

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Health Information Technology Council Meeting

April 17, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	10 min
4. Medicaid Data Sharing Issues Discussion	10 min
5. Charter and Conflict of Interest Recommendations	10 min
6. Measures Performance and Reporting Design Group Summary	10 min
7. Inter-Council Memorandum: Response from the Quality Council	10 min
8. Edge Server Education and Q&A	50 min
9. Next Steps	5 min
10. Appendix	

Medicaid Data Sharing Issues

- Review of the law
 - Discussion of Connecticut's interpretation of the law
 - What other states have done
 - Questions
-
- Note: copies of the summary are available in the back of the room



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Roles and Responsibilities

1. Develops and recommends SIM HIT Council charter
2. Establishes ad hoc task forces to investigate specific technical, functional and integration topics
3. **Discusses options and makes a recommendation using majority consensus.** If necessary, the council will follow a **majority voting process**, assuming a quorum (one co-chair and at least 50 percent of the members are present)
4. Members communicate SIM HIT Council progress back to constituents and bring forward their ideas and issues
5. Works collaboratively with the other SIM groups to collect and share information needed to provide an aligned HIT solution
6. Monitors progress **and financials**, and makes adjustments to stay within the timeline- **pre and post SIM HIT solution implementation**
7. Recommends SIM HIT solutions to the HISC
8. Comes to the meetings prepared by reviewing the materials in advance
9. **Issues, questions and concerns that cannot be resolved by the HIT Council as a group (versus individual members) are escalated to the HISC.**
10. **Has an Executive team that includes the co-chairs and one member from each of the three main stakeholder groups: payer, provider and consumer advocate. The executive team provides input into the agenda and brings to the co-chairs issues voiced by other members.**

Meeting Ground Rules

- Post Meeting Communications
 - **After the meeting members are invited to raise process and content issues with any member of the Executive team**

Executive Team Interaction

- The co-chairs plus three major stakeholders: Payer, provider and consumer advocate attend the pre wire agenda meeting to discuss topics and issues brought forth by other members.

Note: changes in bold



Conflict of Interest Proposed Amendments

Guiding Principle:

- “Comply with the SIM’s Conflict of Interest (COI) protocol, **currently in draft status**”

Conflict of Interest, amend sub bullet 3 under bullet 4 to:

“ If the SIM PMO requests advice from an advisory body regarding the allocation of budgeted funds to support an initiative, it is the duty of the members of that body who have an actual, perceived or potential conflict of interest to disclose that information to the advisory body immediately. At that time the member has the option of recusing himself / herself. If the member does not recuse, then the advisory body will determine if the COI is valid. If so, the member who **could directly benefit** from such decisions or whose organization **would** directly benefit will be asked to recuse himself/herself from voting and potentially from further participation in such deliberations.”

Note: Proposed changes are also being reviewed by the PMO.



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Measures Performance and Reporting Design Group Meeting #2

Summary of HIT Council Design Group response to the Memorandum update and Zato questions

- Overall the group was in favor of the two stage approach under consideration by the Quality Council, which was developed to address the tight timeframe, limited dollars and the need for a technical “win”
- Three categories of questions were developed for Zato (refer to appendix for a complete list of questions):
 - Functionality and “how” it works
 - Explanation of its capabilities to index/tag data and the ability to use the data but not move it
 - Are we getting the Zato tool and the built-in measures? If yes, which ones?



The Design Group identified additional questions and discussion points for the HIT Council to address that are not related to the Zato presentation.

1. Should there be direct communication between the HIT Council and other Council members, especially the Quality Council?
2. The HIT Council must clearly articulate the vendor's deliverable once its functionality is understood and the functional design is crafted. This information should be used to educate the other Councils.
3. Readmissions data may already be available via other state agencies' data sources. Should we consider these to minimize additional work? For example, the Department of Public Health receives readmission data from the Connecticut Hospital Association on an annual basis.
4. The performance measure solution must deliver the January 2016 standup requirements and also be able to grow beyond the first year capability. Therefore, the Council will need to design the solution with both a short and long term lens, even if the long term solution replaces the Year 1 solution.
5. The Design Group would like more details on the deliverables beyond the 2016 measures. Overall they need more information on all performance measurement requirements for Years 2-3.

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Quality Measure Production Narrative - DRAFT

The Council request for the first stage of this initiative is the production of measures of provider performance that can be used by all payers as the basis for shared savings distribution. At a minimum this requires measurement of the provider's performance (advanced network or FQHC) for all patients attributed to that provider by each payer, in aggregate and stratified by race/ethnicity.

