



Connecticut SIM – Health Information Technology

STATE OF CONNECTICUT

HIT work group discussion
July 15, 2013

Agenda for HIT work group meeting #5

Identify existing HIT capabilities in CT

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

Align on level of standardization and explore options to develop necessary capabilities

Develop execution plan that builds off existing capabilities

Agenda for today

- | | |
|---|---------------|
| ▪ Discuss goals for today's meeting, share progress from other work groups, review synthesis from fourth work group meeting | <i>25 min</i> |
| ▪ Recap on how to make Connecticut's HIT infrastructure and capability development distinctive | <i>15 min</i> |
| ▪ Discuss assessment of implementation costs for required capabilities | <i>30 min</i> |
| ▪ Provide feedback and review strawman answers <ul style="list-style-type: none"> – Provide individual feedback around table – Review additional content and feedback on strawman answers | <i>40 min</i> |
| ▪ Discuss work group's ongoing roles/involvement and next steps | <i>10 min</i> |

Today's points for review and discussion

Review



- **Connecticut's sources of distinctiveness** and how they are supported by HIT
- **Progress** from care delivery and payment work groups
- **Synthesis of fourth work group** discussion
 - Need identified to develop a reinvestment and sustainability strategy
 - Prioritized aspects of HIT infrastructure design which can make Connecticut distinctive

Align



- **Assessment of costs** associated with implementing required capabilities
- **Answer to key HIT question and feedback on last week's strawman answers**



Details in next pages

The care delivery and payment work groups are beginning to think through how the new model will be implemented and evaluated

Care delivery work group

- **The care delivery work group met on the 8th of July**
 - Aligned on CT specific approach for practice standards that enable participation and prescribe milestones towards total cost of care accountability
 - Discussed ways in which the community can be involved in the new care delivery model (e.g. community based entities)
- **Next and final meeting on 7/22/2013**

Payment work group

- **The payment work group met on the 1st of July**
 - Defined preliminary version of a scorecard that will be used to track performance in payment model
- **Next meeting on 7/15/2013 (tonight)**

The care delivery work group aligned on developing CT specific practice standards for the new model (1 of 2)

 Recommendation

Options	Considerations	Examples
1 PCMH certification by established accreditation body	<ul style="list-style-type: none"> ▪ PCMH certification may not be truly indicative of advanced care delivery ▪ Well known by providers, and achieved by several already ▪ Potentially onerous for providers 	<ul style="list-style-type: none"> ▪ Vermont's multi-payer Blueprint for Health uses NCQA standards to determine practice eligibility ▪ Maine's Aligning Forces for Quality (AF4Q) uses NCQA standards to certify primary care practices
2 PCMH certification by established accreditation body plus select CT specific interventions/guidelines	<ul style="list-style-type: none"> ▪ As above ▪ May place additional burden on providers as well as state entity to certify ▪ More tailored to CT's goals and needs 	<ul style="list-style-type: none"> ▪ Massachusetts' Medicaid Primary Care Payment Reform Initiative requires participants to achieve NCQA certification and additional criteria of behavioral health integration and medical home transformation
3 CT specific criteria (e.g., self-reported and validated with audits or claims based process metrics)	<ul style="list-style-type: none"> ▪ More tailored to CT's goals and needs ▪ May place additional burden on state entity/ payors to certify ▪ Can be designed in "less onerous" method for providers if relies largely on claims/ shorter set of self-reported criteria 	<ul style="list-style-type: none"> ▪ Oregon uses own standards to determine if practices are considered a Patient-Centered Primary Care Home (overseen by advisory committee) <ul style="list-style-type: none"> – If practice is a NCQA accredited PCMH, it only needs to fill out subset of application¹
4 Other		

The care delivery work group aligned on developing CT specific practice standards for the new model (2 of 2)

Recommendation

- Initial barrier to entry will be low (e.g., self-assessment and statement of commitment) for initial period of program (e.g., first 1-2 years)
- CT will define practice standards (likely pulling from NCQA or CMMI core measures, with potential additions) which will be tied to practice transformation support
 - Details on overseeing body and validation process to be determined
 - Practice standards will become increasingly rigorous and outcome based over time
- Practices which are already NCQA (or other nationally accreditation body) certified will have to meet most important CT specific standards to ensure all practices reach same high bar at end point

The care delivery work group discussed DPH's proposal to integrate primary care and community health with certified support entities

Certified community-based practice support entities



- Community resources can play a critical role in helping meet Connecticut's vision for its new care delivery model
- There is a lack of structures and incentives to drive clinical-community collaboration and coordination in Connecticut
- One possible solution is to operationalize the integration of public health and primary health care through the creation of Certified Community-Based Practice Support Entities

The care delivery work group discussed the need to share information between certified community-based entities and primary care practices

In their last meeting, the payment work group developed a highly preliminary score card for Connecticut's new care model



Highlights from 7/1 payment work group meeting

- Developed a highly preliminary draft of a “0.1 version” scorecard that will continue to be refined
- Defined a set of structure, process, and outcome metrics to assess quality, patient experience and resource utilization
 - Selected metrics tied to prioritized care delivery model interventions
 - In line with the care delivery work group’s recommendation, recommended that the scorecard leverage nationally tracked metrics (e.g., CMMI core measures)
 - There are a subset of HIT-related metrics being considering (e.g., availability of non-visit based options, use of actionable data)

