

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Health Information Technology Council Meeting

August 21, 2015

Agenda Item	Presenter	Timing (Minutes)	Action
1. Introductions	Commissioner Bremby	5	Discuss
2. Public Comments	Commissioner Bremby	5	Discuss
3. Minutes	Commissioner Bremby	5	Approve
4. HIT Charter Review and Confirmation	Commissioner Bremby	10	Approve
5. HIT Environment and Lessons Learned from Other States	Minakshi Tikoo	25	Discuss
6. PTF Update on CCIP	Michelle Moratti	15	Discuss
7. Quality Council Update	Michelle Moratti	5	Discuss
8. Zato Pilot Approach	Michelle Moratti	25	Approve
9. Next Phase Work Group Structure	Michelle Moratti	20	Approve
10. Next Steps	Commissioner Bremby	5	Discuss

4. SIM HIT Council Charter Review and Confirmation

10 min



In the June 11th Steering Committee meeting concerns were raised by many - Ms. Lash, Mr. Raskauskas, Mr. Woodruff, and Ms. Baker...(refer handout for details)

The SIM HIT Council Charter does not look like other SIM workgroup Charters

“it seems like the HIT Council is off doing their own thing”...Ms. McNichol

QUALITY COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for a core set of measures for use in the assessment of primary care, specialty, and hospital provider performance. This workgroup will develop a common provider scorecard format for use by all payers and reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice. SIM aims to achieve top-quintile performance among all states for key measures of quality of care, and increase the proportion of providers meeting quality scorecard targets. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work.

Key questions this work group needs to answer

Measures

1. What are the structure, process, patient engagement and experience, efficiency, disparities-sensitive, outcome, and cost measures that are in use today by national quality bodies and CT's health plans? (e.g. NQF, AHRQ, NCQA, CAPHS)
2. Which of these measures should be adopted to measure provider performance, taking into consideration the target conditions identified in the Innovation Plan?
3. Which of these measures should be adopted to measure provider performance, taking into consideration the prevention goals identified in the Innovation Plan?
4. What other measures could be used as indicators for whole-person-centered care, enhanced access, and coordinated care (e.g. behavioral health, oral health)?
5. What measures could be used as indicators of workforce productivity/timely return to work?

Metrics

1. What are the metrics for each of the measures and how will they be calculated?
2. What methods will be used for risk adjustment and exclusions?

Common Performance Scorecard

1. What are the best examples of performance scorecards currently in use?
2. What will Connecticut's common scorecard across all health plans look like?
3. What is the process for all health plans to implement the common scorecard?
4. How will cross-payer analytics be integrated for a given practice profile, including commercial and public payers?
5. Is there a recommended frequency and schedule that could be adopted across payers?
6. How will the common performance scorecard be integrated with value-based payment calculations?
7. How will the scorecards be made available to the public?

Common Care Experience Survey

1. What are the best examples of care experience surveys currently in use?
2. Is there one survey that would best align with the goals of the Innovation Plan? Are there supplemental questions that should be considered?
3. What is the process for all health plans to implement the common care experience survey?
4. One what schedule should the common care experience survey be administered?
5. How will the common care experience survey be integrated with value-based payment calculations?
6. How will the results of care experience surveys be made available to the public?

EQUITY AND ACCESS COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; recommend a response to demonstrated patient selection and under-service; and define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work. Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. Under-service refers to systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. A finding of failure shall not require proof of intentionality or a plan.

Key questions this work group needs to answer – Phase I – Design & Implementation

Setting Context

1. Equity includes assurance that underserved populations aren't subjected to targeted under-service and patient selection. Disparities in quality, outcomes, and care experience will be within the scope of the Quality Council.

Assessing Risk

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

Guarding against under-service

1. What are the current methods utilized by private and public payers for detecting under-service?
2. Can standard measures and metrics be applied for the detection of under-service?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service?
4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?
5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?
6. What are the mechanisms for consumer complaints of suspected under-service?
7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

Guarding against patient selection

1. What are the current methods utilized by private and public payers for monitoring of patient selection?
2. Can standard measures and metrics be applied for the monitoring of patient selection?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect patient selection?
4. What other methods might be available to monitor for patient selection (e.g., mystery shopper)?
5. Who will monitor, investigate, and report suspected patient selection and what steps should be taken if patient selection is suspected?
6. What are the criteria and processes that a payer might use to disqualify a clinician from shared savings arrangements due to patient selection?
7. What are the mechanisms for consumer complaints of suspected patient selection?
8. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to patient selection?

Questions this work group may opt to consider – Phase II

1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?
2. Care variations and standardization, evidence-based standards?

PRACTICE TRANSFORMATION TASK FORCE

Charter

This Task Force will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for the implementation of the Advanced Medical Home (AMH) model under the Connecticut Healthcare Innovation Plan (SHIP). The AMH Model has five core components: (1) whole-person-centered care; (2) enhanced access; (3) population health management; (4) team-based coordinated care; (5) evidence-informed clinical decision making. This work group will develop the advanced medical home standards, detail the design of a “glide path” program in which providers are offered practice transformation support services for a limited period of time, advise on the process for vendor selection for practice transformation support and practice certification, and coordinate with interdependent workgroups and initiatives. The Task Force will identify key stakeholder groups whose input is essential to various aspects of the Task Force’s work and formulate a plan for engaging these groups to provide for necessary input. The Task Force will convene ad hoc design teams to resolve technical issues that arise in its work.

Key questions this work group needs to answer

Standards

1. What are the medical home standards in use today by the national accrediting bodies and Connecticut’s health plans?
2. Which of these standards align with and would best achieve the AMH core components (listed above)?
3. What additional standards should be considered that are not in use today? (e.g., oral health; NCLAS)
4. What standards should be established for coordinating with behavioral health homes and prevention service centers?
5. Of the above standards, which standards represent core capabilities that are achievable for small practices and essential for improving value?
6. Should the standards be applied uniformly, or should there be adjustments based on practice characteristics?
7. Should such standards be applied by site or by group?

Transformation Process

1. What are the criteria that a practice must meet to qualify for the glide path?
2. What readiness tools exist today and which among them should be adapted for use in the Advanced Medical Home program?
3. What are the milestones that correspond to major achievements in the glide path?
4. Which milestones are recommended as a qualification for advance payments?
5. What are the requirements for certification as an Advanced Medical Home?
6. What process should be used to support practice transformation? On-site assistance? Learning collaboratives?
7. How will this taskforce support the transformation pace and process?
8. What technical assistance should be provided to assist practices with selection, implementation, adoption of EHR?

Transformation Vendor Procurement

1. Should there be a single vendor or multiple vendors? Should they be regional or statewide? Should they be funded fixed grant, flat fee per practice, or paid per successful applicant?
2. Should the level of support and pricing depend upon the practice readiness assessment? For example, should there be tiered levels of support based on level of readiness/gaps or the presence or absence of an EHR?

SIM - Health Information Technology Council

Draft Charter

Purpose

Develop recommendations for the Healthcare Innovation Steering Committee with respect to HIT requirements and technology components by SIM participants (e.g. hospitals, physicians, state agencies, consumers) to achieve the goals of the SIM proposal. Specific recommendations and deliverables (outcomes) include:

- Solution set of scalable and adaptable health information technologies,
- High-level diagram of the technologies and data interactions
- HIT implementation approach and roadmap for SIM participants

Goals

- **Access:** Ensure HIT supports health care service access and delivery, as well as data aggregation method for analysis and quality improvement
- **Connectivity and Exchange:** Achieve integration across and within health care delivery systems and physician practices based on national standards for content and information exchange, and transmit data to the SIM participants.
- **Quality:** Support SIM Quality Initiatives that are quantitative and qualitative enabled by HIT. Provide ongoing monitoring of the data reporting and technology supporting the quality initiatives.

