Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
November 15, 2018	1:00PM – 3:00PM	Webinar

Council Members					
Allan Hackney, HITO (Co-Chair)	X	Mark Schaefer, SIM	X	Robert Blundo, AHCT	
Joseph Quaranta (Co-Chair)	X	Bruce Metz, UCHC CIO	X	Lisa Stump	
Joe Stanford, DSS	X	Ted Doolittle, OHA		Jake Star	X
Mary Kate Mason, DMHAS	X	Kathleen DeMatteo		Patrick Charmel	X
Cindy Butterfield, DCF		David Fusco		Alan Kaye, MD	X
Cheryl Cepelak, DOC		Nicolangelo Scibelli	X	Dina Berlyn	X
Vanessa Hinton, DPH	X	Patricia Checko	X	Prasad Srinivasan, MD	
Dennis C. Mitchell, DDS		Robert Tessier		Tekisha Everette	
Mark Raymond, CIO	X	Robert Rioux		Patrick Troy, MD	
Sandra Czunas, OSC	X	Jeanette DeJesus		Stacy Beck	X
Supporting Leadership					
Victoria Veltri, OHS		Alan Fontes, UConn AIMS	X	Michael Matthews, CedarBridge	X
Sarju Shah, OHS	X	Tom Agresta, MD, UConn Health	X	Chris Robinson, CedarBridge	X
Kelsey Lawlor, OHS		Kate Hayden, UConn Health	X	Tim Pletcher, Velatura	X
Jennifer Richmond, OHS	X	Carol Robinson, CedarBridge	X	Lauren Kosowski, Velatura	X
MJ Lamelin, OHS	X				
Open Appointments					
Representative of the Connecticut State Medical Society (President Pro Tempore of Senate)					
Speaker of the House of Representatives or designee					

Minutes

	Topic	Responsible Party	Time
1.	**Welcome and Call to Order**	**Allan Hackney**	**1:00 PM**
	Sarju Shah welcomed the Council and called the meeting to order. Sarju Shah provided an overview of the agenda and took roll call of Council members.		
2.	**Public Comment**	**Attendees**	**1:05 PM**
	There was no public comment.		
3.	**Review and Approval of October 18, 2018 Minutes**	**Council Members**	**1:10 PM**
	Quorum was not established, so the minutes from October 18, 2018 will be tabled until the next meeting.		
4.	**Updates**	**Commissioner Rod Bremby, DSS**	**1:15 PM**
	Allan Hackney, the Health Information Technology Officer (HITO), provided an update on the all-payer claims database (APCD). Allan wants to bring the advisors up-to-speed on some issues related to the APCD. As background, Allan stated that because of Public Act (PA) 18-91, the APCD Advisory Group has become a standing sub-committee under the Health IT Advisory Council, in addition to the Medication Reconciliation and Polypharmacy Work Group and it is important that the advisors stay aware of any issues that arise. The APCD Advisory Group met last week and discussed a number of issues. The next several slides will outline what was discussed.		

The first issue that was discussed was related to State Fiscal Year 2020 funding. With the APCD, it has been funded through allocations made four years ago into the insurance exchange, which is where the APCD is operated. When the Office of Health Strategy (OHS) was created and implemented, there was never budget for the APCD. The budget always existed in the insurance exchange. OHS aimed to develop an agreement with the insurance exchange to put the funds in a reserve to cover operating expenses for FY2018 and FY2019. This agreement was for $800,000 each of these two years. This is how the APCD has been operated within the insurance exchange by Rob Blundo. The looming issue is that the funding will run out on June 30, 2019.

Different funding approaches were discussed such as the HITECH Act federal funding, including the 90/10 match funding for planning, development, and implementation and the 75/25 match funding for ongoing operations. In each case, there is a number of conditions that need to be met, primarily around the role the APCD plays in the facilitation of Medicaid. OHS is also looking at the integration of the APCD with the Core Data and Analytics Solution (CDAS) through SIM funding. The $800,000 is comprised of two things: one is the contract with the third-party vendor, OnPoint Health Data, who manages the databases and the conversion of claims data, and the second is the time that Rob Blundo allocates to APCD activities. Is there an opportunity to further reduce the costs so that the July 1, 2019 hurdle is lower? The APCD Advisory Group felt it was appropriate to pursue all opportunities, however they feel the HITECH 90/10 funding is the best opportunity. There is plenty of precedent around the country for using HITECH funding for APCD functions.

