



**CONNECTICUT**  
Health Strategy

2024

# ANNUAL REPORT: HEALTH INFORMATION TECHNOLOGY & HEALTH INFORMATION EXCHANGE

A REPORT PURSUANT TO CONNECTICUT GENERAL STATUTE §17b-59a

PREPARED FOR: THE JOINT STANDING COMMITTEES OF CONNECTICUT'S  
GENERAL ASSEMBLY

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# Executive Summary

## 2023 Highlights and Headway

The 2024 Health Information Technology (IT) and Health Information Exchange (HIE) Annual Report (Report) is respectfully submitted to the joint standing committees of Connecticut's General Assembly (CGA) by Deidre Gifford MD, MPH, the Executive Director of the Office of Health Strategy (OHS) and Sumit Sajnani, the Health Information Technology Officer (HITO), with support from Connecticut's Health Information Technology Advisory Council (HITAC). In this annual health IT/HIE report to the CGA, we are pleased to highlight measurable progress in 2023 in connectivity and data-sharing between hospitals, ambulatory provider groups, clinical labs, pharmacies, radiology practices, and public health systems, enabled by Connie, Connecticut's statewide Health Information Exchange (*Section 3* of this report).

We are also happy to report on the outstanding progress being made by state agencies in implementing Connecticut's electronic standards for collecting self-reported Race, Ethnicity, and Language (REL) data in electronic health record systems (EHRs), client management solutions, and in some public health platforms updates (*Section 2*). Other examples of headway on Connecticut's priority health IT and HIE initiatives include:

- New HIE service offerings by Connie, including applications for individuals to have easier access to the own health records (*Section 3*);
- Ongoing engagement with behavioral health providers by OHS and Connie on the value of HIE participation to support data-enriched care coordination (*Sections 1 and 3*);
- Connie's provider-mediated electronic consent service is an initial step toward allowing individuals more agency over the sharing and use of health-related data (*Sections 1 and 3*);
- The All-Payer Claims Database (APCD) is providing state policymakers new insights on the cost and quality of health care services in Connecticut (*Section 5*);
- The HITAC has chartered the Regulations Advisory Subcommittee to provide feedback on the OHS draft HIE regulations with participation requirements for all provider organizations including hospitals and clinical labs (*Section 1*);
- A high-level concept workplan has been drafted to support coordination of services across health and human service (HHS) agencies and address barriers to interagency data exchange (*Section 1*); and
- HITAC has approved a charter for the Health Data Standards Advisory Committee to support the work of the Council, with analysis, evaluations, and recommendations for the adoption of health data standards (*Sections 1 and 2*).

## Measuring HIE Growth and Maturity

Statutory requirements have propelled nearly all the state's hospitals and almost half of the ambulatory provider organizations in the state to integrate their EHR systems with the statewide health information exchange in less than three years; a feat that has required a tremendous level of sustained effort by OHS, Connie's staff and contractors. Many more provider practices have taken the initial step to register with the HIE, and the Connie team is continuing to work diligently to educate and onboard all types of specialty health care and dental clinics, solo practitioners, pharmacies, clinical labs, long-term care providers, and community-based organizations to HIE services.

Connie's Executive Director or a member of the Connie executive team provides the HITAC with a monthly status report of Connie's growth. Reports include metrics such as the number of **connected organizations**, the number of organizations **sending data to Connie**, the number of organizations **accessing data through the Connie HIE platform**, and the number of organizations **receiving notifications from Connie**. Other metrics typically reported are the number of providers that have logged into Connie's Provider Portal to query for patient records on multiple dates as a measure of utilization, satisfaction, and overall value of the program. Metrics also include the number of provider organizations that have signed the Connie Registration Form to begin the onboarding process.

The number and types of HIE use cases approved by OHS and DSS for Connie's production environment, and the number and types of use cases that have advanced from the planning phase to the design, development, and implementation (DDI) phase are important indicators of HIE's maturing technical infrastructure. By all accounts, on all measures, Connie is managing extraordinary growth in the number of organizations connected to the statewide HIE and the number of practitioners using Connie's HIE services.