Scope

Scope: the range and boundaries of the responsibilities of the HIT Council

- In Scope
 - Review of the current and proposed technologies cited in the SIM grant to understand capabilities and uses for Test Model
 - Work collaboratively and actively support two way communications with the other SIM workgroups and councils to develop the HIT design.
 - High level schema of HIT solution
 - SIM HIT solution implementation approach and roadmap
 - Recommendations for technologies to support the SIM initiatives
 - Participation with the SIM HIT Steering Committee and other SIM work groups and councils.

HEALTH INFORMATION TECHNOLOGY (HIT) COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for HIT requirements¹ and technology components in support of SIM goals. This work group will review current and proposed technologies cited in the SIM Model Test Proposal² to understand capabilities and uses for the Test Model, will work collaboratively with the Quality, Practice Transformation, and Equity & Access work groups to develop a high level HIT schema of technologies and data interactions that align SIM initiatives, and will describe the implementation approach/roadmap for recommended technology solutions that are scalable, adaptable, and based on national standards.

Key questions this work group needs to answer

Access

What are the HIT requirements to support recommendations of the Equity & Access Council to guard against under-service or patient selection?

Connectivity and Exchange

1. What are the HIT requirements to support recommendations of the Practice Transformation Task Force?
2. How will HIT support information exchange across providers?
3. What are the HIT requirements to implement and pilot test short-term³ information exchange leveraging existing technology asset: Direct Messaging, ADT-SES?
4. What are the HIT requirements to leverage existing core procurement and implement and pilot test a Consent Registry-Nextgate?
5. What are the HIT requirements and recommended solution(s) to implement and pilot test 1-3 Disease Registries-Nextgate?
6. What are the HIT requirements for procuring Mobile Medical Applications for care management using crowd sourcing?
7. What are the HIT requirements to leverage the existing technology asset: EHR-SAAS hosted by BEST?
8. How will proposed technologies align with existing technologies used by Advanced Networks and FQHCs to avoid redundancies and duplication of efforts?
9. What is the process for introducing and considering new technology and innovation alternatives to those cited in the SIM proposal?

Quality

1. What are the HIT requirements to support recommendations of the Quality Council?
2. What quality measures/metrics will be adopted to measure provider performance with regard to targeted health conditions & prevention goals?
3. Which quality measures/metrics are claims-based and which are clinically-based? Which have priority?
4. How will measures be attributed, aggregated, stored, accessed and reported?
5. What are the potential and recommended data sources for these quality measures?
6. What technology solutions are available to mine the data sources? What are the criteria for selecting a solution? What is the recommended solution?
7. What are the HIT requirements and recommended approach to leverage the existing technology asset: licensing agreement-Zato for edge server indexing for eCQMs?
8. What are the HIT requirements and recommended approach to leverage the existing technology asset: Provider Directory-Nextgate hosted by BEST?
9. What are the HIT requirements and recommended approach to leverage the existing technology asset: eMPI-Nextgate hosted by BEST?
10. How will the technology solution(s) be pilot tested? Is there a short-term and long-term solution?

11. What are the HIT requirements to support cross-payer analytics and the common performance scorecard?
12. What are the SIM MQISSP HIT requirements to link/integrate Medicaid data with the APCD for claims-based quality measures?
13. What are the HIT requirements to leverage existing technology asset for patient risk stratification: pilot test Care Analyzer for MQISSP?
14. How will the quality measure data be stored, organized, aggregated, accessed, and reported? Who will have access to the data?
15. Are there HIT requirements for the common care experience survey?

Roles and Responsibilities

1. Develops and recommends SIM HIT Council charter to the Healthcare Innovation Steering Committee
2. Establishes ad hoc task forces to investigate specific technical, functional and data exchange topics
3. Discusses options and makes a recommendation using majority consensus⁴
4. Members communicate HIT Council progress back to constituents and bring forward their ideas and issues
5. Works collaboratively with the other SIM work groups to collect and share information needed to provide an aligned HIT solution
6. Monitors progress and makes adjustments to stay within the SIM timeline – pre and post SIM HIT solution implementation
7. Makes recommendations to the Healthcare Innovation Steering Committee
8. Comes to HIT Council meetings prepared, by reviewing the materials in advance
9. Escalates issues, questions and concerns that cannot be resolved by the HIT Council as a group to the Healthcare Innovation Steering Committee
10. Establishes an executive team that includes the co-chairs and three members from the HIT Council representing the major stakeholder groups (Consumers, Payers and Providers). The non-co-chair members will be included in the agenda prep calls to assist in agenda development and identify any issues brought forth by council members.

Guiding Principles

1. Advocate for HIT solutions that are scalable and meet existing standards that are available and feasible
2. Comply with SIM's conflict of interest protocol, currently in draft status
3. HIT is a tool to support or supplement care delivery and the collection of necessary data but is not, nor should be the end goal
4. Be the advocate for the role you are representing

Scope - range and boundaries of the responsibilities of the HIT Council

In-Scope

1. Review of the current and proposed technologies cited in the SIM grant to understand capabilities and uses for Test Model
2. Work collaboratively and actively support two way communications with the other SIM workgroups and councils to develop the HIT design.
3. High level schema of HIT solution
4. SIM HIT solution implementation approach and roadmap
5. Recommendations for technologies to support the SIM initiatives
6. Participation with the SIM HIT Steering Committee and other SIM work groups and councils

Out-of-Scope

1. Personal Health Record technology and Patient Portal (from original grant proposal)
2. Development of policies and procedures tied to recommended technologies

5. HIT Environment and Lessons Learned from Other States

25 min



What is approved in the HIT SIM budget?



THE CHARTIS GROUP
Management Consultants

SIM Health IT Budget Narrative

<i>Health Information</i>	1,292,842	3,596,378	3,550,394	2,329,981	10,769,595
<i>Technology</i>					

DSS will contract with UConn for overall HIT/Analytics strategic planning/support, including: staffing costs, travel, and fringe - \$2.44 M; DSS will acquire/implement Care Analyzer-\$700K, Consent Registry- \$1.1M, 1-3 Disease Registries & Mobile Medical Applications -\$2.2M, EMPI-Nextgate-\$209K, Provider Directory-NextGate-\$225K, Direct Messaging/ADT-\$450K, Edge Servers/Indexing/eCQM-\$1M, EHR-SaaS-\$735K; BEST hosting services-\$480K; crowd sourcing-\$360K; expert facilitator for HIT Plan development-\$200K; and APCD edge server linkage and integration of Medicaid data- \$540K. This budget was reduced in several areas and the PHR initiative was eliminated. This budget was also decreased by taking out the equipment/supplies funding of \$4,000 a year, and moving that to the appropriate line item.

What are other SIM states doing?