Dr. Alan Kaye asked if we have turned to HITECH funding before. Allan Hackney explained that we have received HITECH funding through IAPDs – this is the same funding stream. Alan Kaye asked if this IAPD funding is different because it deals with ACPDs. Allan Hackney explained that this is the same funding stream, but we have not yet petitioned CMS on behalf of the APCD. The advisors have asked that we pursue this. Alan Kaye asked when does the IAPD funding run out and if this will be a parallel request. Allan Hackney explained that they can run in parallel. The typical 90/10 funding runs through 2021 and we can continue to propose new uses of this funding for another 31 months or so. Alan Kaye asked if we would ask for more money or if we would submit a new funding request. Allan Hackney said he would propose for new funds, specifically for the APCD issues. Alan Kaye then asked how this funding relates to the division of the funds with DSS and if this was IAPD funds. Allan Hackney said this was IAPD funds and this would be in addition to that. Alan Kaye then asked how much was received before and if this is an unlimited amount. Allan Hackney explained that the limiting factor is the state's ability to come up with the 10% match. The bond funding allocation that has been used for all requests so far has totaled $17 million in funding for HIE services. Allan Hackney has some additional bond funding left over which could be the basis for a match if we ask for more money for the ACPD. Alan Kaye then asked if this funding is automatic or if there is a limit. Allan Hackney explained that CMS is agreeable if you are proposing projects that are in-line with the HITECH act and you have enough state funding.

Mark Raymond stated that the 90/10 funding is for the development of new functionality and the 75/25 is for operational expenses. He asked if we are looking to pursue operating funding. Allan Hackney stated that if you do the 90/10 it needs to focus on creating functionality or services. One of the things that would make this a possibility is the fact that the APCD is still in development in some areas, such as the integration of Medicaid data. There are some things we could use 90/10 funding for along those lines. For activities that are purely operational, you would have to go down a different path. Mark Raymond asked that when the APCD previously had AccessHealth CT funding, did this come from the initial build or from the insurance industry funds. Allan Hackney said he believes that most of the funding came from an appropriation, which was allocated to the insurance exchange. The exchange has not used the insurance assessment for this purpose. Mark Raymond asked if there has been a discussion around using the industry funding. Allan Hackney said that the statute is clear that the APCD needs to be charging fees for data releases and other uses. The ideal situation is to have enough activity where the charges cover the operating expense. Allan said we are making

charges on data releases, but we are not at scale so the amount coming in is helpful, but it is not enough to cover the operating expense.

The second issue that the advisors spent time discussing is the policies and regulations that apply to the APCD. There is an issue that is painful to describe. As a quasi-public entity in Connecticut, the insurance exchange enacts policies by following their bylaws, which stipulate the policy adoption process with the board of directors. Using these processes, the board adopted two policies. One in 2013 which outlined the general policies and procedures, such as which employees can access the data for administrative functions and who is authorized to establish a contract with OnPoint Health. Another policy was issued in 2016 which outlined privacy policies, including data releases and the Data Release Committee. OHS has a memorandum of agreement (MoA) with the insurance exchange that allows OHS to be the administrator of the APCD. With the statute that gave rise to OHS, we needed the MoA to meet the statutory intent. As a result of these policies, OHS cannot access the APCD data for its own purposes. Any of the proposed OHS uses do not comport with the data release policy that has been enacted by the board of directors.

OHS has worked with the Office of the Attorney General (OAG) to explore a number of different ways that OHS might access the data in a meaningful way. OAG has stated that OHS must publish a regulation that supersedes the AccessHealth policies. Allan presented a chart of the Connecticut regulatory process to demonstrate that this will be a cumbersome and lengthy process. OHS will have to go through this process sooner or later, as the MoA expires at the end of June 2019.

