Health IT Advisory Council

March 18, 2021

Agenda

Agenda Item	Time
Welcome and Call to Order	1:00 PM
Public Comment	1:05 PM
Review and Approval of Minutes: February 18, 2021	1:10 PM
Connie Update	1:15 PM
All-Payer Claims Database (APCD) Update	1:30 PM
Five-Year Statewide HealthIT Plan Update	1:45 PM
Presentation and Discussion: Statewide Identity Services for Healthcare and Social Services	2:00 PM
Wrap up and Meeting Adjournment	2:55 PM

Welcome and Call to Order

Public Comment

(2 minutes per commenter)

Review and Approval of:

February 18, 2021 Meeting Minutes

Connie Update

Jenn Searls
Executive Director, Connie

Updates

- Board of Directors Update
  - Stacia Gross, VP Digital Strategy & Operations, Anthem
  - Office of Policy Management appointment
- Payer Forum
- Covid Immunization Reporting Use Case
- Connie Technology Demo – April HITAC Meeting

Health Systems

Yale NewHaven Health

Hartford HealthCare

IPAs/CINs

SOHO HEALTH

CMG COMMUNITY MEDICAL GROUP

Medicaid ASOs

Community Health Network of Connecticut, Inc.

beacon health options

Other

Community Health Center Association of Connecticut

signifyhealth

FQHCs

- First Choice Health Center
- Southwest Community Health Ctr
- Wheeler Clinic

DMHAS Facilities

- Capitol Region Mental Health Center
- Connecticut Mental Health Center
- River Valley Services
- Southeastern Mental Health Authority
- Southwest CT Mental Health System
- Western CT Mental Health Network

BH Providers

- Advanced Behavioral Health
- BHCare
- Bridges Healthcare
- Community Health Resources
- Community Mental Health Affiliates
- Sound Community Services
- United Services
- Wellmore Behavioral Health

HIE

CT HealthLink Connecting for Better Care

Medical Practices

- Candlewood Valley Pediatrics
- Litchfield County Pediatrics
- Pediatric Care Center
- Pediatric Partners
- Pioneer Valley Pediatrics
- Rocky Hill Pediatrics

ProHealth PHYSICIANS

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All-Payer Claims Database Advisory Group Update

Olga Armah
APCD Co-Chair, OHS

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All Payer Claims Database (APCD) Advisory Group

Committee Structure:

20-member committee created by P.A. 12-166 and codified in C.G.S. §19a-755a

- Chaired by the Health Information Technology Officer (HITO) or designee

Mandated members are:

- Commissioners or designees - OPM, Comptroller's, DSS, DPH,DHMAS, DOI, Health Advocate, Chief Information Officer
- Representatives - State medical society, insurance companies (3), insurance purchaser, hospitals, Data Release Committee and a health care provider
- Additional members recommended by the HITO (4) -
  1. Two health care expert from an academic institution
  2. An expert in payment reform
  3. A representative of OHS

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APCD Advisory Group

OHS consults the Advisory Group when:

1. Contracting for, planning, implementing and administering the APCD
2. Obtaining claims data from the State's medical assistance program and Medicare Part A or B
3. Any action to obtain Medicaid and CHIP data
4. Contracting for the collection, management or analysis of data from reporting entities

Purpose of the APCD

1. To provide health services consumers in the state information on the cost and quality of health care services to aid health care related decision-making
2. To be made available to any state agency, insurer, employer, health care provider, consumer, researcher or Access Health CT to review healthcare services utilization, costs and quality while protecting patient privacy

Meetings

Quarterly and public

APCD Advisory Group - Sub Committees

- **Data Privacy & Security Committee**
  1. Conducted a review and analysis of data security, privacy, and data release policies and procedures.
  2. Met for fixed duration in 2019
- **Data Release Committee**
  1. Deliberates on data releases external to OHS
  2. Membership
     1. Advisory Group member and rep of state agency,
     2. APCD data manager,
     3. public health specialist,
     4. health insurance industry,
     5. attorney specialized in health care, privacy and research,
     6. healthcare professional,
     7. hospital administrator with a background in analytics and research,
     8. health researcher,
     9. two consumer representatives with background in health policy, patient advocacy and/or patient safety
  3. Meets – Monthly, 2nd Tuesday of each month, or as needed

APCD Data Types & Years Available

The APCD comprises **medical, pharmacy,** ~~**dental**~~ and ~~**other insurance**~~ claims information from enrollment and eligibility files

Payer Source	Claim Type	Years Available
Commercial* - Fully insured claims - State employees & Retirees - Medicare Advantage (Medical only)	Medical claims Pharmacy claims	1/1/2012 – 9/30/2020
Medicaid	Medical claims Pharmacy claims	1/1/2012 – 9/30/2020
Medicare	Medical claims Pharmacy claims	1/1/2012- 12/31/2019 1/1/2012 – 12/31/2018

*Anthem, Aetna, Cigna East, Cigna West, ConnectiCare, United Healthcare, HealthyCT, Harvard Pilgrim, Optum Health, Oxford, WellCare Health, eviCORE Healthcare, Express Scripts, Caremark

Reporting threshold – 3,000 members

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Examples of APCD Use Cases

DRC Approved Data Extracts & Aggregate

1. Brown University – Using big data to determine Pre-exposure Prophylaxis (PrEP) uptake and persistence in Southern New England
2. Yale University study - Population health total cost of care and care continuity enhancement
3. Yale University – Study on HIV
4. Archway Health Advisors -Identifying best performing providers for developing an episode payment market in Connecticut
5. UConn School of Medicine – Opioid prescribing and its consequences
6. UConn School of Medicine – Episode payment market in CT
7. Comptroller's/Segal Group – Evaluate health care options for small employer groups

OHS & State Initiated Projects

1. Online Cost Estimator
2. Online Scorecard (Quality)

3. Outpatient RX Drugs Transparency Mandate
4. **Rand 3.0 Employer initiated study***
5. **NESCSO Primary care investment project***
6. Cost Growth Benchmark
7. Facility fee legislation on Evaluation & Management vs. Assessment & Management codes
8. Service pricing and availability for Certificate of Need decision making
9. Impact of COVID on adult immunizations
10. Identifying COVID at risk populations and towns of residence to support policy

*** Summary results shared in next slides**

CT APCD Funding Capacity

- CT APCD transferred from Access Health CT to OHS without additional funding
- Analytic resource availability has been challenging
- Funding opportunity
  - Through the Cares Act, there is a federal grant of $2.5m over three years for states to establish or enhance their APCD
  - The opportunity includes ability for states to apply for the non-competitive grant as a region.