Highlights from Round 1 Model Test States

State	SIM HIT Plan
AR	<ul style="list-style-type: none"> Analytics engine and provider portal for Medicaid episode-based care HIE Expansion
MA	<ul style="list-style-type: none"> HIE Functionality for Quality Reporting Adapt MMIS to use quality data as the basis for primary care reform payments Physician Portal - Linkages Between Primary Care Practices and LTSS Electronic Referrals to Community Resources Technical Assistance (EHRs) to Behavioral Health and LTSS Providers
ME	<ul style="list-style-type: none"> Support behavioral health organizations to improve EHR use and participate in HIE Support behavioral health organizations in data analytics capability / quality measurement Goal to add up to 20 new behavioral health organizations to HIE by 2016
MN	<ul style="list-style-type: none"> Secure data exchange between providers across settings (clinic/hospital/LTC/behavioral health/public health/social services) Provider electronic health record (EHR) adoption and HIE grants Expansion of provider data feedback and analytics capacity and reporting
OR	<ul style="list-style-type: none"> Leverage Direct Secure Messaging for improved care coordination Support providers to achieve EHR Meaningful Use Technical Assistance to Medicaid providers Establish Clinical Quality Metrics Registry for Coordinated Care Organizations Statewide provider directory, patient attribution support exchange and analytics
VT	<ul style="list-style-type: none"> Expand HIE to mental health, substance abuse, long-term care, home health providers Pilot a telemedicine program Integrate claims and clinical data to support new payment models Expand healthcare coordination

SIM HIT Plan Highlights

State	
CO	Data aggregation, data reporting, telehealth, data warehouse
DE	Provider tools, expansion of Community Health Records, multi-payer claims and clinical data store and analytics, patient engagement tools
IA	Promotion EHR adoption; Alert system ADT for ACOs;
ID	Over the three-year Model Test period, will engage 180 PCMH-designated clinic sites statewide to adopt and use EHR technology and connect to the HIE.
MI	Promote HIE for participating ACOs, make technical assistance resources available to assist ACOs, Collaborative Learning Network for Health Information Technology and Exchange will help identify gaps in capacity and share best-practice solutions
NY	Deploy a consumer transparency portal, Complete implementation of statewide HIE, Create and implement APCD, Increase data availability to enable third-party innovation in transparency tools
OH	Expand the state data gateway to an enterprise service, connect public health registries to the enterprise HHS data warehouse, provider portal, state HIT plan
RI	Health Care Quality Measurement, Reporting and Feedback System; Statewide Common Provider Directory, Patient engagement tools, APCD;
TN	Provider-facing portal for shared care coordination solution, Quality measures for episodes of care are claims-based, HIE will be integrated with MMIS for ADT feeds, upgrades to EHR systems for behavioral health providers
WA	Enhance HIE, interoperability/EHR adoption behavioral health providers, standardize clinical information, integrate data across health delivery and social service systems, dedicated research and analytics team

State**SIM HIT Plan Highlights - Sources**

CO

<http://www.coloradohealthinstitute.org/uploads/downloads/FinalSIMApplication.pdf>
Page 15

DE

<http://dhss.delaware.gov/dhcc/cmml/files/choosehealthplan.pdf>
Page 67

IA

https://dhs.iowa.gov/sites/default/files/iowa%20Operational%20Plan_FinalOctober2014.pdf
https://dhs.iowa.gov/sites/default/files/iowa%20Project%20Narrative_MedModRevisions.pdf
Page 18

ID

<http://healthandwelfare.idaho.gov/Portals/0/Medical/SHIP/IdahoModelTestOperationalPlan.pdf>
Page 5

MI

http://www.michigan.gov/documents/mdch/Michigan_SIM_Round_Two_Project_Narrative_parts_1-7_485109_7.pdf
page 14

NY

https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_sim_project_narrative.pdf
Page 15

OH

http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=e_p2kypH7G8%3D&tabid=138
Page 8

RI

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Revised%20Project%20Narrative3_2.pdf
Page 17

TN

<http://www.tn.gov/assets/entities/hcfa/attachments/ProjectNarrativeTNSIMgrant.pdf>
Page 16

WA

http://www.hca.wa.gov/hw/Documents/SIM_Grant_Application.pdf
Page 15

	Round 1						Round 2									
	AR	MA	ME	MN	OR	VT	CO	DE	IA	ID	MI	NY	OH	RI	TN	WA
APCD	IP	X	X	X	X	X	X					IP		X	X	X
HIE	X	X	X	X	X	X	X	X	X	X	X	IP	X	X	X	X
<i>Type of Exchange:</i>																
Direct Only					X								X			
Query Only									X							
Direct/Query	X	X	X	X		X	X	X	X		X	X		X	X	X

IP – In Progress

[Directed Exchange](#) – ability to send and receive secure information electronically between care providers to support coordinated care

[Query-based Exchange](#) – ability for providers to find and/or request information on a patient from other providers, often used for unplanned care

Source: *Health Information Exchange*. (2014, 05 12). Retrieved from HealthIT.gov: <http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie>

Deliverable to CMMI by 12/1/2015- SIM HIT Operational Plan

SIM HIT Operational Plan

- 5 Domains:
 - **Rationale** (e.g. technology components that logically support specific Model Test components; data needs, sources & interactions; targeted providers)
 - **Governance** (e.g. HIT org structure, aligning existing assets)
 - **Policy** (e.g. alignment of SIM with state Health IT efforts)
 - **Infrastructure** (e.g. standards-based Health IT)
 - **Technical Assistance** (e.g. to providers participating in SIM program)
- CMS Guidance for SIM HIT Ops Plan currently under review
- Gaps / interdependencies to be identified
- Need to determine process for input from HIT Council

Note: See Handouts June 19th meeting

SIM HIT Operational Plan - Risks

- HIT Ops Plan Due to CMMI 12/01/15
- Timeline synchronicity –
 - Alerted PMO to request 2-month extension
- HIT Ops Plan cannot be developed without HIT Council deliberations and recommendations for translating SIM program requirements into technology requirements. (i.e. 20 Questions)
- HIT Council cannot finalize recommendations without knowing the program needs and priorities of the Quality Council and Practice Transformation Task Force.
- The HIT Ops Plan cannot be finalized without HISC approval of HIT Council recommendations.
- Participating providers and their technical capabilities and data quality are unknown.