What was proposed to the advisors was a page out of the Advisory Council playbook, which was to create a Design Group to review the existing policies, review policies from other states, review commentary from data release applicants, and develop the outline of a proposed regulation that could be reviewed by the ACPD Advisory Group. This process would be completed by the end of February 2019. The Advisory Group agreed with this proposal, but they recommended that we re-energize a privacy sub-committee that has been dormant for about three years, or longer. They felt this committee would be a good tool to work through the regulatory process. Allan thought this was a great suggestion and several of the original members still serve on the Advisory Group.

Mark Raymond said that his understanding of the regulations is that this is a way for state agencies to affect this. Mark asked if an alternative would be to look for statutory changes. Allan Hackney responded that the policies themselves are very specific, such as which employees can access data and what procedures need to be followed. These are very technical as well. Allan said he thinks that the translation of the policies that exist today into a regulation fits the model of regulations that he has observed, but there may be some statutory changes that would be helpful in enabling the regulations. Allan thinks it may be a combination of both approaches. Allan does not see a way around the regulatory process. Mark responded by saying he understand why the regulations process exists and why it is laborious. He appreciates the explanation and concurs that the privacy sub-committee is a good group to take on this role. Allan said he appreciates that comment and added that the one risk is that if you go through the regulatory process, you are putting all of this out for public comment. A lot of the issues are privacy-related. The insurance exchange board meets publicly, but this may shine a brighter light on some sensitive issues. Allan is preparing himself for some issues that arise around privacy implications that will need to be dealt with.

Mary Kate Mason said that she believes the regulatory process may take years. She said that if there is any other way around this, we should explore it. Allan said he agrees and that the Certificate of Need Program has been pursuing regulatory changes since the 1990s. The OAG has been explicit in their instructions and recommendations. If it starts looking like it will take forever, we may explore legislative changes.

The item that was discussed was what can be done in the meantime. We have a regulatory process that may take many months, or even years, and while this occurs all of the OHS data uses, such as related to hospital mergers and acquisitions, is curtailed. OHS will be pursuing a separate enclave, which is a term used by OnPoint Health Data. This is a securely partitioned, virtual work area to use the APCD data. We are pursuing the idea of a separate OHS contract with OnPoint. The actual contract is between OnPoint and the insurance exchange. The new contract will give OHS an enclave and a copy of the data. In order for this to work, OHS will need to use its sovereign immunity to indemnify the insurance exchange, which does not have immunity, to be able to access the data. OHS is pursuing this path and the advisors agrees with this approach. Subsequently, Allan had a conversation with the OnPoint CEO and there may be an opportunity to transfer the complete functions of the APCD over to OHS and this will be explored. We will do one or the other in order to free the data for OHS.

Next, Allan discussed the topic of specialized data releases. This has become an issue. There is a standard way for the data to be de-identified in accordance with HIPAA and Connecticut restrictions, and this works pretty well. Increasingly the data requesters want to have filtering done so that the data is focused on, for example, a particular service area that a hospital may be using for Certificate of Need purposes. Each time this happens, there has to be requirements, data analysis, and programming. We are running out of capacity. We proposed to the advisors that OHS repurpose a vacant IT analyst position into a data analyst and combine the APCD's needs with the Health System Planning Unit. In this case we are talking about someone with access to identifiable data and we need appropriate security and access controls. The key issue is the sharing of the resource. People depend on Rob Blundo, who has multiple roles to play within the insurance exchange, so the concept of providing more capacity is the proposal we were asking the advisors to comment on. There was a great deal of discussion on the fact that the APCD has been under resourced since day one, and they would like to take up the conversation about how more resources can be identified and utilized.