Caveat: Development of a common application among regional states for data requestors

  - There will also be ***voluntary*** submission of self-insured data using a single yet to be developed standard format
  - New England states are exploring the possibility of a joint application
  - The funding is under the purview of HHS which has been charged to set up an Advisory group to develop the grant application process
  - The Advisory group is expected to begin work in March and application process to begin in October

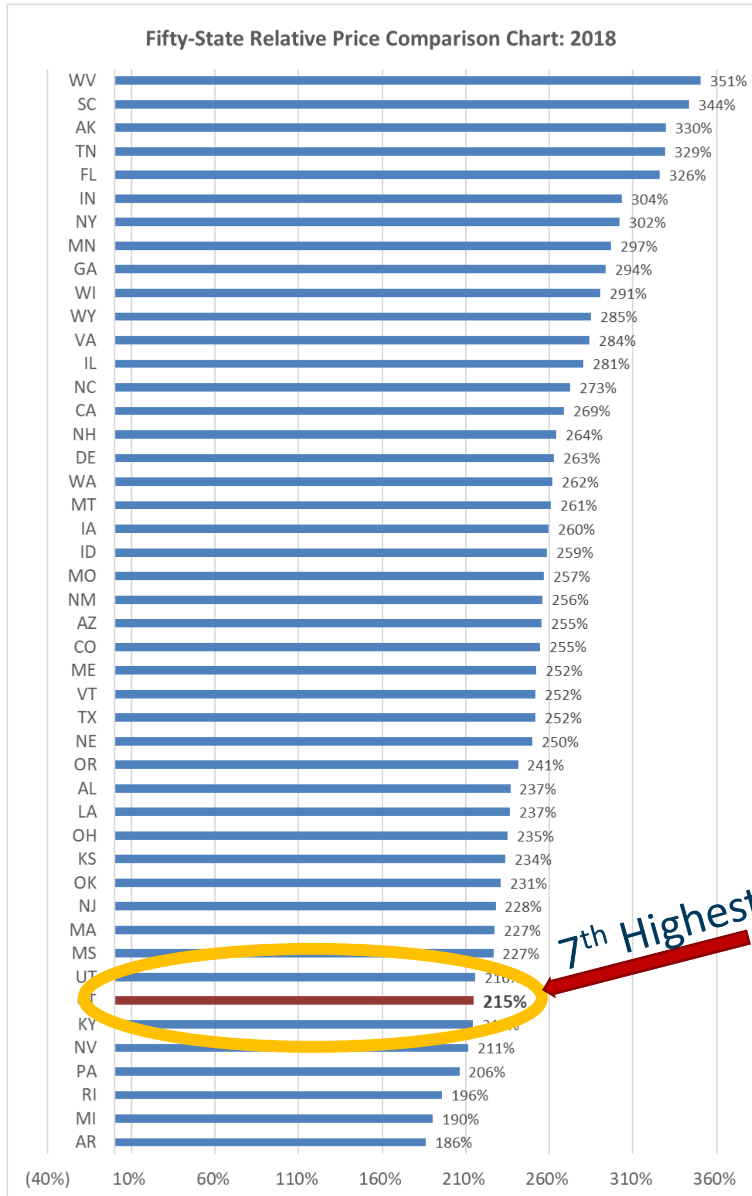
Rand 3.0 Employer Hospital Price Transparency Project

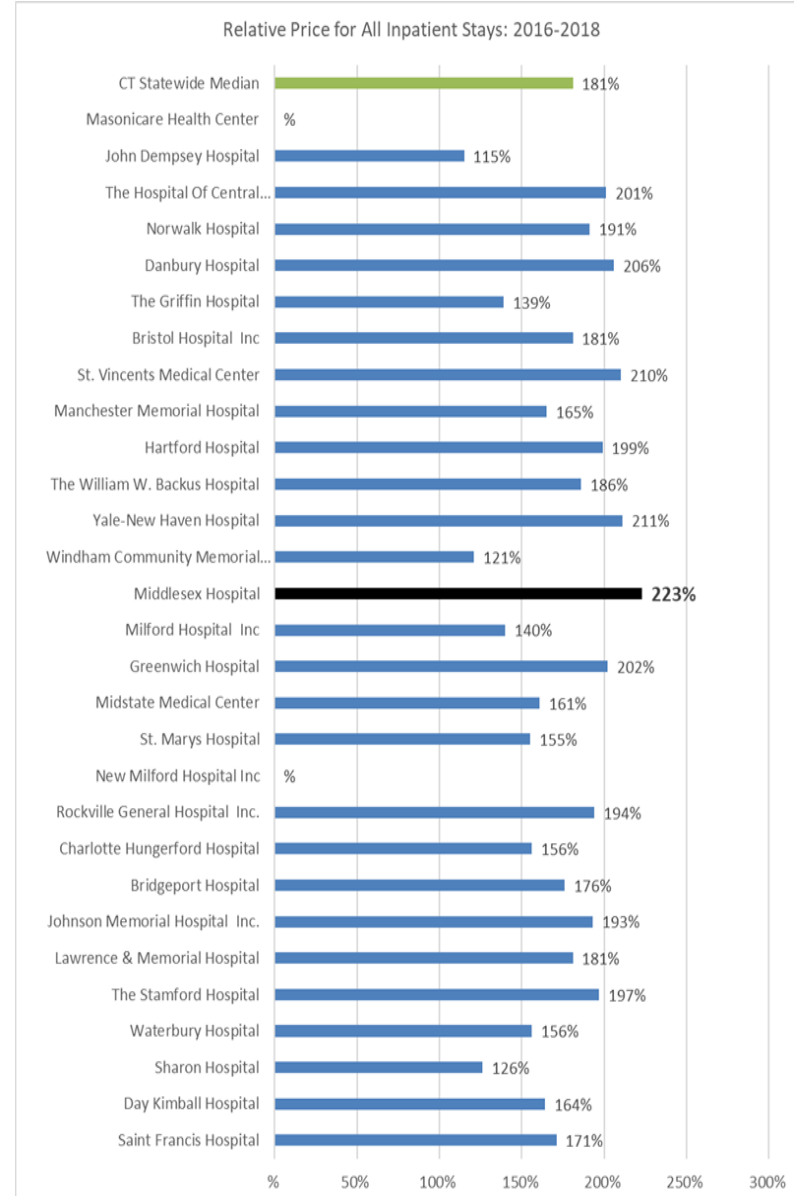
- The hospital price transparency study is the third in an ongoing employer-led initiative to measure and publicly report prices paid for hospital care at hospital- and service-line level
  1. to enable employers to be better-informed shoppers for health plans and provider networks;
  2. to hold hospitals, hospital systems, and health plans accountable for the prices they have negotiated;
  3. to report hospital prices relative to a Medicare benchmark.