Preliminary “version 0.1” scorecard

Population health aspect	Measure title	Population health aspect	Measure title
Whole-person, patient-centered care and pop. health mgmt.	Assessment completion rates ¹	Health-based, coordinated, care (HIT)	30-day care transition measure
	Rehabilitation of consumer panel conducted		Demonstrated use of intensive case mgmt. tool
	Whole-person-centered treatment plan		Assessment of consumer progress towards treatment and follow-up when necessary
	Access to care outside normal business hours		Patient portal
Enhanced access to care (structural and cultural)	Consult capacity	Consumer engagement	Demonstrated use of “Crossing Wally” campaign to raise awareness at the point of care
	Transition services		Provision of quality (cost) information at point of care
	Convenient availability including same day access		Periodic review to ensure self-management care plan reflects no account targeted considerations
	Availability of non-visit based options (e.g., telehealth through telephone, email, text, video)		Quality index ²
Team-based, coordinated, care	Care planning infrastructure	Evidence informed clinical decision making	Adoption of HIT infrastructure
	Follow-up after hospitalization for mental illness		Ability for providers with HIT to receive to data
	Telehealth capabilities		Maintenance of disease registry
	Demonstrated infrastructure to coordinate with community resources including careline, health practitioners and community-based sites of care		Secure use of electronic data (e.g., disease registry)
Team-based, coordinated, care	Adoption of transition e-enrollment	Performance management	Evidence-based, standardized care pathways
	Post-discharge continuing care plan transfered to next level of care provider upon discharge		Bi-directional provider information sharing (e.g., HIE)
	Care transition record transferred to Health Care professional		Demonstrated implementation and periodic review of evidence-based guidelines
	Transition record with specified elements received by discharged by patients		Total medical cost per member
			Utilization index ³
			Participation in learning collaborative
			CMMIS and other patient surveys collected
			Completion of performance review based on practice data to improve value care/contract

1 Based on claims data 2 Either based on clinical data that is already being measured, but is not reported, tools, or a one-time measurement
3 Clinical data that is not being measured/tools 4 Completion of whole person assessments that consider consumer/family, risk, and behavioral health factors and ability to self-manage care 5 Detail on subsequent pages, utilization index for reporting purposes only
Note: Italicized measures indicate OT specific additions (both by the payment workgroup and by the specific care delivery workgroup intervention)

Care delivery and payment work groups have also discussed dimensions on which CT can be distinctive...

Connecticut's points of distinctiveness

Focus on addressing inequalities and improving care for underserved populations

- **Opportunity** to address highest Medicaid spend in the country and stark inequalities in health care access and experience (CT has second worst Gini coefficient¹ in USA)
 - Model lays foundation for increased physical and cultural access, including the use of Project ECHO to improve access to care in rural and underserved areas
- Metrics tracked will hold providers accountable for **understanding the whole person** including his/her behavioral, social and cultural context

Concentration of health care leaders

- Home to several of the **largest health insurers** in the country and prestigious **academic medical centers** with thought leaders
 - Once successful, can spread innovations pioneered in CT to other states
 - Can demonstrate true multi-payer solution

Strength in behavioral health

- **Existing strengths in behavioral health management** and recent **mental health legislation**
- Model aims to **better integrate behavioral health and primary care**

Engaged consumer base

- **Grass roots** population and community health initiatives throughout the state
 - Plan to support existing efforts and integrate with primary care by **certifying community based organizations** to provide population health services
 - Plan to engage **consumer on own care team** with improved information and education

Cross-payer commitment

- Medicaid and largest commercial payers accounting for 85% of commercial lives are in full collaboration and actively involved in co-design

Inclusion of providers of all types

- Two-track model to enable all types of providers to transition into the new care delivery and payment model

...which the HIT work group recommendations support

Proposed HIT recommendations

Focus on addressing inequalities and improving care for underserved populations

- Mine **population health databases** and provide analytics to:
 - Assess system level performance on health indicators (e.g., life expectancy, cancer incidence) and create a comprehensive view of sub-population (e.g., based on income, race, ethnicity) needs and gaps
 - Develop infrastructure to feed information to the point of care to help providers address sub-population needs and close gaps

Concentration of health care leaders

- Leverage payers' **existing advanced analytical capabilities, data assets and infrastructure** to enable an analytics-driven care delivery model
- Learn **best practices** from advanced institutions (e.g., academic medical centers) based on their experience, e.g.:
 - HIT and HIE implementation
 - Care coordination process transformation and technology implementation
 - Advanced analytics and research findings

Strength in behavioral health

- Continue to maintain and scale **existing successful care management models** (e.g., Connecticut Behavioral Health Partnership, Community Care Team)
- Invest in creating **connectivity** (e.g., HIE, consumer/provider/coordinator portal) to further enable engagement between stakeholders

Engaged consumer base

- Explore and implement **consumer-facing technology** to:
 - Support education on health and healthcare
 - Create transparency of cost and quality information
 - Facilitate joint decision making between consumers, providers and care coordinators
- Consider launch/pilot starting with **high risk-populations** (e.g., multiple co-morbidity behavioral health clients)

Cross-payer commitment

- Achieve a multi-payer collaboration/commitment to:
 - Take a **standardized approach** to drive innovation and reduce the administrative burden on providers
 - Create a **single provider interface/portal** to exchange information with providers (e.g., share performance report, input metrics)

