

Health IT Advisory Council

October 19, 2017



CONNECTICUT
HEALTH INFORMATION
TECHNOLOGY OFFICE

Agenda

Welcome and Introductions	1:00 pm
Public Comment	1:05 pm
Review and Approval of Minutes – September 21, 2017	1:07 pm
Updates <ul style="list-style-type: none"> • Welcomes and Introduction of New Staff • Handout: 2018 Council Meeting Dates • Review Action Items of September 21, 2017 Meeting <ul style="list-style-type: none"> • Waste, Fraud, and Abuse • Not-for-profit creation examples – CT and other states 	1:10 pm
Review and Accept Recommendations of the HIE Use Case Design Group	1:15 pm
Sustainability Activity	2:00 pm
All-Payer Claims Database (APCD) Discussion	2:30 pm
Wrap-up, Action Items, and Next Steps	2:50 pm

Public Comment

Review and Approval of September 21, 2017 Minutes

Welcome and Introduction of New Staff

Review of Action Items

Action Item	Date Due
Waste, Fraud, and Abuse	10/19/17
Not-for-profit creation examples – Connecticut and other states	10/19/17

Review Recommendations of HIE Use Case Design Group

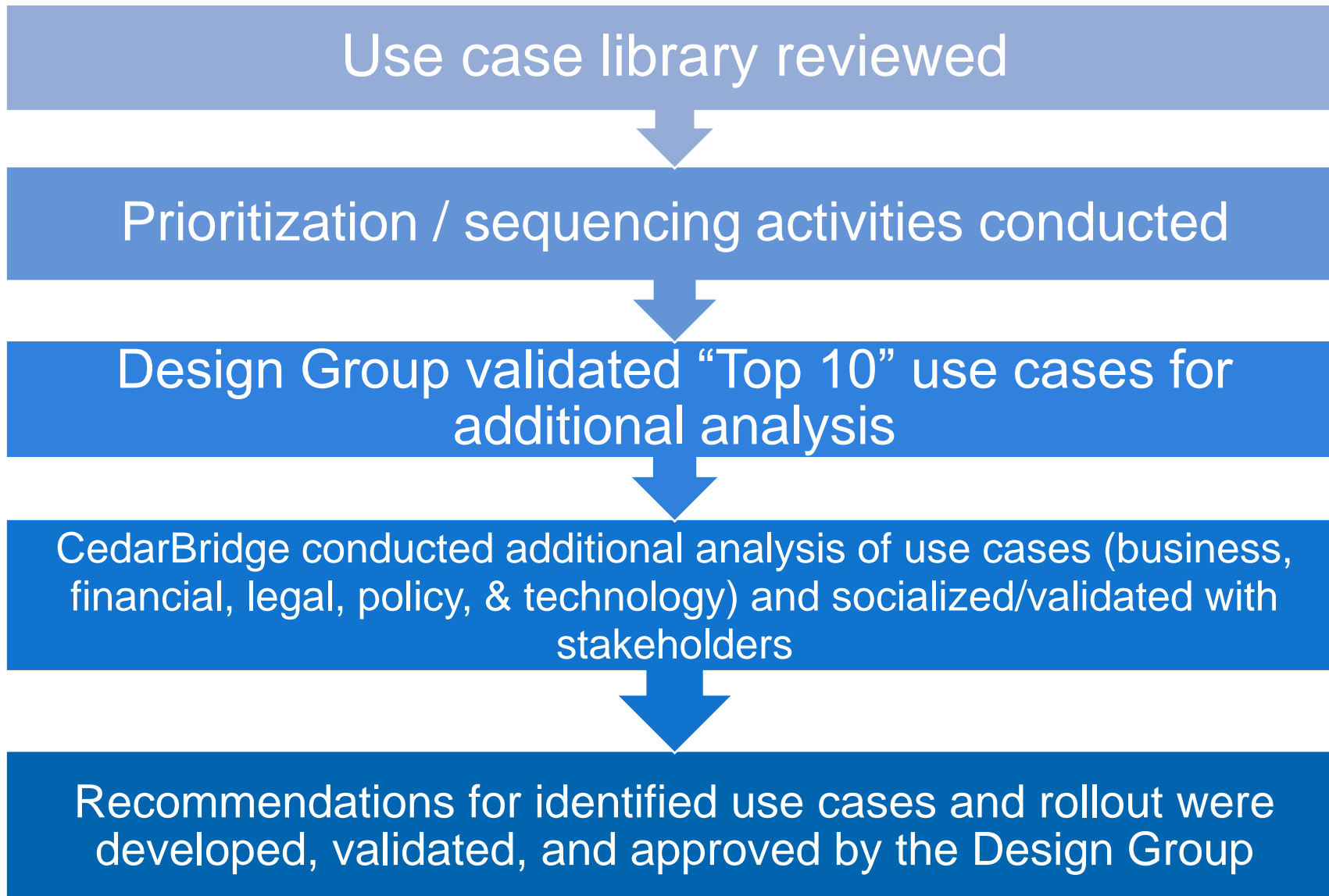
HIE Use Case Design Group Members

Name/Role	Stakeholder Representation
Stacy Beck	Clinical Quality Program Director at Anthem
Pat Checko, DrPH	Co-chair of State Innovation Model Consumer Advisory Board and Health IT Advisory Council Member
Kathy DeMatteo	Chief Information Officer of Western Connecticut Health Network
Gerard Muro, MD	Chief Medical Information Officer of Advanced Radiology Consultants and Board Member of Charter Radiology Network
Mark Raymond	Chief Information Officer for the State of Connecticut and Health IT Advisory Council Member
Jake Star	Chief Information Officer of VNA Community Healthcare and Health IT Advisory Council Member
Lisa Stump, MS, RPh	Senior Vice President and Chief Information Officer of Yale New Haven Health System and Health IT Advisory Council Member

Timeline of HIE Use Case Design Group

Milestones/Deliverables	Dates
Session 1: Kick-off meeting	6/27/17
Session 2: Reviewed use cases (part 1)	7/12/17
Session 3: Reviewed use cases (part 2)	7/19/17
Presented update to Health IT Advisory Council	7/20/17
Session 4: Reviewed use cases (part 3)	7/27/17
Session 5: Reviewed use cases (part 4)	8/2/17
Session 6: Reviewed use cases (part 5) and prioritization criteria for use cases	8/9/17
Session 7: Reviewed final use cases (part 6); Apply prioritization criteria	8/16/17
Presented update to Health IT Advisory Council	8/17/17
Session 8: Reviewed results of prioritization/sequencing activities; Selected "Top 10" use cases (part 1)	8/23/17
Session 9: Selected "Top 10" use cases (part 2); Discussed need for additional meetings	8/30/17
CedarBridge conducted analysis of HIE services and technology infrastructure necessary to support "Top 10" use cases; Researched financial, business, legal, and policy considerations and socialized/validated use cases with stakeholders	8/23/17 – 10/4/17
Presented update to Health IT Advisory Council	9/21/17
Session 10: Reviewed expanded use case documents for identified "Top 10" and preliminary recommendations for use cases	10/4/17
Session 11: Finalized recommendations; Developed plan for delivery of recommendations to the Advisory Council	10/11/17
Presented report and recommendations to the Advisory Council	10/19/17
Delivery of final report and recommendations to HITO and Health IT Advisory Council	10/31/17