Allan then provided an update on the IAPD-U and the State Medicaid Health IT Plan (SMHP). Allan wanted to inform the advisors that DSS intends to submit a new IAPD request for Federal Fiscal Year (FFY) 2019 and FFY2020, which is focused on DSS' needs related to the federal match funding request. This introduces the first request for FFY2020. As a condition, under the most recent IAPD which was approved on September 4, 2018, DSS was required to submit an update to the SMHP. The current SMHP was written and submitted in 2016, and in light of the work that the Advisory Council and the other issues we are discussing, CMS wanted to see a full update to the SMHP. Allan is proposing putting some additional requests together so that the work of the Council is represented in DSS' upcoming IAPD submission, just as we had done previously.

The primary funding request is around technical assistance for organizations to connect to the HIE, which Allan expects to be operational early next year. We have looked at a number of different models from other states. Many states provide a form of technical assistance to healthcare organizations across the state to offset some of the costs and motivate them to connect to the HIE. Given the comments and feedback from the Council, it appears that the model from New Jersey that provides incentives for progress seems to be the most elegant for Connecticut's purposes. We are proposing that we bring forward a request for technical assistance modeled similarly to New Jersey's approach. This is being validated as we speak with state medical societies, the Connecticut Hospital Association, the Community Health Center Association, and some other groups in order to get their buy-in and support. This support has been quite favorable so far. The other thing that is being contemplated is for a Use Case Factory, which is a concept borrowed from Michigan. This will provide flexibility to perform feasibility and design studies, as well as pilot programs for use cases that have surfaced. Since the advisors have come forward with the top 10 use cases in Wave 1 and Wave 2, new energy has surfaced around other use cases, such as precision medicine, medication reconciliation, PDMP connection, consent, and eConsults. There is a lot of energy around these use cases and this would provide

	the flexibility to pivot and determine the needs and feasibility. These are the two predominant aspects of what we are proposing for inclusion in the IAPD. Allan stated that the December meeting will be very important for the Health IT Advisory Council. DSS, in collaboration with the HITO, will bring a new IAPD request in addition to what has already been approved. This will be brought to the Council for your review, approval, and affirmation. December will be a voting meeting for the Council. Allan paused and asked Joe Stanford if there is anything else he wanted to add to this discussion. Joe Stanford stated that everything that has been discussed reflects that was previously discussed. Dr. Alan Kaye said that the first bullet stated that DSS intends to submit an IAPD, then he asked if these efforts will be coordinated or if the Council submission is in addition. Allan Hackney said this submission will be completed together. There is a working committee with DSS that is working on this. The DSS portion will be a separate part of the document and the OHS and Council information will be included in Appendix D. The main body is related to DSS activities, by design. This is the way the format is structure in all states. There is a specific appendix for the HIE-related activities. Alan Kaye asked if there is a chance that just the appendix is denied, and the main body is accepted. Allan Hackney responded that anything is possible with CMS, however they typically if they have an issue with a request, they will do a line-item veto on just one or two items. Alan Kaye expressed concern with the structure and the fact that the Council activities are secondary because they are in an appendix. Allan Hackney said he does not have any concerns about this. The HITECH Act requires the Director of Medicaid to submit these proposals. These requests must go through the Medicaid agency. There has been no history of the funding request in the appendix being subordinate to any other part of the document; CMS treats it all as one. Alan Kaye said that in previous discussions, we heard that the feds were upset about having separate proposals and asked Allan if there is any concern that they will have the same reaction. Allan Hackney said this is possible, but we are working with DSS to find ways to harmonize the approaches in order to reduce this risk. What you will see in December is that DSS is going to pursue a Medicaid-only HIE, just as it was described by Commissioner Bremby and Dr. Tikoo at previous meetings. We are trying to harmonize this as best we can, but this will be what you see. Alan Kaye asked if we are institutionalizing the parallel approaches. Allan Hackney responded that for the funding request, he thinks we are asking for specific funds to serve these two purposes. Allan would not try to influence the Advisory Council to do anything but speak their mind when they see the proposal come forward. Allan said this answer was sort of a yes, and sort of a no. We are going to submit these proposals and Medicaid is making the case that they need these programs for the effective administration of Medicaid and I am doing everything I can to harmonize that, but the harmonization may not meet the expectations of the Advisory Council.		
6.	**State Innovation Model (SIM) Updates**	**Mark Schaefer, OHS**	**1:45 PM**
	Allan Hackney introduced Mark Schaefer who has been working on a number of programs, including the Primary Care Modernization (PCM) and Health Enhancement Communities (HEC), within the State Innovation Model (SIM). There are health IT implications with both of these programs, so it will be important that this group gets an overview of these implications. Mark Schaefer thanked the Council for having him here today and stated that he will be presenting with Deborah Zahn from HMA. Mark said that they are still early in exposing the health IT implications, both local and at the state-level, but we can begin to talk about the new initiatives. Mark began his presentation with historical comments. SIM began in 2014 and had the foremost objective of better aligned quality payment models. When SIM started, they decided to align around the work that had been done in this space by Medicare and in the commercial health plan community, where the Medicare		

