pooling tools	Foundational requirement					
	Provider input into attribution/segment	Foundational requirement					
	Metrics capture (non-clinical and clinical)						■
	Report distribution	Foundational requirement					
	Patient portal		■		■		
C Provider –patient care mgmt tools	Care coordinator workflow tools		■	■			
	Event management based on clinical data (e.g. alerts)	■					
	Clinical-data based analytics (e.g. care gap analysis)	■		■		■	
	Steerage to 24/7 clinical access		■				
	Member engagement tools		■		■		
	Telemonitoring, mobility, home monitoring tools		■		■		
D Provider-provider connectivity	Clinical patient registry	■		■			
	Admission/discharge data	■		■			
	EMR-based clinical data	■		■			

# Considerations for developing a HIT roadmap

HIT capabilities need to be placed onto a staged roadmap based on:

- **Value:** foundational requirements and high impact capabilities need to be prioritized and developed early
- **Current maturity:** existing capabilities need to be leveraged at earlier stages
- **Time to develop/implement:** high complexity technology solutions should roll out at later stages to allow for sufficient lead time for development
- **Interdependency:** critical enablers for other capabilities needs to be prioritized for earlier development

# Example staged approach to roll out technology for innovation in care delivery and payment model

ILLUSTRATIVE



## Initial launch

Meet minimum requirements rapidly through lower tech/cost solutions without interrupting day-to-day operations

## Scaling up

Build tech-enabled solutions to further enhance information transparency and capture most value

## Optimized value and efficiency

Complete system-wide connectivity to maximize efficiency of care

### A Payer Analytics

- Automated **claims-based algorithms** for foundational analytics:
  - Episodes
  - Patient attribution, stratification and pooling
  - Performance and payment

- Enhanced analytics that identifies high priority patients for **targeted intervention**:
  - Care gaps analyses
  - Alert generation

- System level** public health/epidemic analyses
- Patient 360** view enabled by integration of claims and clinical data

### B Provider - payer – patient connectivity

- Multi-payer online** portal for providers to download static electronic performance reports

- Bi-directional** portal that allows data exchange between payers and providers
- Patient portal providing cost transparency and

- HIE-enabled** bidirectional communication and data exchange

### C Provider-patient care management

- Low-tech** care management support, e.g., :
  - Excel list of disease specific high risk/cost patients
  - Care management training modules/playbooks

- Certified** care management vendors and/or workflow tools
- Local EMR** data integrated into care management tool

- Enhanced **care management** tools:
  - Automated patient comm
  - Direct linkage to payer alert
  - 24/7 clinical acces
- Remote monitoring and tele-medicine**