### **Improving Support for Race, Ethnicity and Language (REL) Implementers**

OHS continues to support provider organizations and state agencies as they work to meet the legislative mandates in [CGS §19a-754d](#) to collect standard REL data from patients and clients in their EHR or other data system used for a public health purpose. In 2023, OHS updated the REL standards with a small number of changes to data elements, primarily for clarity and consistency. OHS also expanded the REL Implementation Plan and developed an array of technical assistance resources, offered as stand-alone documents or in the comprehensive Master Toolkit for REL implementers on the OHS website.

### **Coming in 2024: HIE Regulations**

Two sections of the [Connecticut's General Statute \(C.G.S.\), Chapter 319\(o\)](#) require the OHS Executive Director to establish regulations related to statewide health information exchange: C.G.S. §17b-59d(g) requires regulations relating to the administration of the statewide HIE, and C.G.S. §17b-59e(d) directs the OHS Executive Director to adopt regulations around the participation of Connecticut's hospitals, clinical labs, and ambulatory providers in the statewide HIE (*Section 4*). In preparation for drafting HIE regulations, OHS commissioned a comparative analysis of four other states with regulatory mandates for HIE participation by providers and hospitals. The HITAC drafted and approved a charter for a Regulations Advisory Subcommittee to support the Council in reviewing the forthcoming draft regulations.

### **Conclusion**

The efforts in Connecticut to advance health information exchange by connecting electronic health record systems and linking health data across organizations will improve the delivery of health care by supporting better coordination of care and more informed clinical decisions. This connection also improves the ability of policymakers to address racial health disparities when data systems are collecting information that can be more easily combined and compared. The staff and leadership of OHS and Connie, and the members of the HITAC are grateful for the interest and support from the joint committees of the CGA and stand ready to provide additional information about the health IT and HIE programs and services described in the annual report.

# Section 1: The Statewide Health IT Plan

Connecticut’s Statewide Health Information Technology (IT) Plan (Plan) was finalized through a vote of the HITAC (see membership in Appendix A) on December 16, 2021. The process to develop the Plan was described in detail in the 2022 submission of the Annual Report to the Connecticut General Assembly (February 2022).

Six priority focus areas were identified in the Plan (**Table 1**) where there are well-aligned opportunities for improving the delivery of health care, increasing the coordination of health care and social services, fostering innovation, enabling efficiencies for health care providers and government agencies, and addressing health disparities and social determinants of health. Activities for each focus area were identified, including advancing the adoption and use of interoperable technology, delivering technical assistance services, facilitating provider outreach and education, and creating new ways to foster consumer engagement.

Section 1 of the Annual Report provides a summary of activities related to the six focus areas of the Plan.

**Table 1** Statewide Health IT Plan Focus Areas

<b>Focus Area 1</b> Sustain and increase use of Statewide HIE services
<b>Focus Area 2</b> Implement systems to improve health equity and address health-related social needs
<b>Focus Area 3</b> Improve service coordination and data sharing across state HHS agencies
<b>Focus Area 4</b> Support behavioral health providers with the adoption of EHR and HIE services
<b>Focus Area 5</b> Protecting individual’s health information privacy
<b>Focus Area 6</b> Establish electronic data standards to facilitate development of integrated electronic health information systems

## Focus Area 1: Sustain and Increase the Use of Statewide HIE Services

### OHS Activities

A charter was approved by the HITAC for the establishment of an HIE Regulations Advisory Subcommittee (June 2023). OHS conducted an analysis comparing the legal and regulatory frameworks in four states with similar statutory requirements to Connecticut’s, for hospitals, clinical labs, and ambulatory providers to connect and participate in state supported HIE services. The document summarized how electronic health

information exchange legislation has developed and evolved in Maryland, Massachusetts, Nebraska, and Oklahoma over time. These states were selected for the study because each has enacted a mandate for healthcare providers to connect and share data, either with a state designated entity providing HIE services, or through connections with qualified entities meeting the states’ requirements. Common categories of HIE regulations enacted in other states, that are being, or may be, considered in Connecticut are listed in **Table 2** (below).