Inclusion of providers of all types

- Follow **existing CT initiatives (eHealthCT, HITE CT)** to drive adoption of HIT/HIE, but do not make adoption an initial mandate/pre-requisite to maximize provider participation
- Address care coordination needs from different provider segments:
 - Offer process-focused practice transformation support to enable less tech-enabled providers to improve
 - Pre-qualify or create a market place for vendors to encourage smaller providers to invest and adopt technology

Need to identify mechanisms/channels to share innovations, experiences and best practices with peer states



In our last meeting, we discussed overarching considerations for the SIM effort and the ways in which Connecticut can be distinctive

Takeaways

Create CT distinctiveness

Ensure consistency across SIM grant application

Build on existing capabilities

Tailor solutions for broad spectrum of providers

- A solution is not complete without a **reinvestment strategy and plan for sustainability** (not addressed in other awarded SIM testing grants)
- CT can be distinctive in the ways it supports **clinical connectivity, provider care management technology** and **consumer centricity**
- Need to ensure **themes are consistent** across care delivery, payment and HIT work groups:
 - **Building flexibility into system** (e.g., care delivery did not define composition of care team, HIT did not require significant standardization beyond reporting)
 - Supporting **wide range** of providers
- Important to **build on existing infrastructure** in state as opposed to starting from scratch
 - State has already made significant investments in **building an exchange and encouraging EMR adoption**
 - **eHealthCT** has strong relationships with EHR providers
 - **Behavioral health** technical infrastructure is more advanced than in other states
- The solution and its implementation should be tailored to the **landscape of providers in the Connecticut**
 - ~60% of practices are led by **solo practitioners**
 - Operating structure of state-run providers may differ from peer states

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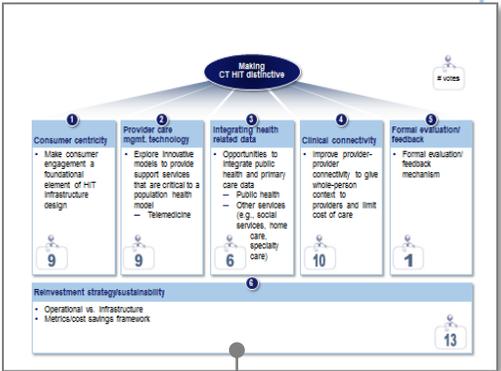
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Focus in near term

Last week we voted to invest in clinical connectivity, care mgmt. technology, and consumer centricity in the short term

NOT MUTUALLY EXCLUSIVE



Aspects

Description

How to be distinctive

Clinical connectivity

Ensure necessary financial and technical assistance are in place to **promote technology adoption** and providers' exchange of health information

Support existing efforts in state to **accelerate EHR adoption**, promote meaningful use, and enable clinical connectivity

Provider care mgmt. technology

Accelerate provider groups' adoption of care management technology

Increase adoption of care mgmt. technology by educating providers, establishing a marketplace with pre-qualified vendors, or developing a shared service

Consumer centricity

Leverage technology to **make consumers a member of their own care team** – educated on healthy behaviors and on high quality, cost efficient care decisions

Leverage existing CT infrastructure, proprietary tools developed by payers or specialized technology vendors to increase consumer centricity

Integrating health-related data

Enable providers to **better manage their populations** by leveraging tailored health related data (e.g., population home care, social)

Connect with DPH's ongoing initiatives to **integrate public health databases**

Share information between **primary care and public health** once infrastructure is established

We also identified **developing a sustainable reinvestment strategy as a top priority**

This question will be addressed by the **SHIP and a cross-work group co-chair team**

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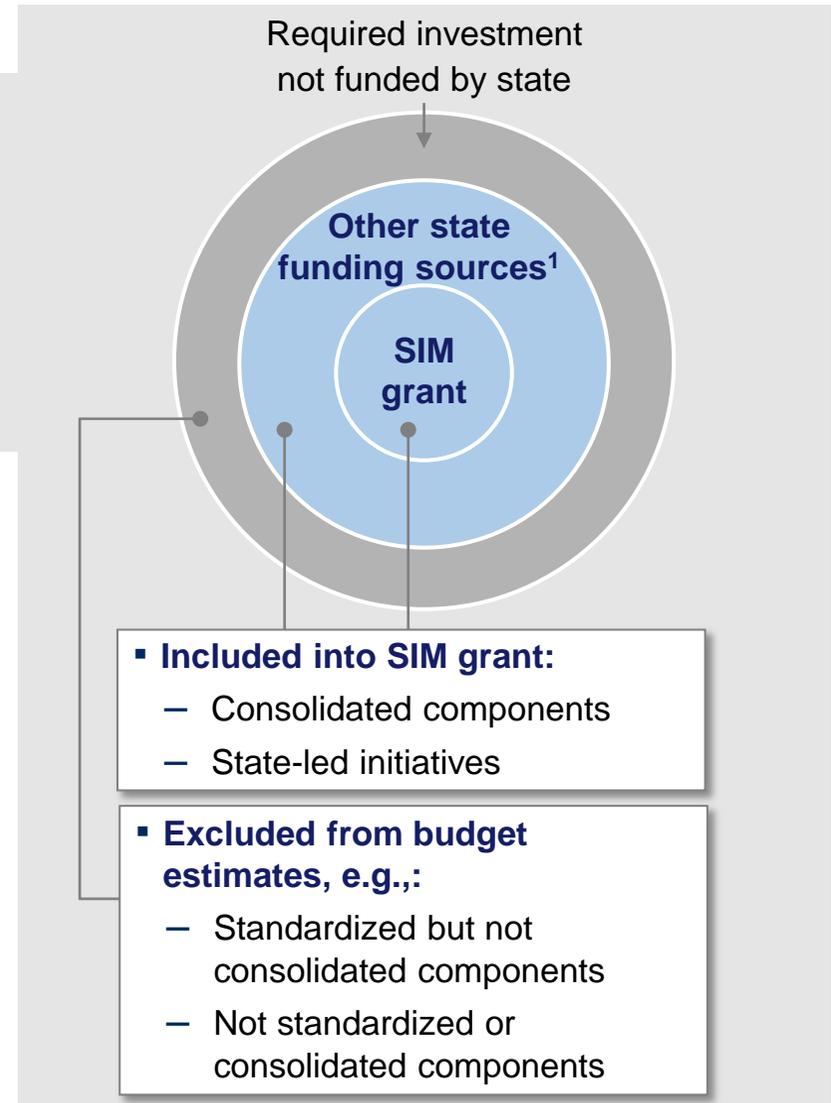
Guiding principles for SIM budget/funding

