PROJECT CHARTER

Connecticut Health Information Technology Program Management Office

Electronic Clinical Quality Measures Design Group

VERSION: 1.0 REVISION DATE: 2/14/2017

Approval of the Project Charter indicates an understanding of the purpose and content described in this deliverable. By signing this deliverable, each individual agrees work should be initiated on this project and necessary resources should be committed as described herein.

Approver Name	Title	Signature	Date
Allan Hackney	Connecticut Health Information Technology Officer		

Contents

Section 1. Project Overview

1.1 Problem Statement and Project Purpose

Describe the business reason(s) for initiating the project, specifically stating the business problem.

⇒ The Health Information Technology Officer is charged with coordinating the implementation of meaningful quality and performance measures, data driven quality improvement, and shared health information technology systems and functionalities within the state. The healthcare system is transitioning from one driven by fee-for-service payment to paying for value through alternative payment models (APM). Successful execution of APMs requires the use of electronic clinical quality measures (eCQMs) that draw from clinical data contained in electronic health records (EHRs) and other clinical sources. The use of such measures in APMs will drive improvement in healthcare outcomes. The SIM Quality Council recommended a common set of quality measures for use by public and private payers in their APMs. Nearly half of these measures are eCQMs that require data from EHRs. Connecticut's payers have not agreed to adopt the eCQM measures, citing the lack of an efficient means to do so. Additionally, consumers and others do not have access to information about the healthcare outcomes achieved by Connecticut's accountable healthcare providers.

⇒ The purpose of this design group is to identify and recommend the objectives and requirements of a shared, statewide health IT-enabled eCQM solution, in the context of APMs.

1.2 Project Goals and Objectives

Describe the business goals and objectives of the design group project. Refine the goals and objectives stated in the Business Case.

⇒ Identification of value propositions of a shared health IT-enabled eCQM solution.

⇒ Identification of priority use cases that can be enabled by a shared eCQM solution.

⇒ Identification of a set of clearly defined business requirements associated with the priority use cases.

⇒ Identification of a set of agreed upon functional requirements that augment and inform the business requirements, including considerations for:

- Clinical data extraction approach likely to meet the needs of a provider community with varying level of readiness for data extraction (as distinct from eCQM extraction);
- Secure data transport;
- Data validation methods, including patient attribution to providers and organizations;
- Desired feedback methods of aggregate and individual quality reports;
- Desired system performance reports and auditing capabilities;
- Other system user needs for health IT-enabled measurement;

- Desired technical assistance framework including targeted and prioritized provider categories, sequence, and prioritized topics (e.g., support with data extraction vs. data analytics).

⇒ Considerations for financial sustainability models.

⇒ Alignment of stakeholders around the above recommendations including Medicaid, commercial payers, accountable provider organizations, and consumers.

⇒ Recommendations should accommodate the Quality Council's recommended common set of quality measures, and other quality measures that present a value proposition to stakeholders.

1.3 Project Scope

Describe the project scope. The scope defines project limits and identifies the products and/or services delivered by the project. The scope establishes the boundaries of the project and should describe products and/or services that are outside of the project scope.

Project Includes
Quality measure processes and use cases as they relate to Medicaid, Medicare, and commercial APMs, including Shared Savings Programs (SSPs).
Quality measure processes and use cases as they relate to the reporting efficiency opportunities and analytic needs of accountable healthcare organizations.
Quality measure processes and use cases as they relate to the Connecticut State Innovation Model's public scorecard initiative and evaluation.
Health IT-enabled quality measure capabilities and processes (e.g., extracting, reporting, aggregating, analyzing) of Connecticut-based healthcare provider organizations that are participating in at least one APM, or will within the next 1-3 years.
All clinical data sources, including healthcare provider EHRs, clinical data registries, the APCD, Office of the State Comptroller data warehouse, and payer specific data repositories. The primary focus, however, is on extraction of clinical data contained within EHRs.

Project Excludes
Specific health IT vendor considerations or recommendations
Overall state health IT architecture recommendations
Quality measure selection

1.4 Critical Success Factors

Describe the factors or characteristics that are deemed critical to the success of a project, such that, in their absence the project will fail.

⇒ Engagement and support of payer representatives, including Medicaid and commercial health plans.

⇒ Ability of stakeholders to commit to 90 minute, bi-weekly meetings for 8 weeks.

