

# Draft Recommendations for Connecticut's Five-Year Statewide Health Information Technology Plan:

- Compilation of Stakeholder Feedback
- Summary of Revisions and Clarifications  
to Health IT Plan Recommendations

September 23, 2021

Prepared for the Connecticut Office of Health Strategy and  
Connecticut Health Information Technology Advisory Council by:



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# Table of Contents

- INTRODUCTION .....3
- FEEDBACK OPPORTUNITIES .....3
  - Summary of Stakeholder Feedback; Revisions, and Clarifications to Recommendations* .....4
  - A Person-Centered Focus—the WHY of the Statewide Health IT Plan* .....4
  - Feedback on Recommendation #1** *Strategies for Widespread Use and Sustainability of Connie Sustainability* .....4
  - Revisions and/or Clarifications to Draft Recommendation #1* .....6
  - Feedback on Recommendation #2** *Systems and Strategies to Address Social Determinants of Health* .....8
  - Revisions, and/or Clarifications to Draft Recommendation #2* .....9
  - Feedback on Recommendation #3** *Service Coordination and Data Integration Across State Agencies* ..... 10
  - Revisions, and/or Clarifications to Draft Recommendation #3* ..... 11
  - Feedback on Recommendation #4** *Support Adoption of EHRs and HIE Services by Behavioral Health Providers* ..... 13
  - Revisions, and/or Clarifications to Draft Recommendation #4* ..... 14
  - Feedback on Recommendation #5** *A Best Possible Medication History HIE Service, Connected Through Connie* ..... 15
  - Revisions, and/or Clarifications to Draft Recommendation #5* ..... 16
  - Feedback on Recommendation #6** *Health Information Privacy to Protect Individuals and Families* ..... 17
  - Revisions, and/or Clarifications to Draft Recommendation #6* ..... 18
- APPENDIX A – FEEDBACK AND PUBLIC COMMENTS RECEIVED ..... 19
- APPENDIX B – LIST OF STAKEHOLDERS PROVIDING FEEDBACK ..... 37
- APPENDIX C – FEEDBACK WEBINAR ATTENDEES ..... 38

## Introduction

In accordance with [Connecticut General Statute \(CGS\) 17b-59a\(3\)\(c\)](#), the Office of Health Strategy (OHS) is working to develop a Statewide Health Information Technology Plan (Health IT Plan) to be executed over a five-year timeframe. Connecticut's [Health Information Technology Advisory Council \(HITAC\)](#), in its advisory capacity to OHS, is providing guidance for the Health IT Plan with important linkages through its members to healthcare consumers, state and local agencies, private-sector healthcare and social service organizations, and to the legislative and executive branches of Connecticut government. Consulting firm CedarBridge Group (CedarBridge) is contracted by OHS to provide health IT and health information exchange (HIE) expertise to support healthcare transformation goals of the state. In June 2021, CedarBridge presented OHS and the HITAC with the findings from an extensive [environmental scan](#) of the current capabilities and future needs for health IT and HIE services, along with a set of draft recommendations for the state's Five-Year Health IT Plan.

This report includes a full compilation of all public comments received from Connecticut stakeholders (Appendix A) and provides a brief summary of where, as a result of one or more stakeholder comments, additions, revisions, and clarifications have been made to the draft recommendations by CedarBridge. The next steps in the final months of the year-long process will be:

1. HITAC members will review the revised recommendations during their September 23<sup>rd</sup> Council meeting and will provide advice and consultation to OHS leadership on whether to adapt or reject any portion of the recommended initiatives for inclusion in the Plan.
2. The OHS Executive Director, in consultation with the Commissioner of the Department of Social Services (DSS), the HITAC, and other state agency leaders, will determine the final set of initiatives to be included in the Five-Year Plan.
3. A draft implementation timeline with a matrix for discussing prioritization of initiatives will be presented at the October HITAC meeting.
4. A draft Sustainability Plan and a draft Compendium of Technical Standards, Policies, and Business Practices<sup>1</sup> will be presented for consideration at the HITAC's November meeting.
5. The final Statewide Health IT Plan will be presented at the December HITAC meeting.<sup>2</sup>

## Feedback Opportunities

Three virtual feedback forums were held to solicit public feedback and elicit discussion on the draft recommendations for Connecticut's Health IT Plan; 25 participants in total attended those engagement opportunities. OHS also disseminated the report through its extensive distribution channels with a request for public comment over a 30-day period between mid-July to mid-August. In addition, several targeted meetings and presentations took place to solicit feedback from state agency leaders, members of the Healthcare Cabinet, and the Medication Reconciliation and Polypharmacy Committee. In total, 145 comments from 38 commenters were received. In addition to the detailed comment log in Appendix A, a list of individuals and organizations who provided feedback is provided in Appendix B.

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<sup>1</sup> The promulgating legislation requires the Statewide Health IT Plan to address standards for electronic health information exchange, including provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols.

<sup>2</sup> At the direction of the OHS Executive Director and the HITAC Chair, one or more short-term workgroups may be established to provide guidance and expertise.

## Summary of Stakeholder Feedback; Revisions, and Clarifications to Recommendations *A Person-Centered Focus—the WHY of the Statewide Health IT Plan*

It is an intentionally demanding process being applied to the development of the Five-Year Statewide Health IT Plan for Connecticut because public/private collaborations will be required for successful implementation of the plan's key initiatives, and it is likely that individuals who are leading the implementation of a plan's strategic initiatives may change over the course of the Plan's lifecycle. Developing shared understandings across large and diverse groups stakeholders on WHY strategic initiatives are prioritized to guide public-sector investments in health IT and HIE services, and WHY some processes and policies are include in the Plan is essential. The June 2021 presentation to Connecticut's Health Information Technology Advisory Council of the Environmental Scan Findings and the Draft Recommendations for the Five-Year Statewide Health IT Plan prompted feedback expressing the need for more explicit conveyance of the "North Star" for all health IT/HIE planning being the individuals and families of Connecticut. Although several recommendations include initiatives for addressing social determinants of health, and the feedback made clear that the North Star, patient-centric message was not explicit enough in draft recommendations.

As a result of stakeholder feedback, additional details on potential implementation steps have been added to many of the recommendations. Each of the six recommendations and have been scrutinized for "person centeredness", not only for how individuals will access, use, and share their own health data, but also for how organizations will adjust to new workflows, new care models, and new definitions of care teams. Each recommendation is designed to improve health and healthcare; improve access to the right services at the right time, improve affordability of care, improve provider satisfaction in delivering high-quality care, improve patient satisfaction with the care we receive, all enabled through health IT.

Most stakeholder comments during the feedback process were specific to a single recommendation. A few specific issues and new ideas were presented during the feedback period that deserve to be featured separately or are applicable across all of the recommendations for the Plan.

- Consumers/patients should be represented on all proposed working groups and subcommittees related to HIE services provided by Connie, and all planning and design workgroups chartered by OHS and HITAC.
- Provider education, oversight, and monitoring protocols must be put in place to prevent information blocking by healthcare entities, as required by the Office of the National Coordinator (ONC)'s [Final Rule on Information Blocking in The CURES Act](#).
- An imperative of Connecticut's enabling legislation for health information technology and health information exchange; that is the prioritization of consumer access to their own health information. The development of a consumer-facing portal within the Connie infrastructure, with easy access to an individual's longitudinal health record must be included as a high priority in the Statewide Health IT Plan for Connecticut.

### **Feedback on Recommendation #1 Strategies for Widespread Use and Sustainability of Connie Sustainability**

Connecticut stakeholders communicated diverse perspectives and expectations for the use of Connie and about future health information exchange services that should be offered. Overall, most feedback was supportive of

the direction and constructive toward the progression of the strategies for improved statewide health information exchange services in Connecticut.

#### SPECIFIC COMMENTS RELATED TO RECOMMENDATION #1

- ❑ Connecticut Hospital Association (CHA) challenged the recommendation of a “public utility model” for master data management services, suggesting such a strategy would require fees on providers for the use of Connie.
- ❑ CHA disagreed with the recommendation Connecticut work toward a single state-wide Admit, Discharge, Transfer (ADT) notification system, suggesting that narrowing options to a common ADT service would adversely affect provider-led innovations.
- ❑ Mixed feedback was received about the recommendation that Connie be leveraged to streamline bidirectional access to public health reporting systems through a public health gateway although most comments were in support of this recommendation.

#### GENERAL COMMENT THEMES FOR RECOMMENDATION #1

- Most stakeholders who commented on the recommendation Connie be considered a public utility for management of master data of patient and provider demographic information agreed with the notion, to improve patient matching and increase patient/provider attribution.
- Several commenters emphasized the value of health analytic services to fund Connie’s sustainability.
- Supporting the master data management and data exchange needs of social service organizations will add to the sustainability of Connie.
- Connie should engage users in design and testing of services on its HIE platform to help ensure adoption.
- Connie should rapidly expand the number, variety, and volume of data being submitted and ingested into the HIE’s data warehouse, in order to increase the value of combined data.

*“...we want to stress the importance of including access through the HIE to the imaging examinations (the “pictures”), as well as the reports...access to both will not only provide better, more timely care, but will preclude the need for repeating examinations...”*

*- Radiology Society of Connecticut*

Revisions and/or Clarifications to Draft Recommendation #1

Substantiative changes to the recommendations are shown in **bold text**.

