Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
Oct. 19, 2017	1:00 pm – 3:00 pm	Legislative Office Building, Hearing Room 1D 300 Capitol Ave., Hartford

Council Members					
Allan Hackney, HITO	X	James Wadleigh, AHCT	X	Robert Rioux	X
Joseph Quaranta, (Co-Chair)	X	Mark Schaefer, SIM	X	Jeannette DeJesus	
Joe Stanford, DSS	X	Robert Darby for UCHC CIO	X	Lisa Stump	X
Michael Michaud, DMHAS	X	Ted Doolittle, OHA	X	Jake Star	
Cindy Butterfield, DCF	X	Kathleen DeMatteo		Patrick Charmel	
Cheryl Cepelak, DOC	X	David Fusco	X	Alan Kaye, MD	X
Vanessa Kapral, DPH	X	Nicolangelo Scibelli	X	Dina Berlyn	X
Dennis C Mitchell, DDS	X	Patricia Checko	X	Jennifer Macierowski	
Mark Raymond, CIO		Robert Tessier	X	Prasad Srinivasan, MD	
Supporting Leadership					
Victoria Veltri, LGO	X	Kelsey Lawlor, HIT PMO	X	Michael Matthews, CedarBridge	X
Robert Blundo, AHCT	X	Dino Puia, HIT PMO	X	Chris Robinson, CedarBridge	X
Jennifer Richmond, HIT PMO	X	Carol Robinson, CedarBridge	X		
To Be Appointed					
Representative of the Connecticut State Medical Society (President Pro Tempore of Senate)					
Health care consumer or a health care consumer advocate (Speaker of the House)					
Physician who provides services in a multispecialty group and who is not employed by a hospital (Majority Leader of House of Rep)					
Speaker of the House of Representatives or designee					

	Agenda	Responsible Person	
1.	**Welcome & Call to Order**	Allan Hackney	1:00 PM
	Call to Order: The tenth regular meeting of the Health IT Advisory Council for 2017 was held on October 19, 2017 in Hearing Room 1D of the Legislative Office Building. The meeting convened at 1:00 p.m.		
2.	**Public Comment**	Attendees	1:05 PM
	There was no public comment.		
3.	**Review and Approval of the September 21, 2017 Minutes**	Council Members	1:07 PM
	The motion to approve the September 21, 2017 minutes was passed unanimously.		
4.	**Updates**	Dino Puia/Kelsey Lawlor	1:10 PM
	Kelsey Lawlor introduced a new member of the HIT PMO, Jennifer Richmond. Jennifer has been hired as a Program Manager to oversee the implementation of the state health information exchange. In her previous role, Jennifer's experience includes involvement/management of three end-to-end EHR implementations, having also led the information technology, quality, clinical, and compliance functions. She has worked in various settings, including private non-profit community settings and hospitals. Jennifer comes to the HIT team from a long career at Clifford Beers Clinic where she was the Compliance and HIPPA Officer. She is a Licensed Clinical Social Worker (LCSW) and holds a Certification in Healthcare Compliance (CHC). Allan Hackney updated the Council on Sarju Shah of the HIT PMO, who gave birth to a baby girl on September 28, 2017. Both Sarju and baby are doing well. Dino Puia reviewed the action items from the September 21, 2017 meeting. A meeting has been set up between Ted Doolittle and Robert Blundo regarding how the HIE can assist in the identification		

	of waste, fraud, and abuse. Additionally, information on Not-for-Profit examples from other states will be included at the end of this document.		
5.	**Review and Acceptance of the HIE Use Case Design Group Recommendations**	Michael Matthews	1:15 PM

Michael Matthews reviewed the findings and recommendations of the HIE Use Case Design Group. The Design Group was composed of the following members:

- **Stacy Beck** – Clinical Quality Program Director at Anthem
- **Pat Checko, Dr PH** – Co-Chair of State Innovation Model Consumer Advisory Board and Health IT Advisory Council member
- **Kathy DeMatteo** – Chief Information Officer of Western Connecticut Health Network
- **Gerarad Muro, MD** – Chief Medical Information Officer of Advanced Radiology Consultants and Board Member of Charter Radiology Network
- **Mark Raymond** – Chief Information Officer of the State of Connecticut and Health IT Advisory Council member
- **Jake Star** – Chief Information Officer of VNA Community Healthcare and Health IT Advisory Council member
- **Lisa Stump, MS, RPh** – Senior Vice President and Chief Information Officer of Yale New Haven Health System and Health IT Advisory Council member

The timeline of the HIE Use Case Design Group began on June 27, 2017 and continued through October 11, 2017, finishing up by presenting the final recommendations to the Health IT Advisory Council on October 19th. The Council's discussion from this session will be taken into consideration before the final report is sent to the Design Group and the HITO.