**Table 2** Comparison of HIE Regulations in 4 States

REGULATORY CONSIDERATIONS	Connecticut: ✓= Established	MD	MA	NE	OK
Defined purpose of a state designated HIE	✓ In statute	✓	✓	✓	✓
Defined administrative and general oversight of state designated HIE	✓ In statute	✓	✓	✓	✓
Requirements for other HIEs operating in the state	Under consideration	✓	✓	–	–
Defined provider participation requirements	Draft requirements under consideration	✓	✓	✓	✓
Defined demographic data elements to be shared by HIE participants	Draft data elements in alignment with USCDI v.2	✓	✓	✓	✓
Defined clinical data elements aligned with <u>United States Core Data for Interoperability (USCDI)</u>	Draft data elements in alignment with USCDI v.2	✓	✓	✓	✓
Defined interoperability standards for providers, aligned with <u>ONC Interoperability Standards Advisory</u>	Draft standards are being developed	✓	✓	✓	✓
Defined process for participation exemption waiver	Under consideration	–	✓	✓	✓
Defined authorities for setting participation fees and accepting grant funding	Under consideration	✓	✓	✓	✓
Defined processes for compliance penalties	Not currently under consideration	✓	✓	✓	–
Defined policies and processes for consumers’ access to data	Connie has developed processes and policies	✓	–	–	–
Defined policies and processes to collect and manage consent for sharing sensitive data	Connie has developed processes and policies	✓	✓	✓	✓
Defined restrictions and limitations on data use from the state designated HIE to the HIE’s participants	Not currently under consideration	✓	–	–	–

The above list is not intended to be comprehensive; other considerations will be evaluated as statewide HIE services evolve. OHS is currently drafting the regulatory criteria for hospitals, clinical labs, and those provider organizations with certified EHR systems capable of connecting to Connie. The HITAC chartered, Regulations Advisory Subcommittee is expected to convene in 2024 to review the OHS draft regulations for hospitals, clinical labs, and providers’ participation in the statewide HIE (Connie).

## Connie Activities

Connie completed Design, Development, and Implementation (DDI) activities for Advance Directives, Dental Health Records, Emergent Images, and Patient Access (to their medical records). It is working to demonstrate

functionality to OHS and the Department of Social Services (DSS) for enhanced Medicaid funding which will increase the use of Connie’s HIE services. At the direction of OHS, Connie is also working on providing additional services which will add to the financial stability of Connie over time. Additional progress of the statewide HIE is included in Section 3 of this report.

## Focus Area 2: Implement Systems to Improve Health Equity, Address Health-Related Social Needs

### OHS and Connie Activities

In April 2023, OHS presented an informational overview to the HITAC on collaborative initiatives underway in Connecticut and across the country to improve coordination of care and linkage to services from medical providers to community resources. Community-based organizations (CBOs) and social service agencies are working closely with healthcare providers through the services of “Community Information Exchange” (CIE) which offers community resource directory services and software solutions to enable electronic referrals to be sent directly from an EHR to CBOs, based on an individual’s needs. Community Information Exchange is a registered trademark of 211 San Diego and is referenced in this document as a concept of integrating clinical, social services and CBO entities.

Connie presented a roadmap for CIE and HIE interoperability (technological collaboration). Connie has been working closely with DSS to offer electronic referrals to address health-related social needs (closed loop), between hospitals, skilled nursing facilities, health care practices, and home and community-based providers for Medicaid beneficiaries.

*Technology Services to Support Care Coordination*



Capturing Health-Related Social Needs (HRSN) data and making it available in conjunction with other clinical health data will result in holistic care, informed treatment, and improved care coordination. Care coordination may now include a referral to a social service provider to address issues such as housing and food insecurity. The two providers can coordinate their care, thus “closing the loop” on referrals and help ensure patients receive follow-ups when needed while making care more efficient for providers and their patients.

Connie’s roadmap for HIE/CIE interoperability is aligned with national standards developed by the [Gravity Project](#), a national public-private initiative developing consensus-driven data standards to support the collection, use, and exchange of data to address the social determinants of health (SDOH).

### Collaborative Community-Based Initiatives Underway

OHS and Connie are working on developing initiatives to enhance the identification of health-related social needs and the coordination of health care and social services.