HIE Design Group Milestones Achieved

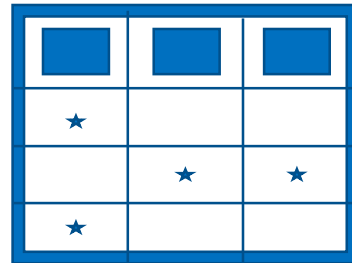


Full Use Case Inventory

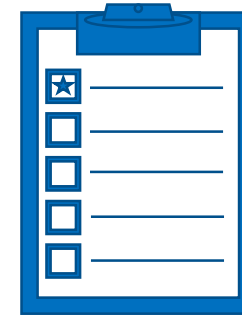
Use Cases	Use Cases
Electronic Clinical Quality Measures (eCQM)	Image Exchange
Immunization Information System (IIS) - Submit and Query/Retrieve	Population Health Analytics
Advance Directives	Public Health Reporting
Opioid Monitoring and Support Services	Lab Results Delivery
Wounded Warriors	Social Determinants of Health
Longitudinal Health Records	Research / Clinical Trials
Emergency Department Super-Utilizers	Patient Portal / Personal Health Record
Medication Reconciliation	Patient-Generated Data
Care Coordination: Referral Management	Medical Orders / Order Management
Care Coordination: Transitions of Care	CHA Dose Registry
Care Coordination: Clinical Encounter Alerts	Bundle Management
Care Coordination: Care Plan Sharing	Emergency Medical Services (EMS)
MOLST	Lab Orders
Disability Determination	Genomics
Life Insurance Underwriting	eConsult

Methodology of Use Case Prioritization/Sequencing Activities

Following the review of use cases, Design Group members engaged in two activities to prioritize and sequence the use cases, with a goal of identifying a “Top 10” for further analysis and validation.



Activity 1: Matrix



Activity 2: Survey

Evaluation Criteria

- Value for Patients/Consumers
- Value for Stakeholders
- Workflow Impact
- Integration, Maintenance, and TA
- Prerequisite Services
- Ease of Implementation
- Scalability
- Existing Infrastructure / Resources

Use Case Prioritization/Sequencing Criteria

1. Value for Patients and Consumers

- Patient-centered, allows patient preference; improves patient safety
- Enable population health improvements, care team engagement, and care coordination

2. Value for Other Stakeholders

- Define ROI and value proposition for stakeholder groups
- Alignment with organization goals and business requirements
- Enable community organization and providers of social services

3. Workflow Impact

- Enabling access to health records by individual providers
- Define impact to clinical and administrative workflows

4. Ease of Implementation

- Implementation readiness / use case maturity / business process
- Procurement process, speed of implementation, training requirements

5. Integration, Maintenance, and TA

- Define resource requirements necessary to support implementation and integration(s), including technical assistance and maintenance

6. Prerequisite Services

- Define services and infrastructure that is necessary to support use cases
- Assessment of prerequisite services for any HIE entity / partner orgs

7. Scalability

- Stand-alone use case vs. clusters
- Leverage HIE services that will support multiple use cases when implemented (economy of scale)

8. Existing Infrastructure / Resources

- Does existing infrastructure meet the needs to stakeholders?
- Governance / scalability of existing infrastructure / resources

Use Cases Identified for Further Analysis

The following use cases were validated and accepted by all Design Group members to be moved into the next phase of analysis/consideration. Additional analysis included research into business, financial, legal, policy, and technical consideration, and the socialization/validation of use cases with targeted stakeholders.

Use Cases Identified for Further Analysis

1. **Immunization Information System (Submit/Query)** – *Affirmed by HIE Use Case DG as a priority*
2. **eCQM** – *Affirmed by HIE Use Case DG as a priority*
3. **Longitudinal Health Record** – *Foundational element for other use cases*
4. **Clinical Encounter Alerts** – *Foundational element for other use cases, including Transitions of Care and ED Super Utilizers*
5. **Public Health Reporting** – *Complementary to, and supportive of the IIS use case*
6. **Population Health Analytics** – *Potential to leverage technology supporting eCQM use case*
7. **Patient Portal / PHR** – *Consistent with the concept of the patient as the “North Star”*
8. **Image Exchange** – *Validated by HIE Use Case DG for further analysis*
9. **Medication Reconciliation** – *Validated by HIE Use Case DG for further analysis*
10. **Advance Directives / MOLST** – *Consistent with the concept of the patient as the “North Star”*

HIE Use Case DG Recommendation: *Wave 1 Use Cases*

eCQM Reporting System

- Affirmed as a priority by the Health IT Advisory Council / stakeholders
- Recommendations created by eCQM DG and validated/approved by Council
- Priority re-affirmed by HIE Use Case DG

Immunization Information System (Submit/Query and Receive)

- Affirmed as a priority by the Health IT Advisory Council / stakeholders
- Recommendations created by IIS DG and validated/approved by Council
- Priority re-affirmed by HIE Use Case DG

Longitudinal Health Records

- Identified and validated by the HIE Use Case DG as a foundational use case that will support scalable statewide HIE services

Public Health Reporting

- Identified as being complementary and supportive of the IIS use case and the IIS DG's recommendations
- Validated by targeted stakeholder discussions

Clinical Encounter Alerts

- Identified and validated by the HIE Use Case DG as a foundational use case that will support scalable statewide HIE services
- Validated by targeted stakeholder discussions

Image Exchange

- Identified as a high-value use case for stakeholders by the HIE Use Case DG and through targeted stakeholder discussions

HIE Use Case DG Recommendation: *Wave 2 Use Cases*

Medication Reconciliation

- Not selected for Wave 1 because of an identified need to first address issues with the medication reconciliation process

MOLST / Advance Directives

- Not selected for Wave 1 because of an identified need to explore and collaborate with existing initiatives in the state