Strategies for Widespread Use and Sustainability of Connie	
<p>Sustainability of Connie must be a top priority for Connecticut leaders. Sustainability includes comprehensive funding strategies; however, it must also rapidly ensure there is tangible value to clinicians through a user-friendly interface that can be readily and efficiently incorporated into clinical workflows. Connie must position its suite of HIE services as a critical public utility for clinicians, public health crises response, and for coordination of community support services. The <a href="#">Connecticut Health IT Advisory Council</a>, an important oversight committee for publicly funded health IT and HIE services, can provide strategies for the successful deployment and sustained operations of Connie.</p>	
Original Recommendations	Revisions and Clarifications
<p>→ Recommend Connecticut Health IT Advisory Council continue to provide advisory support to the Executive Director of the Office of Health Strategy (OHS) and the Health Information Technology Officer (HITO) in evaluating options to help ensure long-term sustainability of Connie’s HIE services, and support the fulfillment of the responsibilities of OHS as described in <a href="#">Connecticut General Statute (CGS) Section (Sec.) 17b-59g(a)(3)</a>.</p>	<p>→ <b>No Change</b></p>
<p>→ Create a HITAC-appointed stakeholder workgroup to review options and provide recommendations to the OHS Executive Director and the HITO for sustainability including, but not limited to, legislation and/or regulatory actions to encourage participation in Connie, with potential funding sources to project Connie as a critical public utility focused on providing baseline health information exchange services, supportive governance models to advance the public utility model, and progression of OHS responsibilities outlined in <a href="#">CGS Sec. 19a-754a</a>.</p>	<p>→ <b>Revisions and Clarifications</b>                      Create a HITAC-appointed stakeholder workgroup to review options and provide <b>advice</b> to the OHS Executive Director and the HITO <b>on ways the State can support Connie’s sustainability</b>, including, but not limited to, legislation and/or regulatory actions to encourage participation in Connie, with potential funding sources to project Connie as a critical public utility focused on providing health information exchange services, <b>governance or oversight needs for the management of statewide master data services</b>, and progression of OHS responsibilities outlined in <a href="#">CGS Sec. 19a-754a</a>.</p> <p><b>The sustainability workgroup’s advisory role should be clearly delineated from the oversight role of Connie’s Board of Directors and the operational roles of Connie’s executive leadership. The workgroup should:</b></p> <ul style="list-style-type: none"> <li>○ Evaluate sustainability strategies of long-standing HIE organizations in other states.</li> <li>○ Develop a comparative analysis showing where savings are accrued across domains (payers, providers, hospitals, state agencies, etc.) when a</li> </ul>

	<p><b>critical mass of provider organizations are participating in one or more of Connie’s use cases.</b></p> <ul style="list-style-type: none"> <li>○ <b>Recommend executive, legislative, agency, and program-level actions to help ensure Connie’s sustainability.</b></li> </ul>
<p>→ Recommend Connie explore partnerships to foster earned revenue through fees.</p>	<p>→ <b><i>Removed Recommendation</i></b></p>
<p>→ In the near-term, Connie should focus on HIE fundamentals (e.g., ADT notifications, lab results and image sharing, medication lists, etc.) with an eye toward useability and workflow integration and limit the number of use cases that will require additional patient consent. Key stakeholders and Connie should consider adoption of a single statewide ADT notification system, rather than the multiple systems presently used in the state (e.g., Project Notify and PatientPing).</p>	<p>→ <b><i>Revised Recommendation:</i></b>  Connie should consider adoption of a single statewide ADT notification system, rather than the multiple systems presently used in the state (e.g., Project Notify and PatientPing).</p> <ul style="list-style-type: none"> <li>○ <b>Connie could consider conducting a survey of users of the competing ADT notification systems in Connecticut to assess the satisfaction of organizations with the system they use.</b></li> <li>○ <b>Connie could also consider conducting a Request for Information (RFI) process to evaluate options for connecting multiple notification systems through a master data management service with application program interfaces (APIs).</b></li> </ul>
<p>→ Payment incentives should be included in contracts between payers and providers to build a critical mass of organizations onboarded and exchanging health information to improve clinical care. In addition to payment incentives, a regional extension center-styled initiative should be instituted to ensure smaller practices and provider groups have the technical supports and training to onboard and utilize the statewide HIE.</p>	<p>→ <b><i>No Change</i></b></p>
<p>→ Connie should be leveraged for health information exchange between local public health departments, providers, and Connecticut’s Department of Public Health to ensure centralized data access and streamlined reporting in public health crises, and ease the administrative burden experienced by local public health departments and providers due to manual data entry, redundant reporting, and difficulty querying public health data systems.</p>	<p>→ <b><i>Incorporate into Recommendation #3</i></b></p>

→ **New Recommendation**

The Office of Health Strategy should conduct a provider education campaign on the Office of the National Coordinator (ONC)'s Final Rule on Information Blocking to encourage greater portability and interoperability of patient health information. This should be followed by clear guidelines for how compliance with the information blocking rules will be monitored and enforced.

→ **New Recommendation**

The Office of Health Strategy should engage Connecticut leaders from accountable care organizations (ACOs) and members of the Primary Care and Community Health Reforms Workgroup to evaluate the use of Connie as a centralized clinical quality measurement and reporting service to support providers' participation in value-based payment models.

→ **New Recommendation**

In conformance with legislative intent and stakeholder feedback, Connie should prioritize the development of a consumer/patient portal. The portal should be offered to individuals for accessing their own health records, without barriers or fees.

→ **New Recommendation**

To increase the value of HIE services, Connie should explore ways to accelerate provider participation in clinical data (e.g., lab, pharmacy, radiology reports, medical images, behavioral and oral health records, etc.).

## Feedback on Recommendation #2 Systems and Strategies to Address Social Determinants of Health

Virtually all stakeholder feedback received on this recommendation section recognized the importance of systematically addressing social determinants of health (SDoH) and encouraged development and use of information sharing systems to improve patient health outcomes and community wellness.

### SPECIFIC COMMENTS RELATED TO RECOMMENDATION #2

- ❑ Connecticut Hospital Association submitted the suggestion that efforts made in this domain strengthen and expand the work being done by [Unite Connecticut](#). Other stakeholders suggested the Connie platform could provide technology for community information exchange and recommended reviewing the work occurring with United Way's [2-1-1 Referral Platform](#).
- ❑ Health Equity Solutions commented that the plan should incorporate the ability to collect patients' insurance status and geocoded residential address, along with Race, Ethnicity, Language (REL) data.
- ❑ Health Equity Solutions also suggested inclusion of a Health Equity Dashboard to access and understand the prevalence of specific health disparities at the neighborhood level and evaluate the effectiveness of interventions.

### GENERAL COMMENT THEMES RELATED TO RECOMMENDATION #2

- Stakeholders indicate staunch support for increased state funding and technical support of community-based organizations (CBOs).
- Stakeholders want to maintain flexibility in provider workflows relative to social needs screening tools but maintain support for SDOH data standards to make data actionable and measurable.



- Comments indicate intensive community-level engagement will be required for CIE planning, along with meaningful opportunities for involvement.

*“Public Act No. 21-35 mandates standardized collection of [REL] data elements and inclusion of these in the HIE. We request that a strategy for the collection of insurance status and geocoded residential address also be considered and incorporated into this recommendation.”*

- Health Equity Solutions

### Revisions, and/or Clarifications to Draft Recommendation #2

Systems and Strategies to Address Social Determinants of Health	
<p>The state, in concert with the Connecticut Hospital Association, should consider allocating technology funding and other resources for community-based organizations to support the acquisition of needed technology to coordinate SDoH screening and referrals for individuals with the health care and human services ecosystem in the state. This includes, but is not limited to, fulfilling the requirements of <a href="#">Public Act Number 21-35 Section 11</a> (An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care In Response to the Pandemic), expansion of the utilization of Unite Connecticut, and exploration of other tools to capture social risk factors and coordinate care across communities.</p>	
Original Recommendations	Revisions and Clarifications
<p>→ Explore the identification and systematic use of a single SDoH screening tool across healthcare settings, similar to <a href="#">North Carolina’s model</a>.</p>	<p>→ <b>Revised Recommendation</b>  <b>The Office of Health Strategy and the HITAC should charter a working group with representatives of community-based organizations, social service agencies (state and local), and provider organizations to establish best practices for capturing social needs and social determinants of health when conducting screenings/assessments. The working group should:</b></p> <ul style="list-style-type: none"> <li>○ Analyze current screening assessment tools in use in Connecticut</li> <li>○ Evaluate technology options for mapping similar data elements between different screening/assessment forms currently in use in Connecticut to common standards</li> <li>○ Engage stakeholders to consider available options</li> <li>○ Develop proof-of-concept pilots to test new workflows for data collection, test new screening/assessment tools, and test tools to map similar data elements to common standards</li> </ul>

<p>→ Establish common data standards in alignment with emerging SDoH standardization collaboratives such as <u>The Gravity Project</u> and <u>SIREN</u>.</p>	<p>→ <b>Revised Recommendation</b> Align with efforts to develop national standards for SdoH data elements and Z-codes in electronic health record systems (<u>The Gravity Project</u> , <u>SIREN</u>)</p>
<p>→ Explore the development of a community information exchange, leveraging state resources in place such as <u>Connie</u>, <u>Health Equity Solutions</u>, <u>Connecticut Health Foundation</u>, the <u>Health Enhancement Communities (HECs)</u>, <u>Unite Connecticut</u>, the <u>Homeless Management Information System</u>, and <u>United Way’s 2-1-1 Referral Directory</u></p>	<p>→ <b>No Change</b></p>
<p>→ Facilitating broad collection of race, ethnicity, and language (REL) data, in accordance with <u>Public Act No. 21-35</u>, as a vehicle to better understand the needs of communities of color and develop a holistic strategy to address health disparities through data availability and analytics to create health insights at the point of care.</p>	<p>→ <b>Revised Recommendation</b> Facilitating broad collection of race, ethnicity, and language (REL) data, in accordance with <u>Public Act No. 21-35</u>, as a vehicle to better understand the needs of communities of color and develop a holistic strategy to address health disparities through data availability and analytics to create health insights at the point of care. <b>The Office of Health Strategy should create a Health Equity Dashboard to understand the prevalence of specific health disparities and evaluate the effectiveness of interventions. Make Health Equity Dashboard tools publicly available and create online training resources to support users.</b></p>
<p>→ Hire and train personnel to manage and operate technology assets.</p>	<p>→ <b>Revised Recommendation</b> <b>The Connecticut General Assembly should ensure adequate funding for hiring and training personnel to manage and operate technology assets. (Refer to similar topic in Recommendation #3.)</b></p>
<p>→ Provide ongoing education and technical assistance to ensure a technically competent workforce.</p>	<p>→ <b>Revised Recommendation</b> <b>The Connecticut General Assembly should provide funding for ongoing education and technical assistance to ensure a technically competent workforce.</b></p>

### Feedback on Recommendation #3 Service Coordination and Data Integration Across State Agencies

Stakeholders both within and outside state government almost uniformly expressed a strong desire for more bi-directional data sharing with and among state agencies. In addition, state leaders wanted to ensure that the Statewide Health IT Plan recognized the significant work already under way to enable more seamless interagency data sharing.