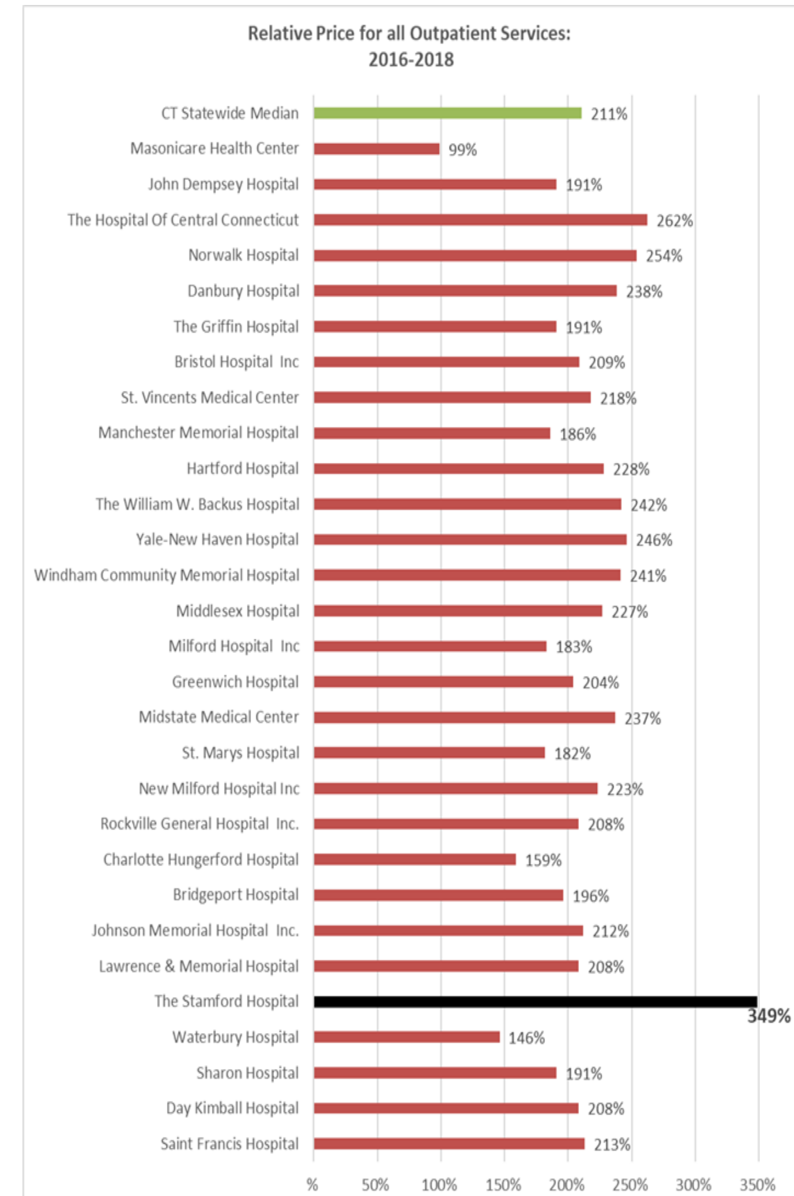
- The Rand Corporation utilized CT's APCD data to prepare a state specific price report which includes summary price measures for CT hospital inpatient, outpatient ED, medical imaging and outpatient surgery

  - The data includes both professional and facility claims for CT hospital providers.

Commercial vs. Medicare Prices for Hospital Services in CT







Source: *RAND Research Report RR-4394-RWJ,"National Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative*

NESCSO Primary Care Investment Project (PCIP)

Primary care:

- No national standard definition and no APCD data field or value in data field to define primary care
- Existing studies vary in definitions (Milbank-Bailit, CO, MA, ME, OR, VT, WA, NESCSO-proposed); payers within states vary (ME study)
- Some studies lack sufficient information (e.g., taxonomy codes) to replicate with APCD data

New England member states (CT, MA, NH, RI, ME) of NESCSO agreed to the PCIP:

- Define and report primary care expenditures as a percentage of total healthcare expenditures by payer with 2017 and 2018 claims data
  - Form the basis for increasing spend to 10% of expenditure as required by EO#5
  - Enable comparability among states and payers
  - Standardize methodology among the state based on provider taxonomy codes and CPT/HCPCS codes
  - Enable ongoing analysis
  - To support state policies on primary care

PCIP timeline:

- Project duration – April – September
  - Data collection and validation – June – August
  - Combined states report – August - September