Throughout this process, The Use Case Library was developed with 31 use cases that were prioritized and sequenced. The Design Group validated the top ten use cases and further evaluated policy and financial considerations, and socialized those with stakeholders. It is important to note that each use case has value, but the challenge the Design Group faced was that not every use case can be implemented in Wave 1. The group needed to determine which use cases create the most value for stakeholders. The Design Group went through a prioritization and sequencing effort. There were specific criteria elements that were used to evaluate the use cases. The outcome of the prioritization activities enabled meaningful discussion and guided decisions by the Design Group. The main focus of the Design Group in evaluating the use cases was whether or not the use case created value for patients, consumers, and other relevant stakeholders in Connecticut, in line with the principle of keeping the patient as the north star. Another main criteria for prioritization was the workflow impact, and how HIE services cannot add burden to caregivers. Michael also explained that the ease of implementation was also a top priority; the discussion included considerations of level of effort, complementary technical infrastructure, and dependencies, as well as integration and technical assistance requirements. Other considerations included prerequisite services, scalability, and existing infrastructure and resources.

Michael then went over the use cases selected for further analysis:

- Immunization Information System (IIS) – Submit and Query/Retrieve
    - This use case was previously endorsed by the Health IT Advisory Council, and investigated/validated by the IIS Design Group. The HIE Use Case DG validated this priority by including the IIS use case in the prioritization activities.
- eCQM

  - This use case was previously endorsed by the Health IT Advisory Council, and investigated/validated by the eCQM Design Group. The HIE Use Case DG validated this priority by including the eCQM use case in the prioritization activities.
- Longitudinal Health Record
  - The Longitudinal Health Record is viewed as a foundational element for other use cases. For example, a patient portal is enabled by providing access to a longitudinal health record.
- Clinical Encounter Alerts
  - This was determined as essential and enables other important use cases, such as Transitions of Care and Emergency Department Super-utilizers.
- Public Health Reporting
  - This is viewed as complementary to, and supportive of the IIS use case. It would not only support IIS but other reportable data elements such as syndromic surveillance, electronic lab reporting, and the cancer registry.
- Population Health Analytics
  - Collection, aggregation, visualization, and analysis of individual health information at the population level supports a variety of activities, such as: driving actionable insights to improve care, determining the effects of risk factors on health outcomes, designing and evaluating health interventions, identifying patient safety events, supporting policy and workforce planning decisions, and solving complex social and health issues.
- Patient Portal
  - This is consistent with the concept of the patient as the North Star and works to promote PA 16-77 to ensure patients have access to data. The data to be accessed through the patient portal is dependent on the technology that will enable longitudinal health records.
- Image Exchange
  - Dr. Muro was on the Design Group and was helpful in reviewing this use case.
  - The use case was reviewed with New York eHealth Collaborative (NYeC). It was discussed how image exchange has been set up throughout the state of New York, and the CIO strongly recommended that this be a prioritized use case.
- Medication Reconciliation (Med Rec)
  - This will need further analysis; the initial analysis was assisted by the UConn School of Pharmacy and it was determined that there is a need for a process re-design before technology can be deployed.
- Advance Directives/MOLST
  - This made the top ten list and is consistent with the patient as the North Star. Additional work is being conducted with the Connecticut MOLST Task Force and Advisory Committee.

After this further analysis, the following use cases were recommended for Wave 1 implementation:

- eCQM Reporting System:
  - eCQM Design Group created recommendations that were validated/approved by the Council and validated by the HIE Use Case Design Group.
- IIS Submit/Query and Receive:
  - IIS Design Group created recommendations that were validated/approved by the Council and validated by the HIE Use Case Design Group
- Longitudinal Health Records:

  - Foundational use case that will support scalable statewide HIE services.
- Public Health Reporting:
  - Complementary and supportive of the IIS use case and IIS DG's recommendations.
  - Validated by targeted stakeholder discussions
- Clinical Encounter Alerts:
  - Identified and validated by Design Group as a foundational use case that will support scalable statewide HIE services
  - Validated by targeted stakeholder discussions
- Image Exchange:
  - Identified as a high-value use case for stakeholders by the HIE Use Case DG and through targeted stakeholder discussions
  - CIO from NYeC said image exchange would easily make his top 5 use cases – very bullish

The use cases included in the Wave 1 recommendation will be enabled by the implementation of core services, such as a master patient index (MPI), healthcare provider directory, attribution system, and consent management system. Connecticut has a green field to pursue HIE services, and has the opportunity to create something great. All of the Wave 1 use cases are achievable and implementable – but none are easy. All will require hard work, but these are a pragmatic grouping.