⇒ Design group members can represent the stakeholder community in their domain.

1.5 Assumptions

Describe any project assumptions related to business, technology, resources, scope, expectations, or schedules.

⇒ Assumes that appropriate data use agreements and financial sustainability options can be implemented.

⇒ Assumes that appropriate vendor selection and management will be determined.

⇒ Assumes that appropriate health IT architecture and standards will be developed.

1.6 Constraints

Describe any project constraints being imposed in areas such as schedule, budget, resources, products to be reused, technology to be employed, products to be acquired, and interfaces to other products. List the project constraints based on the current knowledge today.

⇒ Meeting intensive timeline goals by the 4/20/17 final report milestone.

Section 2. Project Authority and Milestones

2.1 Funding Authority

Identify the funding amount and source of authorization and method of finance approved for the project.

⇒ The funding model will be determined based on the scope and scale of the recommendations of the design group.

2.2 Project Oversight Authority

Describe management control over the project. Describe external oversight bodies and relevant policies that affect the agency governance structure, project management office, and/or vendor management office.

⇒ Section 4 of **Public Act 16-77**, enacted June 2, 2016, authorized the Lieutenant Governor to designate an individual to serve as Health Information Technology Officer and granted the Health Information Technology Officer responsibility for coordinating all state health information technology initiatives. Public Act 16-77 also defines the role of the Health IT Advisory Council to advise the Health Information Technology Officer on developing priorities and policies for the state's health IT efforts.

⇒ The **Connecticut Health Information Technology Officer** will be accountable for the project, reviewing the strategy and recommendations, providing project resources as needed, monitoring progress, and removing barriers. Project resources include facilitation of the design group by health IT consultant group CedarBridge Group LLC, and additional support as needed from the SIM Program Management Office.

⇒ The **Health IT Advisory Council** will be responsible for reviewing and approving the design group recommendations.

⇒ The **eCQM Design Group** will be responsible for developing and providing recommendations to the Health IT Advisory Council and the Health Information Technology Officer.

⇒ The **State Innovation Model Program Management Office** will represent the SIM quality measure alignment and public scorecard initiatives, and facilitate additional input from key stakeholders and partners, including the Quality Council and UConn Health, if needed to support the design group's objectives.

2.3 Major Project Milestones

List the project's major milestones and deliverables and the planned completion dates for delivery. This list should reflect products and/or services delivered to the end user as well as the delivery of key project management or other project-related work products.

Milestone/Deliverable	Planned Completion Date
Kick-Off Meeting: Charter, Value Proposition, Roles and Responsibilities, Timeline	2/16/17
Develop the use case process; Identify provisional set of eCQM use cases	3/02/17
Examine business requirements of provisional use cases	3/09/17
Review preliminary environmental scan, begin to prioritize use cases; **Present progress report to Health IT Advisory Council**	**3/16/17**
Prioritize use cases, informed by preliminary data from environmental scan and stakeholder engagement interviews	3/23/17
Finalize prioritization of use cases; Consider draft functional requirements to meet use case needs;	3/30/17
Considerations for sustainability models and future workgroup needs	4/06/17
Finalize recommendations	4/13/17
Present Final Report and Recommendations to Health IT Advisory Council	**4/20/17**

All meetings are open to the public. Meeting materials will be posted on the **Health IT Advisory Council page.**

Section 3. Project Organization

3.1 Project Structure

Executive Sponsor:

Allan Hackney, Connecticut's Health Information Technology Officer

Project Governance:

Health IT Advisory Council: **Member Listing**

eCQM Design Group:

Name	***Stakeholder Representation***
Patricia Checko D.Ph., MPH	Healthcare consumers
David Fusco MS	Commercial payers
Michael Hunt DO	Community Hospital (designee appointed by Patrick Charmel)
TBD	Providers (designee appointed by Joseph Quaranta MD)
Robert Rioux MA	Federally Qualified Health Centers
Nicolangelo Scibelli LCSW	Behavioral health providers
Nitu Kashyap MD	Hospital system (designee appointed by Lisa Stump)
Tom Woodruff	Office of the State Comptroller
TBD	Medicaid Agency

Design group support:

Name	***Organization***
Karen Bell MD	SME and facilitator, CedarBridge Group
Carol Robinson	SME and co-facilitator, CedarBridge Group
Sarju Shah	PM, Connecticut Health IT Program Management Office
Faina Dookh	PM, State Innovation Model Program Management Office
Michael Matthews	SME, CedarBridge Group
Wayne Houk	PM, CedarBridge Group
Betsy Boyd Flynn	Sr. Consultant, CedarBridge Group

Consulted:

Victoria Veltri, Chief Health Policy Advisor, Office of Lt. Governor Nancy Wyman

The Healthcare Innovation Steering Committee

Council on Medical Assistance Program Oversight (MAPOC)

3.2 Roles and Responsibilities

Summarize roles and responsibilities for the eCQM Design Group and stakeholders identified in the project structure above.