### D Provider-provider connectivity

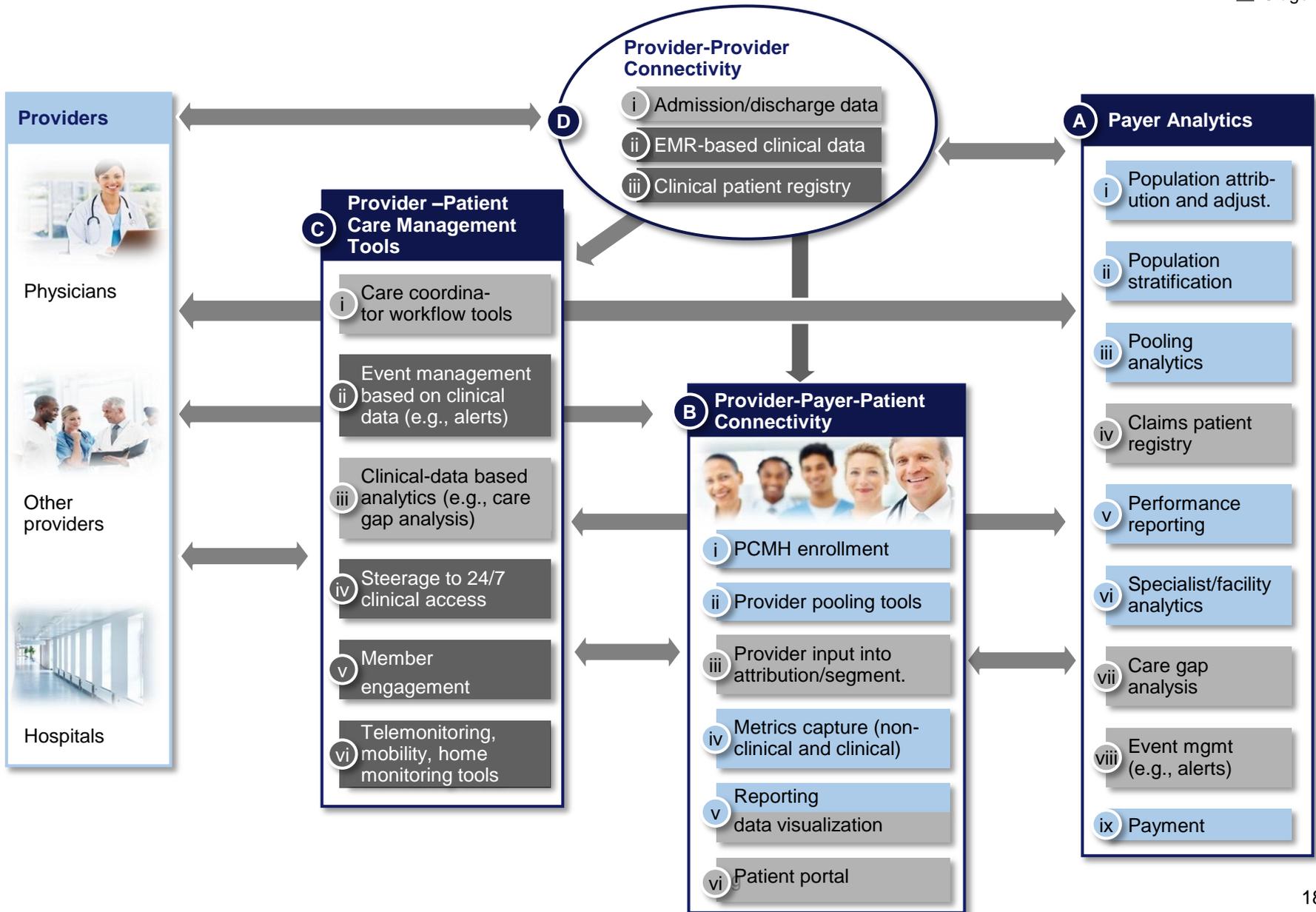
- Low-tech** solutions (e.g., telephone) to allow information exchange between providers to deliver care to same patient

- Admission/discharge** data sharing between hospitals and PCPs

- Clinical patient registry**
- HIE-enabled** bidirectional communication and data exchange

# Typical solution architecture for payer and system infrastructure

- Stage 1
- Stage 2
- Stage 3



## Agenda for HIT work group meeting #2



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## Review the capability road map proposed by the initial hypothesis and refine based on CT specific considerations

### Breakout exercise instructions

- **Breakout (30 min):** Breakout into 4 groups. Each group has one poster and everyone has a pen:
  - Spend 5-10 minutes to think individually
  - Write/draw on the poster to show how you think the capabilities should be moved between the stages
  - Add Connecticut assets that should be leveraged at each stage
  - Add additional capabilities that are required
  - Discuss as a smaller group to share and refine the thinking
- **Group debrief (15 min):** Each group to report out synthesis for full team discussion
  - Which capabilities should be moved to a different stage on the technology roadmap?
  - What CT assets should be leveraged?
  - What additional capabilities are required?