Some of the many notable community-led efforts underway are:

- 2-1-1 Connecticut ([211](#)) is the front door for Connecticut’s Coordinated Access Networks (CAN), which provides diversion, shelter and housing services to those experiencing homelessness and housing insecurity. 2-1-1 staff use screening, intake, and application forms developed by the Department of Housing (DOH), the Department of Mental Health and Addiction Services (DMHAS), the CT Coalition to End Homelessness and Nutmeg (the Homeless Management Information System “HMIS” administrator) and refer eligible persons to CAN service providers. Connecticut’s Homeless Management Information System ([HMIS](#)) keeps records of all individuals and families who have entered into the homeless response system to ensure all providers have access to the most current information, preventing duplicative intake, activities, and services. The Coordinated Access Network providers have data sharing capabilities with the DOH and the DMHAS and is in the process of setting up “read-only” data agreements with the Court Support Services Division (CSSD).
- Eastern Connecticut Health Collaborative ([ECHC](#)) was formed in March of 2017, to bring groups together with a diverse set of qualifications, to address community health-related challenges. United Way of Southeastern Connecticut hosts the ECHC, and the ECHC includes executives representing Human Service organizations, Local Public Health, Federally Qualified Health Centers, Hartford Healthcare, State, Tribal, and Municipal agencies, the partnership is a cross-sector collaborative of partners from health, social service, and other sectors working together to improve community health and equity in health outcomes by addressing root causes. As one of eight Health Improvement Collaboratives in Connecticut, ECHC provided significant input to the OHS on the barriers to effective data sharing between healthcare providers and CBOs in Connecticut.
- The United Way of Central and Northeastern Connecticut ([UWCNEC](#)) is one of multiple United Way organizations within Connecticut. UWCNEC has participated as Connecticut’s community representative in the first cohort of the national initiative, Learning and Action in Policies and Partnerships ([LAPP](#)). The LAPP is an initiative to test new ways to support community-based data-sharing efforts, led by Data Across Sectors for Health ([DASH](#)) and the Center for Health Care Strategies ([CHCS](#)) with support from the Robert Wood Johnson Foundation ([RWJF](#)).
- The Connecticut LAPP team conducted a systems-mapping exercise to inventory the state’s existing multisector data, interoperability, and data access needs and barriers. Twenty focus groups comprised of members and affiliates of ten Health Enhancement Community organizations and other local health improvement collaboratives across Connecticut were held, and more than 140 community members were surveyed as part of this research with the following goals:
  - Understanding the ability for CBOs to access data, including specific data resources and general information sources;

- Identifying and prioritizing the information needs of the CBOs serving Connecticut residents; and
- Making suggestions for addressing identified needs, including resources, policies, and system solutions. Through these efforts, six data access priorities were identified:
  1. Ensure availability of real-time local-level data that reflects demographic groups, such as minority populations or individuals with unique health and social needs;
  2. Ensure availability of real-time local-level data that reflects each neighborhood, town, or community in the area;
  3. Pool resources to link information from existing data sources (e.g., hospitals and community agencies);
  4. Ensure that data sources are published more frequently (ideally in real-time);
  5. Create a centralized infrastructure, designate state staff, and/or finance and train local level staff to help users access relevant information from myriad sources and agencies, assess its quality, and provide analytics; and
  6. Collect stories and qualitative data to share alongside statistical data from agencies.

## Future Activities in Focus Area 2

- Chartering a Social Risk Data Design Group
- Exploring support for CBOs and social service agencies to adopt IT systems
- Convening stakeholders for consideration of statewide CIE shared services hub governance and management needs
- Establishing a neutral CIE Feasibility Planning Committee to validate functional requirements and evaluate existing CIE infrastructure for shared services.

## Focus Area 3: Improve Service Coordination and Data Sharing Across HHS Agencies

### Examples of Cross-Agency Collaboration

In late 2022 and early 2023, four meetings were convened by OHS and the CT Office of Policy Management (OPM) for Connecticut’s HHS agencies to discuss interagency data-sharing to support improved coordination between state agencies administering health and social service programs. The meetings resulted in a concept paper and logic model for an inter-agency “Person-Centered Services Collaborative” (PCSC); both were published in the 2023 Annual Health IT and HIE Report to the CGA. The PCSC concept is a multi-agency effort focused on improving data exchange between state-administered programs to enable better communication and resource planning between agencies and programs serving shared populations.