Recommended use cases for Wave 2 implementation are as follows:

- Medication Reconciliation:
  - Not selected for Wave 1 because of an identified need to first address issues with the medication reconciliation process. Technology cannot be implemented over a broken process. The UConn School of Pharmacy will be involved in the process.
- MOLST/Advance Directives:
  - Not selected for Wave 1 because of an identified need to explore and collaborate with existing initiatives in the state. Mark Schaefer introduced CedarBridge to the Connecticut MOLST Task Force and Advisory Committee, which was legislated to complete a pilot project. On 10/4/17, it was announced that this MOLST pilot program would be implemented statewide. Additional analysis will occur as part of this group.
  - Advance directives are an issue for families and doctors; only 63% of adults have advance directives. There are best practices in place in other parts of the country which could be explored further. Connecticut should consider a registry of advance directives to be accessed by patients, families, and providers.
- Patient Portal:
  - Not selected for Wave 1 because of an identified contingency on the technical architecture to support the Longitudinal Health Record use case. There is a strong desire for a patient portal to enable patients to have access to their complete medical record in the same format that is delivered to their care givers.
- Population Health Analytics:
  - Not selected for Wave 1 because of an identified contingency on the required technical architecture to support the eCQM Reporting System use case.

After discussing the Wave 1 and 2 recommended use cases, Michael outlined the Design Group's proposed rollout for years 1, 2, and 3 of the Use Cases:

- Year 1

  - Core / support services implementation
  - "Wave 1" use case implementation
  - "Wave 2" use case planning
  - Continued assessment of business / functional requirements Revalidated sequencing
- Year 2
  - "Wave 2" use case implementation
  - "Wave 3+" use case planning
  - Continued assessment of business and functional requirements
- Year 3
  - "Wave 3" use case implementation
  - "Wave 4+ planning
  - Continued assessment of business / functional requirements

Michael highlighted that we will need to build out core services and technology. This sets up a rolling timeline of implementation and planning for the next year. Moving forward, there will be a continued assessment of business and functional requirements, as well as a careful analysis of technical infrastructure requirements that will need to be flushed out before a procurement can occur. Sequencing will also be re-evaluated periodically as the market and environment evolves. We live in a dynamic world and we need to reevaluate throughout the process.

Council member Jim Wadleigh asked if the technology infrastructure necessary to implement the use cases will be available and accessible. Michael responded that there will need to be additional detail when we go to procure services. Core services, including identity services, have been included in this discussion since the beginning to complete relationship mapping and facilitate these services and use cases. The presentation in November will dive into this more deeply. Jim Wadleigh asked if it was their assumption that those core services are considered "Wave 0"? Carol Robinson responded that yes, that is one way to look at it, but this infrastructure will be assessed and implemented at the same time as the planning and procurement of services to support the uses cases will be taking place. Jim Wadleigh asked if they had looked to see if these core services already exist. He added that he knows that there is an MPI because we are using it. Michael responded that a key item of the recommendations has been the need to assess the ability to leverage existing infrastructure, when appropriate. This assessment will continue as the planning process progresses.

Pat Checko commented that she feels lucky to have worked on two Design Groups that Michael and Carol have been involved in. It is a remarkable process for anyone who has been involved. First, that you can have a 1.5-hour conference call every week and get so much done. That is attributed to Michael's facilitation and the commitment from the participants. She confirmed that this was a rigorous process and that she considers herself lucky to have been on this group. Michael went through the principles as was discussed during this meeting. As he said, all of these use cases have value but we can't do them all at once. It is important to remember that this is the beginning and not the end. It is also important to remember that part of the process was not looking at the value, but looking at the financial, legal, and business pieces that had input on what goes first, and what goes second. She thanked Michael and Carol for the breadth of knowledge and experience they brought to the process, and for their work that goes on in the background. She also

thanked Tom Agresta for all of his contributions. In their discussion down the road for sustainability, there are a number of use cases that can be brought on down the line that can bring in revenue – disability determination, research, and life insurance that can be put in as add-ons. She also added that the vote for the recommendations was unanimous in the design group. Michael Matthews thanked Pat for her kind comments.