# Example staged approach to roll out technology for innovation in care delivery and payment model

Enter refined stage number in box



Description

Initial launch      Scaling up      Optimized value and efficiency

Core technology

**Payer Analytics**

<b>A-i</b> Population attribution and adjust.	
<b>A-ii</b> Population stratification	
<b>A-iii</b> Pooling analytics	
<b>A-vi</b> Specialist / facility analytics	
<b>A-v</b> Performance reporting	
<b>A-ix</b> Payment	

**Provider-Payer-Patient Connectivity**

<b>B-i</b> PCMH enrollment	
<b>B-ii</b> Provider pooling tools	
<b>B-iv</b> Metrics capture (non-clinical and clinical)	
<b>B-v</b> Reporting	

**Payer Analytics**

<b>A-iv</b> Claims patient registry	
<b>A-vii</b> Care gap analysis	
<b>A-viii</b> Event mgmt (e.g., alerts)	

**Provider-Payer-Patient Connectivity**

<b>B-iii</b> Provider input into attribution/ segment	
<b>B-v</b> Data visualization	
<b>B-vi</b> Patient portal	

**Provider –Patient Care Mgmt. Tools**

<b>C-i</b> Care coordinator workflow tools	
<b>C-iii</b> Clinical-data analytics (e.g., care gap analysis)	
<b>C-v</b> Member engagement tools	

**Provider-Provider Connectivity**

<b>D-i</b> Admission/discharge data	
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**Provider –Patient Care Mgmt. Tools**

<b>C-ii</b> Event management based on clinical data (e.g., alerts)	
<b>C-iv</b> Steerage to 24/7 clinical access	
<b>C-vi</b> Telemonitoring, mobility, home monitoring tools	

**Provider-Provider Connectivity**

<b>D-ii</b> EMR-based clinical data exchange	
<b>D-iii</b> Clinical patient registry	

Additional CT-specific assets

# In the first workshop we identified a number of existing assets in CT that could be leveraged in HIT infrastructure design

NOT EXHAUSTIVE

## Data



- **State sources**
  - OSC data warehouse (across Anthem & United)
  - Licensure data
  - Public health registries: Birth, death, immunization records
  - DMHAS databases (160K users)
  - United Way 211 (referral search)
  - DSS claims database
- **Private sources**
  - CHIME (CT Hospital Association)
  - All payer claims database (APCD)

## Payer Analytics



- **Claims data analytics**
  - Payer risk adjustment and coding analytics
- **Clinical data analytics**
  - CT Tumor registry

## Connectivity



- **Patient access**
  - ConneCT
  - OSC State employee portal
  - Access Health CT

## Break out group debrief session

- Which capabilities should be moved to a different stage on the technology roadmap? Why?
- What CT assets should be leveraged? Why and how?
- What additional capabilities are required? Why?

## Agenda for HIT work group meeting #2



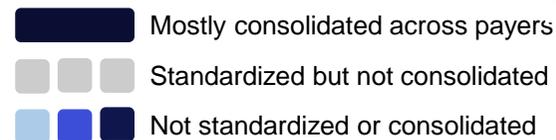
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## Options for infrastructure/technology across multiple payers

Option	Description	Rationale
 <p><b>Mostly consolidated across payers</b></p>	<p>All payers using/sharing same infrastructure and technology</p>	<ul style="list-style-type: none"> <li>▪ Cost synergies from scales across multiple payers</li> <li>▪ Reduced operational complexity and confusion for the users (e.g., provider portal)</li> <li>▪ Foundational requirements for state-wide initiatives (e.g., HIE)</li> </ul>
 <p><b>Standardized but not consolidated</b></p>	<p>Standardized output agreed-upon by all payers with independent execution and delivery</p>	<ul style="list-style-type: none"> <li>▪ Output consistency (e.g., payment calculation, quality metrics, provider reports) required for state-wide roll out</li> <li>▪ Stakeholder complexities associated with shared infrastructure</li> </ul>
 <p><b>Not standardized or consolidated</b></p>	<p>No standardization of output; no technology/ infrastructure sharing or consolidation</p>	<ul style="list-style-type: none"> <li>▪ Cross-payer variation does not impact solution consistency</li> <li>▪ Payers unable/unwilling to standardize</li> </ul>