Shared Services Program (MSSP) model, or the ACO model, emerged in 2012 and quickly results in commercial payers developing similar programs based on two components of the ACO model: measuring quality based on a scorecard of measures and the opportunity to earn savings based on a reduction in waste. The quality scorecard performance serves as a gate for how much savings can be earned. Technology has been a big part of what ACOs have invested in to be successful. EHRs are the foundational investment, as well as analytics overlays. Predictive modeling and health risk stratification is also occurring. There are a lot of different ways that technology is supporting ACO performance. It has been inhibited by the lack of interoperability. The adoption of the ACO model is widespread – 85% of the primary care community, estimated, is in an ACO arrangement and that includes about 10-15 organizations. More than half of the organizations are hospital-anchored. SIM focused on bringing the Medicaid population (20% of the overall state population) into these arrangements and DSS has developed the PCMH+ shared savings program that extends the savings to additional organizations and providers. More than half of the FQHCs are now participating. Statewide, there is more than 1,000,000 beneficiaries (all payer) involved under shared savings arrangements. In addition, commercial payers are 60% aligned on the Core Quality Measure Set, and 125 practices achieved PCMH recognition through SIM. SIM is helping ACOs to contract with community organizations that can help to solve for additional problems.

Mark said that in taking stock of achievements, the task force that launched some care delivery reform initiatives engaged in a discussion of what the program has been achieving thus far. Consumers, providers, and health plans were interviewed and determined that primary care remains largely untransformed. IN addition, in Connecticut with the ACO mode, there have not been deep investments in primary care (5% of the premium dollar is spent on primary care). In primary care, you see a lot of activities around closing gaps in care and care coordination, but you don't see diverse care teams and the integration of other service lines, such as behavioral health. In looking around the Country, there are other models that have taken bundled payment for primary care and flexibly deployed it in order to build team-based care models. There have also been limited investments in preventing avoidable illness and injury in Connecticut. There is less attention spent on pre-diabetic patients, despite the fact that one in every five dollars are being spent on patients with diabetes. There is a reason for this – value-based payment models that prevail today and fee-for-service do not reward investments in primary care of prevention. The two design initiatives are predicated on addressing these limitations.

Mark said that we have an opportunity as a SIM state to invite Medicare into a multi-payer demonstration where we would write a prescription for care delivery and payment reform for a five or ten-year period. Unlike the Medicare offerings that have come out to date, Connecticut would establish the playbook and set the timetable for change. We would invite Medicare to come into a custom Medicare payment reform, as well as other payers. We would be asking them for to pay for primary care differently in a way that enables the person-centered goals we have for primary care and to create an innovative community-driven model of prevention that goes beyond the healthcare sector.

Mark presented a slide that illustrated the aligned and complementary reforms. The community is drawn in the center of the diagram. The ACO model is on the left-hand side and the HEC is on the right-hand side. HEC is focused on multi-sector investments that reward community partners that contribute to prevention outcomes for community members.

Mark then presented information on PCM. There was a report released in January and finalized in June in which the task force identified five goals for primary care and twelve recommendations. Among them is the recommendation that we should expand and diversify the care teams across the state, we should expand patient care outside of traditional office visits, we should double investment in primary care over five years through more flexible payments, and we should reduce the trend in total cost of care. The foundational

assumptions are that eligibility would be limited to practices in Advanced Networks / ACOs/ FQHCs, this is multi-payer, the existing MSSP or other shared savings arrangements would remain in place, and it would rely on hybrid, partial, or full bundles for primary care services.