**SPECIFIC COMMENTS RELATED TO RECOMMENDATION #3**

- ☐ Officials with the Office of Policy and Management (OPM) provided information on work that has been done through several initiatives on interagency data sharing and requested the Health IT Plan align, build on, and/or complement existing initiatives such as [P20 WIN](#), the [2-Gen Initiative](#), and the [Governor’s Task Force on Housing and Supports for Vulnerable Populations](#).

**GENERAL THEMES OF COMMENTS FOR RECOMMENDATION #3**

- Stakeholders expressed support for the Health and Human Service Person-Centered Services Collaborative (HHS-PCSC), but also felt there needs to be patient representation on the committee.
- Comments requested that Connecticut ensure strong consent management protocols related to personally identifiable information housed in state databases.
- State officials request a deeper exploration of the privacy and security considerations of any future data sharing efforts.

*“Hiding the seams of government’ to improve service delivery is a laudable goal, but the state must remain accountable for providing a full and fair disclosure of how it uses patient data. Actions that reduce patient trust in healthcare data systems increase the risk that patients will be less open and complete with providers about their health.”*

- Provider Representative

Revisions, and/or Clarifications to Draft Recommendation #3

Service Coordination and Data Integration Across State Agencies	
Original Recommendations	Revisions and Clarifications
→ The state is benefitting from an infusion of one-time funding from the Centers for Disease Control (CDC) and other federal sources for <u>public health data modernization</u> ; Connecticut should continue with ongoing funding to ensure adequate staff resources are maintained within the Department of Public Health and local health departments	→ <b>Revised Recommendation</b> The Connecticut General Assembly should ensure adequate funding and resources are available to the Connecticut Department of Health and local public health departments for current and ongoing work to protect and improve the health of Connecticut’s population.
→ Create a Public Health Gateway, within Connie, for more seamless flow of information between local health departments, other reporting providers, and the state’s public health reporting systems.	→ <b>Revised Recommendation</b> The Office of Health Strategy should conduct a survey of healthcare providers and local public health departments to determine the highest priority public health information systems for implementing bidirectional connectivity through a gateway interface. OHS should also conduct research to

	<p>evaluate the pros and cons for managing a gateway interface within the Department of Public Health vs. offering the gateway service through Connie.</p>
<p>→ Efforts should build upon <a href="#">P20 Win</a>, <a href="#">CGS 4-67z</a>, <a href="#">CGS 17b-112l(e)</a>, and other initiatives to build shared practices and tools among attorneys representing state agencies to help facilitate data sharing through implementation of standardized legal agreements and processes.</p>	<p>→ <b><i>Revised Recommendation</i></b>  The Office of Policy and Management and the Office of Health Strategy should charter a technical workgroup to develop interoperability standards for state agencies when procuring new information technology systems and/or upgrading legacy information technology systems and evaluate technology options to support electronic data exchange between existing data systems. The technical workgroup should initiate their work immediately to support the Department of Public Health meet the interoperability requirements embedded in the Coronavirus Response and Consolidated Appropriations (CARES) Act and the American Rescue Plan Act (ARPA) for public health data system modernization.</p>
<p>→ Create a Health and Human Service Person-Centered Services Collaborative (HHS-PCSC) as a subcommittee of the HITAC charged with identifying priority scenarios where residents access multiple HHS services and programs. The workgroup should evaluate the intake, enrollment and case management processes, and existing methods for coordination, along with the use of IT systems and processes that facilitate service delivery across all involved agencies. Finally, the workgroup should design systems and data integration programs that “hide the seams” of government for priority scenarios identified.</p>	<p>→ Create a Health and Human Service Person-Centered Services Collaborative (HHS-PCSC) as a standing workgroup of the HITAC, building on the work of the Governor’s Task Force on Housing and Supports for Vulnerable Populations, Connecticut’s Two Generational <a href="#">(2-Gen) Initiative</a>, and other related initiatives. The HHS-PCSC should be charged with identifying priority scenarios where individuals and/or families receiving care and services from multiple state agencies and/or state-funded community based organizations could benefit from the implementation of <a href="#">interagency data sharing strategies</a> for better coordination of care. Because significant work has been done in Connecticut to understand the legal protections around data collected by various state agencies and the <a href="#">legal issues to interagency data sharing</a>, the workgroup should focus on:</p> <ul style="list-style-type: none"> <li>○ Developing policies and repeatable processes to lower the barriers for interagency data sharing</li> <li>○ Developing best practice policies for maintaining transparent and rigorous consent management protocols for the sharing of personally identifiable information across HHS agencies, patients and families, and service providers</li> </ul>

<p>→ Connect HHS agencies’ data systems to Connie, where appropriate, through the creation of a state agency data collaborative designed for government use of Connie. This collaborative should, among other things, build institutional capacity for data governance within and among state agencies.</p>	<p>→ <b>Revised Recommendation</b>  <b>The Office of Policy and Management and the Office of Health Strategy should create a state agency data collaborative to explore the appropriate and legal connection of HHS agency data systems to Connie with the objectives of improving clinical care, improving coordination of services, and improving secure and efficient access to information by providers and organizations providing care and services to individuals and families in Connecticut. This collaborative should, among other things, build institutional capacity for data governance within and among state agencies.</b></p>
<p>→ Develop formal contingency plans within each HHS agency to address the impending loss of institutional knowledge and experience due to state employee retirements and create actionable strategies to employ a new generation of talent in state government.</p>	<p>→ <b>Revised Recommendation</b>  <b>The Office of Policy and Management and the Office of Health Strategy should build on existing research and incorporate emerging data on workforce trends to develop a report for the Connecticut General Assembly and Office of the Governor on the agency information technology workforce needs to support the state’s health priorities, including the health IT and HIE initiatives in the Five-Year Statewide Health IT Plan. The General Assembly should provide funding for HHS agencies to develop formal contingency plans for addressing the impending loss of institutional knowledge and experience in the current information technology workforce due to state employee retirements and changing employment trends, with actionable strategies to employ a new generation of talent in state government.</b></p>
<p>→ Create training programs for all local public health departments to become more sophisticated in the use of existing IT systems for both public health and financial reporting.</p>	<p>→ <b>Revised Recommendation</b>  <b>The Connecticut General Assembly should provide funding for the Department of Health for creation and dissemination of educational materials and training programs for all local public health departments to become more sophisticated in the use of <b>new and</b> existing IT systems for both public health and financial reporting.</b></p>

**Feedback on Recommendation #4 Support Adoption of EHRs and HIE Services by Behavioral Health Providers**

Regarding behavioral health, privacy concerns were top of mind for stakeholders. A considerable number of behavioral health providers reported strong opposition to any type of data sharing, citing patient confidentiality

as the reason. Stakeholders requested additional due diligence be conducted to better understand barriers both to the adoption of electronic tools and data sharing and to address provider concerns.

**GENERAL THEMES OF COMMENTS FOR RECOMMENDATION #4**

- Stakeholder feedback underscored the importance of understanding the concerns expressed by behavioral health providers during the environmental scan about the legal barriers to sharing behavioral health data in Connecticut, and how data sharing may adversely impact patient trust of their behavioral health providers.

*“We agree with the value of greater engagement of behavioral health providers in health IT and HIE and welcome the opportunity to engage on that front.”*

Jenn Searls, Executive Director of Connie

Revisions, and/or Clarifications to Draft Recommendation #4

Support Adoption of EHR and HIE Services by Behavioral Health Providers	
Some sectors of the healthcare delivery system continue to lag in terms of EHR adoption, notably behavioral health providers in Connecticut.	
Original Recommendations	Revisions and Clarifications
<p>→ The Office of Health Strategy, in partnership with Connecticut’s Department of Mental Health and Addiction Services, Department of Social Services, and stakeholder groups representing behavioral health providers, should develop and implement an educational campaign to break down the cultural resistance expressed by many behavioral health providers around the use of information technology solutions, including EHRs and HIE services. Strategies to address concerns around the privacy of sensitive health information and potential associated liability should be included as part of the educational campaign.</p>	<p>→ <b>Revised Recommendation</b>                      The Office of Health Strategy, in partnership with Connecticut’s Department of Mental Health and Addiction Services, Department of Social Services, and stakeholder groups representing behavioral health providers, should develop and implement an educational campaign to break down the cultural resistance expressed by many behavioral health providers around the use of information technology solutions, including EHRs and HIE services. Strategies to address concerns around the privacy of sensitive health information and potential associated liability should be included as part of the educational campaign. <b>OHS and partnering state agencies should begin this work by conducting a series of listening sessions to understand the unique challenges of behavioral health providers and their patients, when considering setting goals for the adoption of EHR and HIE services. Listening sessions should inform educational efforts.</b></p>

<p>→ Technical assistance and ongoing training should be provided to behavioral health providers to support the transition to more integrated models of care where electronic closed loop referrals and bidirectional data exchange are required.</p>	<p>→ <b>Revised Recommendation</b>  <b>Funding from the state budget should be earmarked for</b> technical assistance and ongoing training for behavioral health providers to support the transition to more integrated models of care where electronic closed loop referrals and bidirectional data exchange are required.</p>
<p>→ Financial incentives for data exchange and quality reporting should be included in payer contracts, including those executed by self-insured employers and Medicaid.</p>	<p>→ <b>No Changes</b></p>

### Feedback on Recommendation #5 A Best Possible Medication History HIE Service, Connected Through Connie

Healthcare providers report a high need for access to patients’ medication data – something which is not widely available at the present time. Recommendation #5 suggests Connecticut should explore the expansion of the Connecticut Prescription Monitoring and Reporting System (CPMRS), Connecticut’s Prescription Drug Monitoring Program (PDMP), through policy or legislation, to require submission of all prescription and medication fill, and prescription related medical devices data from pharmacies, including long-term care pharmacies, and prescribers or alternative medication fill data sources. This should include an evaluation of variability in data quality and completeness, timeliness, and the cost of various data sources.