# 3 core models to support care delivery and payment innovation technology and capabilities



## Example options for standardization (not exhaustive)

Components	I Coordinated	II Standardized output	III Shared infrastructure
<b>Payer capabilities</b>			
Provider portal	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightblue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: blue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>
Claims-based tools			
▪ Reporting	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>
▪ All other tools/capabilities	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightblue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: blue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightblue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: blue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>
▪ Data	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightblue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: blue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightblue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: blue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>
<b>Other capabilities</b>			
Care management tools	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightblue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: blue;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span> <span style="display: inline-block; width: 15px; height: 15px; background-color: lightgrey;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>
HIE	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>	<span style="display: inline-block; width: 15px; height: 15px; background-color: darkblue;"></span>

▪ **Key considerations:**

- Single portal and standardized reporting format to reduce provider operational complexity and confusion
- Separate data, analytics and report generation given complexity of consolidating payer data and infrastructure in 3 years
- Cross-payer certification for care management tools to give providers options and eliminate needs for complex payer in-house development/customization

## Agenda for HIT work group meeting #2

Identify existing HIT capabilities in CT

Evaluate HIT capabilities that will enable components of new care delivery model

Align on level of standardization necessary across these capabilities

Develop execution plan that builds off existing capabilities

### Agenda for today

- |  |                      |
|--|----------------------|
| <ul style="list-style-type: none"> <li>▪ 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</li> </ul> | <i>15 min</i>        |
| <ul style="list-style-type: none"> <li>▪ 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</li> </ul>                  | <i>15 min</i>        |
| <ul style="list-style-type: none"> <li>▪ Review example HIT infrastructure design that could support the components of the recommended care model</li> </ul>   | <i>20 min</i>        |
| <ul style="list-style-type: none"> <li>▪ 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)</li> </ul>                  | <i>45 min</i>        |
| <ul style="list-style-type: none"> <li>▪ Introduce potential levels of standardization that would need to be applied to the infrastructure and capabilities across the different stakeholders</li> </ul>                                       | <i>15 min</i>        |
| <ul style="list-style-type: none"> <li>▪ <b>Align on next steps</b></li> </ul>   | <b><i>10 min</i></b> |

## Next steps for HIT work group

### Meeting

### Objectives/decisions

**1<sup>st</sup> meeting**  
(5/20)

- Understanding of HIT capabilities that will be required across key stakeholders under new care delivery and payment models
- Criteria and approach to assess payer and health system capabilities

**2<sup>nd</sup> meeting**  
(6/3)

- Understanding of current HIT capabilities and linkages across stakeholders (e.g. patients, payers, providers) in CT and how these could be leveraged in the proposed design
- Evaluation of required HIT capabilities under new care delivery model
- Initial view on potential models for HIT standardization

**3<sup>rd</sup> meeting**  
(6/17)

- **Strawman for HIT standardization across key components**
- **Options to develop required capabilities (e.g., public utility vs. proprietary solutions, build vs. buy)**
- **Potential sequencing of required capabilities (e.g., feasibility, cost, day-one need)**
- **Early assessment of costs of implementing required capabilities**