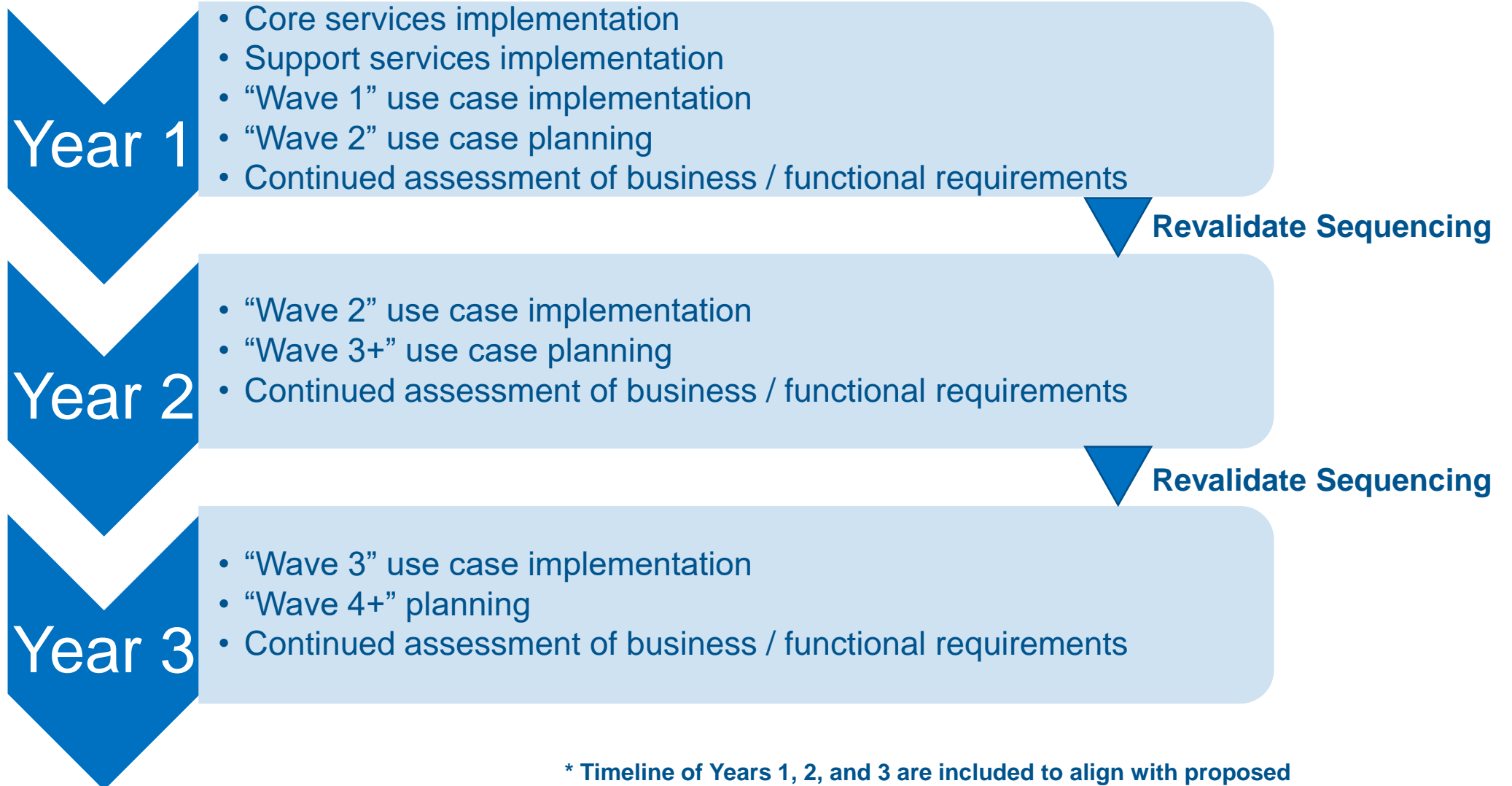
Patient Portal

- Not selected for Wave 1 because of an identified contingency on the technical architecture to support the Longitudinal Health Record use case

Population Health Analytics

- Not selected for Wave 1 because of an identified contingency on the required technical architecture to support the eCQM Reporting System use case

HIE Use Case DG Recommendation: *Rollout of Use Cases**



* Timeline of Years 1, 2, and 3 are included to align with proposed schedule that will be incorporated in SIM Operation Plan and IAPD-U

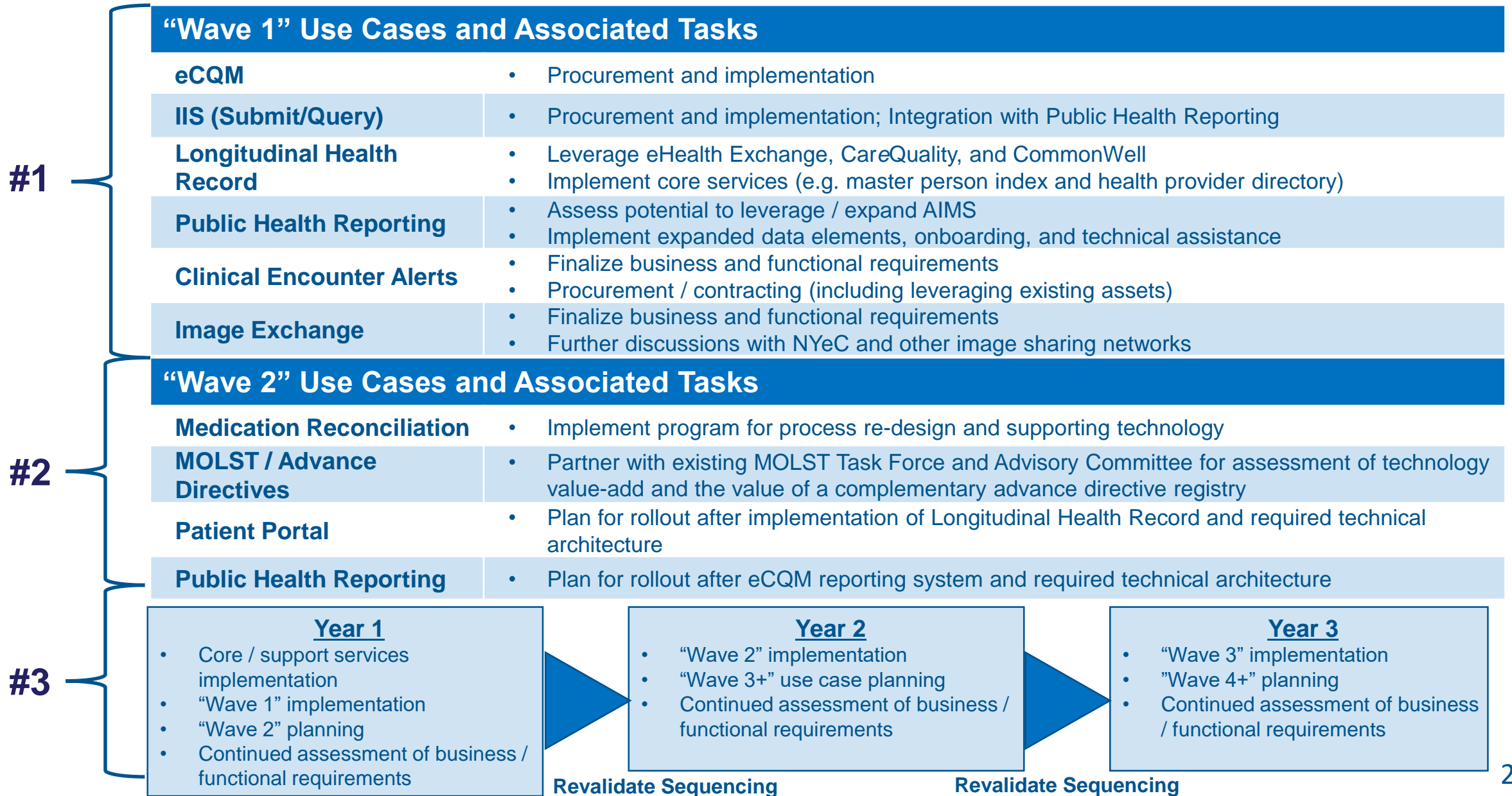
Future Use Cases (Not in “Top 10”)

The following use cases were reviewed and the value of each for stakeholders was identified. While not recommended for “Wave 1” or “Wave 2” implementation, these use cases should continue to be assessed for when and how they might become a part of the Connecticut interoperability ecosystem.