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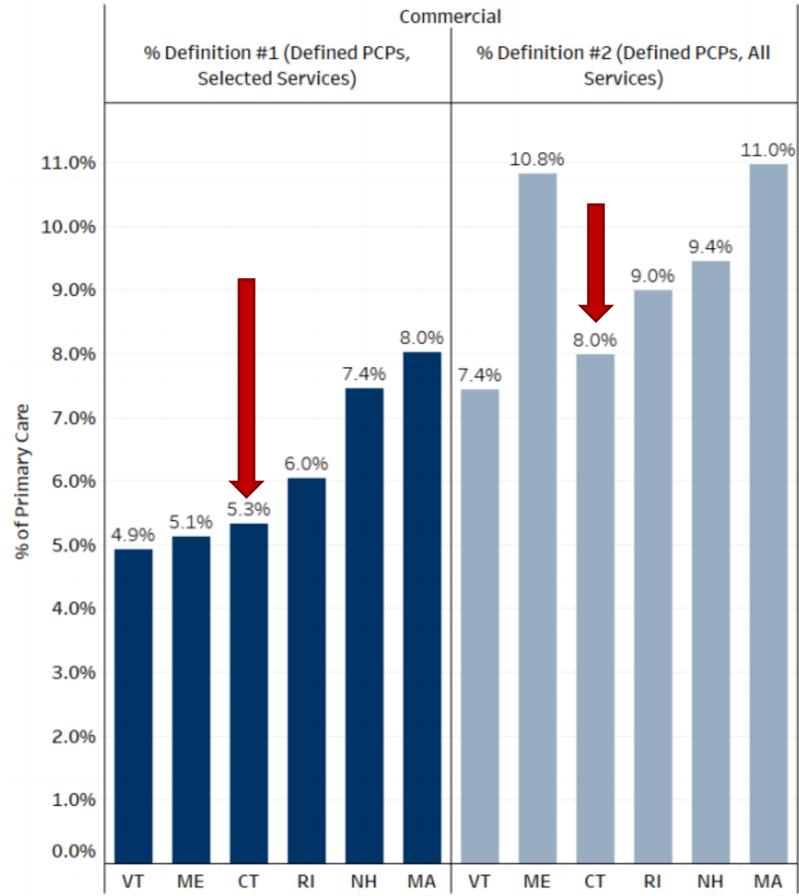
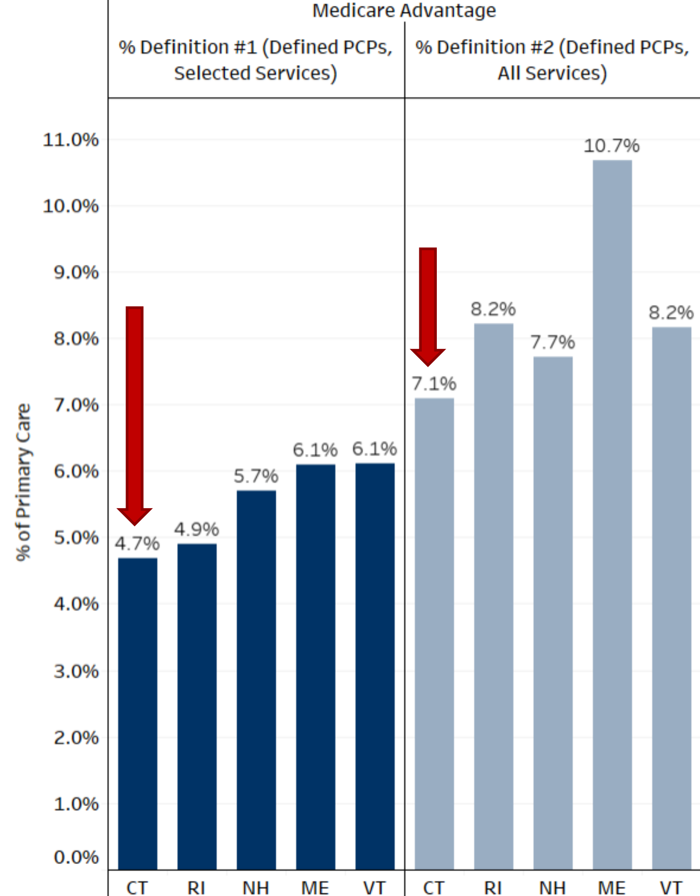
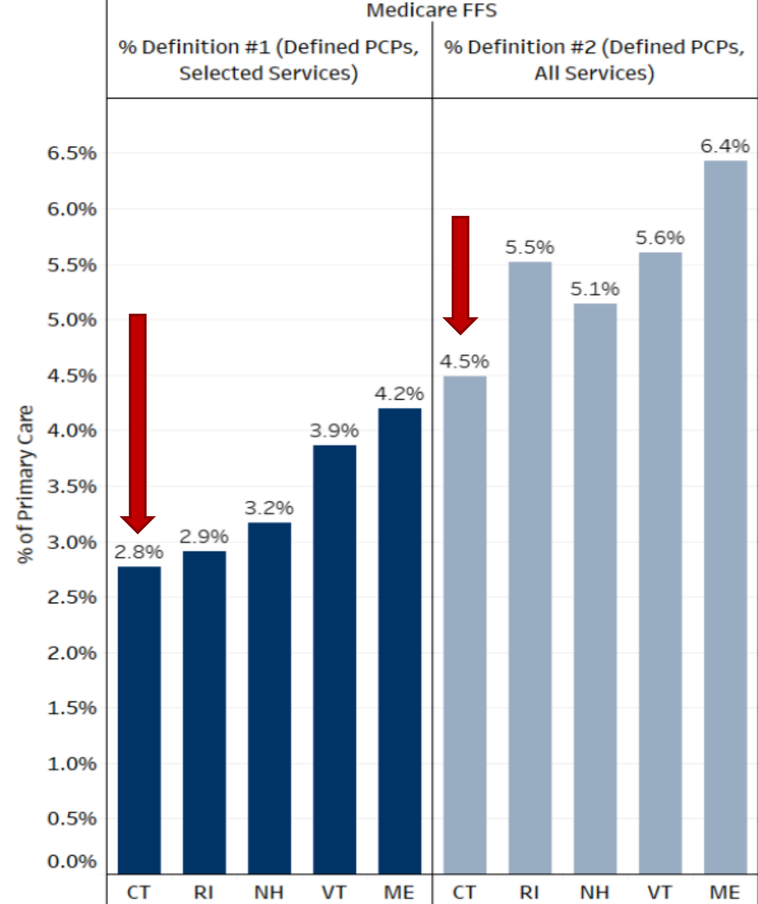
NESCSO Primary Care Investment Project Results







Source: New England States Consortium Systems Organization. December 2020. *The New England States' All-Payer Report on Primary Care Payments.*

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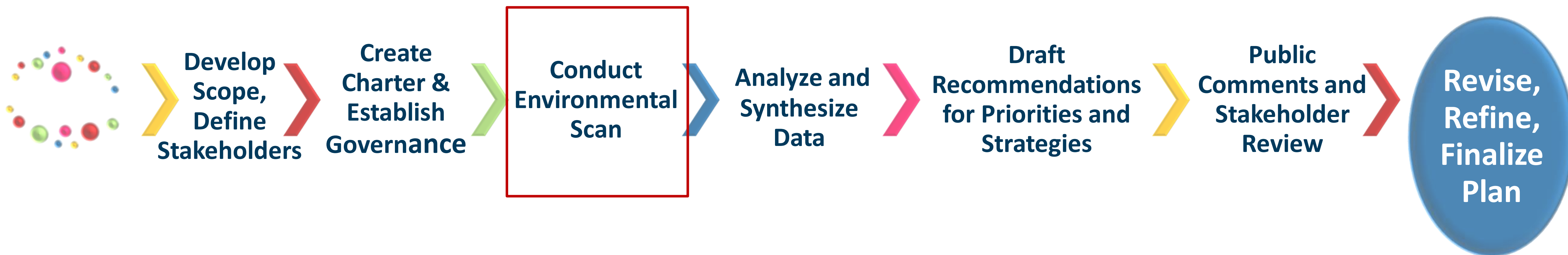
Monthly Update