Mark explained that an extensive stakeholder engagement process has been deployed, including primary care practitioners, ACOs and Advance Networks, FQHCs, an employer advisory group, individual payers, the commercial payers. They have begun meetings with hospitals and health systems, which is one of the areas where the avoidable use would come from. They are working with the Consumer Advisory Board to do consumer engagement and input and to facilitate consumer participation in all design groups. They have a Practice Transformation Task Force which has spawned design groups in many areas of potential advancement. There is a separate Payment Reform Council. This work is well underway, and the design groups have provisionally recommended the capabilities. This work will not be completed until mid-January, when draft capabilities will be presented to the advisors.

The current capabilities under consideration include eConsult, integrated care teams, phone and text support, remote patient monitoring, behavioral health integration, and a concept called Practice Specialization (geared towards complex and specialized populations, such as geriatrics). The people who do specialized primary care say it is important to customize a practice so that it is attuned to the needs of the populations it is serving.

Mark discussed the payment reform model options that are under consideration. The Payment Reform Council is recommending that there be a basic bundle, which will take office visit revenue and convert it to an up-front payment either quarterly or monthly, and supplement this with a bundle that will pay for the additional costs of new care team members and other investments, and that the costs of vaccinations and other services would remain as fee-for-service.

Mark presented the PCM high-level timeline. They are trying to achieve the first phase of design work by January or February 2019. They will invite other payers to align with this model and undertake their own planning processes that will be aligned with whatever deal they negotiate with Medicare.

Mark then presented a slide on the role of health IT in PCM. There is a variety of ways that information exchange across settings and networks could be useful, such as expanded use of diverse care teams, home visits, telemedicine, eConsults, remote patient monitoring, behavioral health integration, and community integration. Solving for the exchange of information across networks and care sites, but also with non-affiliated sub-specialty partners, hospitals, and non-healthcare community organizations. These exchange solutions would be enabling of the overall efforts. In addition, the ability to monitor ongoing service utilization. We have an interest in ensuring that when the care is bundled, there is flexibility that is used in the service of patient care. Also, it will be important to facilitate an expanded set of eCQMs that will be available to the entities that are participating.

Bruce Metz thanked Mark for his comprehensive presentation and asked when Mark went through his timeline, what would be implemented during the implementation period. Mark Schaefer responded that a fair bit will involve creating the operations to support the administration of different payment models, including an attribution-based PMPM payment for the basic and supplemental bundles. Payers will need time to engineer this. The other item is that the pre-implementation period would involve setting up a technical assistance strategy; a means by which networks could avail themselves of expertise that will enable them to undertake the change. With the current program, they have found that just paying for community health workers (CHWs) does not equate to the meaningful and cost-effective use of CHWs in a way that comports itself to an evidence-based model. It does not address the clinical workflow and re-engineering that needs to be done and the consideration if they are deployed in an effective manner. We have found that ACOs

appreciate the ability to get connected to a technical assistance infrastructure that enables them to do this effectively. The same could be said to integrating eConsults into a practice. There is a whole lot of thought that needs to be given in how this is staged.

Dr. Bruce Metz asked what is the service, or work product, or expertise that will be offered to the various stakeholders. Mark responded that the design groups are focused on describing what the capability is, such as eConsults and the ability to identify patients with the need for a face-to-face visit with a specialist. The design groups are not actually describing the use case, nor are they charged with introducing the three or four platforms that may enable the implementation or the configuration of an existing platform. This is work that will need to involved Allan's team. Some of this work is internal and we will just be providing technical assistance. Bruce Metz said that he would assume that in Connecticut, most PCPs are in a large group practice, or are part of a hospital or health system, and a small percentage are independent. All of the larger entities will have active programs around the technologies and you need to figure out how you will interact, especially with the larger groups. There is an intermediary piece here for how you take what you are describing and then gear it towards the ecosystem that most PCPs are a part of currently and spell this out. Some organizations don't need this level of assistance, so it is defining how we will interact. It is not clear to me how this gets filtered down into something operational. Mark responded that they have found that most ACOs already have an enterprise-wide information technology strategy and they have their own consultants for how they configure changes within their local ecosystem. We may look for ways to help fund what is needed in terms of internal development work, or some of this work could be rolled into supplemental payments. This temporary funding stream could be deployed in a way that fits the gaps as you see them as related to the capabilities. We cannot tell you what the gaps are, or the best ways to address them. In other areas, such as facilitating community integration and linkages, most systems don't have a way to effectively manage and track referrals.