While competing state priorities and resource constraints have delayed the PCSC work, there are other successful cross-agency initiatives that can serve as models for current and future HHS data-sharing initiatives.

One such program is **P20 WIN**, which is Connecticut’s state longitudinal data system and is the mechanism by which data from multiple agencies are matched to address critical policy questions and improve educational programs that are essential to the state’s social and economic health.

The online [Fact Sheet](#) explains that P20 WIN is a federated data system that has been operational since 2014, a guide to answer policy questions, fulfill federal and state reporting requirements; support program review; inform school districts of postsecondary outcomes; provide employment and wage outcome data; and support research and analysis on a variety of topics.

Participating Agencies in the P20 WIN include the Office of Early Childhood (OEC), the State Department of Education (SDE), Connecticut State Colleges and Universities (CSCU), the University of Connecticut (UConn), the CT Conference of Independent Colleges (CCIC), the Department of Labor (DOL), the Department of Social Services (DSS), the Department of Children and Families (DCF), the Office of Higher Education (OHE), and the CT Coalition to End Homeless (CCEH).

P20 WIN has an Executive Board and a Data Governing Board that develop and implement the necessary policies and procedures for a multi-agency data-sharing system to address broad policy questions and state needs. OPM administers the program management to support the continued operation and improvement of the P20 Win data resources for the benefit of participating agencies and the State. The Department of Labor (DOL) is the Data Integration Hub for P20 WIN and conducts all data matching for approved data requests for the participating agencies.

P20 WIN demonstrates the importance of governance—organizational governance and data governance—for trusted data-sharing between state agencies. The investments made by DOL in sustaining the P20 WIN technical infrastructure and by OMB in sustaining the P20 WIN program management, and the ongoing commitment to collaboration by the P20 WIN agencies are other success factors of P20 WIN.

The COVID 19 pandemic put enormous strains on many sectors of the U.S. workforce, including on state and local agencies, and on the entire health care delivery system. While workforce shortages are not universal, the impacts of the current tight labor market are exacerbated by the number of people needing government-sponsored services. Higher numbers of vulnerable populations are experiencing hunger and homelessness, with correlating increases in depression, anxiety, addiction, and crime. The need for sustained cross-agency initiatives to coordinate benefits and services for individuals and families in need of public assistance has never been greater. At the same time, technology to link data sets and data systems has vastly improved over the past decade, in part a result of government’s push for interoperable data standards. These factors only serve to increase the imperatives for leadership and funding to support interagency data-sharing that will lead to more effective care and coordinated services, supported as efficiently as possible with workforce strategies that extend the availability of limited resources.

Another example of cross-agency collaboration is what is currently known as “Opportunity Centers”\*, a shared resources model of care concept being developed by DSS Commissioner Barton Reeves in collaboration with the CT Department of Labor, Department of Housing, and Office of Early Childhood. The Opportunity Centers will open doors for equitable access to services that meet the diverse needs of individuals and families in Connecticut, supporting their health and economic mobility to thrive. Launching in the summer of 2024 the states’ first Opportunity Center will open at the Department of Social Services Greater Hartford Office as a Pre-Pilot. The Pre-Pilot is a rapid test-and-learn approach that will enable a controlled approach to a new integrated service delivery model with participation from the Department of Social Services, Office of Early Childhood, Department of Housing, Department of Aging and Disability Services and the Office of Workforce Strategy. The Opportunity Centers will leverage and scale the enabling technology of Health.CT to facilitate appointment scheduling, intake processes and coordination of care for programs and services.