■ Budgeted in SIM application
■ Not budgeted in SIM application

ILLUSTRATIVE

- **Scope** of budget estimates for example states:
 - Investments related to **the State's** implementation (e.g., excludes private payer development costs)
 - Costs supported by SIM and all **additional state funding sources** (e.g., state general revenue, federal match¹)
 - **Timeframe** of budget covering SIM testing phase (~3 years, stages 1 and 2 on roadmap)

- SIM funding uses **prohibited** or **out of scope**:
 - Supplanting existing Federal, State, local, or private funding
 - Satisfying state matching requirements
 - Matching other federal funds
 - Supporting a 3rd-party's existing legal responsibilities
 - Uses unrelated to the proposed delivery/payment model
 - Lobbying/advocating changes in law
 - Changes to the EHR incentive program for eligible professionals and eligible hospitals



¹ Other funding sources budgeted in Arkansas SIM testing grant, other states vary in whether they provide details on additional funding sources

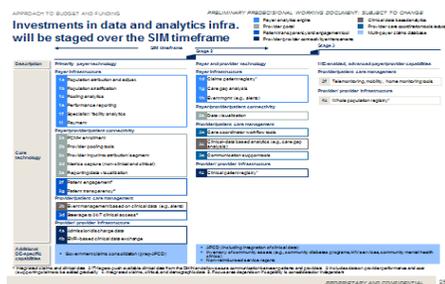
Existing CMMI SIM testing grants were examined to help estimate Connecticut's infrastructure investments

Survey SIM testing grant infrastructure component investments



- Examine awarded **testing grant applications** and identify infrastructure components related to data and analytics, e.g.,
 - Payer analytics
 - Provider portal
 - Patient tools
 - Provider education
 - Provider-provider connectivity enhancements

Map CT required capabilities to infrastructure components



- Focus on **stages 1 and 2** road-map capabilities (similar to SIM testing timeframe)
- **Map** stages 1 and 2 capabilities to the infrastructure components identified in the testing grants
- Use the mapping to identify **reference points** for the cost of CT development

Determine CT-specific data and analytics costs for innovation



- **Review** estimates with workgroup to adjust for CT
- Discuss **potential cost refinements** based on CT's context:
 - Smaller population (e.g., education scales to population)
 - Existing assets (e.g., leverage HIE for provider portal)

Cost estimates were made for Connecticut based on budgets of successful SIM testing grants

Highly preliminary



	SIM testing grant point of reference	Preliminary Connecticut estimate	Rationale
<p><i>Payer Analytics</i></p> <p>A Payer analytics</p>	<ul style="list-style-type: none"> \$5.6M for PCHM analytics engine (\$2.6M for system integration, \$3.0M for software license and maintenance) - <i>Arkansas</i> 	\$5-6 M	<ul style="list-style-type: none"> Estimated to be same as Arkansas with ~10% range
<p><i>Provider-Payer-Patient Connectivity</i></p> <p>B Provider portal</p>	<ul style="list-style-type: none"> \$13.1M¹ for provider portal and data entry (software/equipment costs (\$8.6M), contractor support (\$4.3M), DHS staff (\$0.2M)) - <i>Arkansas</i> 	\$6-7M	<ul style="list-style-type: none"> Estimated to be half of Arkansas estimate, given CT is not developing episodes, with ~10% range
<p>C Patient portal</p>	<ul style="list-style-type: none"> N/A 	\$6-7M	<ul style="list-style-type: none"> Assumed same estimate as for the provider portal
<p><i>Provider-Patient Care Mgmt. Tools</i></p> <p>D Care management tools</p>	<ul style="list-style-type: none"> \$0.3M to develop web-based support for provider learning collaboratives and collect consumer experience data (e.g., CAHPS) - <i>Minnesota</i> 	<\$1M provider education	<ul style="list-style-type: none"> Assumed same as Minnesota Care management technology will be funded via provider investments
<p><i>Provider-Provider Connectivity</i></p> <p>E HIE²</p>	<ul style="list-style-type: none"> \$9.9M to develop plan to connect BH and LTSS providers to HIE, HIE system enhancements (e.g. national connection), and grants to build HIE and EHR connectivity – <i>Minnesota</i> \$5.9M HIE: Expanded connectivity of HIE infrastructure(mental health, substance abuse, and LTSS providers), telemedicine - <i>Vermont</i> 	\$6-10M	<ul style="list-style-type: none"> Bounded estimate using Vermont for low end and Minnesota for high end Investment focused on LTSS and BH EMR/HIE (avoids potential conflict with other funding sources)
		Total: \$24-31M	
		Total w/o HIE: \$18-21M	

Are there other data points (potentially in state) to reference?