#### SPECIFIC COMMENTS RELATED TO RECOMMENDATION #5

- ❏ The Connecticut Hospital Association supports exploring more complete medication fill data sources but cautioned that the project should prevent any possibility of disrupting Connecticut PDMP’s efficient functions.
- ❏ One stakeholder expressed significant objections to exploring the use of the PDMP for patient’s best possible medication history on the grounds that the PDMP does not provide patients the opportunity to give their consent for sharing their health information, or the ability to opt-out.

#### GENERAL THEMES OF COMMENTS FOR RECOMMENDATION #5

- Participants in a feedback webinar expressed consistent support for the exploration of medication fill data sources that could help to establish an electronic registry for patients’ best possible medication history.
- Representatives from the Medication Reconciliation and Polypharmacy Committee (MRPC) indicated PDMP as a medication fill data source may be putting a solution before the necessary research on all medication fill sources; additional research is currently being conducted.

*“The Department of Consumer Protection has done outstanding work creating, managing, and building the PDMP. It is a bright spot in Connecticut’s health IT landscape. Any integration with or through Connie should only be done if it does not disrupt the current success of the PDMP and does not interfere with DCP’s oversight and management of that program, or with patient rights”*

- Connecticut Hospital Association

Revisions, and/or Clarifications to Draft Recommendation #5

A Best Possible Medication History HIE Service, Connected Through Connie	
Stakeholders across the spectrum report a high need for access to medication data – something which is not widely available at the present time. Below are recommendations to address this need.	
Original Recommendations	Revisions and Clarifications
<p>→ Explore the expansion of the Connecticut Prescription Drug Monitoring Program through policy or legislation if needed, to require submission of all prescription and medication fill, and prescription related medical devices data from pharmacies, including long-term care pharmacies, and prescribers. These efforts should leverage existing data sources such as PBMs, EHRs, and pharmacy gateways.</p>	<p>→ <b>Revised Recommendation</b>  <b>When exploring expansion of the Connecticut Prescription Monitoring and Reporting System (CPMRS) for a source of medication fill data for a Best Possible Medication History service offered by Connie, a thorough and transparent evaluation of the current laws and policies governing access and use of CPRMS for law enforcement activities must be conducted to determine whether legal and/or policy changes are needed, including but not limited to consent requirements and the ability for individuals to opt-out. Potential disruptions and/or interruptions to current CPMRS functionality for prescribers must also be evaluated.</b></p>
<p>→ Explore additional or alternative medication fill data sources, including variability in data quality and completeness, timeliness, and cost of various data sources.</p>	<p>→ <b>No Change</b></p>
<p>→ Establish Single Sign-On (SSO) capabilities between Connie and CPMRS for ease of access to PDMP data for Connecticut providers which has started with the integration and may be complete Summer, 2021. Support for the Gateway integration beyond the current 2-year limited funding should be explored which will allow for a Single Sign-On (SSO) to be leveraged and the full value of the CPRMS to continue to be realized.</p>	<p>→ <b>No Change</b></p>



→ Charge the Medication Reconciliation and Polypharmacy Committee with designing a glide path for expansion of the PDMP to additional drug classes and drug types.

→ **Revised Recommendation**  
**A Connie workgroup for the Best Possible Medication History (BPMH) use case should integrate expertise from the Medication Reconciliation and Polypharmacy Committee and include leadership of the CPMRS program. The BPMH workgroup should have the opportunity to provide feedback to the CPMRS program on potential expansion of the PDMP to additional drug classes and drug types.**

## Feedback on Recommendation #6 Health Information Privacy to Protect Individuals and Families

Feedback on the draft recommendations reflected a culture of distrust among some stakeholders pertaining to the use and disclosure of patients' protected health information. Some stakeholders expressed a desire for a deeper and more nuanced understanding of consumer sentiment and preferences to inform policymaking at Connie and within the state.

### SPECIFIC COMMENTS RELATED TO RECOMMENDATION #6

- ❑ One commenter emphasized the need for more robust consumer engagement to identify the major concerns related to health IT and health information exchange, prior to creating policy based on the interests of various stakeholder groups.
- ❑ While there were no objections to the establishment of a Patient Health Information Protection Office (PHIPO), two commenters questioned which state agency should be most appropriate home for the new office.

### GENERAL THEMES OF COMMENTS FOR RECOMMENDATION #6

- A broad array of commenters reiterated their belief that most consumers do not know how or with whom their information is being shared.
- Stakeholder comments requested that Connie and state agencies be transparent and consistent in any educational content being created around consent policies.
- One commenter suggested the state play a central role in managing consent, especially as it relates to Connie.

*"When patients are told that truly only their direct medical providers will see their records, they are less concerned about privacy. However, they may not be comfortable with their dentist or dermatologist seeing their full OB-GYN record for example without their express permission"*

- HITAC Member

Revisions, and/or Clarifications to Draft Recommendation #6

Health Information Privacy to Protect Individuals and Families	
<p>Critical to the establishment of trusted health information exchange services is the assurance that patient health information is secure, restricted only to view by appropriate healthcare providers, and updated to reflect the patient’s consent preferences for the disclosure of their health information</p>	
Original Recommendations	Revisions and Clarifications
<p>→ Create a public video series highlighting what the statewide health information exchange is, and how protected health information is shared across healthcare providers and professionals.</p>	<p>→ <b>Revised Recommendation</b>  <b>Include educational materials and media directed toward providers to assist them in establishing consent management processes for sharing patient information, and best practices for talking to patients about providing informed consent and their health data rights</b></p>
<p>→ Host town hall meetings with state government leaders providing information and education to members of the public on their rights to provide informed consent for the electronic sharing of their health information.</p>	<p>→ <b>No Change</b></p>
<p>→ Appropriate funds through the legislature for the Office of Health Strategy to establish a Patient Health Information Protection Office (PHIPO) tasked with:</p> <ul style="list-style-type: none"> <li>○ Establishing and evolving state policy for the use and disclosure of patient health information through the statewide health information exchange.</li> <li>○ Monitoring, analyzing, and reporting on trends in patient complaints around inappropriate disclosures of health information, and overall experience and knowledge of the statewide health information exchange; and</li> <li>○ Enforcing penalties and fines for inappropriate disclosures of patient health information.</li> </ul>	<p>→ <b>Revised Recommendation</b>  <b>Appropriate funds through the legislature to establish a Patient Health Information Protection Office (PHIPO) tasked with:</b></p> <ul style="list-style-type: none"> <li>○ <b>Establishing and evolving state policy for the use and disclosure of patient health information through health information exchange services</b></li> <li>○ <b>Monitoring, analyzing, and reporting on trends in patient complaints around inappropriate disclosures of health information, and overall experience and knowledge of health information exchange services</b></li> <li>○ <b>Enforcing penalties and fines for inappropriate disclosures of patient health information”</b></li> </ul>
<p>→ Propose legislation that would require healthcare providers to use consistent protocols for the collection of patient consent preferences, inclusive of the creation of statewide paper and electronic consent forms offering more granular consent options that includes the provider to whom consent is given, reason for consent and a timeframe for consent.</p>	<p>→ <b>No Change</b></p>

## Appendix A – Feedback and Public Comments Received

[Note: some comments are paraphrased from verbal feedback given during webinars.]

Name	Organization	Feedback
<b>Charles Brown</b>	Central Connecticut Health District	[investments in CBO infrastructure and training] Is critically important as sharing from healthcare facilities will cause a vast increase in caseloads, without support at the ground level in basic infrastructure that will be buried
<b>Charles Brown</b>	Central Connecticut Health District	I would add Local Health Departments to all of these recommendations
<b>Dashni Sathasivam</b>	Health Equity Solutions	Amplify and contextualize consumer voice. The report states that 502 consumers provided responses to the eScan Survey, comprising a “representative sample of Connecticut’s residents.” It is challenging to understand the definition of representative being used without more data to describe the cohort of consumers engaged. We respectfully ask that the following demographic data elements collected in the consumer survey be included in the report: race, ethnicity, gender, age, geography, and household income. While we understand it may not be feasible to embed responses to all questions asked in the consumer survey within the report, we suggest that the aggregated responses to all 28 survey questions be appended to showcase the richness of the data that was collected and provide greater transparency.
<b>Dashni Sathasivam</b>	Health Equity Solutions	Furthermore, the report explicitly mentions the focus group conducted with the Office of Health Strategy’s Consumer Advisory Council (CAC). Members commented that the consumers serving on the CAC were reflective of above average residents with respect to their access to the internet, information, and overall understanding of the health care landscape. Given this, members raised questions about the eScan’s engagement strategy to solicit feedback and data from the average consumer. Lastly, among the 13 quotes from various stakeholders featured throughout the report, there was no direct quote embodying a consumer, family, or patient voice. We recommend including a consumer quote and additional details on the limitations of the consumer engagement. For example, we suggest that the report note specific communities who may not have been engaged in this eScan, but whose voice would be valuable to include in future engagement efforts related to Connecticut’s health IT.