Use Cases Not in the “Top 10”

Opioid Monitoring and Support Services	Research / Clinical Trials
Wounded Warriors	Patient-Generated Data
Emergency Department Super-Utilizers	Medical Orders / Order Management
Care Coordination: Referral Management	CHA Dose Registry
Care Coordination: Transitions of Care	Bundle Management
Care Coordination: Care Plan Sharing	Emergency Medical Services (EMS)
Disability Determination	Lab Orders
Life Insurance Underwriting	Genomics
Lab Results Delivery	eConsult
Social Determinants of Health	

Recommendations for Approval



Acceptance of HIE Use Case Design Group Recommendations

Sustainability Overview and Discussion

Sustainability: Not a New Issue

The spread of sustainable HIEs and other interoperable health information systems will enable the health care industry to take a major step forward in improving the quality, safety and efficiency of care. First, however, HIE stakeholders must embrace fiscal responsibility and viability to make sure that the promise of HIEs remains in lockstep with the economics.



By John Glaser, Ph.D.,
Senior Advisor, Deloitte Center for Health Solutions

Deloitte.

Health Information
Exchange (HIE)
Business Models

*The Path to Sustainable
Financial Success*

Produced by the
Deloitte Center for
Health Solutions

Audit, Tax, Consulting, Financial Advisory

HIE Benefits: *“The Usual Suspects”*

- ▶ Improve **patient safety** by reducing medication and medical errors;
- ▶ Increase **efficiency** by eliminating unnecessary paperwork and handling;
- ▶ Provide caregivers with clinical decision support tools for **more effective care and treatment**;
- ▶ **Eliminate redundant or unnecessary testing**;
- ▶ Improve **public health reporting and monitoring**;
- ▶ **Engage healthcare consumers** regarding their own personal health information;
- ▶ Improve **healthcare quality and outcomes**; and
- ▶ **Reduce health related costs.**



By Saurabh Rahurkar, Joshua R. Vest, and Nir Menachemi

Despite The Spread Of Health Information Exchange, There Is Little Evidence Of Its Impact On Cost, Use, And Quality Of Care

ABSTRACT Health information exchange (HIE), which is the transfer of electronic information such as laboratory results, clinical summaries, and medication lists, is believed to boost efficiency, reduce health care costs, and improve outcomes for patients. Stimulated by federal financial incentives, about two-thirds of hospitals and almost half of physician practices are now engaged in some type of HIE with outside organizations. To determine how HIE has affected such health care measures as cost, service use, and quality, we identified twenty-seven scientific studies, extracted selected characteristics from each, and meta-analyzed these characteristics for trends. Overall, 57 percent of published analyses reported some benefit from HIE. However, articles employing study designs having strong internal validity, such as randomized controlled trials or quasi-experiments, were significantly less likely than others to associate HIE with benefits. Among six articles with strong internal validity, one study reported paradoxical negative effects, three studies found no effect, and two studies reported that HIE led to benefits. Furthermore, these two studies had narrower focuses than the others. Overall, little generalizable evidence currently exists regarding benefits attributable to HIE.

Health Information Exchange as a Driver of Improved Population Health

Julia Adler-Milstein, PhD

January 19, 2017

- ▶ Evidence is weak, and mixed
 - ▶ Suggests low levels of use, often due to poor workflow integration
 - ▶ Most consistent evidence comes from emergency department settings and avoiding redundant utilization
 - ▶ Little insight into mechanisms

Annals of Internal Medicine

REVIEW

Usage and Effect of Health Information Exchange

A Systematic Review

Robert S. Rudin, PhD; Aneesa Motala, BA; Caroline L. Goldzweig, MD, MSHS; and Paul G. Shekelle, MD, PhD

Background: Health information exchange (HIE) is increasing in the United States, and it is incentivized by government policies.

Purpose: To systematically review and evaluate evidence of the use and effect of HIE on clinical care.

Data Sources: Selected databases from 1 January 2003 to 31 May 2014.

Study Selection: English-language hypothesis-testing or quantitative studies of several types of data exchange among unaffiliated organizations for use in clinical care that addressed health outcomes, efficiency, utilization, costs, satisfaction, HIE usage, sustainability, and attitudes or barriers.

Data Extraction: Data extraction was done in duplicate.

Data Synthesis: Low-quality evidence from 12 hypothesis-testing studies supports an effect of HIE use on reduced use or costs in the emergency department. Direct evidence that HIEs were used by providers was reported in 21 studies involving 13 distinct HIE organizations, 6 of which were located in New York, and generally showed usage in less than 10% of patient encounters. Findings

from 17 studies of sustainability suggest that approximately one quarter of existing HIE organizations consider themselves financially stable. Findings from 38 studies about attitudes and barriers showed that providers, patients, and other stakeholders consider HIE to be valuable, but barriers include technical and workflow issues, costs, and privacy concerns.

Limitation: Publication bias, possible selective reporting of outcomes, and a dearth of reporting on context and implementation processes.

Conclusion: Health information exchange use probably reduces emergency department usage and costs in some cases. Effects on other outcomes are unknown. All stakeholders claim to value HIE, but many barriers to acceptance and sustainability exist. A small portion of operational HIEs have been evaluated, and more research is needed to identify and understand success factors.

Primary Funding Source: U.S. Department of Veterans Affairs. (PROSPERO registration number: CRD42014007469)

Ann Intern Med. 2014;161:803-811. doi:10.7326/M14-0877 www.annals.org
For author affiliations, see end of text.

Case Study in Value Creation: *Disability Determination*

- ▶ **For Patients and Families**
 - Disability determination turnaround reduced by 35%
- ▶ **For Social Security Administration**
 - Efficiencies vs. paper-based process
- ▶ **For Health System**
 - \$2.2M revenue enhancement for 4-hospital system

Social Security Administration (SSA)
Specialized Advisory and Assistance Services (SAAS)

**Using the Nationwide Health Information Network to
Deliver Value to Disability Claimants:**

A Case Study of Social Security Administration and
MedVirginia Use of MEGAHIT for Disability Determination



Sue S. Feldman, RN, MEd
Thomas A. Horan, PhD

Kay Center for E-Health Research
Claremont Graduate University

Emerging Evidence

Reducing Medicare Spending through Electronic Information Exchange: The Role of Incentives and Exchange Maturity

Idris Adjerid*, Julia Adler-Milstein**, Corey Angst*

*University of Notre Dame

**University of Michigan

We find significant cost reductions in healthcare markets that have established operational HIEs, with an average reduction in spending of \$139 (1.4% decrease) per Medicare beneficiary per year. We also find that these reductions occur disproportionately in healthcare markets where providers have financial incentives to use an HIE to reduce spending and when HIEs are more mature.