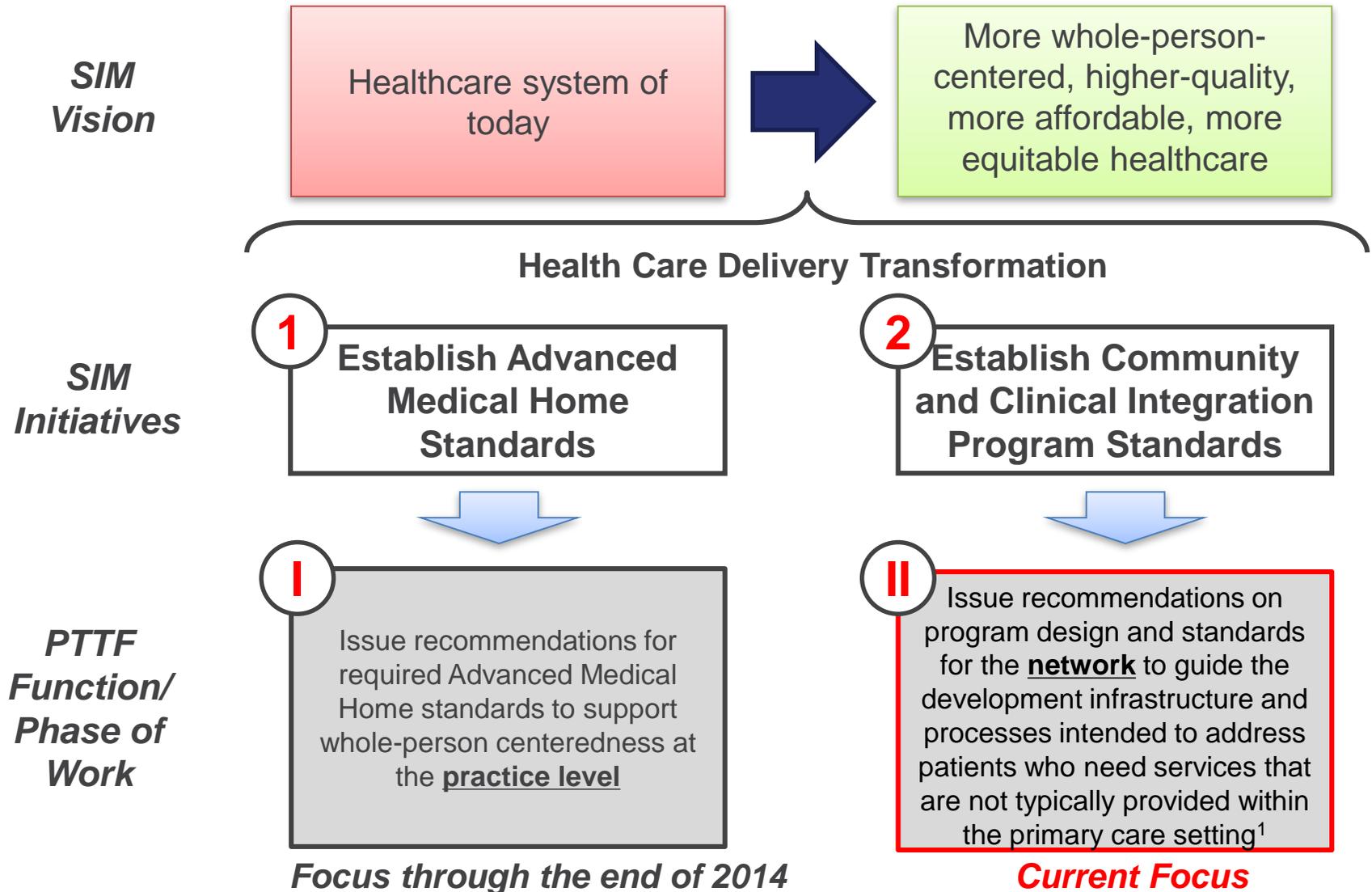
5. Update on CCIP Design Effort

15 min



1. Educate HIT Council on CCIP design progress to date
2. Discuss initial inventory of IT design implications of emerging program design
3. Provide HIT input to CCIP design effort prior to completion of final design

PTTF's Charge in the Context of SIM



Notes:¹ This could include specialists that are outside the network (e.g.; behavioral health providers), clinically related support services (e.g.; pharmacists or dietitians), social support services (e.g.; housing or vocational assistance)

- To be eligible for CCIP technical assistance support, the Advanced Network or FQHC must be participating in the Medicaid Quality Improvement and Shared Savings Program (MQISSP)
- The MQISSP RFP process will include a commitment to participate in CCIP and meet CCIP requirements
- Although the MQISSP RFP will be used to identify CCIP participants, CCIP capabilities will be “payer agnostic”...they will apply to all patients regardless of who their insurer is (i.e. Medicare, Medicaid, commercial)

IT Considerations for Emerging Program Components

1. Identify Patients

- 2. Connect Patient to Care Team/CHW
- 3. Care Team conducts needs assessment
- 4. Care Team develops shared care plan with patient
- 5. Care Team executes and monitors shared care plan
- 6. Patient improves and no longer needs additional care management

Recommendation	IT Considerations	
1.01 Patient Identification: Complex – At a minimum providers should deploy some type of basic analytic capabilities to risk stratify patients considering a combination of utilization data (claims) and clinical, behavioral, and social determinants of health data (EMR based). Networks should strive to use more complex analytics involving predictive modeling if possible.	Data	EMR and Claims EMPI Provider Registry Modification HIE-dependent Patient Registry
	Analytics/ Functions	Identification and risk stratification Predictive modeling and forecasting
	Reporting /Feedback	Reporting on process and outcomes (quality metrics)

IT Considerations for Emerging Program Components

1. Identify Patients

2. Connect Patient to Care Team/CHW

3. Care Team conducts needs assessment

4. Care Team develops shared care plan with patient

5. Care Team executes and monitors shared care plan

6. Patient improves and no longer needs additional care management

Recommendation	IT Considerations	
<p>1.02 Patient Identification: Equity - It was proposed that depending on the capabilities of the network at a minimum the network assess gaps in health outcomes by OMB racial categories (seven race categorizations) and the outcomes evaluated should be tied to metrics on the aligned quality scorecard (diabetes, asthma, and hypertension)</p>	Data	EMR and Claims EMPI Provider Registry Modification HIE-dependent Patient Registry
	Analytics/Functions	Identification of health gaps by racial categories and confirmed outcome measures for key conditions
	Reporting/Feedback	Reporting on process and outcomes (quality metrics)
<p>1.02 Patient Identification: Equity - It was proposed that depending on the capabilities of the network at a minimum the network assess gaps in health outcomes by OMB racial categories (seven race categorizations) and the outcomes evaluated should be tied to metrics on the aligned quality scorecard (diabetes, asthma, and hypertension)</p>	Data	EMR and Claims EMPI Provider Registry Modification
	Analytics/Functions	Identification of health gaps by racial categories and confirmed outcome measures for key conditions
	Reporting/Feedback	Reporting on process and outcomes (quality metrics)

IT Considerations for Emerging Program Components

1. Identify Patients	Recommendation	IT Considerations	
2. Connect Patient to Care Team/CHW	1.03 Multidisciplinary Care Team Structure – It is recommended that the teams include the following functions: (1) a case management function, (2) a clinically focused care coordination function/patient navigation function, (3) patient liaison dedicated to patient education and management of social services that <u>should be fulfilled by a CHW</u> ; and (4) a manager to oversee the coordination of functions and the complexity of delivering care across multiple settings. The MDT should also build out non-core team member functions who will provide on-going support in key areas (e.g. dieticians and pharmacists) as needed)	Data	EMR and Claims EMPI Provider Registry Modification (clinical and nonclinical providers)
3. Care Team conducts needs assessment			Analytics/ Functions
4. Care Team develops shared care plan with patient		Reporting/ Feedback	Reporting care management status to clinical and nonclinical team members across a wide range of network participants serving populations
5. Care Team executes and monitors shared care plan			
6. Patient improves and no longer needs additional care management			

IT Considerations for Emerging Program Components

- 1. Identify Patients
- 2. Connect Patient to Care Team/CHW
- 3. Care Team conducts needs assessment
- 4. Care Team develops shared care plan with patient
- 5. Care Team executes and monitors shared care plan
- 6. Patient improves and no longer needs additional care management

Recommendation	IT Considerations	
1.04 Multidisciplinary Team Behavioral Health – All teams should have open access to or have a team member who is a behavioral health professional capable of comprehensive behavioral health assessments	Data	EMR and Claims inclusive of BH EMPI inclusive of BH/ED's Provider Registry Modification inclusive of BH
	Analytics/ Functions	Referral to BH and participation of BH provider in M/D teams
	Reporting/ Feedback	Reporting on process and outcomes (BH metrics)