Lisa Stump commented that she was impressed by the breadth of experience that the membership brought to the design group, and the comfort level they established to challenge their views and take a holistic and incredibly well-done view of the challenges and the solution. She agreed that the leadership and management process was well-done. She hopes that the Council appreciates the work and can weigh-in on the process.

Dina Berlyn asked if the reason why the Patient Portal was included in Wave 2, as opposed to Wave 1, was due to the technical limitations. She specified that she asked only because it is required by the legislation. Michael Matthews responded that this assumption was correct.

Robert Darby asked why Transitions of Care did not make the top 10. Were there any roadblocks? Michael responded that the design group felt that the clinical encounter alerts technology and functionality is supportive of the Transitions of Care use case. Beyond ADT it gets a little complicated, like sharing a care plan. Some states are doing this, but the starting point would still be Encounter Alerts.

Dr. Alan Kaye asked if the Council is being asked to vote on just Wave 1, or the entire three-year plan, and if there will be a reevaluation process? Michael responded that the recommendations would be to proceed with Wave 1, including core services, and to continue with the assessment and planning of Wave 2. There is a planning and design aspect that is part of the recommendations and during this planning work, there might be some changes to sequencing. Dr. Kaye asked if, with the longitudinal health record, we might find that the lab reporting use case might just fall into place, even though it's not specifically delineated in Wave 2. Michael responded that absolutely the use cases for Wave 2 could shift based on continued analysis, and the revalidation of sequencing.

Dave Fusco asked if the Council could receive some more information on what the scope and scale of the work is for the core services. Does this make us vulnerable to slipping? Carol Robinson responded that this is a great question. CedarBridge has done core services planning in other states. CedarBridge and HITO are developing are developing paths to move through the development process more quickly than has occurred in other states, based on what we have learned. In a lot of places around the country, the mindset is "if we build it, they will come," but there need to be buy-in of the value initially. The Wave 1 use cases have value propositions that will accrue at different places within the ecosystems. You are never going to get equal accrual of value across a system that is complicated. Dave Fusco asked if all of the Use Cases are dependent on the core services. Carol responded that there are different ways this can be architected, and they are evaluating these options.

Over the next couple of months, as procurement is planned and as the HIE entity evolves there will be future decision points. Dave Fusco asked if core services and support will consume year 1, and if we are doing ourselves a disservice by labeling Wave 1 as "year 1"? Michael responded that there will be a project roadmap that will come to this group which will provide clarity on the timeline. Wave 1 does not directly equate to Year 1.

Dr. Mark Schaefer stated that the recommendations for Wave 1 make sense to him. In terms of Dina's comment about the patient portal, he asked why we think that the state should be creating a consumer interface for the longitudinal health record? It seems that once the longitudinal health record is stood up, then EHR-based patient portals will be able to show this information to consumers. The complexity of this makes it so the efficiency will not be in place for 10 years. Some very big companies are looking at application solutions that will give patients an economic view of their information. Dina Berlyn responded that this was one of the big goals of the legislation – to give people the ability to access all of their information in one place. Carol Robinson stated that they recently attended a conference and learned that there are 80K-100K health apps on Google Play and the App Store. The notion is that you may have an app that will help you with your diabetes, one for your eyesight, etc. There is complexity of that with data being in so many systems and so many devices, in home and otherwise. We are optimistic that this is moving forward – when you look at what is being done with Apple HealthKit and Apple ResearchKit. If it is the traditional personal health record or another innovative solution, it will be something that can be done more quickly than what you are imagining. Pat Checko added that when they spoke with consumers, this was a major priority for them and it is a priority to have it as a part of the overall process. Personally, she would have a lot more confidence about the protection of information in the HIE than she would in an Apple App. Lisa Stump stated that the large EHR vendors are working to make the patient portals better. Epic now has ability for consumers to aggregate their data across six major EHRs. There are so many tools in play. In the HIE Use Case Design Group, our thinking was that it is very important for patients to have access to the same information that is being provided to their care team, compiled in the same format. Dina Berlyn responded that the legislation specifically states that the patient must have access to data, so it is a requirement.

Allan Hackney broaches the acceptance of the HIE Use Case Design Group recommendations as an initial framework for deployment of the use cases. Michael Matthews clarifies that the recommendation from the Design Group is to accept the framework as an initial approach for services in Connecticut and initial deployment for planning and design going forward.

Pat Checko makes the motion for approval, Rob Rioux seconds the motion. Motion passes unanimously without any abstentions.