Pat Checko asked Mark about the monitoring and eCQM components. She believes this is already ongoing through the work of Tom Agresta and Alan Fontes through CDAS, and there are people who are willing to participate. Mark responded that the work by Tom Agresta and others from Allan's team with ACOs in Connecticut is laying the foundation for OSC to be an active driver of this pilot. PCM does not represent a significant change in the strategy because we are not proposing a separate set of quality measures for primary care, it just makes the measures all the more important, as they will become the main source of provider performance data. Pat asked as this develops, will it be part of the population database that we are trying to build that can utilize social determinants and other important data to evaluate how well we are doing. Mark said yes, absolutely.

Mark said that neither the PCM or HEC have been endorsed by the administration, so they are outlining options for the administration's consideration. Next, Mark introduced Deb Zahn who will present information related to the HEC program. This is intended to be the complement to the PCM reform in the sense that this is about focusing on improving community health and prevention. Deb described some of the proposed features of HEC. We are in the process of developing a framework that looks at what we want to accomplish overall, and the parameters that will be essential components. There is still a lot of work to be done to determine what will need to happen at the community level. HECs are focused on improving community health and preventing poor health outcomes across many sectors, instead of clinical outcomes, by focusing on social determinants of health and other root causes of poor health. These HECs would be multi-sector collaboratives, such as housing, social services, food security, and more. These would operate within a defined geographic area, which have not yet been determined. They would be working on three main things – improving child well-being (pre-birth through age 8) focused on adverse childhood experiences, improving healthy weight and physical fitness for all Connecticut residents, and increasing health equity. The idea is to have the various sectors coming together to implement interrelated strategies to address the root causes of

poor health. The SIM project is focused on creating an economic environment that would make HECs sustainable, such as through the multi-payer demonstration.

Deb explained that HECs would have additional develop and design work in 2019, and that HECs will launch after that. They could select additional priorities, but the intent is to have a statewide focus and move the needle at the statewide level.

Deb explained the health IT implications of HEC, as currently proposed. There are two levels – first, is at a community level, HECs will need to be able to conduct analytic activities that will allow them to design and deploy effective interventions, and second is that a robust IT and data infrastructure is critical for HECs to achieve their goals and collect and report on provisional statewide measures. The measures have not yet been selected. After the framework is released, we will need to determine what these measures will need to be at a state-level. Several things will need to happen amongst HECS. They will need to utilize the IT and data infrastructure to both extract and receive feeds of data from various sources, including clinical sources to which partners within HEC may not have previously had access. To accelerate the process of developing an infrastructure that will best support the HECs, the HEC initiative can leverage the Core Data and Analytics Solution (CDAS) currently in development by OHS, with analytics resources at the UConn AIMs group. This will be clearly outlined in the framework.

Deb explained CDAS and said this is a good fit for the HECs, as it will get at person-centered analytics and will be available to a wide variety of stakeholders. CDAS will acquire and create a sizable foundation of state's health data, such as APCD, clinical data, medical and pharmacy claims data, and social determinants of health. The data within the CDAS will be used to create advanced innovative analytics to provide information and insight to guide and support interventions. HECs will use CDAS proactively to help them make decisions on the interventions. We imagine CDAS will be used for the advanced analytics that will need to quantify what is happening at a state level. This is critical in the ability to participate in the multi-payer demonstration. There are a number of things that stakeholders liked about CDAS, such as efficiency in development, flexibility in data elements, and that it can accept data in multiple formats. CDAS will also be able to allow for the segmentation of reports so that stakeholders can get down to more nuanced information. An example that we heard is that HECs would utilize CDAS to access baseline data to identify hot spots of need within the local geography to better target interventions, upload HEC intervention outputs to meet reporting requirements and track activities, and monitor local HEC progress toward statewide prevention benchmarks.