Environmental Scan Activities for the Five-Year Statewide HealthIT Plan

Vatsala Pathy, Senior Director
CedarBridge Group

Process and Timeline for Health IT Plan



November 2020

Monthly HITAC Updates

December 2021

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Environmental Scan Process

Interactive Engagement Webinars: Listen, Share, Learn, Collaborate
Register at: http://bit.ly/ct_hit_plan

Topics
Behavioral Health & Everyone Else *Sharing Sensitive Data Without Compromising Privacy*
Integrating Social Needs Data *Knowing the Person Really Matters when Delivering Person-Centered Care*
Prepare, Care, Protect, Measure, and Monitor *Technology and Data Needs for a Strong Public Health System*
Warm Handoffs, Better Care, Lower Costs *Timely Information Moving Between Long Term & Post-Acute Care, Emergency Medical Services, Hospitals & Health Systems, and Primary Care*
Connect the Dots to Improve the Outcomes *Eliminating Barriers to Protect and Care for Connecticut's Children in Need*
Prioritizing and Governing Investments *Should Secure, Person- Centered, Health IT/ HIE Services be Considered a Common Need of All Connecticut Residents (i.e., public utility services for improving health)?*

Electronic Surveys
March – April 2021

- Public health
- Ambulatory providers
- Long term and post-acute care
- Behavioral health
- Emergency medical services
- Social services
- Payors

Key Informant Interviews & Focus Groups
February – April 2021

General Assembly members; state agency leaders; HITAC members; members of other agency workgroups and committees; associations; labs; imaging centers; pharmacies; health plans; hospitals; local public health officials; health advocacy groups; business groups; community organizations; academic institutions; and others, when relevant.

Virtual Forums Completed To Date

Topics	Early Key Themes
Behavioral Health & Everyone Else *Sharing Sensitive Data Without Compromising Privacy*	✓ Most attendees felt patient health data is adequately protected in the current state. ✓ Better coordination with physical health providers and full client records at the point of care were identified as top priorities. ✓ Attendees support improved coordination and alignment across organizations as it relates to information sharing regulations in order to enable the flow of behavioral health data.
Integrating Social Needs Data *Knowing the Person Really Matters when Delivering Person-Centered Care*	✓ Entities have disparate data systems for intake, screening, and referral. If new systems are procured, there needs to be a clear ROI in order to minimize the burdens on front line staff. ✓ Social services organizations lag behind healthcare providers in terms of investments in technology and data analysis. The need for financial resources and workforce are significant and will be necessary in a sustained manner. ✓ Clients are not consistently screened for social risk factors and social risk data is not standardized, limiting the efficacy of population health interventions. ✓ There is growing utilization of closed loop referral systems in hospitals across the state. These investments should be leveraged by the state.

Virtual Forums Completed To Date

Topics	Early Key Themes
Connect the Dots to Improve the Outcomes *Eliminating Barriers to Protect and Care for Connecticut's Children in Need*	✓ Providers lack insight into follow-up care and services in systems outside of their own. ✓ There are a number of innovative efforts (e.g., Integrated Care for Kids, 500 Familiar Faces) to support data and technology for children in need. Creating useable dashboards that integrate data across initiatives and providers in a synergistic manner would be very helpful. ✓ Data sharing between healthcare providers and community organizations and investments in population health analytics and dashboards were identified as top priorities.
Prepare, Care, Protect, Measure, and Monitor *Technology and Data Needs for a Strong Public Health System*	✓ A majority of attendees ranked the state's use of data to support the response to COVID-19 as insufficient. ✓ Attendees supported interfaces between existing EHR systems in order to obtain better population health data analytics. ✓ Improved interoperability of state public health systems with local health districts and providers; investments in population health research and analytics; and systems and data to improve the speed of response to public health crises and emergencies were identified as the top priorities.

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Electronic Surveys

Electronic Surveys March – April 2021
• Twenty-minute surveys consisting of approximately 35 questions are in the final stages of completion • Ambulatory provider survey will be fielded in conjunction with DSS and its contractor, Myers & Stauffer • In conjunction with state agencies and associations, CedarBridge will field additional surveys: ❑ Public health survey ❑ Long term and post-acute care ❑ Behavioral health ❑ Emergency medical services ❑ Social services ❑ Payers Please help us disseminate the surveys to appropriate organizations! Contact us at: Vatsala.pathy@cedarbridgegroup.com for survey links.

Remainder of 2021 HITAC Meeting Schedule

Subject to Change

Month	Standing Agenda	5-Year Statewide Health IT Plan	*Program and Workgroup Updates/Reports*	*Informational Presentations*
March	Connie Report	Engagement Progress Report	All Payer Claims Database (APCD) Update	Shared data services for identity resolution and attribution
April	Connie Report	Initial Insights from Stakeholder Engagement	CRISP and CDAS overview/demo	Race, Ethnicity, and Language Data Collection
May	Connie Report	**Environmental Scan Findings** (Report & Discussion)		
June	Connie Report	**Draft Recommendations for Health IT Plan Action Steps** (Report & Discussion)	Support Act / PDMP Activities Update	Public Health Systems Modernization: Dealing with the Present; Preparing for the Future
July	Connie Report	**Stakeholder Feedback** on Draft Recommendations for HealthIT Plan Strategies & Action Steps (Brief Update)	OHS: Connie Operational APD	Investing in Insights: Comparison Study on State Health Analytic Programs
August	Connie Report	**Summary of Stakeholder Feedback** on Draft Recommendations for Strategies & Action Steps	Primary Care & Community Health Reforms Workgroup (PCCHR) Report	Data Systems, & HIE Services Needed to Support New Models of Payment & Whole Person Care
September	Connie Report	**Recommended Additions, Subtractions, Revisions, & Clarifications** to HealthIT Roadmap Strategies & Action Steps (Report & Discussion)	Cost Growth/Quality Benchmarks/Primary Care Targets	Best Practices Study: Technical Assistance & Training to Increase Adoption & Use of Health IT & HIE
October	Connie Report	**Proposed Health IT Plan Milestones** - Discussion	APCD Update	Ensuring Accountability of Public/Private Investments in IT Systems and Data Services
November	Connie Report	**Final 5-Year Statewide Health IT Plan: Strategies, Action Steps, & Milestones** (Report & Discussion)	Medication Reconciliation and Poly-Pharmacy Committee (MRPC) Update	Regulatory & Payment Levers for Advancing Data Interoperability
December	Connie Report	**Final 5-Year Statewide Health IT Plan: Implementation Metrics & Annual Review Process** (Report & Discussion)		