Allan Hackney stated that he had the privilege of listening to eight of the eleven sessions. It was a thoughtful, collaborative process and he continues to be impressed by the knowledge

	and passion of the members, not only in this Design Group, but the eCQM and immunization groups prior as well. Michael Matthews stated that he would like to pause for a moment and appreciate the words of the Design Group. If you think about when they first came onto the scene, it was a blank slate for them to guide a process of discernment with the stakeholders in Connecticut and then continue to whittle that down into focus on how that would be applied moving forward. The Design Group did great work, but could not have done so without the support of the Council.		
6.	**Sustainability Activity**	Michael Matthews	2:00 PM

	Michael Matthews stated that The Design Group had several sustainability conversations, both in general and in reference to specific use cases. The issue is not the upfront funding but how to continue to generate operating revenue to maintain, support, and enhance services going forward. This discussion is to present some ideas, concepts, and information around business models and sustainability – this is not recommendations or guidance, it is laying a framework of information.
	
	Michael went on to explain that sustainability is not a new issue – the elimination of redundant or unnecessary testing is usually the benefit that is touted. Dr. Checko has stated that ROI is more than just financial return, but also includes patient safety, quality, and other items that could go into a positive valuation.
	
	There is no hard data on impact analysis, but that is improving. Dr. Julia Adler-Milstein (whose work has been mentioned previously to the Council) has done research on the impact of an HIE in a state or community. The results show that HIEs are underutilized and that most benefits are seen currently in emergency departments and through the elimination of duplicative tests.
	• Case Study in Value Creation: Disability Determination
	  ○ Social Security Administration found it takes 120 days for the disability determination process, due to paper processing. SSA came to the Virginia HIE and determined that disability turn around decreased by 35% through the use of standardized information exchange. For the health system, in addition to decreased requests for medical records, they also increased revenue.
	• Emerging Evidence
	  ○ On average reduction in spending of $139 per Medicare beneficiary per year, which extrapolates to $3B in annual savings if extended to the entire population.
	• Clinical Research and HIEs
	  ○ There is emerging interest amongst research organizations
	  ○ Research organizations and clinical trials are interested in clinical encounter alerts and the ability to track patients care.
	• HIE Sustainability Models Survey: Results and Analysis
	  ○ 12 out of 14 surveyed HIEs were funded on either a monthly fee, an annual subscription, or a combination of subscription and fee for services.
	  ○ Image exchange, reporting and analytics, and clinical quality measure support were the three services that were requested, but not provided by HIEs.
	  ○ “There is no silver bullet”
	• Brookings Institute – Sustainable Business Model for HIE Platforms: The Solution to Interoperability in Healthcare IT		

- Different stakeholder groups have different value propositions. It is important to recognize the unique value propositions in the state in order to create a sustainable business model.

- Role of the State
  - Effective use of legislation and policy levers, as well as leveraging investments.
  - Challenges include: limited demand, sustainability, and HIE integration.
- Guidance from National Governors Association
  - Development of standardized consent forms, guidance, etc. and strategies to address market barriers.
  - Can use authority to hold people accountable and to serve as a convener.
- Role of Policy Makers
  - Moving past the EHR Interoperability Blame Game – "only policymakers have a clear, strong interest in promoting interoperability."
- Driving to sustainability:
  - Focus on Demand
  - Leverage value-based care initiatives
  - Define and support a "healthcare data economy"
  - Support necessary workflow changes with technical assistance and education
  - Engage payers
  - Innovate (e.g. clinical research)
  - Allocate expenses judiciously
  - Include funding for development of a long-term financial sustainability plan in IAPD
  - Implement rigorous measures of usage and value
  - Ongoing communication avenues with all stakeholders
  - Privacy, security, and confidentiality must be present in all systems and services
  - System must be designed for optimal ease of use

Following this portion of the presentation, Ted Doolittle thanked Michael for this work to discuss sustainability. He also wanted to draw attention to the fraud prevention system at CMS which was started six years ago. It is an analytics system that detects fraud. He suggested that we should look at the conversation between CMS and HHS OIG around how to conservatively estimate value of this tool and the scope of fraud. If you could conservatively estimate costs that are avoided by preventing fraud, this could be a source of revenue. Michael responded that this is a great point.