Assumes that:

- all measures are eCQM measures that can be produced by any ONC certified EHR
- providers are responsible for developing their own analytic methods to inform continuous quality improvement, and
- all measures and any associated data are de-identified from point of extraction

Stage 1 - End User Requirements – For discussion

- End users for stage 1 will include:
 - PMO – generates the aggregated reports and posts appropriate information to inform a consumer view of provider quality
 - Payer – reliable and valid performance data for use by all payers in value-based payment scorecard and shared savings distribution
 - Provider – performance information for use in monitoring progress over time and informing areas for focused improvement

Stage 1 - End User Requirements – For discussion

- Payers will not require patient level detail, there will need to be a robust audit process whereby an auditor is provided access to patient level data in order to certify the accuracy/validity of the reported measures

Or

- Payers will require identifiable data so that they can audit directly and so that they can limit the measure to specific accounts/contracts...e.g., fully insured, individual self-funded accounts, exchange products

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Edge Server Education and Q & A Session

Presenter:

Paul McOwen, CEO

Purpose:

Education on the capabilities and status of the Zato Solution

Questions for Paul:

Refer to Appendix



Principals Supporting Connecticut DSS

- Paul McOwen (CEO) – Administrative Director of a National Science Foundation research center and Deputy Chairman of Computer Science Department at University of Massachusetts, Amherst; managed development, deployment of interoperability software
- Dr. Daniel Heinze, PhD (Founder and Chief Scientist) – CTO, chief inventor/architect for A-Life Medical (acquired by UnitedHealth in 2010); developed the most widely used system for automated medical text processing and coding in the healthcare industry
- Dr. John Holbrook, MD (Founder) – Created first 24/7 Hospitalist program in the U.S.; Director, Chief Medical Officer, VP for hospitals, hospital associations, state programs, medical software companies, health related insurance companies
- Dr. Winthrop F. Whitcomb, MD (Founder) – Co-Founder of the Society of Hospital Medicine (> 10,000 healthcare professionals); hospital VP, Medical Director for Quality Improvement and Clinical Documentation Improvement; Chief Medical Officer for Remedy Partners

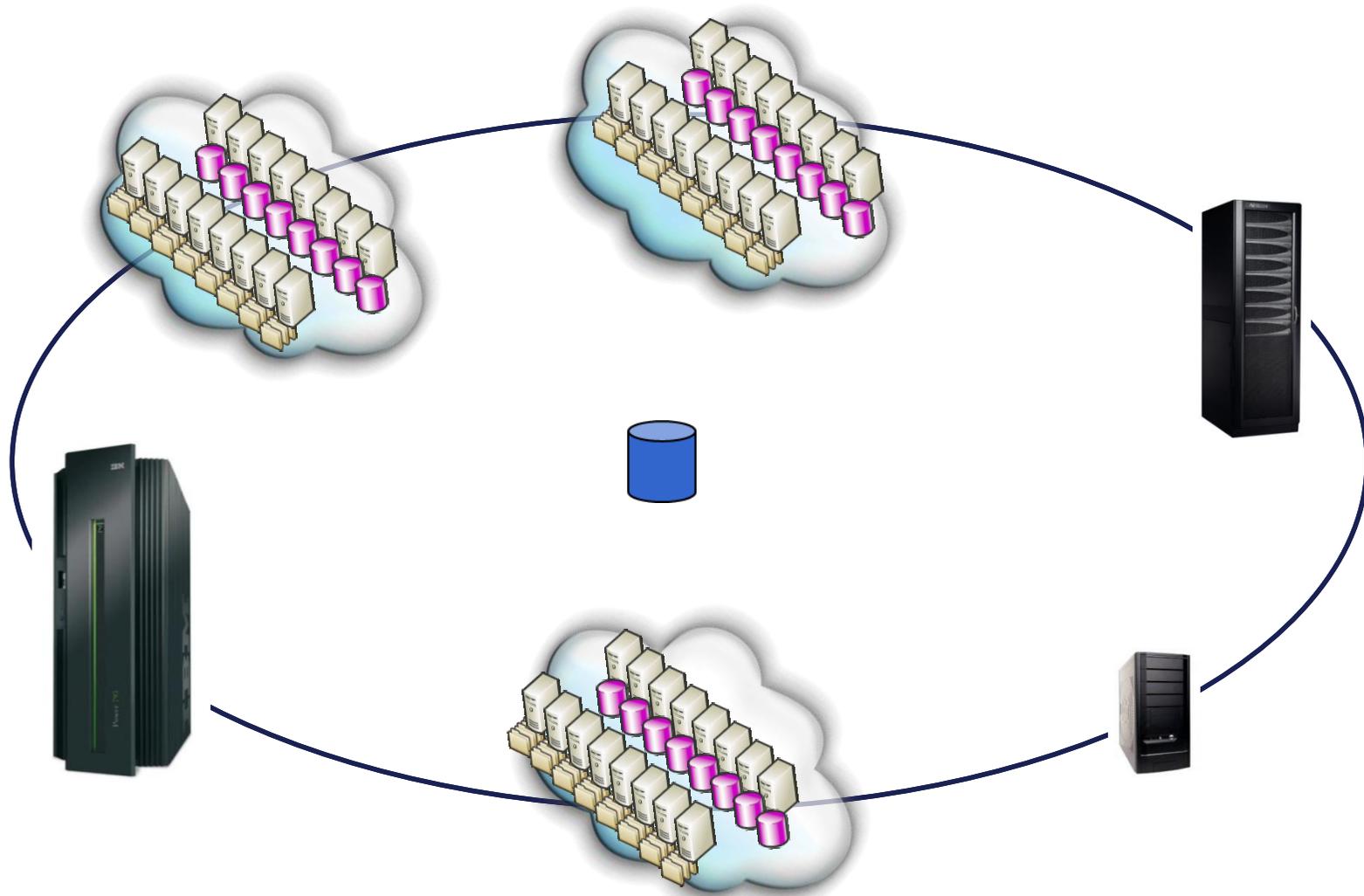
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www.zatohealth.com 617 834-8105