Nic Scibelli asked if there are any plans to incorporate data from other state agencies into CDAS. Deb did not know the answer to this question. Her understanding is that it could, but she defers to Allan. Allan Hackney said there is not a specific plan to incorporate data from those sources, but he would be happy to discuss this.

Pat Checko said that she knows they are focused very heavily on the social determinant information, and she knows that all of the players that have the pilot are very thankful for CDAS. She has recently been approached about concerns regarding a competing activity from the Hospital Association regarding social determinants of health. Allan Hackney thanked Pat for bringing this up. He said they are aware of this initiative and that Sarju will be a member of the committee. We are monitoring and working collaboratively.

Dr. Alan Kaye said that these presentations were thorough and eye opening and aggressive in terms of the goals. He thinks this is wonderful. This helps the Council have these environmental considerations. The HIE components are kind of like the APCD – we need an APCD to get the claims data. The HIE is more focused on this but it is a way to have better healthcare for the patient regardless of the paradigm. You can't have a good healthcare system unless all providers have the necessary information from previous encounters. These are tremendous aspirations, but I hope we won't lose our vision to allow for the exchange of information for the

	immediate, clinical care of our patient. We are developing lots of modules that will be applied to the HIE, SIM, and other areas, but I am concerned we will lose focus on what I see as the main mandate of the public act, which is to make sure providers and patients can exchange information. Allan Hackney thanked Alan Kaye for his comment and assured the Council that he is laser focused on ensuring that the data starts moving and sharing in a more efficient and robust fashion. This is the primary mission. Everything you have heard today is in parallel with this. Alan Kaye said the first presentation said we need to align primary care doctors, but nobody is currently aligned, and this is a monumental task to change all physicians, hospitals, and payers. If we focus on the big picture, we will miss opportunities to improve patient care. Dr. Bruce Metz wanted to reinforce what Allan said and thanked Allan for the current work going on for the HIE, which is quite impressive. If we think about reform in Connecticut, we are in line with two legs of the stool – strengthening primary care and HECs. A third leg, which has a bigger needle and a bigger return, is the better management of chronic conditions. This is where most healthcare spending goes. Bruce asked if Mark and Allan have considered what would be involved in a similar type effort in this area. Mark Schaefer responded that the cost-effective management of chronic disease is central to the PCM efforts which is to have a team of folks that are available. Right now, we have a lot of people with diabetes who have a couple of provider visits per year, and we cross our fingers between visits. The idea of patient navigators and health management is central to the PCM efforts and the idea of a diverse care team. The management of chronic conditions is probably one of the central components of pediatrics. Some of what is being worked on here around information exchange and reducing waste ought to be rewarded in the current value-based payment model. The real money, and the long game, is not in better management of diabetes, it is in trying to get ahead of diabetes and get ahead of the curve. If we could bend the curve ever so slightly in the overweight obesity trend in the older population, it would equate to between $1 billion and $3 billion in savings that could come back to sustain these investments. Changing lifestyle and behavior is difficult, but not impossible if you use a range of levers. When I think of the things that will sustain a more comprehensive state-enabled health IT enterprise, I think of cutting a deal with Medicare and Medicaid, and some self-funded employers, around the ability to bend this curve. Mark thanked everyone for their interest and would love to come back as they get further along in their work.		
8.	**Wrap up and Meeting Adjournment**	**Allan Hackney**	**2:45 PM**
	Allan asked for a motion to adjourn the meeting. Pat Checko created the motion to adjourn and the meeting was adjourned. The next meeting is on December 20, 2018.		

Upcoming Meeting Schedule: 2018 Dates – December 20th
Meeting information is located at: https://portal.ct.gov/OHS/Services/Health-Information-Technology