Important Elements of a Comprehensive Health IT Plan

- Adoption/promotion of standards
- Communication strategies
- Consumer engagement strategies
- Data system interoperability
- Financing strategies and sustainability plans
- Security and privacy requirements including implementation of consent policies
- Implementation timelines
- Improving data quality
- Interagency data sharing
- Measurement and analytics
- Prioritizing health IT investments
- Public/private governance options
- Regulatory and payment levers
- Resource requirements
- Technical assistance and ongoing training
- Digital health
- Broadband connectivity
- Telehealth policy needs
- Shared data services for identity resolution and attribution
- ✓ Standardizing and integrating social determinants & social services data

Presentation and Discussion: Statewide Identity Services for Healthcare and Social Services

Carol Robinson, CEO
CedarBridge Group

Quick Poll

The challenges of ensuring patient/client information follows individuals across continuums of care, the national trends moving toward quality measurement and value-based payments in healthcare, and the need to accurately match records for the same individuals across an increasing number of disparate systems have created an imperative for Connecticut to implement a statewide "source of truth" service for provider and individual identity data.

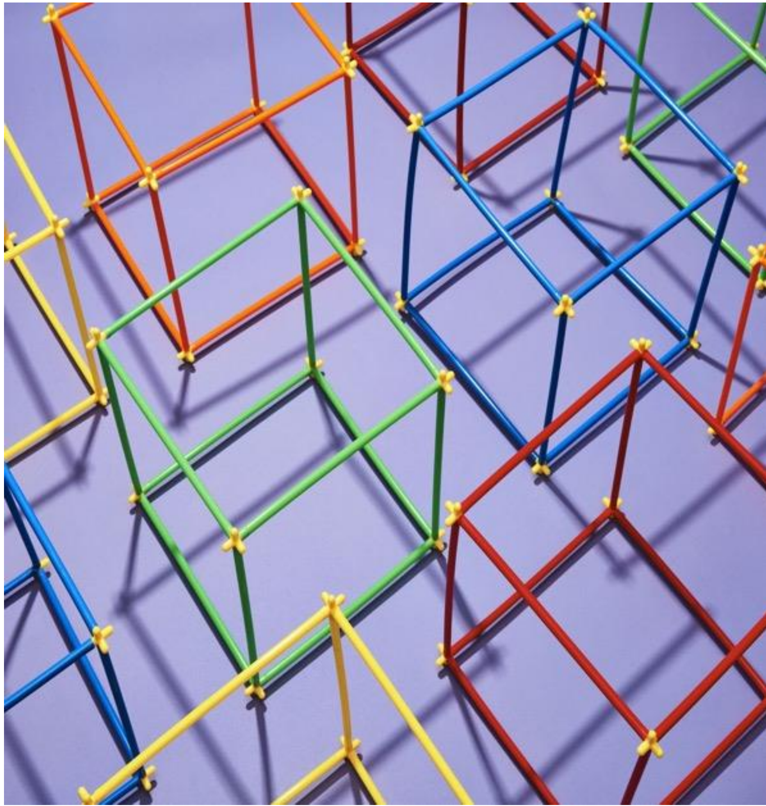
a) Agree

b) Disagree

c) Neither agree or disagree, but open to learning more

d) Would love to see it happen, but skeptical the effort would be successful

A Statewide Identity Management System Could Include:



A master person index with demographic data for individuals (patients and/or clients)

A master provider and health organization directory

211 directory data of community-based organizations

An attribution service with algorithms and data stewards for matching individuals to their care team providers (healthcare practices and community-based organizations)

A consent management service for individuals to provide legal authorization for sharing and/or viewing sensitive information among teams of health and social service providers (essential for “whole person care” delivery models)

Master Patient Index

A Master Patient Index (MPI) is necessary to ensure accuracy and availability of a person's health information.