1 Includes provider portal for both PCMH and episodes
 2 This refers to non-medical (e.g., LTSS, BH) HIE support which avoids potential conflict with other funding sources

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List of infrastructure/technology design questions addressed for SIM



■ For today's review

- A** What capabilities are required across key stakeholders (e.g., payers, providers, community agencies) to implement the target care delivery and payment model?
- B** What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model?
- C** What is the optimal level of payer infrastructure standardization across each component (e.g., data, analytics, pooling, reporting, portal)?
- D** What is the best strategy to develop the required HIT capabilities?
- E** What will be the pace of roll-out of the required capabilities throughout the state?
- F** What is the budget and funding model to develop these capabilities?
- G** How can we create distinctiveness?
- H** What are the opportunities/challenges for HIE/EHR adoption, and approaches to improve HIT?
- I** What is the approach to reach rural providers, small practices, and behavioral health providers?
- J** What is the strategy to coordinate with state-wide HIT initiatives?
- K** What is the cost allocation plan or methodology?
- L** What is impact on MMIS, including implementation timelines?

CMMI
questions



I What is the approach to reach rural providers, small practices, and behavioral health providers?

■ Details following

Rural and small providers

- Encourage adoption of HIT/HIE, but do not make adoption a prerequisite to maximize provider participation
- Offer process-focused practice transformation support to enable less tech-enabled providers to improve

Additional detail to be added by state HIT coordinator

Behavioral health providers

- The approach to reach behavioral health providers should build on CT's existing successful models (e.g., Connecticut Behavioral Health Partnership, Community Care Team)
- Opportunities to enable connectivity between patients, providers and coordinators to further enhance care coordination

I Example successful behavioral health model: Community Care Teams



The Community Care Team has been successful reforming behavioral health care for target patients

Problem addressed

- Deficiencies in the behavioral health system have led to **overwhelmed emergency departments (EDs)** and subsequent **sub-par patient care and financial losses**.
- High risk behavioral health patients (e.g., suffering from alcoholism, chronic mental illness) are frequenting EDs because they are **not being adequately cared for in the existing system**

The Community Care Team solution

- **The Community Care Team (CCT)** was established in 2010 **to improve behavioral health care, especially for high frequency ED utilizers**
 - Founded by Middlesex Hospital, Gilead Community Services Inc, Rushford, River Valley Services¹
 - Guiding principles are to use community collaboration, through multi-agency partnerships and care planning, to provide patient centered care and improved outcomes
- The CCT meets once a week to review and **discuss care management strategy** for high ED utilizer patients
 - **A health promotion advocate** plays a critical role in the strategy for non DMHAS patients, **performing care coordination and case management**
 - He/she provides direct and indirect referrals to treatment and **follows up with nonDMHAS patients in the community**

Demonstrated success

- The CCT has demonstrated **impressive results in both hospital cost savings and patients' improved quality of life**
 - 52 patients who received CCT intervention for more than 6 months experienced a **52% reduction in combined ED and inpatient visits**, leading to decreased losses of ~\$485K
 - The average CCT patient also experienced decrease in losses, around ~\$9K
 - Improved quality of life including increase sobriety, housing, and re-connection with family
- **CCT plans to expand to treat more patients** (e.g., expand to at risk patients) and to share results across the state at @CT forums.

¹ Since then the CCT has expanded to include an additional 5 member organizations - CT Valley Hospital, St. Vincent DePaul, Community Health Center, Advanced Behavioral Health, Value Options CT, and Community Health Network
SOURCE: Communication with executive at Gilead Community Services, Inc.



1 Example opportunity to further enhance care coordination through connectivity

Creating a consumer-provider-coordinator collaboration portal

ILLUSTRATIVE

1. Consumer input
2. Provider/coordinator input
3. Provider system input (e.g., EHR)

Snapshot of Consumer X

- Current medications
- Allergies
- Medical concerns/Dx
- Recent appointments
- Lab Results

Plan for Consumer X

Consumer A's health promotion advocate is scheduling appointment his next appointment

Resources available

- Call 1-800-555-555 for community support program in your county
- Email yourdoctor@ for provider support

Click [here](#) for Safety Plan

Portal accessible by consumers and all members of provider team

- Encourages joint decision making between consumer and all members of his/her care team (e.g., physicians, nurses, health promotion advocates, care coordinators)
- Addresses several dimensions of distinctiveness
 - Consumer/patient centricity and engagement
 - Joint decision making between patients and providers
 - Care coordination/management
 - Health information sharing
 - Behavioral health care

Feedback on last work group meeting and investment recommendations

Feedback on July 8th meeting

- **Guidance** from the delivery system (DS) and payment reform (PR) groups **remains too general**. A better defined vision of a transformed system would guide more focused HIT recommendations.
- Regarding the areas of distinctiveness, **the best solution would pull proportionately from all categories** (including sustainability) to achieve the SIM vision.