State MU Reporting for Provider Groups is Evolving

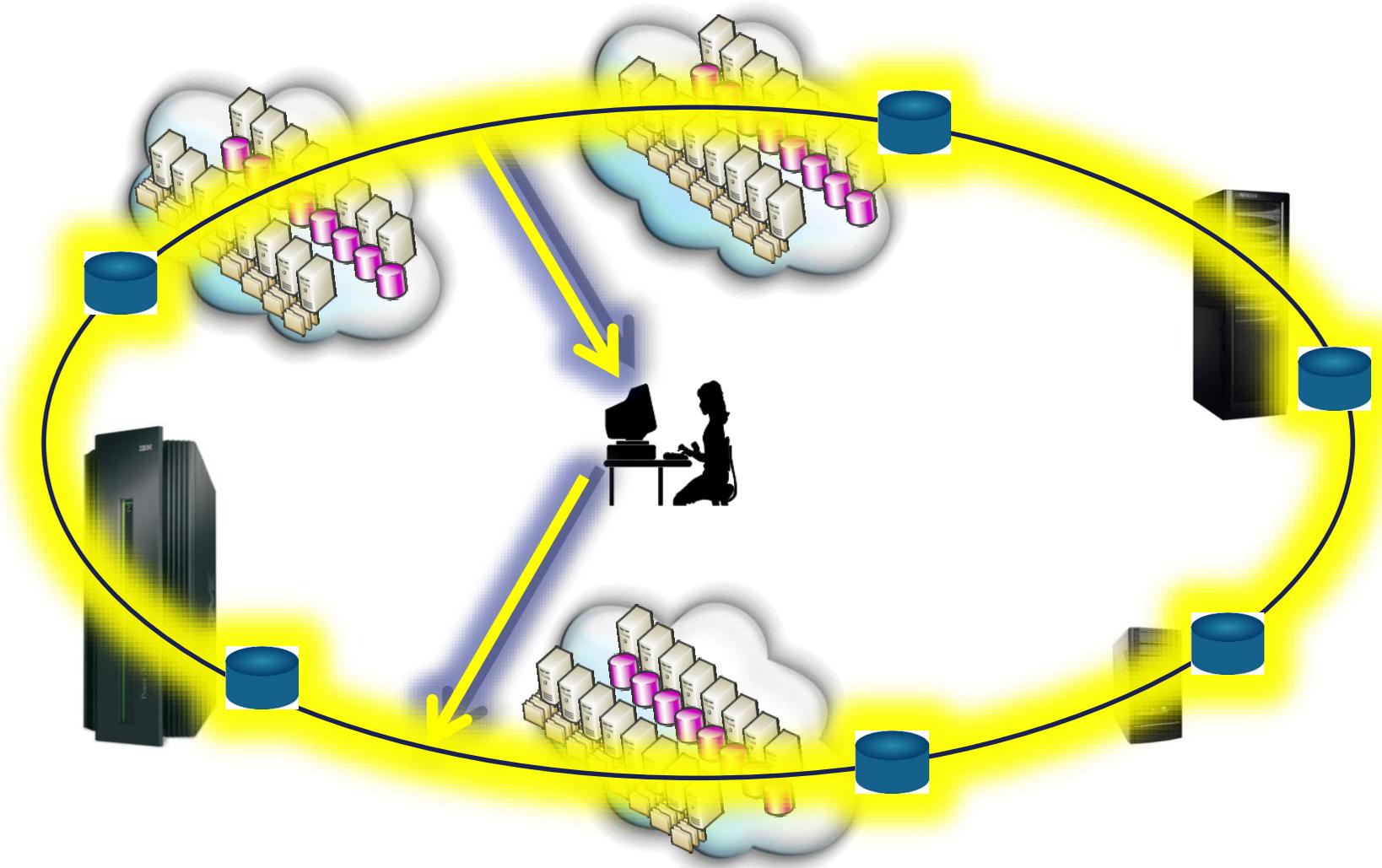
1. Processes modeled on federal MU reporting have not delivered consistent, complete, comparable data efficiently from disparate EHRs and other data silos
2. Open Source reporting models are a useful and affordable resource
3. Federal data reporting model is shifting to support a changing payment model
4. Interoperability software provides the fidelity back to the EHRs and data silos to :
 - a) Enable efficient, affordable verification and auditing of submitted data
 - b) Incentivize Providers for reporting more useful data
 - c) Correlate reporting criteria need with payments, outcomes, and costs
 - d) Incentivize enabled improvements in quality of care and cost effectiveness