Name/Role	Responsibility
Patricia Checko, D.Ph., MPH	Provide consumer perspective representation, including engaging the Consumer Advisory Board on key deliberations. The consumer representative should be prepared to speak to the need for transparency of data reflecting the cost, health outcomes, and quality scores of providers and organizations, to inform better consumer decision-making when choosing providers and health plans.
David Fusco, MS	Provide commercial payer perspective representation, including engaging decision-makers within each Connecticut-based commercial payer organization. This representative should be able to speak to the current and planned capacity for payers' health IT-enabled clinical quality measurement processes, value propositions, priority business and use cases, considerations for financing models, and considerations for alignment.
Michael Hunt, DO	Provide healthcare provider perspective representation, including engaging provider community to ensure accurate representation. The provider representatives should be able to speak to current and planned provider capacity for clinical data extraction, aggregation, and reporting; priority business and use cases for an aligned health IT-enabled electronic quality measurement system.
TBD	Provide healthcare provider perspective representation, including engaging provider community to ensure accurate representation. The provider representatives should be able to speak to current and planned provider capacity for clinical data extraction, aggregation, and reporting; priority business and use cases for an aligned health IT-enabled electronic quality measurement system.
Robert Rioux, MA	Provide broad FQHC perspective representation. The representative for FQHCs should be able to speak to current and planned FQHC capacity for clinical data extraction, aggregation, and reporting; priority business and use cases for an aligned health IT-enabled electronic quality measurement system.
Nicolangelo Scibelli, LCSW	Provide behavioral health provider perspective representation. The representative of behavioral health should be able to speak to the challenges of most behavioral health EHR systems' technical ability to collect and extract quality measures in standard formats and opportunities to provide the behavioral health provider community training, education, and workflow support to improve their ability to participate in APMs and quality improvement initiatives.
Nitu Kashyap, MD	Provide hospital and academic medical center perspective representation, including engaging the large system provider community to ensure accurate representation. This representative should able to speak to current and planned large hospital system capacity for clinical data extraction, aggregation, and reporting; priority business and use cases for an aligned health IT-enabled electronic quality measurement system.
Tom Woodruff	Provide Office of the State Comptroller (OSC) representation, particularly as it relates to its commercial payer health benefit contracts for state employees. The OSC representative should be able to speak to OSC's current and planned efforts leveraging their commercial contracts to promote the use of clinical data extraction, aggregation, and reporting; and the priority business and use cases they see for leveraging purchasing power to incentivize providers to participate in APMs and quality improvement initiatives.
DSS TBD	Provide Medicaid perspective representation. This representative should be able to provide a clinician's perspective regarding the current and planned capacity of Medicaid's clinical quality measurement processes, value propositions, and priority business needs and process use cases.

3.3 Project Facilities and Resources

Describe the project's requirements for facilities and resources, such as office space, special facilities, computer equipment, office equipment, and support tools. Identify responsibilities by role for provisioning the specific items needed to support the project environment.

Resource Requirement	Responsibility
Consultants – subject matter expertise, facilitation, content development and synthesis of discussions and decisions by Design Group	Connecticut's Health Information Technology Program Management Office – CedarBridge Group
Web meeting technology	Connecticut's Health Information Technology Program Management Office – CedarBridge Group

Section 4. Glossary

Define all terms and acronyms required to interpret the Project Charter properly.