Effective HIE Use, Federal Incentives May Save Medicare Billions

Evidence shows mature HIE use and well-aligned federal incentives could save Medicare \$3.12 billion on average each year.



Clinical Research and HIEs

Research on medication adherence and health outcomes fundamentally relies on complete patient data including medication history and laboratory test results.

Patients, especially with chronic conditions, often receive care from different health care facilities, and patient data are usually scattered across different “islands”. It is impossible to generate complete patient-level data from multiple sources without support of an HIE.

Facilitating Clinical Research through the Health Information Exchange: Lipid Control as an Example

Vivienne J. Zhu, MD, MS,^{1,2} Wanzhu Tu, Ph.D,^{1,2} Marc B. Rosenman, MD,^{1,2}
J. Marc Overhage, MD, Ph.D^{1,2}

¹Regenstrief Institute and ²Indiana University School of Medicine, IN

ABSTRACT

Using data from the Indiana Network of Patient Care (INPC), we analyzed long-term statin adherence patterns and their effects on low-density lipoprotein cholesterol (LDL-C) control among patients with type 2 diabetes. Statin adherence was measured by proportion of days covered (PDC) for a 6-month interval prior to each LDL-C test date. Patient demographic and clinical characteristics were used as covariates for LDL-C control and predictors for statin adherence. From 4,350 eligible subjects, 25,596 6-month PDC and LDL-C level pairs were formed between 2001 and 2009. Rates of suboptimal adherence and suboptimal LDL-C control were 68.5% and 46.6%, respectively. Positive predictors for LDL-C control included adherence to statin (OR: 1.87, $p < 0.0001$) and older age (OR: 1.11, $p = 0.01$). Significant risk factors for non-adherence were young age, female gender, African American race and newly-treated status. This study demonstrated the utility of a health information exchange in health outcome and clinical effectiveness research.

INTRODUCTION

One of the challenges for performing health outcome and clinical effectiveness research is assembling the appropriate data particularly when studying a question that involves care in multiple disparate settings. A well-established health information exchange (HIE) supports key components of health outcome research and chronic care management including diabetes.¹ The main features of our HIE infrastructure are as follows: a centrally managed federated data repository; standard medical terminology usage for patient data acquisition; interconnected linkages among different hospitals, laboratories, pharmacies and clinics while maintaining data integrity, quality and security; robust patient matching and patient-centric

Hyperlipidemia has a high prevalence in type 2 diabetes and causes high rates of macrovascular complications. Up to 80% of patients with type 2 diabetes will develop or die of macrovascular diseases.⁴ In order to control macrovascular risk factors among patients with type 2 diabetes for both primary and secondary prevention, the American College of Physicians (ACP) recommended widespread statin (3-HYDROXY-3-METHYL-glutaryl coenzyme A [HMG-CoA] reductase inhibitor) use to lower serum cholesterol, with a target low-density lipoprotein cholesterol (LDL-C) level of 100mg/dL.⁵

Despite the known high macrovascular risks and the evidence-based guidelines for vascular protection, suboptimal lipid control is widely observed among patients with type 2 diabetes in clinical settings.⁶ Clinical trials have analyzed statin adherence patterns and have found a significant correlation between adherence to statins and LDL-C reduction.⁷⁻⁸ However, these studies usually follow patient medication taking behavior for only a short time period, while medication adherence changes over time especially for patients with chronic conditions. In addition, patients in a usual-care setting often do not adhere to prescribed treatment regimens and regular LDL-C laboratory tests as closely as those in a clinical trial. Medication non-adherence to statins has been demonstrated to be a barrier for patients in usual care settings to obtain benefits from statins.⁹ These discrepancies suggest that a longitudinal study of real-world clinical settings is necessary to compare the magnitude of benefits of statin therapy to that which is demonstrated in clinical trials.

Research on medication adherence and health outcomes fundamentally relies on complete patient data including medication history and laboratory test results. Patients, especially with chronic conditions, often receive care from different health care facilities,

HIE Sustainability Models Survey: *Results and Analysis*

HIE Sustainability Models Survey Results and Analysis

HIMSS FY16 HIE *inPractice* Task Force



“...one of the most important things that an HIE can do is engage their community to better understand the specific gaps and needs that exist and how new services will translate into value for members.”

- ▶ **Fourteen HIEs surveyed**
- ▶ **Services covered**
 - Community health record (13/14)
 - Direct Messaging (13/14)
 - ADT Alerts (12/14)
 - Patient Matching (12/14)
 - Results Delivery (10/14)
- ▶ **Funding model**
 - Monthly Fee/Annual Subscription (9/14)
 - Combination of subscription and fee for service (3/14)
 - Fee for service (1/14)
 - Public good (1/14)
- ▶ **Critical mass of adoption > 50%**
- ▶ **Services requested, but not provided**
 - Image Exchange
 - Reporting and Analytics
 - Clinical Quality Measure (CQM) support
- ▶ **No silver bullet**

Sustainable Business Model for HIE Platforms: *The Solution to Interoperability in Healthcare IT*

The HIE Platform’s Potential Services and Financing Sources

Niam Yaraghi

Potential Customers	HIE Service	Financing Sources
ACO	Access to health records	Reduced costs and increased margin of benefits
Payers	Prompting physicians to use the recent test results instead of ordering new ones / customized alerts and summaries of health data	Shared savings program between the HIE platforms, healthcare providers, and payers
Patients	Access to organized personal health records	Customized reports and alerts provided through third party vendors, such as mobile apps
NIH	Customize patient data summaries	A part of the budget of the research projects that are currently allocated to data collection
Pharmaceutical companies	Customized patient data summaries	Faster research projects and more efficient marketing strategies
Public health authorities	Data analytics / customized summaries of health data	A part of the budget that is currently allocated to the slow and expensive data collection and analysis tasks



Role of the State

▶ Enablers

- Effective use of legislation
- Effective use of policy levers, such as grants, incentives, and executive orders
- Strategic leveraging of existing investments in HIE

▶ Common Challenges

- Limited demand for HIE
- Sustainability
- HIE integration into provider workflow

FINAL REPORT

Key Challenges to Enabling Health

Information Exchange and How States

Can Help

DATE:

August 2014

PRESENTED TO:

The Office of the National Coordinator
for Health Information Technology
U.S. Department of Health and Human
Services
Washington, DC

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Guidance from National Governors Association

Connecticut: Use Legislative, Regulatory and Contracting Authority to Bolster Exchange

Connecticut signed into law a bill—Conn. PA No. 15-146—that prohibits hospitals, health systems and EHR providers from “health information blocking.”⁴⁹ The legislation establishes that such action is an unfair trade practice. Health information blocking is defined in the statute as:

“(A) knowingly interfering with or knowingly engaging in business practices or other conduct that is reasonably likely to interfere with the ability of patients, health care providers or other authorized persons to access, exchange or use electronic health records, or (B) knowingly using an electronic health record system to both (i) steer patient referrals to affiliated providers, and (ii) prevent or unreasonably interfere with patient referrals to health care providers who are not affiliated providers but shall not include legitimate referrals between providers participating in an accountable care organizations or similar value-based collaborative care models.”