A Data Warehouse or Data Lake Requires Copying and Aggregation of Diverse Healthcare Application Data for Centralized Processing



Cooperative 'Edge Processing' Spans a Navigable Network of Data Repositories ('Virtual Data Lake') without Data Centralization

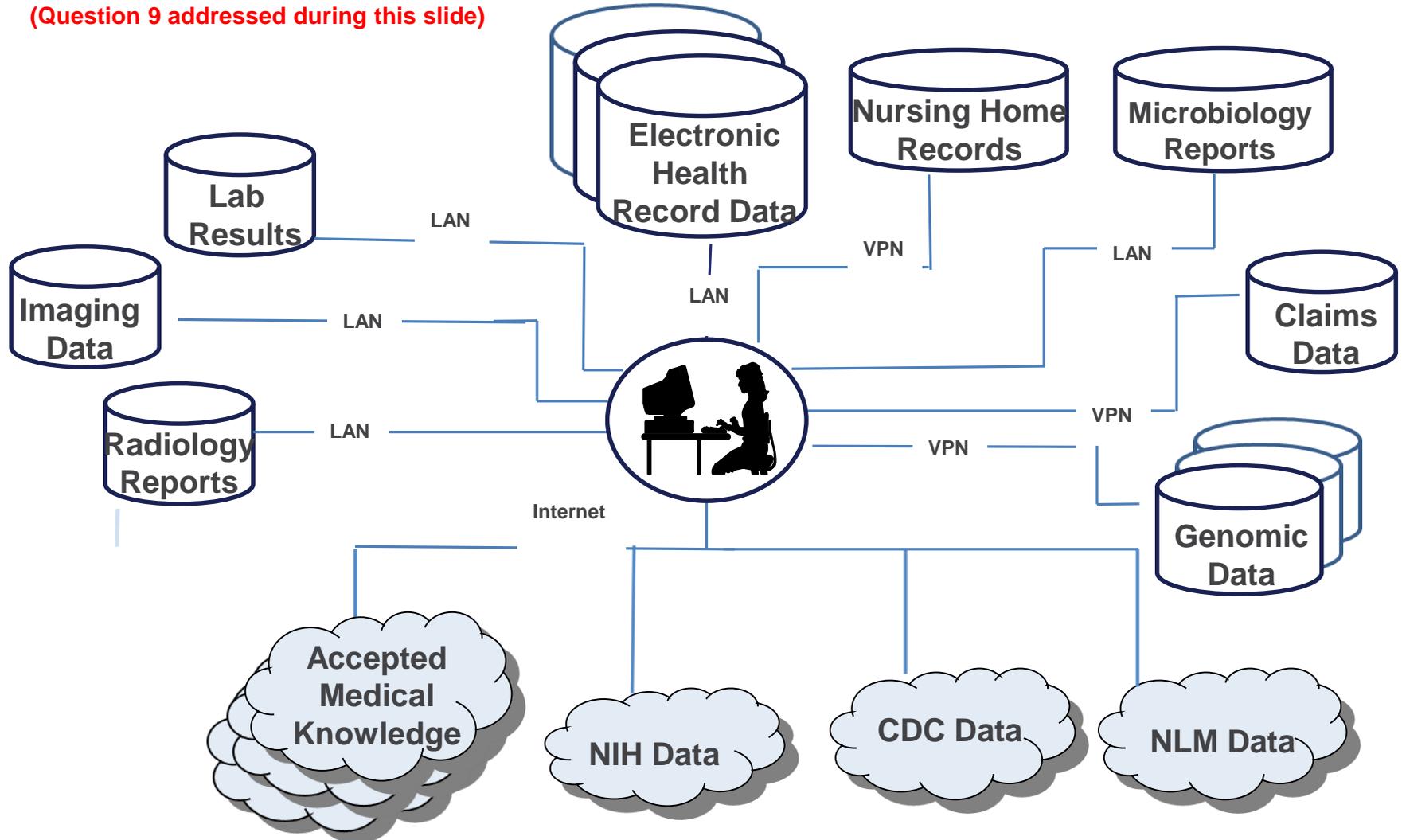
(Questions 1-6 addressed during this slide)