Dr. Quaranta said that he had four related questions. First, he stated that he was going to be taking an opposite view of the EHR vendors – that he believe we are letting them off the hook and it is not right. Anyone who has been doing interoperability work has seen how difficult it is to connect disparate EHRs into a system, and EHR vendors have made it a profit center. Next, he stated that the system has failed providers in providing a supply of usable data. There is not a provider out there who hasn't experienced exasperation at missing data. The demand is there, but there needs to be an easily used access point. He also noted that the current ACO model in Connecticut does not support the ability to fund an HIE. He has extensive experience working with ACOs, and the predominant up-side shared savings model seen in Connecticut will not financially support an HIE. Finally, Dr. Quaranta stated that the financial benefits accrue in a population-based way and ultimately accrue to payers. If the value is accruing to the large-scale payers of vendors, then we have to find a way to pull funding from the large-scale beneficiaries. Carol Robinson responded that these points are well-said, and that CedarBridge is in agreement. The 21st Century Cures is the

	federal stick that has been coming towards vendors. The certification of EHRs has been notoriously weak. Dr. Allan Kaye commented that these were superb presentations, especially the second. The point that the presentation made is the first justification for SB-811. The EHR doesn't make money by giving access. Once they were told they had to do it, they built it in. The survey on the sustainability model goes with comment about lab results. Results delivery was being provided by 10 out of 14 HIEs surveyed because it is easy, but also valuable.		
7.	**APCD Discussion**	Robert Blundo	2:30 PM
	Allan Hackney and Robert Blundo had a conversation about the All-Payer Claims Database (APCD) and thought that it was a good time to give the Council an update on accomplishments and next steps, including walking through legislative changes, mission, vision, strategies, and progress on strategies. Robert Blundo then gave the Council a presentation on the legislative charges of the APCD, the high-level vision and mission of the APCD, the Core Strategies that have been established in order to achieve the vision and mission, and providing an update of the two core strategies that have been achieved. The APCD is guided by three main legislative points. It aims to help consumers make informed decisions, make data available for requests for people maintaining triple health aim, and maintain a website with all applicable data. The intended audiences are consumers, state agencies, insurers, employers, and providers. From an APCD perspective, the vision is to improve health at all levels. The mission is to improve transparencies and disparities in health equity. The Core Strategies are broken out into four main components: • Strategy 1 – Integrate data across all payers for a comprehensive longitudinal data warehouse for effective research on long-term treatment, quality, outcomes, costs, and utilization trends. • Strategy 2 – Support private sector, academic, and federal/state health reform and population health initiatives with available data, information, and analyses. • Strategy 3 – Provide transparency for Connecticut's consumers and providers about the cost and quality of healthcare services, with an emphasis on consumer access to care and decision making • Strategy 4 – Analyze and address disparities in healthcare based on race, ethnicity, income, geography, and other population characteristics and state demographics. The APCD collected data in 2016 and has accomplished the first two, and are supporting strategies 3 and 4. Robert Blundo continued to discuss the different types of data that the APCD collects: • Administrative or billing data generated from paid claims incurred in medical and pharmacy settings, including drug claims data administered through medical and pharmacy benefits. • Reporting requirements – reporting entities with more than 3,000 members enrolled must submit data. • Reporting format – claims submitted in standardized format established by APCD. Data points include ICD codes, dates of services, provider ID, drug code, financial components, and provider/facility codes.		

- Claims Dates – claims span CY2012 – CY2017. Data submitted monthly.
- Total Volume – over 75 million claims and $30 billion paid by characters. Pharmacy claims – over 129 million claims, $11.9 billion paid by carriers and 42.6 thousand unique drug codes.
- Entities Reporting Data:
    - Caremark
    - Express Scripts
    - United Health
    - Connecticare
    - Aetna
    - Anthem
    - Cigna
    - WellCare
    - Harvard Pilgrim
    - Healthy CT
- What is available through Data Release?
    - Enrollees and enrollment data
        - Fully-insured / non-ERISA plans (~900,000 lives)
        - State employees are not fully covered by ERISA, so they are included in data
    - Medical Claims
        - All claims / encounters paid by submitting carrier
    - Pharmacy Claims
        - All claims / encounters paid by submitting carrier
    - Provider/Facility Directory

The data that is ***not*** included in the APCD is outlined below:

- Lives covered under self-insured ERISA plans
- Part 2 SUD claims – SUD claims provided by 42 CFR Part 2 providers
    - This is negligible and accounts for 0.5% of claims
- Denied claims – fully denied claims not collected; partially denied claims are collected
- Test Result Values – lab, imaging, biometrics, and physician derived data
- Third-party Data – risk scoring, social determinants, knowledge base, etc.
- HIPAA Safe Harbor Variables – 18 HIPAA identifiers
- Dental Claims – dental claims not required for submission
- Ancillary Financials – plan premiums, capitation payments, performance payments, administrative fees, rebates

Robert Blundo recapped the Data Release charge of the APCD. It is governed by Public Act 13-247, and will be rolled out in two phases. The first phase entails developing a data release process, tools, and capabilities, along with other administrative support services. Phase two entails the promotion and delivery of data release services. Additionally, there will be engagement with potential requestors to ensure capabilities, opportunities, and services are recognized. He also noted that there is a data release committee, led by Pat Checko, that governs the process of who data can be released to, and how it can safely be released.