IT Considerations for Emerging Program Components

- 1. Identify Patients
- 2. Connect Patient to Care Team/CHW
- 3. Care Team conducts needs assessment
- 4. Care Team develops shared care plan with patient
- 5. Care Team executes and monitors shared care plan
- 6. Patient improves and no longer needs additional care management

Recommendation	IT Considerations	
1.05 Multidisciplinary Team Credentials - It is recommended that: (1) the behavioral health professional assigned to the core team be a clinician with at least a master's level license and (2) that Community Health Workers should receive certification required by the AN/FQHC and/or the contracted organization as well as any disease state specified training required to address the targeted equity gap. For all other functions there will be no mandatory minimum licensing recommendations.	Data	Provider credentialing and certification
	Analytics/Functions	Referral to CHW
	Reporting/Feedback	Reporting on process and outcomes (BH metrics)

IT Considerations for Emerging Program Components

1. Identify Patients	Recommendation	IT Considerations	
2. Connect Patient to Care Team/CHW	1.05 Multidisciplinary Team Credentials - It is recommended that: (1) the behavioral health professional assigned to the core team be a clinician with at least a master's level license and (2) that Community Health Workers should receive certification required by the AN/FQHC and/or the contracted organization as well as any disease state specified training required to address the targeted equity gap. For all other functions there will be no mandatory minimum licensing recommendations.	Data	Provider credentialing and certification
3. Care Team conducts needs assessment		Analytics/Functions	Referral to CHW
4. Care Team develops shared care plan with patient		Reporting/Feedback	Reporting on process and outcomes (BH metrics)
5. Care Team executes and monitors shared care plan	1.06 Multidisciplinary Team Case Load - There are different approaches to ensuring appropriate case-load (patients to team ratio) of the MDTs to ensure effectiveness of the Multidisciplinary Care Team. It is recommended that optimal ratios be developed by the local teams based off of the network needs.	Data	None
6. Patient improves and no longer needs additional care		Analytics/Functions	None
management		Reporting/Feedback	None

IT Considerations for Emerging Program Components

- 1. Identify Patients
- 2. Connect Patient to Care Team/CHW
- 3. Care Team conducts needs assessment
- 4. Care Team develops shared care plan with patient
- 5. Care Team executes and monitors shared care plan
- 6. Patient improves and no longer needs additional care management

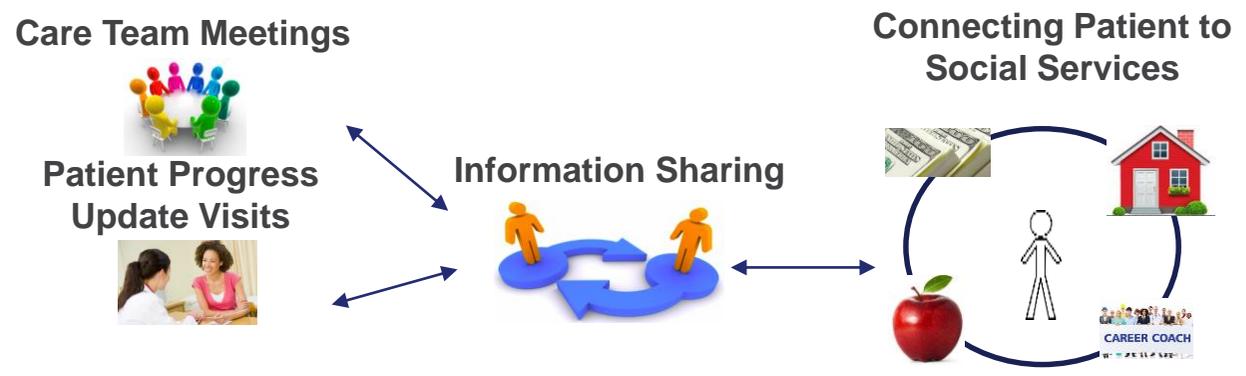
Recommendation	IT Considerations	
1.07 Multidisciplinary Team Training – It is recommended that all members of the care team receive team-based training including communications training in a team setting and methods to encourage person-centered orientation of care as well as a basic level of behavioral health training. Exact training protocols are not mandatory, but documentation of what training was conducted and that all multidisciplinary team members participated will be required.	Data	Provider credentialing and certification Provider Database Modification
	Analytics/ Functions	None
	Reporting/ Feedback	Reporting on training completed
1.07 Multidisciplinary Care Team & CHW Relationship with Network –It is recommended that local practices adapt their own strategy to deploy the multidisciplinary team resources, including the decision whether to directly employ care team members within their current practices, at the network level, or to partner with an out of network organization as long as all functions are fulfilled with appropriate care team members and patient needs are being met.	Data	Provider credentialing and certification Provider Database Modification
	Analytics/ Functions	None
	Reporting/ Feedback	Reporting on training completed

IT Considerations for Emerging Program Components

1. Identify Patients	Recommendation	IT Considerations		
2. Connect Patient to Care Team/CHW	<p>Under Development:</p> <p>Initial thoughts on the <u>needs assessment</u>:</p> <ul style="list-style-type: none"> • PTTF should provide a comprehensive understanding of the root cause of the patient’s condition not just the immediate circumstances • Suggested guidance on the types of issues it should cover – patient history to determine how the team can best support patient goals, relevant clinical issues, social, and behavioral • Important to ask patient what they feel they are most challenged by • Discussed idea of an eco-map to assess patient history, but there was concern about assessment becoming too burdensome on patient and provider <p>Initial thoughts on the <u>shared care plan</u>:</p> <ul style="list-style-type: none"> • Should be patient centered and the patient should be actively involved in developing the plan • Should reflect the needs assessment • Should set treatment goals to be met within a specific timeframe 	Data	Patient EMR	
3. Care Team conducts needs assessment		Analytics/ Functions	Assessment Tool Patient and Provider access to care plan	
4. Care Team develops shared care plan with patient		Reporting/ Feedback	Reporting updates to M/D team and patient	
5. Care Team executes and monitors shared care plan				
6. Patient improves and no longer needs additional care management				