Edge Server Education and Q & A Session

Spanning Data Centers and Organizations Simultaneously for Interoperability, Productivity, and Global Views

(Question 9 addressed during this slide)



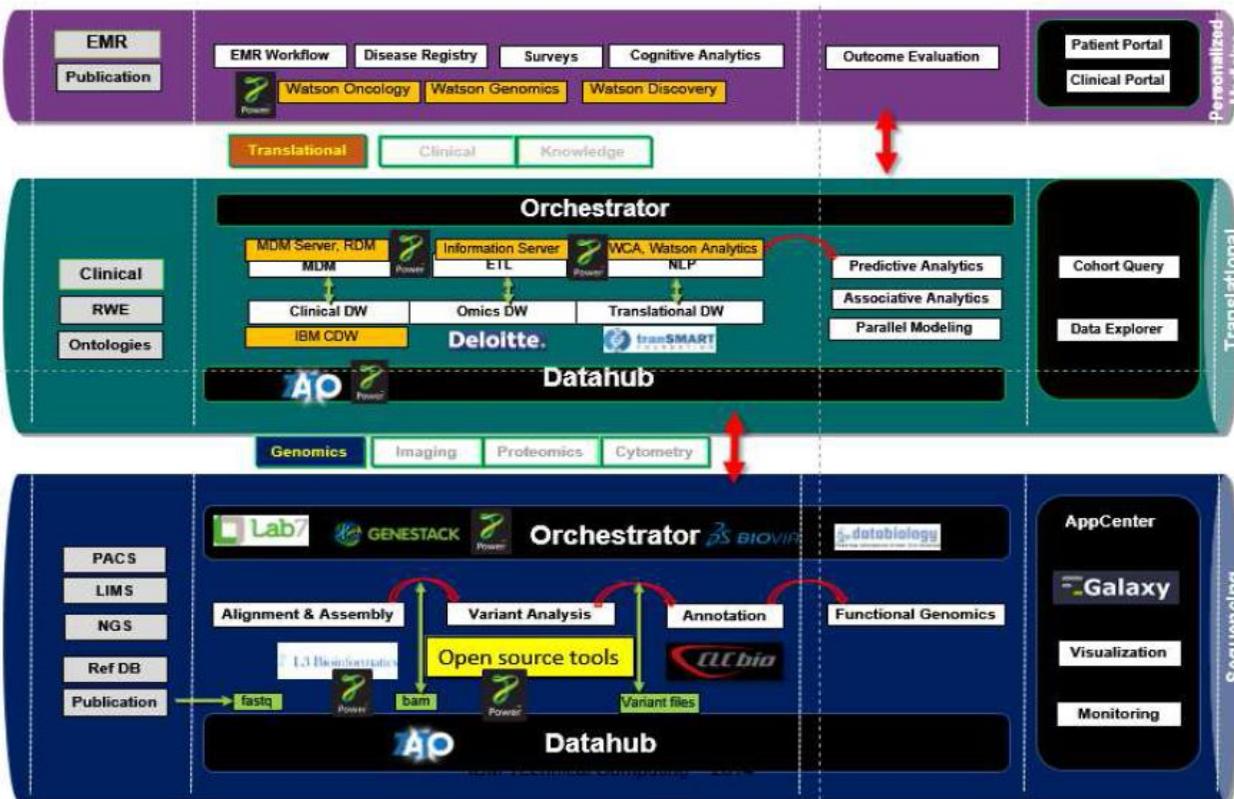
Some of the Sites Where Zato's Edge Processing Software Has Been Installed for Production, Demonstration, or Testing