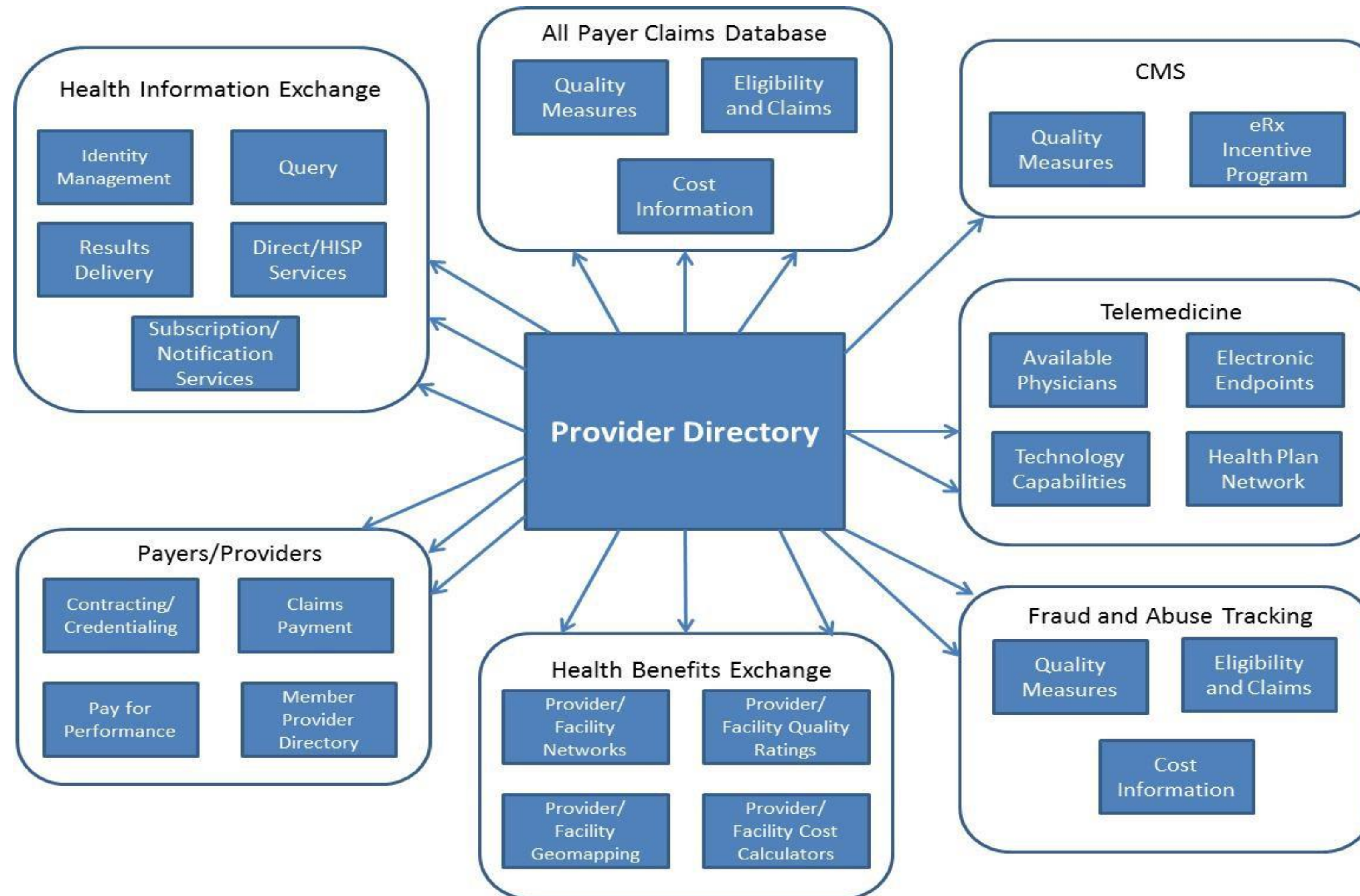
An MPI with a standard set of demographic data and algorithms for linking assigned identifiers (Health Plan IDs, patient ID numbers, etc.) will improve care coordination, ensure better patient safety with more accurate matching of patient records across multiple entities, and increase the accuracy of quality measurement for value-based payment models.

Master Provider Directory

A Provider Directory is a maintained electronic database of information about health care providers. The term provider directory can mean many different things to people, and varying levels of detail about providers and organizations can be included in a directory, including but not limited to, provider's full name, physical location of practice site(s), secure messaging information, credentials, offered services, hours of operation, languages, specialties, patient attribution to the provider, and provider attribution to a clinic, health system, health plan and payer.

Provider Directories should manage the provider information at the organization level and individual provider level. Provider Directories are intended to gather provider information from authorized local, regional, state and national sources, as stewards of the most accurate and current data.

What Might a Statewide Provider Directory Look Like?



https://www.healthit.gov/sites/default/files/provider_directory_solutions_final.pdf

Provider Directory Challenges

Provider Challenges

Inaccuracies in provider directories can often be attributed to providers struggling with how to respond to a health plan's request for data because:

- The provider receives multiple requests from several different health plans on an ongoing basis
- The data submission requirements are different for each health plan and can become a burden to the provider's staff
- There is no standardization for health plans to ask questions of the provider

Payer Challenges

- Getting providers to comply with their requests and respond
- Providers are frustrated by of the number of health plan requests they receive
- An inability to validate the provider's locations
- Many providers provide services for more than one organization
- Lack of "source of truth" for provider data

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Provider Directory Proof Points

A 2018 CMS survey of provider directories found **48.74%** of the provider directory locations listed had at least one inaccuracy.

Of the 5,602 providers reviewed by CMS, 50.14% (2,809) of the providers had at least one deficiency.

Of the 10,504 locations reviewed by CMS, 48.74% (5,120) had at least one deficiency in the location.

- In 1,393 reviews, the provider should not have been listed at any of the locations in the directory.
- 690 incorrect or disconnected phone numbers
- 364 incorrect addresses
- 221 instances where the provider was no longer accepting new patients, however, the directory said they were accepting new patients

Patient Matching

Patient matching is defined as the identification and linking of one patient's data within and across health systems in order to obtain a comprehensive view of that patient's health care record.

At a minimum, this is accomplished by linking multiple demographic data fields such as name, birth date, phone number, and address.

Patient matching is a critical component to interoperability and the nation's health information technology infrastructure.

Recent Patient Matching Efforts at ONC

- **2020-2018**
  - HEART Work Group Specifications (Health Relationship Trust Profiles)
  - FHIR at Scale Task Force, Identity Tiger Team
  - USCDI (Patient Demographics)
  - ONC ISA, Patient Demographic Record Matching
  - ONC Symposium on Patient Matching for PDMPs
  - ONC Patient Matching, Aggregation, and Linking (PMAL) Project, Final Report
  - 2020 ONC Annual Meeting, Unique Perspectives on Unique Patient IDs
  - ONC Identity and Matching Working Session, June 2020
  - ONC Working Session #2: Patient Identity and Matching, August 2020
- **2017**
  - Patient Demographic Data Quality (PDDQ) Framework
  - Patient Matching, Aggregating & Linking (PMAL)
  - Patient Matching Algorithm Challenge (PMAC)
  - Interoperability in Action Webinar: Patient Matching
- **2016**
  - Safety Assurance Factors for EHR Resilience (SAFER): Patient Identification
- **2014**
  - Patient Identification and Matching, Final Report

https://www.healthit.gov/topic/patient-identity-and-patient-record-matching

Patient Matching Woes

Needle in a haystack

With 3.4 million patients in Harris Health System's database, similar names and dates of birth pose a challenge when matching patients with their medical records.

Percentage of times ...