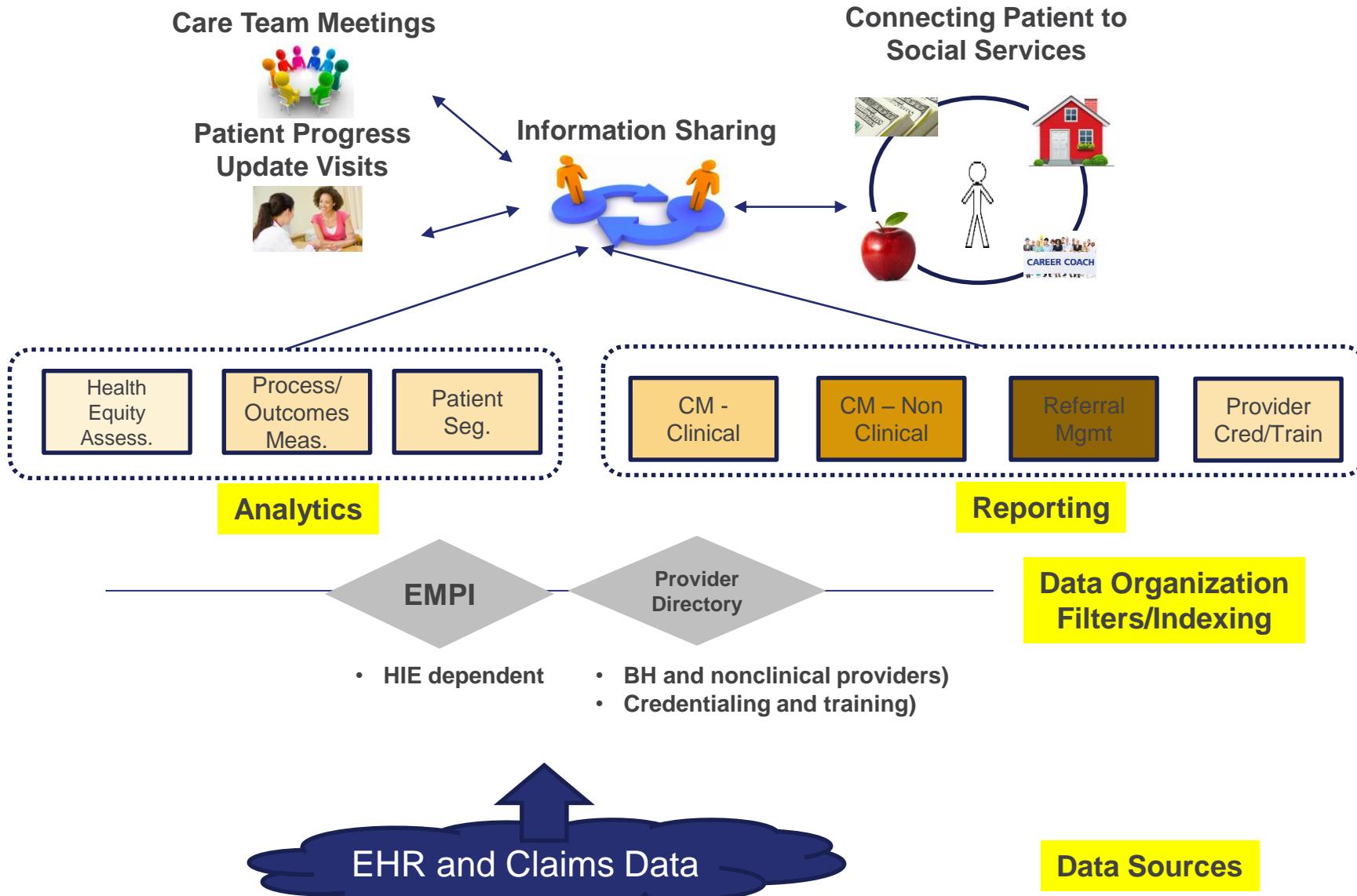
IT Considerations for Emerging Program Components

1. Identify Patients
2. Connect Patient to Care Team/CHW
3. Care Team conducts needs assessment
4. Care Team develops shared care plan with patient
5. Care Team executes and monitors shared care plan
6. Patient improves and no longer needs additional care management



Recommendation	IT Considerations	
<p>Under development:</p> <p>Protocols and processes for team communication (frequency, format, etc.)</p>	<p>Data</p>	<p>Patient EMR Care Plan Updates</p>
<p>Protocols and processes for communicating on patient progress between meetings</p>	<p>Analytics/ Functions</p>	<p>Care Management Tool accessed by M/D members and patients</p>
<p>Technology solution to seamlessly share care plan and communicate with all team members, including community support services if necessary</p>	<p>Reporting/ Feedback</p>	<p>Reporting updates to M/D team and patient</p>

Summary and Relationship Between Assets



CCIP Timeline

	July	Aug	Sept	Oct
PTTF Meetings	28	TBD	1 TBD	8
CCIP Design Sessions	16	6 (DG 2) 19 (DG3)		
Key Activities	<div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px; margin-bottom: 5px;">PTTF articulation of standards for CCIP</div> <div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px; margin-bottom: 5px;">Design groups support development of standards</div> <div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px; margin-bottom: 5px;">Communication with MAPOC CMC and other key stakeholders¹</div> <div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px; margin-bottom: 5px;">Research, evidence review</div> <div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px; margin-bottom: 5px;">Draft & edit report</div> <div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px;">Public input</div>			<div style="border: 1px solid black; background-color: #e0f0e0; padding: 5px;">Report revisions based on HISC feedback, additional coordination with MAPOC CMC as needed</div>

Specific HIT Timetable to be developed once completion of design. New technologies will require more time

HIT Input

- HIT Receives Logic Model/Program Design to Inform Design
- HIT Launches design effort

HIT Design Effort (TBD)
Coordinated with other HIT efforts



7. Update on Quality Council Design Effort

5 min



1. Update on plan to use both EMR and claims-based measures and associated timeframe
2. Confirm or modify approach to pilot two measures (or more)
3. Confirm HIT Council design process and timing