<p><b>Dashni Sathasivam</b></p>	<p>Health Equity Solutions</p>	<p>Prioritize cultural and linguistic appropriateness within education and outreach efforts for consumers, providers, and health systems personnel. HES is in full support of the strategies outlined under Recommendation 6. In an effort to enhance cultural and linguistic inclusivity we suggest adding a recommendation to align education and outreach efforts with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards. Integrating CLAS standards into practice allows health systems to better meet consumers where they are by bridging cultural and literacy differences and, therefore, are imperative when considering any consumer-centered strategy focused on disseminating information. Formally embracing these standards would positively increase a patient’s likelihood of truly understanding their consent options. We also suggest expanding education and outreach efforts to include building capacity of providers to ask questions about consent preferences in a more culturally sensitive manner. Overall, training in data collection is needed for all health professionals and staff to improve communications with consumers and total rates of data completeness.</p>
<p><b>Dashni Sathasivam</b></p>	<p>Health Equity Solutions</p>	<p>Leverage findings from the Health Equity Data Analytics (HEDA) reports that were conducted under the State Innovation Model (SIM). The 2019 report to OHS identified the following 3 key health equity data elements for incorporation in the data architecture of the, then forthcoming, statewide Health Information Exchange (HIE): race/ethnicity, insurance status, and geocoded residential address. As mentioned under Recommendation 2 in the eScan report, Public Act No. 21-35 mandates standardized collection of race, ethnicity, and language data elements and inclusion of these in the HIE. We request that a strategy for the collection of insurance status and geocoded residential address also be considered and incorporated into this recommendation.</p>

<b>Dashni Sathasivam</b>	Health Equity Solutions	Include a strategy to facilitate accessibility and transparency for public stakeholders. We respectfully ask that the draft recommendations also include a Health Equity Dashboard as a strategy to address health equity and social determinants of health. As outlined in the 2020 HEDA User Stories Report, a health equity dashboard would be one mechanism to facilitate accessible and actionable reporting of these data to the public. A public facing, interactive data visualization platform would allow decisionmakers, advocates, policymakers, health care providers, and the general public to quickly access information. A dashboard that allows users to filter data by factors such as race, ethnicity, geography, and time period and view the intersection of multiple characteristics could facilitate centering equity in decision-making. High-quality, easily available data is needed to spur action. If we can arm not just our state agencies, but all stakeholders with equity-focused information, we can more rapidly identify health disparities and course-correct programs and policies to address these disparities across all levels of practice and throughout the state.
<b>Donna Drouin</b>	PFA Consulting	I believe there is value in comparisons across states also
<b>Donna Drouin</b>	PFA Consulting	[Agree] as long as it is a pull instead of push to the centralized info
<b>Donna Drouin</b>	PFA Consulting	Providers need to be confident in patient info sharing or they will use protected notes only, that will not help anyone. Slippery slope on BH we have patients who were VERY concerned about where info would end up and impact them down the road and requested no note in their file be made
<b>Donna Drouin</b>	PFA Consulting	so redundancy.... which would not be attractive for physicians - goes back to the original inquiry what about existing systems....
<b>Donna Drouin</b>	PFA Consulting	I think you will confuse people even more until issues we've been mentioning are resolved. Confusion around where the information resides and who has access to it. Larger systems like Epic has addressed that concern. Its delivered from hospital systems. Epic can be modified for each system. Collection activity is not consistent. No transparency on where your information is, not helpful to encourage patients. Sharing with patients that we use something else, it may confused it. Unsure if townhalls would be there yet.
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	Practitioner in the state, made comment to CBG 4 years ago, each of the 4 hospital systems spending over \$1B to obtain Epic as their in hospital system, one corporation (Epic) that had the information system within each hospital system, internally proprietary. Hartford couldn't speak with Yale providers. Information was gapped, labs and x-rays. HIE intermediary, more prudent and cost effective to have an interface interoperable networking by Epic for the 4 hospital systems to talk to one another. Seamless exchange to access their health information.

<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	Yes but way too low a bar - we have opportunity to be much more robust. SDH impacts external: race, poverty level. Much better understanding around things aren't determinants of our health but impacts of the healthcare and health. Be much more robust around socioeconomic. For example, climate change will impact health and disease worldwide. Politics determines how things are regulated. Political determinants of disease. Design an optimal population platform, everyone can share in at every point of care, be much more robust. Unlimited capabilities to store and analyze data. Turn data into intelligence, better our information will become if we look into the future in how we co-design this platform.
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	Ortho surgeon, worked in opioid addiction, physical is separated from mental health. Need to address this and critical for integrated functioning.
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	Taking care of patients that are not prescribed, think of OTC meds, non-prescription meds around recreationalization of marijuana, medication side effect profiles. Billing and coding purposes should be included, vitamins, marijuana, anything that would be interfaced with their prescriptions, Would not be included in Epic or Cerner. A lot of patients may not think they are meds as providers define it as medicines.
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	Privacy and confidentiality out very liberal while at the same time we a larger ecosystem trying to improve health. One of the problems is that general public doesn't even understand what happens when they post on Facebook or order on Amazon, where that data goes and is stored. Hackable breaches, people can discriminate against folks with their healthcare data. It's not the capture and storage, the focus should be how the data is used for health and how it can be misused or discriminated toward, need some societal and cultural sanctions. Impacts all data.
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	I believe I understand and appreciate many of the impetuses to get this endeavor actualized - 2004 to the present - including increasing, even exponentiating, complexity of caring +, burgeoning treatment and interventional options, escalating costs and expenditures for "sickness care", moving targets and stressors on Health s and Well Being outcomes, accelerating risks and dys - eases, especially harsh toward most vulnerable / resource strained parts of population, the exposure of gaps and insufficiencies by the Covid - Sars pandemic of December 2019, and .....+. Populations / communities at higher risk magnitude : impoverished, lesser formal educational acumen, higher immigration quotient, "of color", climate change burdened, incarcerated, habituated - addicted, mentally compromised / dysregulated, with disabilities / impairments, with co morbidities, without insurance / underinsured, unemployed / underemployed, homeless, without broadband and technology

		access, the medically / system - navigation ill - literate, the elderly alone, the isolated / rural, and .....+ . Please note these “ categorizations “ are neither priorities nor focus in the mentioning - highlighted to reflect that they must be included - to exclude anyone is to diminish the richness of the data needed for Health s intelligence and intelligent monitoring - AND useful for regulators, legislators, policy makers, payers and payees, planners, think tanks, task forces, administrators, Boards, and .....+ moving us further forward.
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT	the “ ideal goal “ then of our external information network is to purposefully, meaningfully, optimally collect, capture, collate, make available with perfect fidelity whenever needed by whomever is helping, to be respectful of dignity and non discrimination at every point of interaction / caring +, and always to be pointing toward more Health s and Wellness, more Well Being and Well Becoming for every, EVERY, single individual, maximizing value, precision, excellence, and accountability to ALL users, ALL interfacers. Thus, your “ stakeholders “ are not only those stated in this document - rather, 3.6 million CT humans.
<b>Gary Archambault</b>	Department of Public Health	Effort is largely underway due to current data integration staff. Challenges are around data sharing for public health. Collect minimum data for public health. Privacy and security implications. Connie becomes the center of the universe. Not well defined in a draft recommendation, concerning for those responsible for the data. Cost associated is staggering.
<b>Gary Archambault</b>	Department of Public Health	statements around funding in early slides, there’s been very little state money to fund surveillance systems, funded under Fed agreements. Is there a recommendation that the state start paying for those?
<b>Glenn Galloway</b>	RAYUS Radiology	As an independent community provider, we strongly support the focus on establishing interoperability fundamentals. The state’s HIE efforts provide an avenue to expand patient choice and can help to alleviate “electronic fencing” tactics that can harm independent, community-based providers. Following the spirit of SB 445 (2017), which requires the bi-directional exchange of patient records, RAYUS Radiology supports the continued emphasis on interoperability contained in the draft environmental scan. Additional consideration should be given to inclusion of ordering and prescribing mechanisms in the HIE system to allow for patients to have their orders or prescriptions sent to providers of their choice. Additionally, special attention should be given to medical images to ensure they are not overlooked as a key element of communication and should be contained within the medical records accessible on the HIE.