... **two or more patients** shared the same last and first name

0% **7.3%** or 249,213 patients 100%

... **five or more patients** shared the same last and first name

0% **2.2%** or 76,354 patients 100%

... **two or more patients** shared the same last name, first name and date of birth

0% **2%** or 69,807 100%

2,488 **Number of patients** named Maria Garcia

231 **Number of Maria Garcias** sharing the same date of birth

Source: Harris Health System

- At Harris Health System, Maria Garcia wasn't the only problem. **About 249,000 of the system's patients shared a first and last name with at least one other patient,** according to a system analysis
- Harris Health, which treats a large immigrant population, also faces challenges since "**a lot of our patients don't have Social Security numbers**"
- Poor patient matching also results in steep costs. Inaccurate patient identification accounts for roughly **$1,950 in duplicative medical care costs per inpatient and $1.5 million in denied claims per hospital each year**, according to a survey by Black Book Market Research.

https://www.modernhealthcare.com/operations/biometrics-algorithms-help-boost-hospitals-patient-matching-rates

Benefits of Statewide Identity Services

Improve data quality and completeness	Consumers could be provided the ability to validate and update demographic information to improve data across all systems. A statewide MPI could make the master system changes available to improve MPI data across systems.
Increase revenue	By reducing duplicative services and workflow inefficiencies and Improving efficiencies in contracting and payment processes, providers could increase earnings.
Expand value-based models of care	Attribution services support accurate quality measurement, increasing trust of providers to take on risk and would support the appropriate routing of secure messaging, transitions of care, and notifications/alerts.
Keep patients in network	Better data would enhance coordination of benefits across commercial and public payers, improve consumers' ability to identify in-network providers and ensure fewer "surprise billing" incidents from out-of-network provider services
More individual control over data use	Individuals could authorize the use of their data for determination of benefits, care and service coordination, research, and other purposes.
Leverage economies of scale	Identity services could lower costs for state agencies and private-sector organizations by serving as a "source of truth".
Improve services and increase satisfaction	By providing consumer access to up-to-date information such as whether providers are accepting new patients, languages spoken. and any special services provided, individuals are more likely to establish care relationships that meet their needs.

Identity Services Would Support State Agency Programs

Public Health

- Supports state lab newborn screenings, vital statistics, and death records
- Supports population health measurement across geographic areas
- Patient's data is matched, improving patient and population registries

Social Services

- Could include child welfare, foster care system, WIC, and other social service programs to support case management and coordination of services
- Opportunities to integrate social services data into clinical systems and workflows

Medicaid

- Support notifications for transitions of care
- Match Medicaid beneficiaries to benefit eligibility, PCP enrollment, care delivery services, care coordination
- Support individual risk stratification scores by connecting individuals across government systems
- Analyze healthcare access and workforce shortages for planning and policymaking
- Improve auditing capabilities and fraud detection

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What are Other States Doing?

Rhode Island

Rhode Island commissioned a study in 2013 on provider data management across state agencies, provider organizations, health plans, and the state's HIE Rhode Island Quality Institute (RIQI).

- Recommendations included a single centralized provider database as a source of truth across entities.
- RIQI was awarded a contract to develop a master provider directory; significant work has been done.
- State funding expired and has not yet been renewed.
- RIQI experienced challenges in keeping data up-to-date.
- Rhode Island's Statewide Health IT Roadmap identifies common credentialing as a priority; it is anticipated there will be renewed efforts on the Rhode Island statewide provider directory.

Colorado

Colorado received CMS approval for 90/10 HITECH funding for a statewide Master Person Index and a Master Provider Directory in 2016.

- Business and functional requirements were developed and vetted with stakeholders in 2017.
- Analysis of state's data organizations (CORHIO, QHN, CCMCN, CIVHC) done to support the functional requirements.
- Colorado's Dept. of Health and Environment and Dept. of Regulatory Agencies are piloting a provider database to analyze provider shortages and payments. Identity validation is done through CORHIO. The state's intention is to expand this effort to a statewide provider directory.
- Colorado's Office of eHealth Innovation chartered a workgroup on identity services, led by State CIO and endorsed by the Governor
- Data sharing agreements have been executed between Medicaid, Dept. of Human Services, WIC and SNAP programs thus far.

California

California's statewide provider directory, known as Symphony, is being developed through a cross industry collaboration of health plans and provider organizations.

- The effort was a result of California's Senate Bill 137 (SB-137), which went into effect in 2016 as the "toothiest" provider directory law to date.
- SB-137 requires California providers to regularly attest to the accuracy of their data to state regulators, setting the stage for collaboration that would have been otherwise difficult to attain.
- Symphony was launched in August 2018 with 3 large health plans, 2 large provider organizations, and 10 independent practices.
- As of September 2020, 14 health plans and over 95 provider organizations had onboarded to the Symphony platform

Oregon

In 2013 Oregon's legislature unanimously passed Senate Bill 604 to develop a statewide common credentialing system, with the goals to reduce costs and administrative burdens by eliminating duplication and centralized data collection.

- Oregon intended to utilize the common credentialing system to feed and maintain a statewide master provider directory.
- The statewide provider directory effort is ongoing in Oregon, but the common credentialing system program is currently suspended due to "unanticipated costs and complexities".

Quick Poll Questions and Discussion

Quick Poll Questions:

1. On a scale of 1-5, with 5 being the highest level of benefit, how much do you think you think Connecticut would benefit from statewide identity management services for healthcare and social service purposes, as described?

2. What level of priority would you place on a common statewide identity management system in a 5-Year Statewide HealthIT Roadmap?
   a) High
   b) Medium
   c) Low
   d) Not at all

3. What do you think the biggest barrier would be to a statewide identity management system for in Connecticut?
   a) Provider resistance to keeping information updated in a new system
   b) Health plan or health system resistance to having provider data broadly available
   c) Negotiating state agency data-sharing agreements
   d) Buy-in from state policymakers (i.e., Colorado Governor, California State Assembly)

4. If Connecticut were to implement identity services for healthcare and social service purposes, what type of oversight and accountability do you think would make the most sense?
   a) The services should be run by a state agency.
   b) Contractual oversight by a state agency and a public/private entity would be sufficient.
   c) A Public Utility Board or Commission with regulatory authority should ensure conformance with data standards, appropriate and fair fee structures, data security, vendor performance, legal compliance, etc.)

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Discussion

Please Send Comments, Ideas, and Questions for Connecticut's 5-Year Statewide Health IT Roadmap to:

cthealthitplan@cedarbridgegroup.com

CedarBridge Group

Vatsala.pathy@cedarbridgegroup.com
carol@cedarbridgegroup.com

www.cedarbridgegroup.com

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Announcements and General Discussion

Dr. Quaranta, Council Members

Wrap up and Next Steps

Contact Information

Tina Kumar, HIT Lead Stakeholder Engagement, Tina.Kumar@ct.gov
General E-Mail, OHS@ct.gov

Health IT Advisory Council Website:

https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council

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