8. Discussion of Zato Pilot and Approach

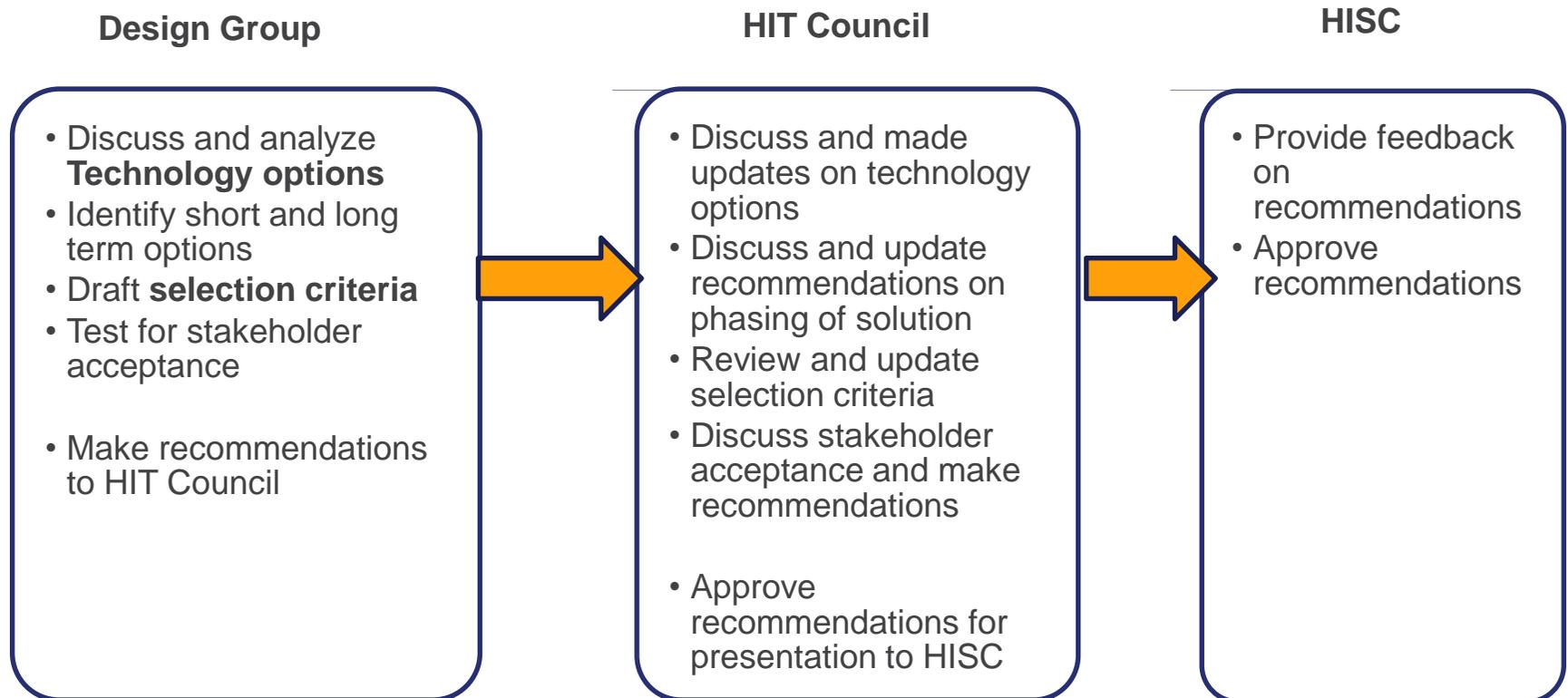
25 min



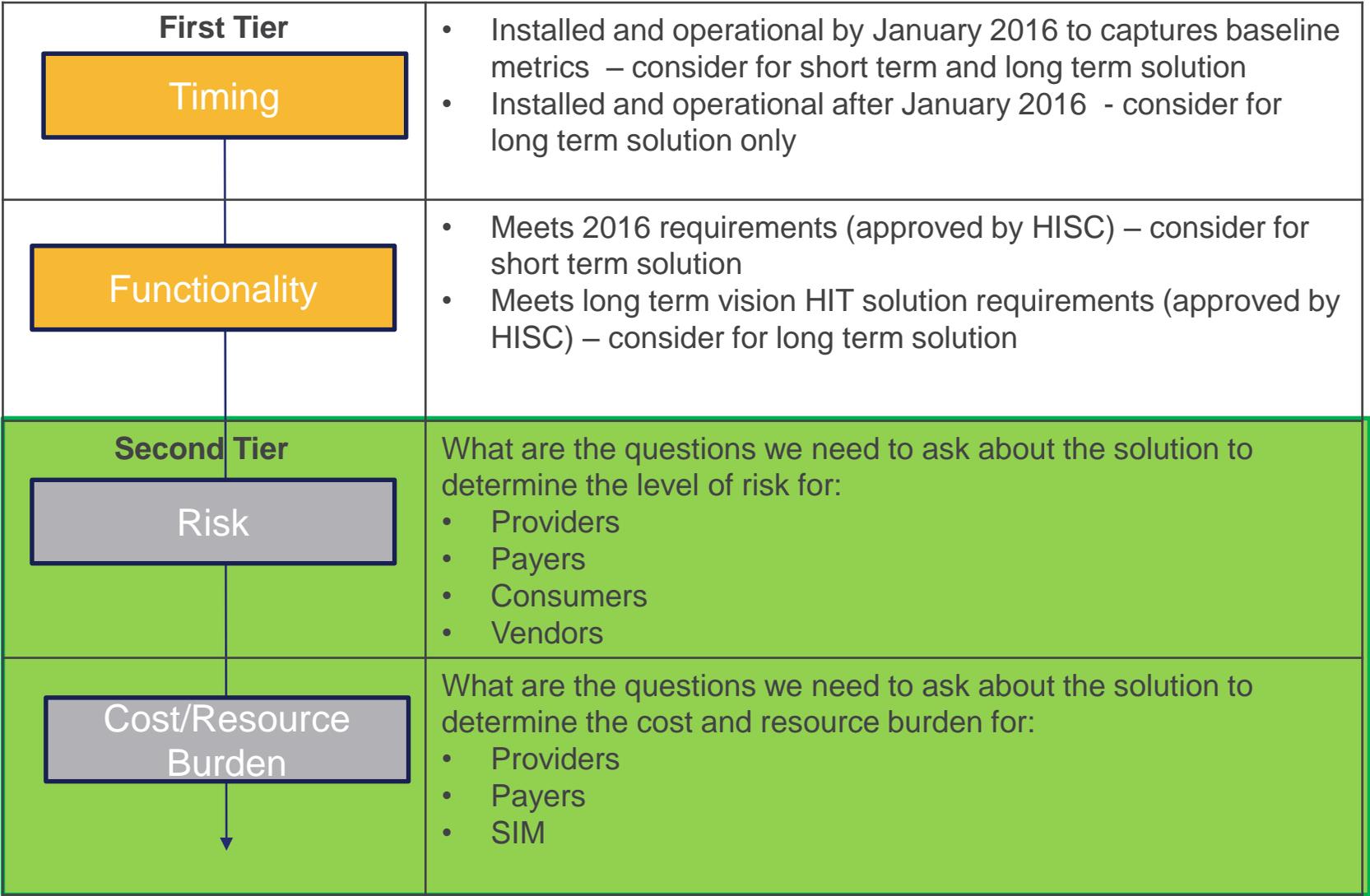
1. Review approach to short term/long term solution evaluation and considerations (discussed at last HIT Council Meeting 6/15)
2. Agree on initial approach to pilot Zato technology's ability to support production and reporting of quality metrics including:
 1. **Timing**
 2. **Participation**
 3. **Oversight and Evaluation Process**
 4. **Criteria for Evaluation**
 5. **Process for Recommendation Development and Approval**
3. Charter Work Group to launch Pilot Sub Group to design and conduct pilot

Quality Measures and Reporting Design Group Process

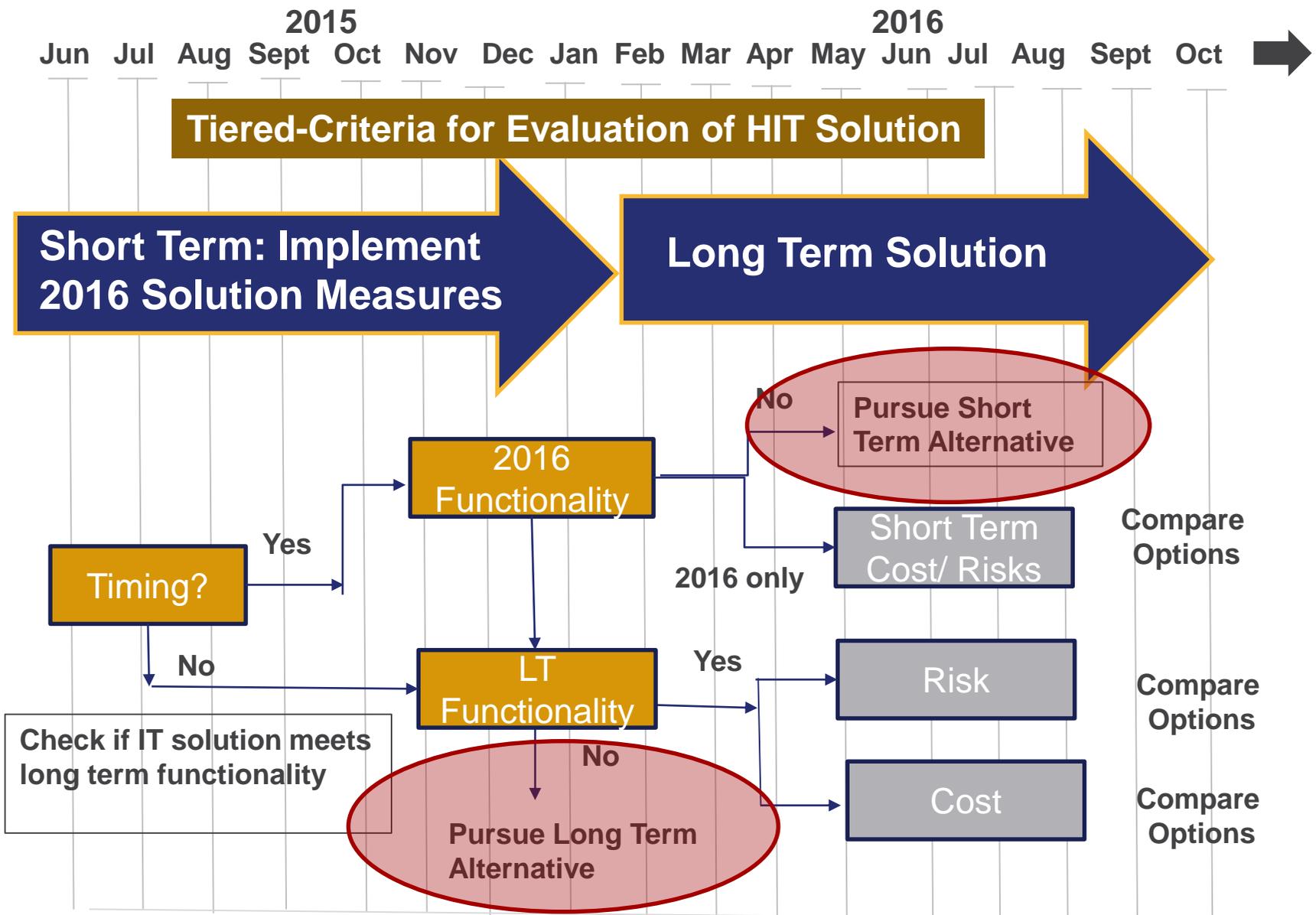
The design group is tasked by the HIT Council to investigate technologies and options for HIT solutions to support the quality measures and reporting requirements for SIM. Findings are reporting to the HIT Council. The Council updates and makes recommendations to the HISC