<b>John Brady</b>	Connecticut Hospital Association	The recommendations should be more patient-focused. While the purpose of the project is to assess and align state health data efforts, patients should be the North Star at all times. The state should be building toward what is best for patients, both at the individual level and population level. We urge that patients be more central to the recommendations.
<b>John Brady</b>	Connecticut Hospital Association	The recommendations underestimate and undervalue the vast health IT infrastructure resources that exist in the private sector. Healthcare providers and health insurers, along with their data and technology partners, have invested billions of dollars to build, operate, and maintain a complex and highly functional health information ecosystem for their patients and insureds. The state government has historically underfunded its own health IT infrastructure, and now there is a gap. The gap needs to be addressed, and we applaud the current administration for recognizing this. The state should take care to avoid disrupting what works while it attempts to redress its deferred investment in health IT.
<b>John Brady</b>	Connecticut Hospital Association	<p>Connecticut has underinvested in public health technology and workforce for decades. This has resulted in serious gaps in the state’s public health infrastructure. CHA and its member hospitals have raised these concerns for years, and repeatedly urged action. A significant course correction must occur for Connecticut to build basic data systems that most other states already have. These deficits have hampered DPH in carrying out many routine processes such as: building a cyber-based vital statistics infrastructure; moving from paper to electronic processes for a variety of reporting mandates including communicable disease surveillance, electronic lab reporting, and modernizing newborn screening; and allowing bidirectional data exchange that can better serve patients. Much work is being done in these areas under the current administration, which we commend, and we look forward to continuing to work together on those efforts. But DPH needs, and deserves, financial and structural support to move these projects forward in a rapid and sustainable fashion, to include an array of solutions and technologies.</p> <p>While we agree that DPH should leverage Connie when it makes sense, right now, for many public health technology issues, it may be necessary for DPH to explore other more direct, more immediately available options. The public health data infrastructure needs an immediate injection of state funding, focused attention on acquiring technology, and a fulltime, skilled data workforce, with a variety of pathways and solutions including but not limited to Connie.</p>



<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>We strongly object to any scheme that requires healthcare providers to fund Connie, whether by fees, taxes, or a so-called “public utility model” (see report at page 32). The state is already mandating that providers engage with Connie, and that they send a wide array of individual patient data to Connie. Those activities cost each provider thousands of dollars in both IT costs and workforce costs, much of which will not be reimbursed. If the state mandates that providers must also pay for Connie, that will create even more burden on providers. It would essentially be a provider tax that directly contributes to cost growth. The state should be paying for Connie. The state has underfunded health information technology for decades. The state should make a concerted effort to meet its core responsibilities by providing adequate funding for Connie through a general appropriation or another funding stream that reflects the general public benefit of a functioning health information exchange.</p>
<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>We strongly oppose using Connie in any way that: reduces innovation and use of emerging technologies by providers; constrains providers seeking varied technology solutions to improve care; or dictates the functionality, resources, or systems that providers must use based on the state’s health IT vision.</p> <p>Forcing a one-size-fits-all or lowest common denominator approach based on the state’s vision of the healthcare landscape is not a viable solution. The state should not pressure providers to use a specific EMR, or use specific software, or participate solely in the state-selected encounter notification system. To do so would create forced “efficiencies” that are short-sighted, ill-conceived, and may risk compromising patient benefit. The “one-size” approach suggested in Recommendation 1 is concerning: “Key stakeholders and Connie should consider adoption of a single statewide ADT notification system, rather than the multiple systems presently used in the state (e.g., Project Notify and PatientPing).”</p>

<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>We commend the state’s recognition of the importance of developing systems to address social influencers of health (SIOH). As referenced in the report, Connecticut’s hospitals have launched Unite Connecticut and subsidized the deployment of Unite Us, an SIOH screening and closed-loop referral platform that is intended to support the systematic use of SIOH screening tools across a wide variety of settings. In fact, CHA’s approach is quite similar to the North Carolina model referenced in the recommendation—Unite Connecticut has been held up as a model by Aligning for Health in the promotion of SIOH screening legislation in Congress. Unite Connecticut is the most widespread SIOH screening and closed-loop referral system in use in Connecticut and has been adopted by approximately half of Connecticut’s hospitals, a half dozen FQHCs, and Medicaid’s medical ASO, Community Health Network of Connecticut. Nearly 300 community-based organizations are enrolled as network support providers.</p> <p>The State could do much to strengthen Unite Connecticut, e.g., by arranging for the participation of all state-operated healthcare settings, whether inpatient or residential psychiatric and substance use settings, outpatient services provided by Connecticut Mental Health Centers, or client facing offices such as the Department of Children and Families’ regional offices. The use of a closed-loop referral system could also be established as a requirement of state contracted healthcare service providers, whether the system is Unite Us or another platform. Similar requirements could be established for providers of community-based organizations and support services, such as Community Action Agencies, WIC programs, health departments, area agencies on aging, etc. After all, any referral platform depends on a comprehensive network of community support providers.</p>
<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>Recommendation 2 also recognizes that the expansion of SIOH screening and referral depends on a robust system of social and economic support services and the technical wherewithal to participate in and use such systems. We believe that it is foremost the state’s responsibility to ensure funding is sufficient to support the essential work and capacity of community-based organizations and technical assistance and training to enable their participation in closed loop referral and screening activities. The latter is a one-time expense that should be part of the HIT roadmap.</p>
<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>As the deployment of these systems becomes more widespread and evidence accumulates to support standardized screening questions, we support the adoption of standards developed in collaboration with healthcare, social service providers, and community-based organizations. Such data standardization is a prerequisite to the envisioned exchange of community health information and the use of this information to support predictive</p>

		analytics and the work of cross-sector collaborations focused on place-based, root-cause, social, environmental, and economic solutions.
<b>John Brady</b>	Connecticut Hospital Association	Finally, the recommendation references the importance of capturing granular race, ethnicity, and language (REL) data. Several Connecticut health systems were among the first to collect the granular race/ethnic information referenced in PA 21-35 as part of the State Innovation Model. We recognize the power of these data and look forward to supporting the statewide expansion of the collection of REL data across all healthcare providers and settings.
<b>John Brady</b>	Connecticut Hospital Association	We generally agree with the recommendations discussed in Recommendation 3. One point that requires clarification is the recommendation that the state “should design systems and data integration programs that ‘hide the seams’ of government for priority scenarios identified.” “Hiding the seams of government” to improve service delivery is a laudable goal, but the state must remain accountable for providing a full and fair disclosure of how it uses patient data. Actions that reduce patient trust in healthcare data systems increase the risk that patients will be less open and complete with providers about their health. Healthcare data should be used, first and foremost, to improve patient care and patient experience. We strongly urge that the decisions and permissions on flow and use of patient data and personal data by and between state agencies be transparently disclosed by the state, Connie, and all agencies, and those uses should be delineated and made known in materials that are prepared in connection with Recommendation 6.
<b>John Brady</b>	Connecticut Hospital Association	We also encourage the state to employ HIPAA privacy and security parameters for agencies’ use, access, sharing and maintenance of health data, even in instances where adherence to HIPAA is not strictly required of the state pursuant to federal law. The state’s adherence to these basic rules is essential to patient privacy and to preserving the fragile trust that patients have in current health data systems and infrastructure.

<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>We support the state assisting providers with the move to electronic records, when that support is what the providers want and in the best interests of their patients. The state, however, should not force providers to utilize technology for the sake of using technology. Recommendation 4 describes that the state “should develop and implement an educational campaign to break down the cultural resistance expressed by many behavioral health providers around the use of information technology solutions.” To assert that behavioral health providers merely need to have their construct broken down, as if their position is naturally flawed, is mildly dismissive.</p> <p>We urge that the state first work with the behavioral health community to better understand their concerns before attempting to alter their approach to recordkeeping. In addition to reasonable privacy concerns, the cost of implementing and maintaining health IT systems can be overwhelming, particularly for small providers. Behavioral health providers are already scarce in Connecticut. The state should be judicious in creating pressure on these providers to adopt what is often expensive technology.</p>
<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>We support the work of the Medication Reconciliation and Polypharmacy Committee. We urge that solutions for sharing a Best Possible Medication History through Connie, and any changes to the PDMP, be approached in a manner that avoids additional burden on providers (e.g., added cost, added workflow time, etc.), and does not disrupt the functionality or efficiency of the PDMP system.</p> <p>The Department of Consumer Protection has done outstanding work creating, managing, and building the PDMP. It is a bright spot in Connecticut’s health IT landscape. Any integration with or through Connie should only be done if it does not disrupt the current success of the PDMP, and does not interfere with DCP’s oversight and management of that program, or with patient rights.</p>
<p><b>John Brady</b></p>	<p>Connecticut Hospital Association</p>	<p>It is essential that OHS and Connie provide transparent, understandable, and reproducible educational materials and collateral instruments (including consent forms) for how Connie obtains, processes, and uses patient data, but there should not be a new set of rules beyond those already found in law.</p> <p>We urge that the state use HIPAA as its guiding principle for how data are used by Connie. One of the strengths of HIPAA is that it creates a universal approach to data sharing and patient rights instead of the confusion caused by a 50-state patchwork of rules. Adding state-specific rules is anathema to improved data exchange. Connecticut should remove artificial barriers to data sharing, move toward a HIPAA framework, and avoid creating more hurdles to data exchange.</p>

<b>John Brady</b>	Connecticut Hospital Association	Providers will have little role in determining the parameters of how Connie uses data, and no role in deciding how the state uses those data. That makes it essential for OHS and Connie to manage the consent process for data in and out of Connie. It is unworkable, perhaps impossible, for providers to manage the consent process, or provide a clear picture of what the state or Connie will do with patient data. Those parameters, and especially protections, must come from OHS and the state, they must be made known to providers and patients, and they must be transparent about how Connie and the state intend to use the data that providers are required by law to send to Connie.
<b>Karen Lawler</b>		Agreed but expand to include exchange of other clinical information beyond ADT along the lines of the spirit of information blocking provisions. Looking to fully exchange clinical info amongst providers through Connie.
<b>Mario Garcia, MD</b>	Department of Public Health	Certain aspects of data collection, SDH looking at broad range of sectors and areas that are so wide, how do we reconcile what is really important? What are the SDH that really matter? Recognizing the systems and structures and using it as a starting point. Make an effort to reconcile to the importance of the data, SDH cannot be standardize on the national level. The issue with the statewide tool, people are already using a tool. How do you bring the tools and reconcile what they are doing?
<b>Nancy Barrett</b>	Department of Public Health	What does 'user friendly functionality' mean for CT WIZ and CTEDSS? CTEDSS has a defined approved users for its function as a surveillance and case management system for public health - state (DPH) and Local health. So could you expand on this please?
<b>Nancy Barrett</b>	Department of Public Health	Difficult to comment without specifics on the recommendations. Making high level recommendation with no explanation behind it, public might take it face value. Public lacks understanding and education around recommendations for HIEs. Has occurred before. Standardized national data processing, into end user systems. Provider reporting is never as good as getting lab reports, reportable diseases. Poor quality compared to lab reports, lots of paper processing for providers. Streamline electronic provider reporting in place.  EHR/EMR vendors are supposed to meet federal certification standards and be able to use defined standardized formats for public health reporting. Sent to just panelists.
<b>Nancy Barrett</b>	Department of Public Health	Social determinants of health is new-ish. Is there some place where this is begin defined and an accepted definition? How is this information is being collected?
<b>Nancy Barrett</b>	Department of Public Health	So maybe recommendation [on a HHS collaborative for exploring state date systems to connect to Connie] should be dropped at this point in time.