(Question 13 addressed during this slide)

- Baystate Health (Springfield, MA)
- Berkshire Life (Springfield)
- Connecticut DSS (BEST data center)
- Dept of Defense (Defense Cyber Crimes Center, multiple DOD agencies)
- Dept of Homeland Security (multiple agencies, divisions and locations)
- Elsevier (Netherlands)
- FBI (multiple divisions and locations)
- IBM IZPower appliance, PowerGene Architecture (multiple IBM locations)
- Netezza (Massachusetts)
- Pfizer Inc. (New York)
- Raytheon (Dulles VA)
- SOCA (UK)

IBM PowerGene Architecture: Extended View

PowerGene is an ecosystem of data management and analytics tools developed by IBM and industry-leading commercial and open source software providers



v7.5.4

January 2015

6

Resources Requested of a Provider Site for a Demonstrable and Re-Usable Reference Implementation

(Dr. Tikoo question addressed during this slide)

1. DBA time for schema review set up for indexing initial data sources
2. User time for use case input and feedback
3. Server, storage, network resources for the size of the implementation
4. On boarding paperwork for Zato Health staff vetting, access
5. Management time for planning/guidance/oversight/feedback and viewing incremental demonstrations

Note: Actual time is proportional to the size of implementation. For example, implementation for a large multi-hospital provider would likely require a minimum of 46 total hours of Provider personnel resources over a 3-month implementation period.



FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

“Doc Fix” Law and Sustainable Growth Rate

- Consolidates MU2, Physician Quality Reporting System, Value-based Modifier into a single system:
 - Merit Based Incentive Payment System
- Replaces SGR permanently
- Awards bonuses to MD groups with > 25% of revenue in alternative payment models:
 - ACOs, bundled payments, medical homes
- Implication: Hospitals partnering with MDs in these models is a business imperative

Reporting Clinical Quality Measures Example Controlling High Blood Pressure (Question 11 addressed during this slide)

Clinical Quality Measure NFQ 0018

Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Required Data Elements

Applicable Diagnosis (ICD-9, ICD-10, SNOMED) codes for Hypertension

Applicable Claims/Registry #236

Office Encounter or face or face interaction (SNOMED, CPT) code

Exclusion:

Applicable Diagnosis (ICD-9, ICD-10, SNOMED) codes for Pregnancy, ESRD, CKD stage 5, renal transplant