Robert Blundo also discussed the de-identified data release capabilities of the APCD, regulations for which are set forth in 45 CFR 164.514 and allow data to be used for research purposes without exposing identifying characteristics.

	Finally, Robert Blundo overviewed the strategic goals and objectives of the APCD. The APCD aims to provide transparency for Connecticut's consumers and providers about the cost and quality of healthcare services, with an emphasis on consumer access to care and decision-making. The goals are to: • Promote and leverage existing best in-class consumer transparency tools • Complete development of Analyze Health website • Complete development of remaining reports to ensure highest level of meaningful impact on intended audience • Supplement existing data with third-party sources to maximize utility in disparities research • Support new and ongoing research initiatives Following the presentation, Council member Lisa Stump commented that she believes there is an important polarity that has been surfaced. In terms of the APCD, there is reference to a fee schedule to access the data. This is because there is a cost to collect data, maintain data, and ensure that it is reported correctly. That relates to HIE data and the cost charged by EHR vendors. Providers sit on data that can be shared. There is a variety of options of EHRs for providers because they like autonomy. Those complexities are the things that impose cost on sharing data, and she cautioned that the Council must be aware that it costs money to compile and curate data, as well as to request data, and this is not a sustainable model.		
8.	**Wrap up, Action Items and Next Steps**	Dino Puia/Kelsey Lawlor	2:50 PM
	No new action items were recorded. Allan Hackney closed the meeting.		

Meeting Schedule 2017 Dates –Nov. 16, Dec. 21

Meeting information is located at: http://portal.ct.gov/office-of-the-lt-governor/health-it-advisory-council

Health Information Technology Advisory Council

Meeting Minutes

State	Name	Website	SHIEC Member	Structure
Alabama	One Health Record	onehealthrecord.alabama.gov		Agency
Alaska	Alaska eHealth Network (AeHN)	www.ak-ehealth.org		501(c)(3)
Arizona	Arizona Health-e Connection	www.azhec.org	Y	Pub/Pvt Collab.
Arkansas	Arkansas Office of Health Information Technology	www.ohit.arkansas.gov	Y	Agency
Arkansas	State Health Alliance for Records Exchange	www.sharearkansas.com	Y	Agency
California	ConnectHealthcare	www.connecthealthcare.org	Y	501(c)(3) Pub. Benefit Corp.
California	San Diego Health Connect	www.sdhealthconnect.org	Y	501(c)(3)
California	Santa Cruz HIE	www.santacruzhie.org	Y	501(c)(3)
Colorado	Colorado RHIO	www.corhio.org	Y	501(c)(3)
Colorado	Quality Health Network	www.qualityhealthnetwork.org	Y	501(c)(3)
Connecticut	CTHealthLink	www.cthealthlink.com	Y	501(c)(6)
Connecticut	Western Connecticut Health Network	www.westernconnecticuthealthnetwork.org	Y	Private
Delaware	Delaware HIN	dhin.org	Y	501(c)(3)
District of Columbia	DC HIE	dhcf.dc.gov		Agency subcontract to 501(c)(3)
Florida	FL HIE	www.florida-hie.net		Agency
Georgia	Georgia HIN	www.gahin.org	Y	Pub/Pvt Collab.
Georgia	HealtheParadigm	www.healtheparadigm.com		501(c)(6)
Hawaii	Hawaii HIE	www.hawaiihie.org		501(c)(3)
Idaho	Idaho Health Data Exchange	www.idahohde.org	Y	501(c)(6)
Illinois	Communities of Illinois HIE (CIHIE)	www.cihie.org		501(c)(3)
Indiana	HealthLINC	www.healthlinc.org	Y	501(c)(3)
Indiana	Indiana HIE	www.ihie.org	Y	501(c)(3)
Indiana	Michiana HIN	www.mhin.org	Y	501(c)(3)
Iowa	IHIN	www.iowaehealth.org		Agency
Kansas	Kansas HIN	www.khinonline.org	Y	501(c)(3)
Kentucky	Kentucky HIE	www.khie.ky.gov	Y	Agency
Louisiana	Greater New Orleans HIE	www.gnohie.org	Y	509(a)(3)
Louisiana	Louisiana Health Care Quality Forum	www.lhcqf.org	Y	501(c)(3)
Maine	HealthInfoNet	hinfonet.org		501(c)(3)
Maryland	CRISP	www.crisphealth.org	Y	501(c)(3)
Massachusetts	Mass Hiway	www.masshiway.net		Agency
Michigan	Great Lakes Health Connect	www.glhc.org	Y	501(c)(3)
Michigan	Michigan Health Information Network	mihin.org		501(c)(3)
Minnesota	Allina Health System	www.allinahealth.org		501(c)(3)
Minnesota	Koble-MN	www.koblegroup.com		LLC
Minnesota	South Country Health Alliance	www.mnscha.org		Agency (county)
Minnesota	Southern Prairie Community Care	caretrachio.org		Agency (county)
Mississippi	MS-HIN	www.ms-hin.ms.gov		Agency
Missouri	Missouri Health Connection	www.missourihealthconnection.org	Y	501(c)(3)
Montana	N/A	N/A		N/A
Nebraska	Nebraska Health Information Initiative	www.nehii.org	Y	501(c)(3)
Nevada	HealtHIE Nevada	healthienevada.org		501(c)(3)