<b>Nancy Barrett</b>	Department of Public Health	Agree with this recommendation. This is a better use cases for an HIE. It's been done by other states, providers on treatment history. Perfect first step.
<b>Nancy Barrett</b>	Department of Public Health	Categorical funding, legal obligation to accept the cooperative agreements, ton of covid money but have to follow the fed rules around how to use the funds. It's not an open set of money.
<b>Paul Lanza</b>	Connecticut Dental Health Partnership	At the Connecticut Dental Health Partnership, one of our main priorities is medical/dental integration, and many of our initiatives are focused on promoting oral health to HUSKY Health members and to the state of Connecticut as a whole. In fact, we have entered into an agreement with CONNIE to further that goal. I would recommend a Sector Specific Section on "Dental/Oral Health" that highlights the need for the inclusion of the dental community and the shared goal toward medical/dental integration in this environmental scan. The Connecticut Dental Health Partnership is happy to assist in this endeavor.
<b>Roger Carrington</b>	Beacon Health Options	<ul style="list-style-type: none"> <li>• Additional emphasis should be placed on use case design geared towards enhancing overall behavioral and medical care in Connecticut with more discussion around where the most impactful source data resides.</li> <li>• HIE implementation dates seem to be influx based on shifting priorities or newly considered complexities. Momentum towards standing up production functionality and meeting timelines will build stakeholder confidence in Connie.</li> <li>• To our knowledge, technical specifications documents for data exchange have not been shared with non-provider entities. Distribution of this information will help the ASO's plan for technical connectivity to Connie.</li> </ul>
<b>Steve Wolfson, MD</b>	Connecticut State Medical Society	Also, how do you propose to work between the Yale and Hartford systems, and the Middlesex systems? Interaction between the systems with Connie? In the past, acting as though they pose international boundaries with passports and vaccines, to interact between those systems. Concerns around silos.
<b>Steve Wolfson, MD</b>	Connecticut State Medical Society	Addressing housing insecurity is also critical. Even at the level of finding where patients are to follow up.
<b>Steve Wolfson, MD</b>	Connecticut State Medical Society	One hurdle is the role of EPIC. This was devised primarily for billing and does that clearly. But as a storage and communication mechanism for clinical info, it is lacking
<b>Steve Wolfson, MD</b>	Connecticut State Medical Society	YES. Critical. So many patients are on multiple meds, from multiple providers.

<b>Steve Wolfson, MD</b>	Connecticut State Medical Society	Agree with Frank again. I have a list of all my Rx and non Rx meds that I take to all office visits. Wish this were generalizable. There is also the problem of formularies that are maintained by hospitals and by outpatient systems. Often conflicting.
<b>Steve Wolfson, MD</b>	Connecticut State Medical Society	Agree with recommendations. Question whether the system can be made easy for practitioners. The 20 minute time limit for patient visits is a major hurdle
<b>Supriyo Chatterjee</b>	Independent	Public comments around informed consent with a provider if you want to opt in or opt out, cannot be a default opt out anymore, medicine has come to the point where technology, have providers to educate patients on opting in. no acceptable because if ethics and informed consent. Strong foundation on medical ethics. We can learn from CA who has been doing exchange for years, we keep hearing about privacy, public understanding etc., CT might not get anywhere unless we get the knowledge barriers out of the way.
<b>Supriyo Chatterjee</b>	Independent	Is there a state-wide effort to standardize information for public health that'll be used with the PH gateway
<b>Supriyo Chatterjee</b>	Independent	Appreciates that we have a new office to handle data privacy, is this an extension of the community counsel? What is the representation? Health data is important.
<b>Supriyo Chatterjee</b>	Independent	Supports Dr Garcia. SDH is very critical, engineering problem, data is unstructured and not really defined. National effort called gravity project ( <a href="https://www.hl7.org/gravity/">https://www.hl7.org/gravity/</a> ). HL7 used widely in different systems for engineering. Need more examination, the data is too wide.
<b>Supriyo Chatterjee</b>	Independent	With the advent of healthcare data, technology, and the changes in clinical practice these bring – the nature of the risks and challenges have a deeper impact on the patient-physician relationship <sup>4</sup> which is fiduciary and based on informed consent. Current recommendations for a 'Consent Policy' falls short of a framework to address complexities that may be encountered within the Health Information Technology Plan that includes 'Connie' HIE. Healthcare data is generated and consumed by technology and artificial intelligence techniques that changes the medical practice itself. The technology goes beyond administrative resource allocation and into clinical diagnostics. This brings significant concern for patient privacy and for compliance <sup>5</sup> . The volume of patient data are not all covered by HIPAA - that is but a tip of a "data iceberg" (see pic below). The draft Statewide Health Information Technology Plan does not adequately address the concerns outside the tip of the "data iceberg" which remains

		<p>outside the shelter of HIPAA.</p> <p>While there is a provision for an ‘opt-out’ – the patient would still like to know the choices before making a decision. ‘Meaningful consent occurs when the patient makes an informed decision and the choice is properly recorded and maintained.’<sup>6</sup> The patient’s meaningful choice in a decision is defined as<sup>7</sup>:</p> <ol style="list-style-type: none"><li>1. Made with advance knowledge/time,</li><li>2. Not used for discriminatory purposes or as condition for receiving medical treatment,</li><li>3. Made with full transparency and education,</li><li>4. Commensurate with circumstances for why health information is exchanged,</li><li>5. Consistent with patient expectations, and</li><li>6. Revocable at any time.</li></ol> <p>The patient’s decision-making and interest incorporates four key factors:</p> <ul style="list-style-type: none"><li>· Who could access their health information?</li><li>· What type of information could be accessed or shared?</li><li>· How is information protected and secured?</li><li>· Why may information be accessed or shared (i.e., purpose of use)?</li></ul> <p>Final recommendation – reconsider the consent policy to ‘opt-in’ The neighboring states of New York, Massachusetts, and Rhode Island currently follow an ‘opt-in’ policy for their State Health Information HIE<sup>25</sup>. It is recommended that the State reconsider the current stance into a similar one of ‘opt-in’. As mentioned above - evolving technologies and an increasing application of it in clinical practice changes the fiduciary nature of patient physician relationship into an emphasis of a medical informed consent<sup>26</sup>. The patient’s healthcare data is an intrinsic part of the medical diagnosis which may be performed by learning algorithms.</p>
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<p><b>Supriyo Chatterjee</b></p>	<p>Independent</p>	<p>It is not known how consent validation is performed. More importantly are there facilities where the consent trail is logged? This would audit all consent transactions made and attempted. This is different that the annual/biannual system audits. Transaction audit logs performs a 'trust but verify' action that can mitigate liability should an infringement occur (or in the case of a cyber breach). Most Consent Management Solution (CMS) systems do incorporate validation and audits. This is regardless of the consent policy choice of 'opt-in' or 'opt-out' or a combination of both (giving granular control of choice elements).</p>
<p><b>Supriyo Chatterjee</b></p>	<p>Independent</p>	<p>Near future state of 'Connie' – Patient-centric health data availability. Currently, 'Connie' is based on the premise – “As the HIE builds its technical capabilities, a robust consent management solution will be identified that expands patient options for managing access to their personal health information (PHI)”<sup>13</sup>. This currently puts limitations on 'meaningful consent' by the lack of a Consent Management Solution (CMS). As mentioned above, the importance of a CMS performing validation and audit logs of transactions within an HIE. It can help facilitate the important requirement of having patient-centric data provisions - the 21st Century Cures Act and the Interoperability and Patient Access final rule (CMS-9115-F)<sup>14</sup>. A CMS is utilized in conjunction with the 'Master Patient Index (MPI)' for consent validation. The 'Information Blocking' regulations that came into effect on April 5, 2021 are limited to structured healthcare data (conforming to US Code Data for Interoperability USCDI). However, a majority of health data (estimated at over 75%) remains unstructured and must be accommodated within the 'Connie' system by October 2022. As the Office of the National Coordinator for Health IT, Micky Tripathi pointed out recently – “In 18 months, the floodgates will open, making healthcare organizations responsible for sharing that structured data as well as some unstructured data, presenting a bigger challenge”. The implication of this directive will vastly affect data management, data analytics, and data quality: “Once that 18 months is over, it is everything. It's text notes, transcriptions, and other kinds of documents. The only way that we'll be able to get our arms around that is using algorithms, machine learning, and other kinds of approaches, such as natural language processing, to be able to take advantage of on behalf of the patient, on behalf of better quality, to be able to take advantage of that broader, comprehensive information that's available.” This is clearly not feasible without a robust Consent Management Solution (CMS) and leaves only 18 months for a patient-centric implementation.</p>