Term or Acronym	Definition
Advanced Networks or Accountable healthcare providers or Accountable healthcare organizations (ACOs)	A group of healthcare providers with a unified focus on providing coordinated care usually focused on a defined population; ensuring that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
Alternative payment model (APM)	A type of payment model that incorporates an accounting of quality and cost of care, rather than a traditional fee-for-service. In most APMs, providers or provider organizations are eligible for incentive payments and/or risk-sharing arrangements. Examples include upside and downside shared savings programs, bundled payments, and global budgets. See the **Healthcare Payment Learning & Action Network APM White Paper** for a comprehensive APM framework.
Attribution	The process of linking a consumer (patient) and their health care provider or providers through a matching / rules-based algorithm to measure quality, cost and health outcomes in healthcare delivery. Accurate attribution of patients to their providers is critical to the success of APMs, both for prospective care coordination and for retrospective measurement of care standards, and requires the technical infrastructure of a master patient index and a master provider directory.
Council on Medical Assistance Program Oversight (MAPOC)	The collaborative body established in 1994 to advise the Department of Social Services (DSS) on matters relating to administering the Medicaid Managed Care Program. Public Act 17b-28 expanded the scope of the Council to include oversight of all Medicaid enrollees. Subcommittees have been created that focus on consumer access, care management, quality improvement, and complex care communities.
Data extraction	The activity and considerations related to harvesting data from electronic system sources for purposes of quality measurement, reporting, or storage, or loading data into another database/information system.

Term or Acronym	Definition
Electronic clinical quality measures (eCQM)	eCQM is a clinical quality measure that is expressed and formatted to use data from electronic health records (EHR) and/or health information technology systems to measure health care quality, specifically data captured in structured form during the process of patient care.[1] To report eCQMs from an EHR, standardized data must be extracted via widely adopted standards. They include the Health Level Seven (HL7) standard known as the Health Quality Measures Format (HQMF), which represents a clinical quality measure as an electronic Extensible Markup Language (XML) document that can be captured or stored in the EHR so that the data can be sent or shared electronically.
Electronic health record (EHR)	An information system containing an electronic version of a patient's medical history, that is maintained by the provider over time. The EHR may include the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.
Federally Qualified Health Center (FQHC)	An organization providing comprehensive healthcare services, often including primary care, dental, and mental health services, for an underserved area or population that qualifies for funding under Section 330 of the Public Health Service Act.
Health IT Advisory Council	Advisory group created by Public Act 15-146, and revised under Public Act 16-77, to advise in the development of priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts. The Advisory Council is also charged with advising in the development and implementation of the statewide health information technology plan and health IT standards.
Health IT-enabled Quality Measurement	The measurement of cost and quality utilizing a broader universe of data sources, aggregation, analytics, reporting, and feedback applications and functions enabling population-, community-, and patient-centric measurement informing total cost of care, quality of care, and improved outcomes.[2]
Health Information Technology Officer (HITO)	Position created by Public Act 16-77. Designated by the Lieutenant Governor and responsible for coordinating all state health information technology initiatives.
Office of the State Comptroller (OSC)	The office mandated to administer and manage medical, dental, and pharmacy benefit programs for state employees, retirees, and family members through its Healthcare Policy & Benefit Services Division. Total beneficiaries exceed 200,000.

[1] http://ecqi.healthit.gov/content/glossary-ecqi-terms
[2] ONC SIM Health IT Resource Center: Health IT-Enabled Quality Measurement Strategic Implementation Guide

Term or Acronym	Definition
Shared Savings Programs (SSPs)	A form of a value based payment/ alternative payment model that incents networks of providers to manage healthcare spending and improve quality for a defined patient population by sharing with those organizations a portion of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures, and then shared between payer and providers. Shared savings programs require providers to meet defined targets with respect to quality metrics in order to qualify for shared savings.
State Innovation Model (SIM)	The State Innovation Model (SIM) initiative partners with states to advance multi-payer healthcare payment and delivery system reform models. Each state-led model aims to achieve better quality of care, lower costs, and improved health for the population of the participating states or territory. The initiative is testing the ability of state governments to utilize policy and regulatory levers to accelerate health system transformation to meet these aims. Connecticut's SIM initiative is being coordinated out of the SIM Program Management Office.
SIM Quality Council	Work group created as part of the SIM governance structure to serve as an advisory board for the SIM quality alignment work stream, charged with developing a common set of quality measures.
The Healthcare Innovation Steering Committee	The Connecticut SIM initiative's main advisory committee, chaired by the Lieutenant Governor.
Quality Measures (QM)	Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable and timely care. [3]

[3] **https://www.cms.gov/Medicare/Quality-initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/QualityMeasures/**

Section 5. Revision History

Identify document changes.

Version	Date	Name	Description
1.0	2/14/17		First Draft