State	Name	Website	SHIEC Member	Structure
New Hampshire	NHHIO	nhhio.org		501(c)(3)
New Jersey	Jersey Health Connect	www.jerseyhealthconnect.org	Y	501(c)(3)
New Mexico	New Mexico Health Information Collaborative	www.lcfresearch.org		501(c)(3)
New York	Bronx RHIO	www.bronxrhio.org	Y	501(c)(3)
New York	Greater Rochester RHIO	www.grrhio.org	Y	501(c)(3)
New York	Health Information Exchange of New York	hixny.org	Y	501(c)(3)
New York	HealtheConnections	www.healtheconnections.org	Y	501(c)(3)
New York	Healthix	healthix.org	Y	501(c)(3)
New York	HealthLinkNY	www.healthlinkny.com	Y	501(c)(3)
New York	Statewide Health Information Network for New York	www.nyehealth.org		501(c)(3)
New York	Western New York Health Link	www.wnyhealthelink.com	Y	501(c)(3)
North Carolina	North Carolina HIE Authority	hiea.nc.gov	Y	Agency
North Dakota	North Dakota HIN	www.ndhin.org	Y	Agency
Ohio	Greater Dayton Area Hospital Association	www.gdaha.org	Y	501(c)(6)
Oklahoma	My Health Access	www.myhealthaccess.net	Y	501(c)(3)
Oregon	CareAccord	www.careaccord.org		Agency
Pennsylvania	HealthShare Exchange of Southeastern PA	www.hsxsepa.org	Y	501(c)(3)
Pennsylvania	Keystone HIE	www.keyhie.org	Y	Moving to Agency
Puerto Rico	PR HIN	www.prhin.net		Agency (territory)
Rhode Island	CurrentCare	www.currentcareri.org		501(c)(3)
Rhode Island	Rhode Island Quality Institute	www.riqi.org	Y	501(c)(3)
South Carolina	Carolina eHealth Network	www.carolinaehealthnetwork.com		501(c)(6)
South Carolina	SC HIE	www.schiex.org		501(c)(3)
South Dakota	South Dakota Health Link	www.sdhealthlink.org		Agency
Tennessee	East Tennessee HIN	www.ethin.org	Y	501(c)(3)
Texas	Healthcare Access San Antonio	www.hasatx.org	Y	501(c)(3)
Texas	Paso del Norte HIE	www.pdnhie.org	Y	501(c)(3)
Utah	Utah HIN	www.uhin.org	Y	501(c)(3)
Vermont	Vermont HIE	www.vitl.net	Y	501(c)(3)
Virginia	Connect Virginia	www.connectvirginia.org	Y	501(c)(3)
Washington	OneHealthPort	www.onehealthport.com		Pub/Pvt Collab.
West Virginia	West Virginia HIN	wvhin.org	Y	501(c)(3)
Wisconsin	Wisconsin Statewide HIN	www.wishin.org		501(c)(3)
Wyoming	Wyoming Total Health Record	wyomingthr.wyo.gov		Agency