<p><b>Supriyo Chatterjee</b></p>	<p>Independent</p>	<p>Health Equity – ‘opt-in’ REL data and ‘selection biases’. While Race, Ethnicity, &amp; Language (REL) data acquisition and management could lead to systemic improvements – it is no easy task. Varying cultural groups and their preferences calls for a concerted effort in patient education and health literacy in order to ‘opt-in’ their REL data elements and ‘opt-out’ of ‘Connie’ should they want to exercise their prerogative. Regardless of state statutory requirements – REL data elements cannot be mandated upon patients without their explicit consent. However, the consent and associated data elements needs to be recorded because it is used in stratification analysis and to gauge allocation, population health, and health inequities. In applying such algorithmic functions, missing data elements can introduce ‘biases’. The recent discovery of bias in a decision-making algorithm has garnered interest in the medical press, including the State of New York regulatory body. A more recent study found the need for corrections of algorithmic bias across clinical fields – from cardiology to urology. Algorithms need complete data elements with transparency, accountability, and ‘explainability’ to mitigate clinical, ethical, and legal issues. These data elements need to be managed by a comprehensive Consent Management Solution (CMS) with provisions for audits and traceability.</p>
<p><b>Supriyo Chatterjee</b></p>	<p>Independent</p>	<p>Utilization and Monetization As the patient consumer data will be managed by various vendors and institutions – it gives them the opportunity of utilization and monetization of patient consumer data<sup>24</sup>. How will the concern of utilization and monetization of the patient consumer data be addressed? Can the patient consumer completely opt-out of the utilization and monetization of their data?</p>
<p><b>Susan Israel, MD</b></p>	<p>Independent</p>	<p>When patients are told that truly only their direct medical providers will see their records, they are less concerned about privacy. However, they may not be comfortable with their dentist or dermatologist seeing their full OB-GYN record for example without their express permission.</p>

<p><b>Susan Israel, MD</b></p>	<p>Independent</p>	<p>Hopefully, consent will be the underlying foundation of all movement of intimate, identified medical and other data held by Connie and state agencies.</p> <p>However, Recommendation 5 is the antithesis to patient consent or the opt-out of Connie because it calls for a mandated Best Possible Medication History – BPMH database on each patient/citizen, that is without our consent. The proposal is to add a complete medication list to the already mandated Prescription Drug Monitoring Program – PDMP list for controlled substances. Please note that the PDMP was created to prevent overdoses which necessitated it to be organized to enable a wider access to it, than is allowed into medical records. Thus, if this mandate is implemented, all of us will have less medical privacy because the list of one’s medications is a list of one’s diagnoses which may be available to law enforcement, pharmacies, companies processing the data, state oversight agencies, etc.</p>
<p><b>Susan Israel, MD</b></p>	<p>Independent</p>	<p>Recommendation 6 says that “Critical to the establishment of a trusted health information exchange is the assurance that patient health information is secure, restricted only to view by appropriate healthcare professionals.” If “appropriate healthcare professionals” means anyone other than the nurse, physician assistant or doctor that cares directly for you, then those other people need to be spelled out exactly to consumers. One example of others seeing identified medical data would be Connie’s “internal HIA management and operations such as (but may not be limited to) consent management and HIPAA audits,” apparently even if we opt-out of Connie. Would this mean that Connie sees the identified Direct Messaging Data sent though it by providers to each other (without explicit consent)? Thus, any additional groups with access need to be described further in detail to consumers for complete transparency.</p>
<p><b>Susan Israel, MD</b></p>	<p>Independent</p>	<p>Regarding that “Commercial health plans and public payers such as DSS and OSC expressed a need for clinical data, as opposed to claims data, to conduct more comprehensive population health analytics” and regarding that “Connie could provide payer-neutral interoperability of patient health records for their providers to see the full picture of their members’ health status,” will the solution be that payers, including commercial ones, will be allowed to access one’s complete medical record, beyond what is just needed to pay a claim, without patient consent? And would this mean that all of one’s providers have access to all of one’s medical records without the patient’s consent for each provider, meaning that one’s eye doctor gets to see all of one’s reproductive health information without one’s explicit consent? Will this mean the OHS oversight agencies will see Connie medical records without consent?</p>

<b>Susan Israel, MD</b>	Independent	<p>Recommendation 3, Service Coordination and Data Integration Across State Agencies: “Connect HHS agencies’ data systems to Connie, where appropriate, through the creation of a state agency data collaborative designed for government use of Connie. This collaborative should, among other things, build institutional capacity for data governance within and among state agencies.” Many of the state agencies have intimate and very private citizen data, but now these data will all be in one mega database in Connie? Would the Office of Early Childhood, Dept. of Mental Health and Addiction, Dept. of Social Services, etc. now have access to the child’s or adult’s full medical record through Connie? Will Public Health have even more direct access to one’s full medical record than they do now without patient consent?</p> <p>Also, would it be possible for the State of Connecticut to use the Connie database for various purposes such as New York State’s plan to mix their agency information of health records, proof of age and driver’s licenses to create a geolocation mechanism to track Covid - 19 vaccine compliance?</p>
<b>Susan Israel, MD</b>	Independent	<p>It would be wonderful if Connie’s “Affirmative Consent” could be implemented, meaning that patients would need to give their explicit written permission for the sharing of their “HIV, mental health, alcohol and substance abuse, reproductive health, sexually transmitted disease, and genetic testing information.”</p>
<b>Thomas Farquhar, MD</b>	Radiological Society of Connecticut	<p>This is especially critical in the area of imaging studies, which are a significant component of almost all episodes of patient care. Frequently, patients go to providers in adjacent medical communities where their electronic records may be on different platforms or different versions of the same platform. Also, imaging tests are frequently performed in independent imaging centers and even in the offices of the treating doctors – e.g., orthopedists, cardiologists, primary care physicians, etc. This is especially true and most critical with respect to emergency room encounters. In these acute situations, it is critical to efficient and effective patient care to have the patient’s historical data form the community – again, imaging tests are among the most critical.</p> <p>Lastly, as the saying goes: “A picture is worth a thousand words.” Thus, we want to stress the importance of including access through the HIE to the imaging examinations (the “pictures”), as well as the reports. Our experience is that access to both will not only provide better, more timely care, but will preclude the need for repeating examinations, some individually expensive and collectively a major component of the cost of care.</p>

## Appendix B – List of Stakeholders Providing Feedback

<b>Name</b>	<b>Organization</b>
<b>Roger Carrington</b>	Beacon Health Options
<b>Charles Brown</b>	Central Connecticut Health District
<b>Angie DeMello</b>	Congregations Organized for a New Connecticut
<b>Paul Lanza</b>	Connecticut Dental Health Partnership
<b>Dina Berlyn, J.D.</b>	Office of Senator Martin Looney
<b>John Brady</b>	Connecticut Hospital Association
<b>Steve Wolfson, MD</b>	Connecticut State Medical Society
<b>Jenn Searls</b>	Connie
<b>Diana Mager</b>	CT Association of Healthcare at Home
<b>Mark Abraham</b>	DataHaven
<b>Mark Raymond</b>	Department of Administrative Services
<b>Rod Marriott</b>	Department of Consumer Protection
<b>Stephen McConaughy</b>	Department of Public Health
<b>Nancy Barrett</b>	Department of Public Health
<b>Lynn Sosa, MD</b>	Department of Public Health
<b>Orlando Velasco</b>	Department of Public Health
<b>Gary Archambault</b>	Department of Public Health
<b>Mario Garcia, MD</b>	Department of Public Health
<b>Pat Charmel</b>	Griffin Hospital, HITAC Member
<b>Sean Jeffery, Pharm. D.</b>	Hartford Health Care
<b>Pat Checko</b>	HITAC Member
<b>Dashni Sathasivam</b>	Health Equity Solutions
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT
<b>Karen Lawler</b>	Hospital for Special Care
<b>Alan Kaye, MD</b>	HITAC Member
<b>Susan Israel, MD</b>	HITAC Member
<b>Supriyo Chatterjee</b>	Independent
<b>Scott Gaul</b>	Office of Policy Management
<b>Donna Druin</b>	PFA Consulting
<b>Thomas Farquhar, MD</b>	Radiological Society of Connecticut
<b>Glenn Galloway</b>	RAYUS Radiology
<b>Pareesa Charmchi</b>	The Connecticut Oral Health Initiative
<b>Tom Agresta, MD</b>	UConn Health
<b>Nate Rickles, Pharm. D, Ph.D.</b>	UConn School of Pharmacy
<b>Rick Brush</b>	Wellville
<b>Lisa Stump</b>	Yale New Haven Health System, HITAC Member
<b>Lyn Salsgiver</b>	Yale New Haven Health System
<b>Nitu Kashyap, MD</b>	Yale New Haven Health System

## Appendix C – Feedback Webinar Attendees

<b>Attendee</b>	<b>Organization</b>
<b>Peter DeBiasi</b>	Access Community Action Agency
<b>Charles Brown</b>	Central Connecticut Health District
<b>Steven Wolfson, MD</b>	Connecticut State Medical Society
<b>Gary Archambault</b>	CT Department of Public Health
<b>Mario Garcia, MD</b>	CT Department of Public Health
<b>Nancy Barrett</b>	CT Department of Public Health
<b>Vanessa Hinton</b>	CT Department of Public Health, HITAC Member
<b>Michael Gilbert</b>	CT Department of Social Services
<b>Kevin Ryan</b>	Connecticut General Assembly
<b>Roy Jeffus</b>	General Dynamics Information Technology
<b>Frank Maletz, MD</b>	HEALTHspital Family Foundation CT
<b>Beth Cooper</b>	Hospital for Special Care
<b>Karen Lawler</b>	Hospital for Special Care
<b>Supriyo Chatterjee</b>	Engaged Consumer
<b>Linda Kowalski</b>	Kowalski Group, LLC
<b>Brad Weeks</b>	Kowalski Group, LLC
<b>Effie Malley</b>	Myers and Stauffer
<b>Hannah Lawrence</b>	Myers and Stauffer
<b>Donna Drouin</b>	PFA Consulting
<b>Zachary Brunnert</b>	RAYUS Radiology
<b>Jeanne OBrien</b>	Value Care Alliance
<b>Tracy Raab</b>	Value Care Alliance
<b>Tyler Eggett</b>	Value Care Alliance
<b>Shannon Kane</b>	Value Care Alliance
<b>Nelly Angah</b>	Yale New Haven Health System