HIT investment overarching considerations

- Support a **population health** perspective
- Encourage **public-private partnerships**
- Leverage previous **federal CT investments** (e.g., HIX – HealthCT)
- Balance spending between **infrastructure development and programmatic initiatives** aimed at achieving short-term savings
- Develop a **sustainability plan with a re-investment strategy** and sustainable revenue source(s)
- Consider proposed **public utility model** framework¹
- Support **judicious public policy reforms** including streamlining consumer consent policies, combining APCD+HITE-CT, data and software interoperability (with explicit prohibitions against anti-competitive practices) and standard metrics across payers and delivery systems which are aligned with national benchmarks

HIT investment tactical priorities

- Enable some **key system's capabilities** to manage cost and quality (e.g., risk stratification routines, predictive modeling, care management and care coordination)
- **Revamp MMIS** (DSS claims payment engine) so that new capability matches or surpasses best commercial claim payment (i.e.: supports ICD-10 environment), data acquisition and transmittal capability
- Improve **human service agencies** data sharing capabilities (may start with 3-4 agencies like DSS, DMHAS, DDS and DPH) and **leverage system-wide unique member identifier** and **shared portal** for end-users to determine agency specific program eligibility
- Enable **HITE-CT to link private HIE hubs** across the state and beyond
- Integrate APCD and HITE-CT and achieve a **minimum 2-tier claims + clinical data structure**
 - Tier-1 uses de-identified data. Example use: State-wide **balanced score card report**
 - Tier 2 uses PHI data: Example use: Create **unique member-specific clinical-claims longitudinal record**

¹ Villagra VG. (2012). Accelerating the Adoption of Medical Homes in Connecticut: A Chronic Care Support System Modeled after Public Utilities. Connecticut Medicine, 76(3), 73-76

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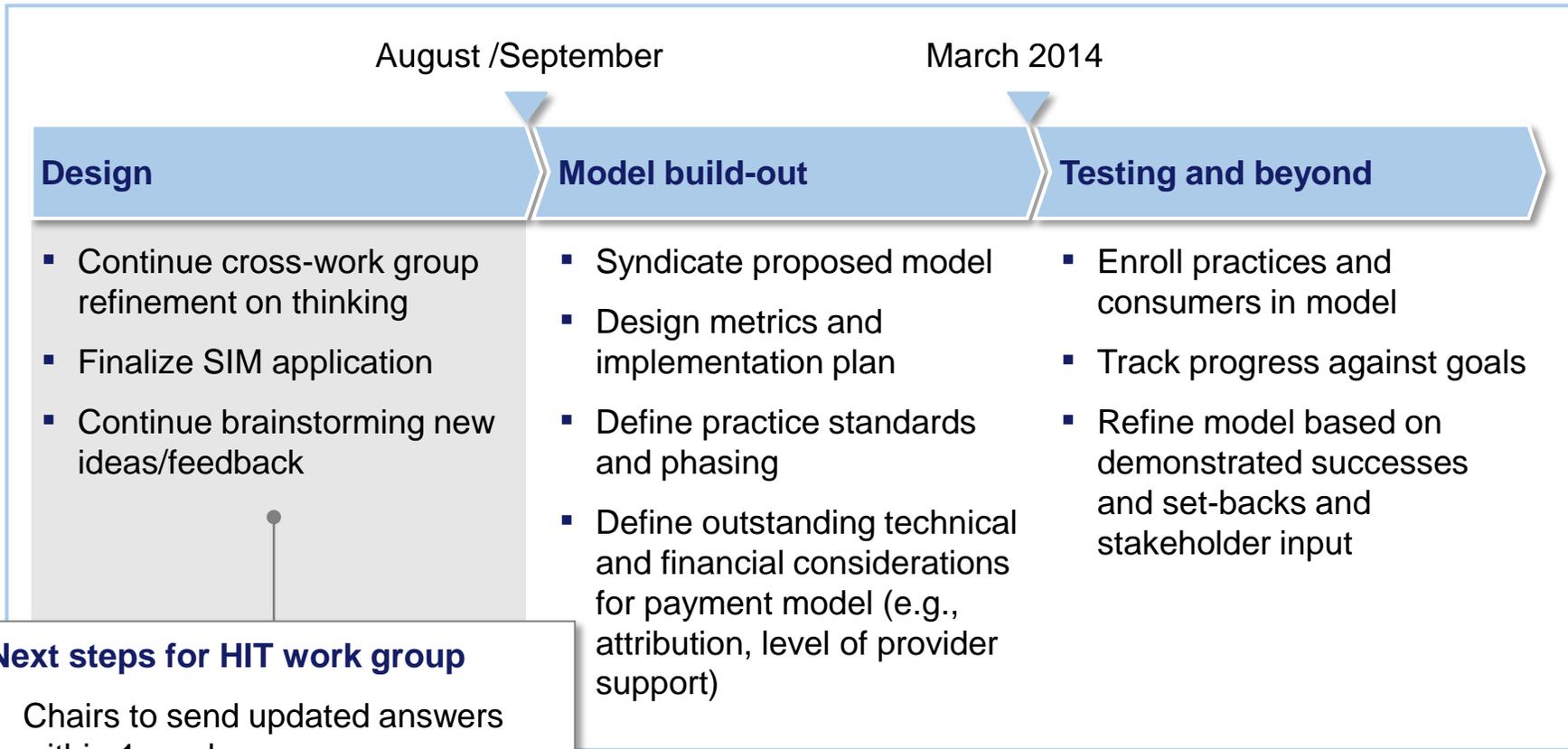
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Although this marks the end of our bi-weekly work group meetings, we have a plan to continue working together

 In progress

STRAWMAN



Next steps for HIT work group

- Chairs to send updated answers within 1 week
- Meet monthly (by phone) to review and refine answers if needed

Appendix

A What capabilities are required across key stakeholders to implement the target care delivery and payment model?