Sources of data

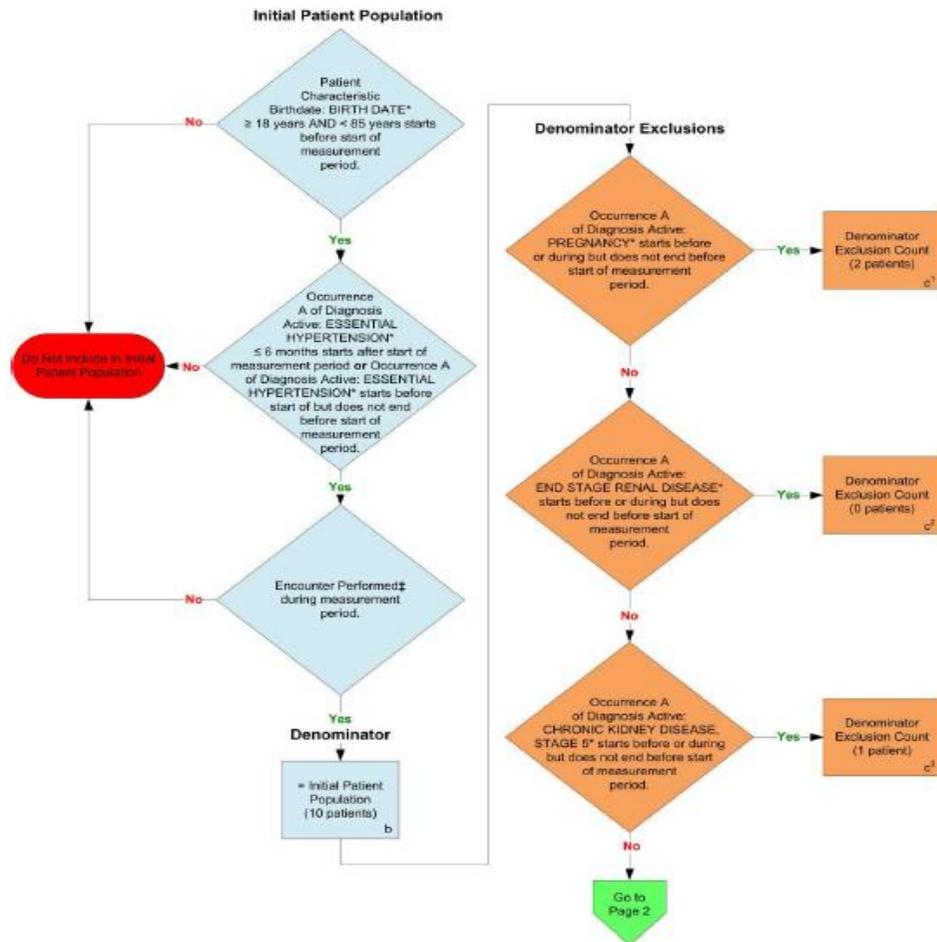
HL7 feed

Index of EHR database

Registry

NQF 0018: Controlling High Blood Pressure

2014 eCQM Flow
Measure Identifier: CMS165v3
NQF 0018: Controlling High Blood Pressure



*Please refer to the specific section of the eCQM to identify the QDM data elements and associated value sets for use in reporting this eCQM.

‡ For a listing of appropriate encounters, please refer to the QDM data elements and associated value sets as specific data elements have not been listed.

MU Reporting Example

Diabetes: Hemoglobin A1c Poor Control

(Question 11 addressed during this slide)

Clinical Quality Measure NFQ 0059

Percentage of patients 18 – 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c > 9.0% during the measurement period

Required Data Elements

Applicable Diagnosis (ICD-9, ICD-10, SNOMED) codes for Diabetes

Applicable (LOINC) code for Hemoglobin A1c linked to a lab result

Office Encounter or face or face interaction (SNOMED) code

Exclusion:

Applicable Diagnosis (ICD-10, SNOMED) code for Gestational Diabetes

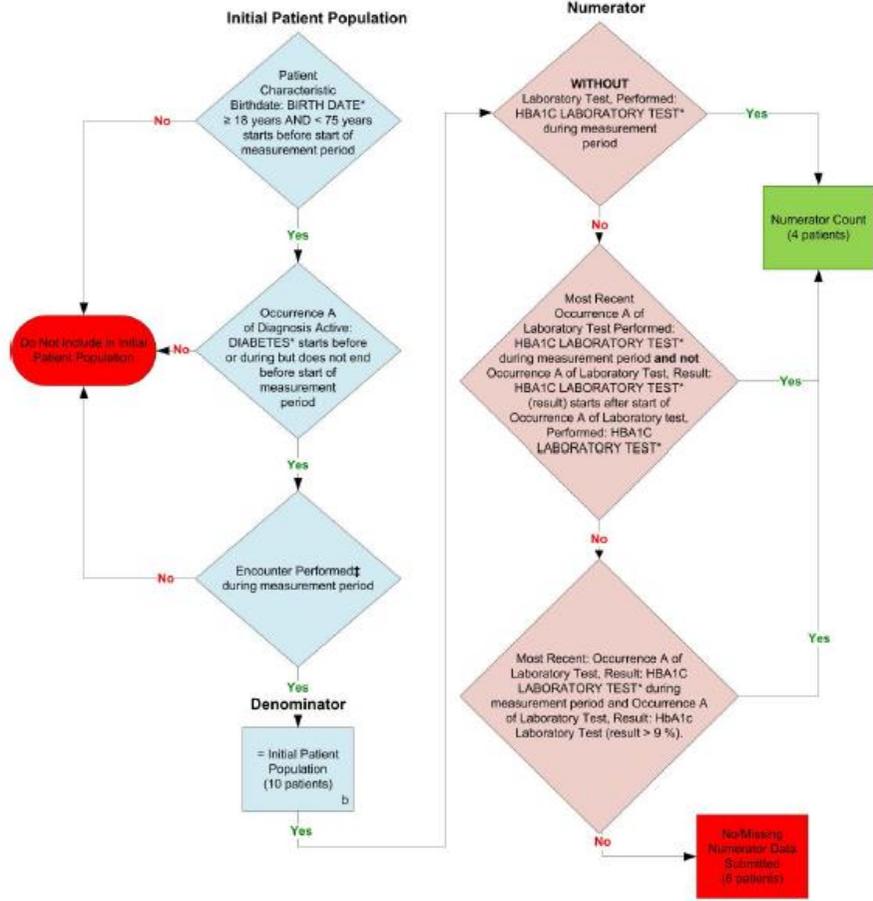
Sources of data

HL7 feed

Index of EHR database

NQF 0059: Diabetes: Hemoglobin A1c Poor Control

2014 eCQM Flow
 Measure Identifier: CMS122v3
 NQF 0059: Diabetes: Hemoglobin A1c Poor Control



*Please refer to the specific section of the eMeasure to identify the QDM data elements and associated value sets for use in reporting this eMeasure.
 ‡ For a listing of appropriate encounters, please refer to the QDM data elements and associated value sets as specific data elements have not been listed.