State Strategies to Address Legal and Market Barriers and Increase Information Flow Between Health Care Providers

State Strategies to Address Legal Barriers

Fully Align State Privacy Laws With HIPAA

Pass a law that supersedes all more restrictive state privacy laws to allow providers and hospitals to exchange information in accordance with HIPAA.

Partially Align State Privacy Laws With HIPAA

Amend select statutes to allow certain types of information, such as information exchanged electronically, to be exchanged in accordance with HIPAA.

Create Standardized Consent Forms

Create a standardized consent form that provides a “one stop” approach to gaining patient permission for sharing information.

State Guidance and Education

Issue guidance and provide education to providers about how to comply with state and federal law, including clarifying legal intent and addressing common misconceptions.

State Strategies to Address Market Barriers

Create Meaningful Economic Interests That Encourage Exchange of Health Information

Create or adjust payments to incentivize exchange of health information or penalize lack of exchange.

Use Legislative, Regulatory and Contracting Authority to Bolster Exchange of Information

Pass laws or issue regulations that expressly prohibit information blocking or require information exchange.

Set the Vision and Hold People Accountable

Set statewide vision for interoperable exchange of health information and use bully pulpit to elevate best practices and place pressure on those lagging behind.

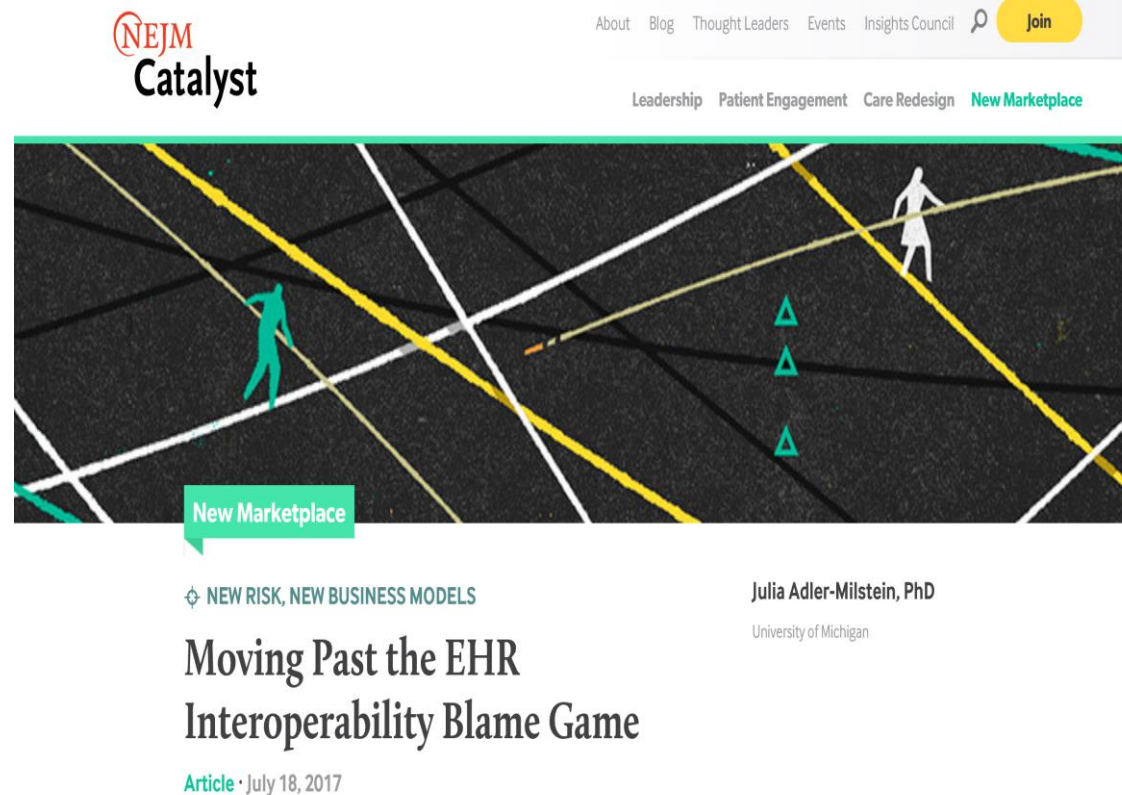
Serve as Convener

Bring key stakeholders to the table to work together toward interoperable exchange of health information.

The primary way a state can create economic interest for information exchange is through its larger efforts to change the way health care is paid for, delivered and measured.

Role of Policymakers

Without strong incentives that would have created market demand for robust interoperability from the start, we now must retrofit interoperability, rather than having it be a core attribute of our health IT ecosystem.”



NEJM Catalyst

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Leadership Patient Engagement Care Redesign **New Marketplace**

New Marketplace

NEW RISK, NEW BUSINESS MODELS

Moving Past the EHR Interoperability Blame Game

Julia Adler-Milstein, PhD
University of Michigan

Article · July 18, 2017

Of the stakeholders, only policymakers have a clear, strong interest in promoting interoperability. Therefore, it is up to them to ensure that robust, cross-vendor interoperability is a stay-in-business issue for EHR vendors and providers.”

Driving to Sustainability

1. **Focus on demand:** *Emphasize not just “supply” of interoperability, but “demand” for data sharing*
2. **Leverage value-based care initiatives:** *Support the data sharing needs of ACOs, clinically integrated networks, Advanced Networks, and other value-based care initiatives in Connecticut*
3. **Define and support a “healthcare data economy”:** *Create opportunities to monetize the value of data sharing and analytics*
4. **Support necessary workflow changes with technical assistance and education:** *Provide services needed to ensure all providers / caregivers have the capacity and know-how to participate in interoperability*
5. **Engage payers:** *Further align improved outcomes and financial incentives*
6. **Innovate (e.g. clinical research):** *Explore use cases with stakeholders who do not typically participate in HIE initiatives*
7. **Allocate expenses judiciously:** *Ensure cost allocations align with value creation*
8. **Include funding for development of a long-term financial sustainability plan in IAPD:** *Provide a roadmap and business model for future success*
9. **Implement rigorous measures of usage and value:** *Build these measures into the deployment of any and all technologies*
10. **Ongoing communication avenues with all stakeholders:** *Ensure that the benefits of HIE services accrue to all*
11. **Privacy, security, and confidentiality must be present in all systems and services**
12. **System must be designed for optimal ease of use**

Council Discussion

All-Payer Claims Database (APCD) Discussion

Access Health CT

Connecticut APCD Overview



APCD Charge & Primary Distribution Channels



Legislative Charge

Public Act 13-247 enabled the Exchange:

- (i) to utilize healthcare information collected from Data Submitters to provide healthcare consumers in Connecticut with information concerning the cost and quality of healthcare services that allows such consumers to make more informed healthcare decisions; and
- (ii) to disclose Data to state agencies, insurers, employers, healthcare providers, consumers, researchers and others for purposes of reviewing such Data as it relates to health care utilization, costs or quality of healthcare services.