Category	Strawman answer	Typical tech pathway
<p>Payer analytics complemented by provider analytics</p>	<ul style="list-style-type: none"> Tools for payers to analyze claims to produce payment-related analytics, including metrics for outcome, quality and cost Complemented by provider analytics based on clinical data 	<ul style="list-style-type: none"> Heavy upfront development/sourcing followed by incremental enhancement
<p>Provider-payer-patient connectivity</p>	<ul style="list-style-type: none"> Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models 	<ul style="list-style-type: none"> Start with basic or low tech solutions to allow time for development or sourcing of tech-enabled enhancement
<p>Provider-patient care mgmt. tools</p>	<ul style="list-style-type: none"> Provider tools (e.g., workflow, event management, analytics) to coordinate the medical services for a patient 	<ul style="list-style-type: none"> Dependent on state-specific starting point and strategy in place
<p>Provider-provider connectivity</p>	<ul style="list-style-type: none"> Integrated clinical data exchange among doctors, hospitals, and other health care providers through a secure, electronic network 	

B What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model?

Category	Strawman answer
<p>Payer analytics complemented by provider analytics</p>	<ul style="list-style-type: none"> ▪ Existing payer risk adjustment, performance analytics tools deployed as part of PCMH/ACO pilots ▪ All payers claims database efforts (APCD) led by AccessHealth CT (potential when established) ▪ Tools to analyze clinical data among some providers (e.g. ACOs)
<p>Provider-payer-patient connectivity</p>	<ul style="list-style-type: none"> ▪ Payers' existing portals: <ul style="list-style-type: none"> – Provider portals that connect providers, health plans and practice management systems (e.g. Availity for Anthem) – Patient portals that allows enrollees to track claims and account activity, find doctors and services, access health advice and get answers to coverage questions (e.g., myCigna for Cigna) ▪ AccessHealth CT developing a patient portal to give comparison information for consumers on the Health Insurance Exchange
<p>Provider-patient care mgmt. tools</p>	<ul style="list-style-type: none"> ▪ DMHAS managing a system of care for behavioral health populations that includes care management tools
<p>Provider-provider connectivity</p>	<ul style="list-style-type: none"> ▪ HITE-CT promoting adoption of point-to-point connectivity tools (via direct messaging) for exchange of information between providers ▪ Large provider systems (e.g. Hartford Healthcare, Yale) with localized health information exchange solutions

What is the optimal level of payer infrastructure standardization across each component (e.g., data, analytics, pooling, reporting, portal)?

Category	Strawman answer
Payer Analytics (complemented by provider analytics)	<p>Standardized but not consolidated</p> <ul style="list-style-type: none"> Highly standardized metrics/analytics/reports created by payers' independent infrastructure Potential to leverage All Payer Claims Database (APCD) when established Claims-based analytics complemented by provider analysis of clinical data to better manage quality of care delivery and outcomes For provider analytics, leverage existing metrics (e.g., meaningful use) to minimize operational complexity/disruption and allow for comparisons across systems
Provider-payer-patient connectivity	<p>Mostly consolidated across payers</p> <ul style="list-style-type: none"> Need for a single portal for providers to access information from and submit metrics to multiple payers thus reducing operational complexity and user confusion
Provider-patient care mgmt. tools	<p>Following common guidelines but not consolidated</p> <ul style="list-style-type: none"> Providers committed to adopting care management process/technology but having flexibility to select vendors/solutions independently Potential options: <ul style="list-style-type: none"> Develop population health how-to manual and/or training that includes application of HIT capabilities (e.g. using excel to risk stratify the population) Provide minimum set of technology to enable provider care management Pre-qualify vendors or develop a shared services model to simplify the evaluation and procurement process while giving providers access to enhanced care management tools
Provider-provider connectivity	<p>Standardized but not consolidated</p> <ul style="list-style-type: none"> Exchange of health information between providers is a key enabler of a population health model SHIP/SIM needs to stay connected with HITE-CT as it facilitates provider-provider connectivity: <ul style="list-style-type: none"> Focus currently on accelerating adoption of direct messaging that will enable point-to-point exchange of health data Eventual goal to transition to a clearing house model for health information exchange between provider groups (HIE)

D What is the best strategy to develop the required HIT capabilities?

Category	Strawman answer
Payer analytics complemented by provider analytics	<ul style="list-style-type: none">▪ Begin with building on payer's own population health analytics and continue to establish the full set of tools required in the end state▪ In the longer term, look to leverage APCD to provide system level analytics that informs public health policy and consumer facing analytics that allows for cost/quality comparison across payers/providers
Provider-payer-patient connectivity	<ul style="list-style-type: none">▪ Select and scale a single existing provider portal for use across multiple payers▪ Leverage AccessHealth CT and APCD patient portal to promote consumer engagement efforts▪ Potentially develop state relationships with 3rd party patient engagement tool vendors (e.g. Castlight, Truven Health Analytics etc.)
Provider-patient care mgmt. tools	<ul style="list-style-type: none">▪ Educate and inform (near term): Set adoption requirements and provide information/coaching to adopt technology and/or source services▪ Create marketplace (potential option for medium term): Pre-qualify vendors and pre-negotiate discounted pricing▪ Develop shared services (potential option for long term): Create a state-wide solution for all providers in the state to 'plug-in' to
Provider-provider connectivity	<ul style="list-style-type: none">▪ Follow HITE-CT strategy: evolution from adoption of point-to-point connectivity tools (via direct messaging) towards health information exchange via a clearing house model (HIE)

SOURCE: HIT workgroup discussions

E What will be the pace of roll-out of the required capabilities throughout the state?