**4<sup>th</sup> meeting**  
(7/1)

- Capability roadmap
- Strawman budget
- Assessment of potential funding sources

**5<sup>th</sup> meeting**  
(7/15)

- Finalized budget
- Finalized funding sources



# Appendix

# Payer analytics

A Payer analytics	Description
i Population attribution and adjust.	<ul style="list-style-type: none"> <li>Claim analytics to attribute patients to PCMH and adjust PCMH's PMPM and gainsharing based on patients' claim history</li> </ul>
ii Population stratification	<ul style="list-style-type: none"> <li>Claim analytics used to segment a PCMH's patient population based on expected utilization of health resources, and help providers identify patients most likely to benefit from increased care coordination</li> </ul>
iii Pooling analytics	<ul style="list-style-type: none"> <li>Claim analytics to determine overall population risk and adjusted total cost of care for a group of providers forming a PCMH</li> </ul>
iv Claims patient registry	<ul style="list-style-type: none"> <li>Registry of patients attributed to each PCMH, associated patient claims, and series of analytics used to identify patients by disease state, recent utilization, ect.</li> </ul>
v Performance reporting	<ul style="list-style-type: none"> <li>Analytics and reports to determine and share provider performance in program – based on quality, cost, and utilization metrics</li> </ul>
vi Specialist / facility analytics	<ul style="list-style-type: none"> <li>Analytics to identify specialist / facility that demonstrate the highest performance for treating a given condition</li> </ul>
vii Care gap analysis <sup>1</sup>	<ul style="list-style-type: none"> <li>Claim analytics to identify gaps in care (e.g., missing cholesterol screening for patient with cardiac disease)</li> </ul>
viii Event mgmt (e.g., alerts) <sup>1</sup>	<ul style="list-style-type: none"> <li>Alerts issued based on recent events (e.g., discharge from hospital) or care gap analyses (e.g., two claims submitted for drugs with serious interactions)</li> </ul>
ix Payment	<ul style="list-style-type: none"> <li>Analytics and systems used to calculate PCMH shared savings and make payment</li> </ul>

<sup>1</sup> May be performed by care coordination systems

## Provider-Payer connectivity

### B Provider-Payer Connectivity

#### i PCMH enrollment

#### Description

- Web-based form that allows provider to enter information about themselves and express interest in participating in the PCMH program

#### ii Provider pooling tools

- Web-based tool that allows providers to explore population size, risk mix, and shared savings potential from partnering with other providers to form a PCMH

#### iii Provider input into attribution/segment

- Web-based tool that allows providers to react to patient attribution / segmentation for PCMH

#### iv Metrics capture (non-clinical and clinical)

- Web interface that allows providers to input clinical and non-clinical information used for performance reporting

#### v Reporting and data visualization

- Web interface that gives providers access to static reports and ability to visualize underlying data claims and / or clinical data dynamically

## Provider care management tools

C Provider care management tools	Description
i Care coordinator workflow tools	<ul style="list-style-type: none"> <li>Set of tools to help care coordinators prioritize patient outreach efforts based on patient demographic and disease state, urgency and complexity of issues, and overall value of intervention; also record care coordination activities/ interactions</li> </ul>
ii Event management based on clinical data (e.g., alerts)	<ul style="list-style-type: none"> <li>Clinical analytics used to send provider alerts when patient requires intervention (e.g., vaccination reminders) and automatically create follow-up activities with data and activity dependences</li> </ul>
iii Clinical-data based analytics (e.g., care gap analysis)	<ul style="list-style-type: none"> <li>Claim analytics to determine overall population risk and adjusted total cost of care for a group of providers forming a PCMH</li> </ul>
iv Steerage to 24/7 clinical access	<ul style="list-style-type: none"> <li>Telephone support for patients to get 24/7 clinical advice from providers who have access to the patient's clinical history</li> </ul>
v Communication support tools	<ul style="list-style-type: none"> <li>Set of tools to send reminders / updates through email, text message, or mail to select patient populations at appropriate times (e.g., timely reminder for annual eye visit)</li> </ul>
vi Telemonitoring, mobility, home monitoring tools	<ul style="list-style-type: none"> <li>Remote monitoring capabilities for patients with select diseases (e.g., wireless scale for CHF patients)</li> </ul>

## Provider-provider connectivity

### D Provider-provider connectivity

#### i Admission/discharge data

#### Description

- Web (and potentially API) based tool that supports either direct data entry or batch upload of admission and discharge data to be input by hospitals daily. Fields may include patient ID, patient name, admit and discharge dates, major procedures, and admitting diagnosis. Information to be exchanged daily with either payors or provider portal (One entity will be responsible for parsing data by PCMH and their corresponding patient attribution)

#### ii EMR-based clinical data

- API based communication that supports exchange of all clinical information contained in EMRs

#### iii Clinical patient registry

- Searchable data store that collects and integrates data from all available sources in HIE (and other data stores) and makes information available in a push or pull format