SAMPLE CALCULATION:

Performance Rate** = $\frac{\text{Numerator (a=4 patients)}}{\text{Denominator (b=10 patients) - Denominator Exclusions (N/A) - Denominator Exceptions (N/A)}} = 40.00\%$

** For performance, a lower rate indicates better performance.

Multiple HIT Uses for Edge Processing Interoperability

(Questions 7, 8,10, and 12 addressed during in the next 3 slides)

1. Extract clinical concepts required for existing MU reporting and new reporting standards. Provides a secure remote link back to source medical records without moving the data.
2. Flexible re-use of extracted clinical concepts for reporting quality of care measures, cost effectiveness, re-admission information, and other healthcare information stored in one or more EHR systems and other data silos in one or multiple hospitals, nursing homes, and medical testing organizations.
3. Provides a secure remote link in real time to the clinical note to provide alerts for documentation/clinical deficiencies. Provides a unified view across the ACO of multiple points of care.

Multiple HIT Uses for Edge Processing Interoperability

4. Extract key clinical concepts from inpatient records for purposes of automated ICD-9 coding (with a path to ICD-10), SNOMED awareness, DRG coding, and Clinical Documentation Improvement. Access to key clinical facts in real time during a hospitalization provides a dashboard for accurate decision-making and real-time quality alerts.
5. Accountability reporting to achieve full reimbursement to states for Medicaid services provided to state residents, where the data needed for the analysis may be stored in multiple silos and CMS reimbursement policies might change from time to time for various cohort groups.
6. Productive and accurate analysis for claims verification and auditing.

Multiple HIT Uses for Edge Processing Interoperability

7. Meaningful use at the point of care: real time access to current inpatient and outpatient patient-specific records throughout a region, across multiple data silos, fulfills a primary goal of health information exchange: access to patient medications, allergies, diagnoses, and recent clinical encounters is cost effective in routine care, and critical for emergency care.
8. Paid-up state-wide license to use the Interoperability Platform. Applications are freely distributed for use on the platform. API enables interfacing with and seamless feeding of data to other applications such as the open source PopHealth MU reporting application.

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1. Suggested Agenda for May

- Discussion of Medicare SSP/ACO sampling method for measure calculation (Design Group)
- Review and comparison of different technology options (Design Group)
- Discussion of options and recommendation for short-term solution (full HIT Council)
- Process for re-evaluating options for long-term solution (full HIT Council)
- Inter-council memorandum process discussion (full HIT Council)

2. Other Topics

- CTO resource
- June agenda topics



Appendix

Zato Questions

1. In the video explanation of the system, the speaker stated that the solution "overlays systems." Please explain what that means in general, and give at least one specific example relevant to our initiative.
2. Again from the video, the speaker states that the solution "Does not move the data from the EHR." Please explain in greater detail what that means and how it applies to our solution requirements.
3. There are restrictions on access to some data (e.g., Medicaid). Can the Zato edge server technology access all data sources?
4. The SIM HIT design needs to take into account that individual providers have varying levels of technology. How can we prepare for the spectrum of technologies including no technology at all?
5. How does the SIM HIT design address the gap/overlap factor? (for providers that don't have EHRs and patients who see multiple providers)

Zato Questions, continued

6. Please provide additional information on Zato's capabilities for collecting and aggregating data.
7. How does an individual provider or ACO benefit from having the edge server and software?
8. If the Zato solution is selected, will it act as an aggregating tool exclusively or will there be additional capabilities built into the software? For example, Zato's demonstration [video](#), viewed by Design Group participants prior to the meeting, alludes to a built-in capability to calculate and report CMMI standards.
9. Will we need to create a database and warehouse as the complexity of the data collection and reporting/analytics increases in years 2-5?
10. Can Zato measure improvement and public health 20/20 indicators?

11. Can Zato be used to calculate meaningful usage measures?
12. If Zato has programs to produce FQHC standards, can they demonstrate how those programs are used?
13. Where has Zato been installed?