Public Act 15-146 enabled the Exchange:

To, within available resources, establish and maintain a consumer health information Internet web site to assist consumers in making informed decisions concerning their health care and informed choices among health care providers.

Distribution Channels



Web



Data Extracts

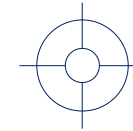


Reports



Analytic Services

Intended Audience



Consumers



State Agencies



Insurers



Employers



Providers



Other



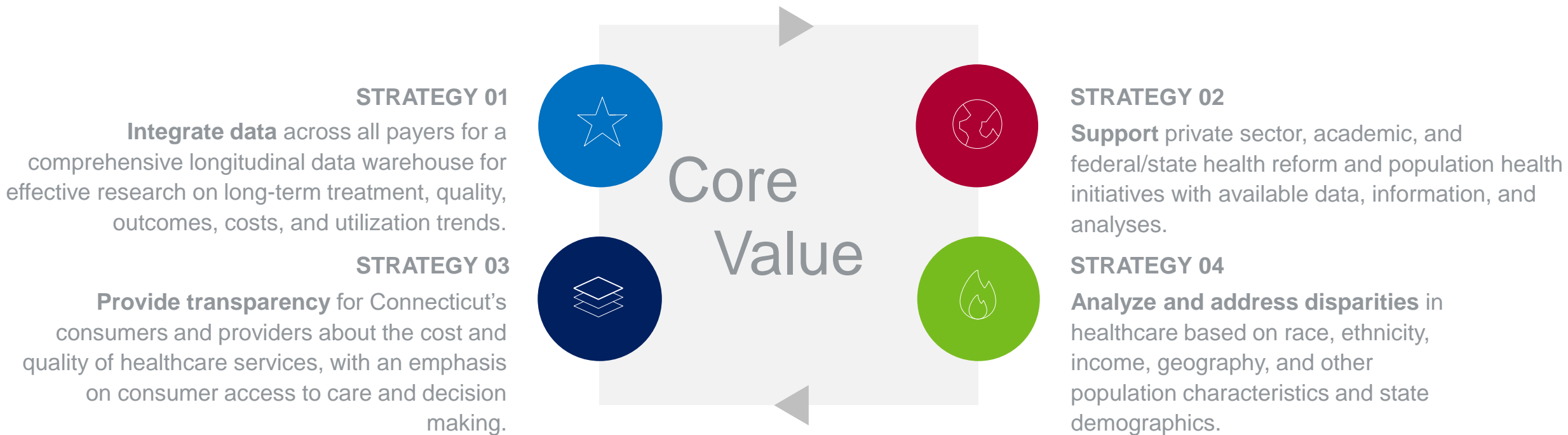
Proposed Vision & Mission (*From 3/9/2017*)



Vision: Improve the health of Connecticut's residents through the collection and analysis of data and the promotion of research addressing safety, quality, transparency, access, and efficiency at all levels of health care delivery.

Mission: Enhance consumer choice through healthcare price and quality transparency, improve population health, enhance outcomes, reduce disparities, improve health equity, and reduce cost of care by developing, using, and sharing Connecticut's All Payer Claims Database. Facilitate data driven research for the development of comprehensive, actionable and accurate information to inform policy.

Core Strategies (From 3/9/2017)



Four core strategies to facilitate the mission and achieve vision



Data Collection & Integration

Which Data Does The APCD Collect?

What Data Are Payers Required to Submit?

Administrative or billing data generated from paid claims incurred in medical and pharmacy settings. Includes drug claims data administered through medical and pharmacy benefits.



Reporting Requirements

Reporting Entities with more than 3,000 members enrolled must submit



Reporting Format

Claims submitted in standardized format established by APCD



Claims Dates

Claims span CY2012 – CY2017. Data submitted monthly



Total Volume*

Medical Claims:

Over 75 million claims
\$30 billion paid by carriers

Pharmacy Claims:

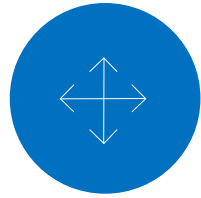
Over 129 million claims
\$11.9 billion paid by carriers
42.6 thousand unique drug codes

Entities Reporting Data

- Caremark
- Express Scripts**
- United Health
- Connecticare
- Aetna
- Anthem
- Cigna
- WellCare
- Harvard Pilgrim
- Healthy CT

* Figures do not include Medicare FFS or Medicaid claims

What's Available Through DR?



Enrollees

- ✓ CY 2012 – Present (n- 1 month)
- ✓ Data includes info on: *Administrative, Enrollee Coverage, Enrollee Demographics, Financials, Payers, Providers, Safe Harbor (2)*
- ✓ Fully insured/Non-ERISA plans (~900k Lives)



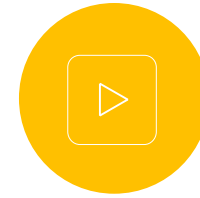
Medical Claims

- ✓ All claims/encounters paid by submitting carrier
- ✓ Data includes info on: *Administrative, Enrollee Coverage, Claim Detail, Diagnosis Codes, Procedure Codes, Financials, Payers, Providers, Safe Harbor (12)*



Pharmacy Claims

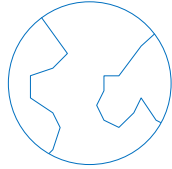
- ✓ All claims/encounters paid by submitting carrier
- ✓ Data includes info on: *Administrative, Enrollee Coverage, Claim Detail, Diagnosis Codes, Procedure Codes, Financials, Payers, Providers, Safe Harbor (12)*



Provider/Facility Directory

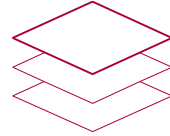
- ✓ Billing, rendering, prescribing, pharmacy, primary care provider IDs (varying completion rate)
- ✓ Data includes info on: Unblended and composite provider IDs and NPIs
- ✓ 512k Unique National Provider Identifiers

What's Not Available?



ERISA

Lives covered under self-insured ERISA plans



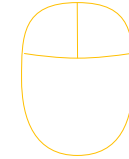
Part 2 SUD claims

SUD claims provided by Part 2 providers



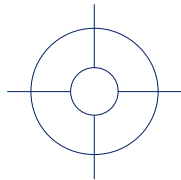
Denied Claims

Fully denied claims not collected



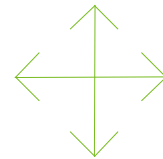
Test Result Values

Lab, imaging, biometrics, and physician derived data



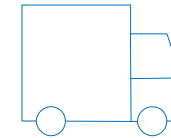
Third Party Data

Risk scoring, social determinants, knowledge base, etc.