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 yrs)	Stage 3 (3+ yrs)
Payer analytics complemented by provider analytics	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify 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
Provider-payer-patient connectivity	Multi-payer online portal for providers to receive static reports; basic patient portal to allow consumers to enter quality metric data	Bi-directional provider-payer portal with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
Provider-patient care mgmt. tools	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools 	
Provider-provider connectivity	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange ¹ solutions	Potentially integrate state-wide Health Information Exchange ¹

¹ HITE-CT will drive adoption of provider-provider connectivity tools and eventual creation of a state-wide health information exchange

H What are the opportunities/challenges for HIE/EHR adoption, and approaches to improve HIT?



To be updated by state HIT coordinator

J What is the strategy to coordinate with state-wide HIT initiatives?



To be updated by state HIT coordinator

L What is impact on MMIS, including implementation timelines?



- MMIS is the system of record for all Medicaid claims and payments and will continue this function into the future. The CT SIM initiative will **leverage the Medicaid DSS to complement state analytics** with measures to track state outcomes
- MMIS can serve as the starting point for different **data integration approaches**
- Aggregate MMIS Medicaid claims with state employee claims into a single database as a **start to a multi-payer claims database for analyzing outcomes, quality, and cost**
- Integrate MMIS Medicaid claims data with HIE clinical data to create a **comprehensive patient view** of Medicaid patients
- CT will leverage Medicaid DSS to support SIM initiative analytics to calculate measures required to **track performance of the new delivery and payment model**
- The CT SIM initiative does not anticipate substantial changes in MMIS functions

Open questions across work streams (1 of 2)

Question	Period in which to develop answer			Method
	Design		Pre-testing	
	By Aug	By Oct	By March 2014	
1 How will CT's comprehensive solution be distinctive?	✓			Work group
2 What will be the measureable state-wide aspiration for change over the next 3-5 years?	✓			SHIP
3a What is the extent to which providers need to pool together or aggregate to participate in model?	✓			Co-chairs + work group
3b What is Connecticut's reinvestment and sustainability strategy for enabling infrastructure?	✓			Co-chairs + SHIP
3c What is the optimal level of upfront investment and provider support in Years 1,2,3, and beyond?			Detail – payer specific ✓	<i>Design:</i> Co-chairs <i>Pre-testing:</i> Payer coalition
4 What will be the strategy and plan for integrating the consumer/ community to increase consumer/ community engagement and improve population health management?	Strategy ✓	Detail ✓		HCC+ Community Taskforce
5 What will be the requested policy and legislative changes to support the new care delivery, payment, and HIT models?	ID req'd changes ✓	Strategy ✓		Policy Taskforce

Open questions across work streams (2 of 2)

Question	Period in which to develop answer			
	Design		Pre-testing	
	By Aug	By Oct	By March 2014	Method
6 What will be the practice standards for providers to be recognized under Connecticut's accreditation model and how will they be phased?	Strategy ✓		Detail ✓	<i>Design:</i> Completed <i>Pre-testing:</i> Practice standards/metrics taskforce
7 For what metrics will providers be accountable in years 1-5?	Strategy ✓		Detail ✓	<i>Design:</i> PWG <i>Pre-testing:</i> Practice standards/metrics taskforce
8 How will attribution be assigned to a lead provider?	Strategy ✓		Detail – payer specific ✓	<i>Design:</i> PWG <i>Pre-testing:</i> Payer coalition
9 What strategies will be employed to improve workforce capacity and capabilities?		✓		UCHC/ DPH taskforce
10 What will be the governance model during the testing phase?		✓		SHIP
11 How will SIM testing grant funds be allocated?		✓		SHIP
12 How will individual payers set their risk corridors, performance targets, and risk adjustors?			Detail – payer specific ✓	Payer coalition

Proposed operating model for remainder of design and pre-testing phases

Design			Pre-testing				Mandate	
Aug	Sept	Oct	Nov	Dec	Jan	Feb		Mar
SHIP: Every 3 weeks								<ul style="list-style-type: none"> Overall oversight Solicitation of feedback Decisions on 2, 3c, 10, 11
HCC: Monthly								<ul style="list-style-type: none"> Input into 4 Solicitation of feedback from broader community
UCHC/ DPH taskforce: Every week								<ul style="list-style-type: none"> Ownership of 9
Community taskforce: Biweekly								<ul style="list-style-type: none"> Recommendation on 4
Policy taskforce: Biweekly								<ul style="list-style-type: none"> Recommendation on 5
	▲	▲	▲					<ul style="list-style-type: none"> Solicitation of feedback from broader community Incorporation of feedback into plan and application
	<ul style="list-style-type: none"> Payment work group Care delivery work group HIT work group 							<ul style="list-style-type: none"> Recommendation on 6,7
				Practice standards/metrics taskforce: Monthly				<ul style="list-style-type: none"> Sharing and review of payer-specific decisions
				Cross-payer coalition: Monthly				