HIT Solution Tiered Selection Criteria



Evaluation Process – First Tier Criteria



HIT Solution Functionality

- Data collection
- Data aggregation/measure aggregation
- Reporting and analysis

Accountable Council

- HIT Council
 - All functionality is automated
 - At least one function is automated
- Quality Council
 - No automated functionality



Proposed Zato Pilot Approach

1. Timing

October – February 2016



September	October	November	December	January
<p>1.Solicit Participants via procurement process</p> <p>2.Distribute and orient participants (i.e. requirements etc.)</p> <p>3.Launch Zato Pilot Team under direction of Work Group</p>	<ul style="list-style-type: none"> • Launch Data Collection and Metric Calculation 1st Round • Test/refine • Prepare for 2nd Round 	<ul style="list-style-type: none"> • Evaluate against criteria • Provide input to participants and direction on refinement • Identify process vs. technology considerations 	<ul style="list-style-type: none"> • Test initial findings with HIT Council • Seek input on 3rd Round • Complete 3rd round and conduct final evaluation 	<ul style="list-style-type: none"> • Test final recommendations with HIT Council

Proposed Zato Pilot Approach

2. Participation

October – January 2015



Approach to Participation:

- Open to all Advanced Networks and FQHC's who meet business process and IT requirements
- Funding support (if any) to be determined
- Reporting and Pilot team participation requirements
- Requirements verified and tested with Zato

August	September
1.A Work Group meets with procurement support to develop RFP specifications (2-3 times in August)	1.Solicit Participants via procurement process
2.Presentation to HIT in early September for Approval. HISC?	2.Distribute and orient participants (i.e. requirements etc.)
	3.Launch Zato Pilot Team under direction of Work Group

Second Tier Selection Criteria: Risks and Costs

3. Criteria

For Discussion

Payers

- Can the solution designate attributed population by plan? By member and by plan and plan sponsor?
- Is the audit application accurate?
- What is the cost to install and support the solution?
- What technical and analytical skills are needed?
- Are the costs in line with the expected benefits for participation?
Are the costs clearly defined?

Providers

- What level of interoperability can be achieved? All data? Quality measures? Not enough for SIM?
- Will the care providers need to change online documentation process to collect the data for the solution?
- Are the costs in line with the expected benefits for participation?
Are the costs clearly defined?
- Does the provider have the skills and resource to support the solution?

Consumer

- What is the level of patient data exposure outside of the EHR?
- What safeguards are in place to maintain patient confidentiality?
- Will there be a need to use a consent registry to record consumer authorization?

Second Tier Selection Criteria: Risks and Costs

3. Criteria

For Discussion

SIM PMO / State

- What assurances are documented that solution meets the SIM requirements?
- Will the PMO have the right number and types of skills needed to manage the solution? Infrastructure, end user issues?
- What is the risk that payers decide not to participate? Providers?
- Are the processes and procedures in place to manage the solution vendor and the user sites?
- **What is the cost to install and support the solution at the SIM site?**

Vendor/ Technology

- Does the vendor have a track record in healthcare?
- Does the vendor/product have a track record for the proposed solution?
- How well does their data normalization meet our requirements?
- What audit capabilities are provided to assure accurate data aggregation?
- What is the financial viability of the vendor?
- Does the vendor have sufficient technical and support resources? Does the solution have additional functionality that we can use in future years? Will they customize the solution for our needs?
- **What additional costs do they anticipate for this initiative? Is it within the SIM budget?**

9. Next Phase Work Group Approach

20 min



1. Discuss and approve transitioning from current Design Work Group effort to two parallel efforts focused on oversight of the Zato pilot and the development of the long term solution

Proposed Work Group Approach

Design Work Group (close and transition to two work groups)

HIT Council

- Approve Pilot Design (today, early September)
- Approve Pilot Participants (early September)
- Review pilot updates (October through December)
- Review pilot recommendation and present HISC for final approval (January)

Long Term Solution Group

Pilot Oversight Group

- Execute pilot (September through December)
- Develop updates for Work Group and HIT (bi-weekly)
- Prepare recommendation for consideration by Work Group (Monthly)

- Design longer term solution given criteria
- Incorporate input from pilot to inform design

Charter and Membership Approach to Work Groups

Overall Approach to Launch of Work Groups

- **Members nominated by HIT Council from HIT Council membership**
- **Public nomination and voting (today)**
- **No duplication of membership**
- **5-7 members per group**
- **1 member reserved for CCIP representative (for input not decision making)**
- **1 member reserved for Quality Council representative (for input not decision making)**
- **Both develop recommendations for review and approval of the HIT Council**
- **Members from participating organizations in the Zato Pilot can not participate in the this Zato Pilot Work Group. Provisional appointments can be made pending confirmation**

Work Group	Charter	Timing/Nature of Commitment
<ul style="list-style-type: none">• Pilot Oversight Group	<ul style="list-style-type: none">• Further design and execute pilot• Develop updates for Work Group and HIT• Prepare recommendation for consideration by HIT Council	<ul style="list-style-type: none">• Bi-Weekly Meetings (by phone)• September through December
<ul style="list-style-type: none">• Long Term Solution Group	<ul style="list-style-type: none">• Design longer term HIT solution for Quality, CCIP and other Task Force programmatic requirements	<ul style="list-style-type: none">• Bi-Weekly Meetings (by phone)• September through January

10. Next Steps

5 min



- Scheduled required Work Group Meetings – Zato and Long Term Work Group
- Solicit participation in Pilot Sub Group (from Design Work Group Membership)
- Confirm and solicit pilot requirements from Quality Council
- Conduct initial briefing with Zato representatives
- Others?