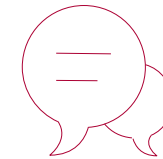
HIPAA Safe Harbor Variables

18 HIPAA identifiers



Dental Claims

Dental claims not required for submission



Ancillary Financials

Plan premiums, capitation payments, performance payments, administrative fees, rebates

APCD Data Release Update

Data Release (DR) Recap



Legislative Charge (PA 13-247):

The exchange shall: B) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services.

Phase 1: Develop DR Process, Tools, and Capabilities



Develop and implement core requirements to achieve DR capabilities:

Administration: Data release application, dictionary, & support materials

Software/Tools: Extract creation and delivery tool

Support: Admin support and documentation

Phase 2: Promotion and Delivery



Engage potential requestors to ensure capabilities, opportunities, and services are recognized.

DR Process & Turn-Around Time

End to End application process can take between 17 to 40 days depending on time of month an application is submitted. All requests must follow the data release process outlined by Privacy Policy & Procedures.



Data Release Application

Requestor general information, project summary, research details, data selection, and security/integrity.



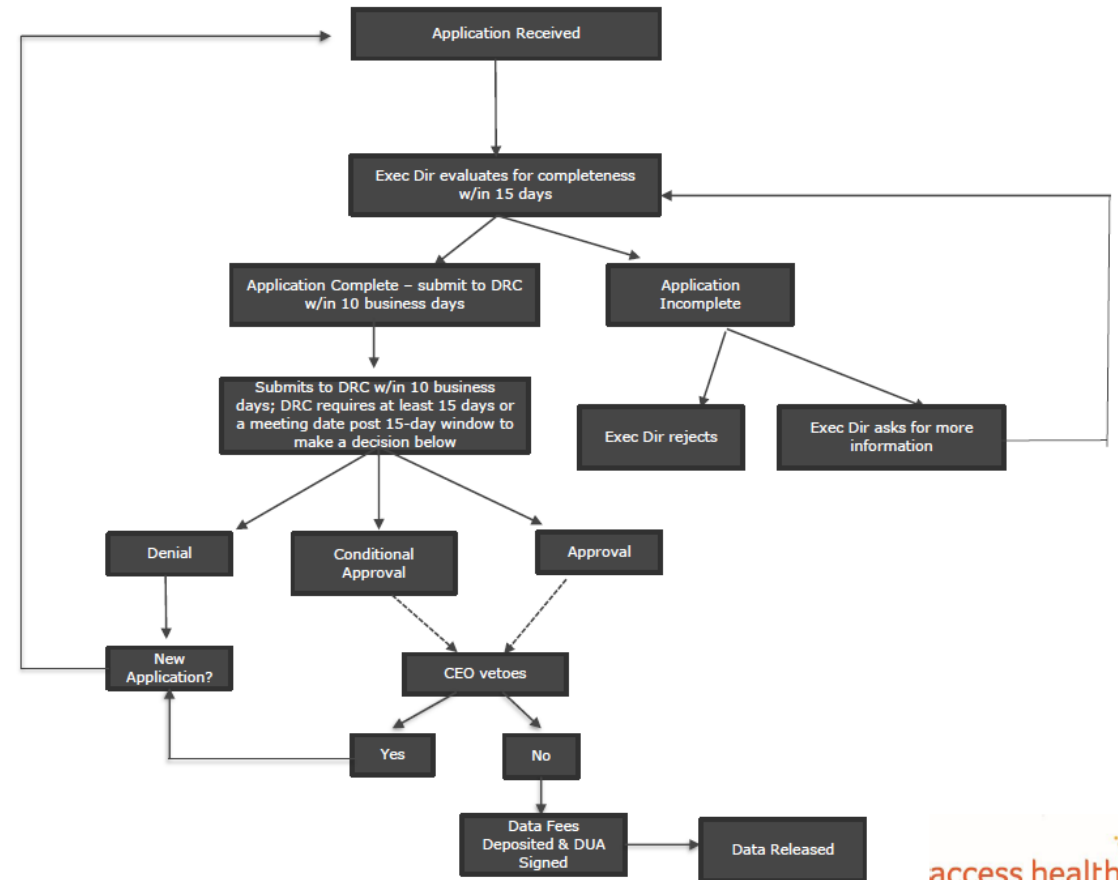
Data Release Committee

Review application alignment with objectives, re-identification risk, safeguard adequacy, and research design.



Data Use Agreement, Fees, & Extract

User agrees to fee schedule, DUA requirements. Standard extract creation within 5 business days (after 1st release).



De-Identified Data Release

Identifiers removed, as set forth in 45 CFR 164.514



18 HIPAA identifiers removed from dataset



Age caps applied (over 89, less than 1) & geography reduced to 3 digit zip*



All dates related to service and payments masked



Supplementary safeguards imposed to reduce unique characteristics

** First three digits of zip codes only if the geographic area covered by all zip codes beginning with those three digits has a population greater than 20,000 or the zip codes for those areas are changed to 000 in the data set.*



Reporting on Transparency and Disparities

APCD – Strategic Goals & Objectives

Provide transparency for Connecticut’s consumers and providers about the cost and quality of healthcare services, with an emphasis on consumer access to care and decision making

Goals	Objectives
Promote & leverage existing best in-class consumer transparency tools	<ul style="list-style-type: none"> • Identify leading consumer information and price transparency solutions that align with Vision • Ensure resources are not expended duplicating efforts
Complete development of Analyze Health website	<ul style="list-style-type: none"> • Finalize strategy to ensure site accomplishes PA 13-247 and PA 15-146 • Ensure target audience is clearly delineated, finalize UI development, and ensure content match audience needs
Complete development of remaining reports to ensure highest level of meaningful impact to intended audience	<ul style="list-style-type: none"> • Determine achievable and sustainable reports with highest impact • Communicate methodologies with stakeholders • Communicate and execute an implementation plan

APCD – Strategic Goals & Objectives



Analyze and address disparities in healthcare based on race, ethnicity, income, geography, and other population characteristics and state demographics

Goals	Objectives
Supplement existing data with third-party sources to maximize utility in disparities research	<ul style="list-style-type: none">• Partner with in-state Agencies such as DPH & AHCT to utilize ancillary data• Utilize software and third party data to enhance power of social determinant data
Support new and ongoing research initiatives	<ul style="list-style-type: none">• Support state researchers and advocates in health equity research and initiatives through data release and analysis

Wrap up and Next Steps

Next Health IT Advisory Council Meeting

Thursday November 16, 2017 | 1:00 pm – 3:00 pm

Legislative Office Building, Hearing Room 1D

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Health IT Advisory Council Website:

<http://portal.ct.gov/Office-of-the-Lt-Governor/Health-IT-Advisory-Council>