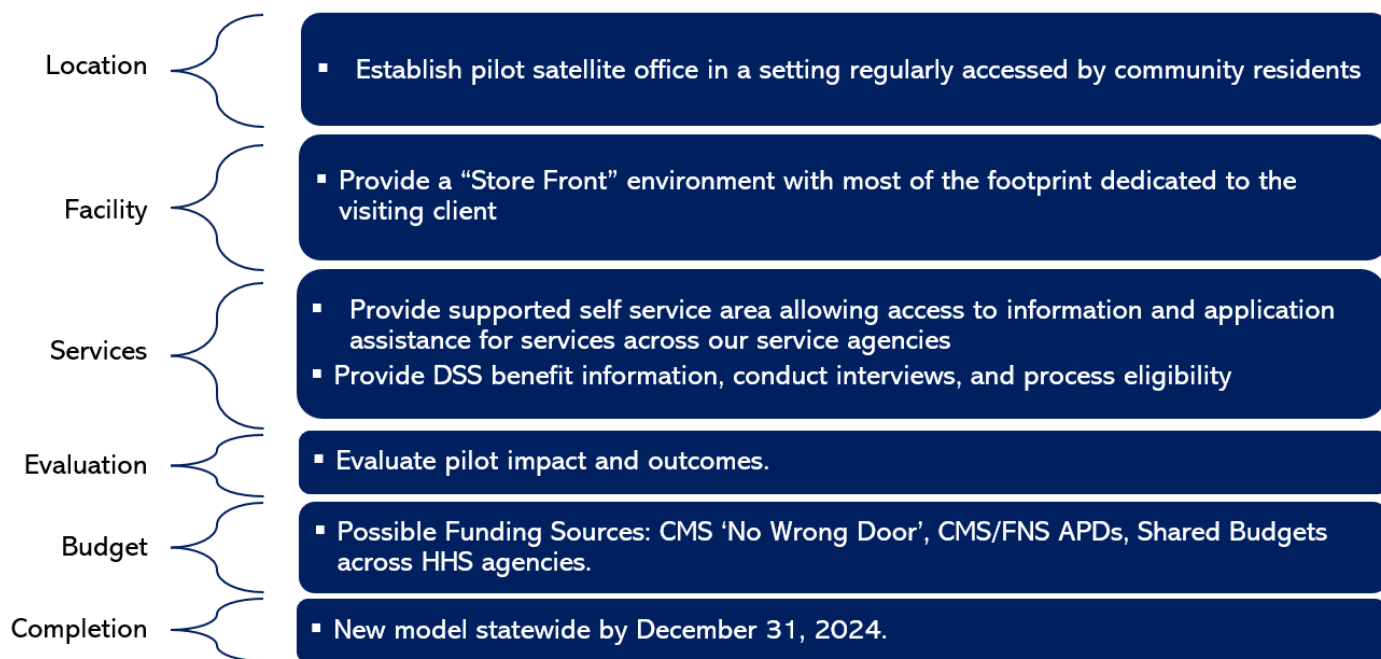
\*Please note that the information contained in this report regarding Opportunity Centers is current as of July 2024, whereas other topics cover activities through December 2023. **Figure 1** Plan for Opportunity Centers Rollout

Information on service offerings and screen for eligibility				
Who might be eligible for services from two or more agencies.		Who may be considered to be at risk, (ex. refugees, DDS clients aging out, DMHAS transitioning to community)		
Self service capabilities to facilitate coordinated service delivery				
Invite residents to apply leveraging shared data across agencies and CBO's	Coordinated approach to data collection and accuracy using shared data for both in person and virtual clients	Convenient appointment scheduling for in person support and interviews	Appointments coordinated to deliver warm transfers in person or via telephone as appropriate	Aggregate and track service delivery progress, decisions and actions in coordinated dashboard
Co-location of services to address the needs of the target population				
Fully staff Enhanced Resource Centers as in Phase One utilizing CBOs with high utilization.		State agencies and community partners to staff RCs on a rotating schedule.		
Points for Consideration				
This Phase will require significant coordination with all state and community agencies.		The scope of MyCT build will need to be considerably expanded and accelerated		

**Table 3** Opportunity Centers Concept

## Opportunity Centers Concept

PROPOSAL PHASE ONE  
Focused Delivery Model and Pilot



## Focus Area 4: Support Behavioral Health Providers with Adoption of EHR and HIE Services

### OHS Activities

Following the behavioral health informational sessions held in 2022, OHS partnered with Department of Mental Health and Addiction Services (DMHAS) and conducted a series of listening sessions in 2023. These listening sessions included behavioral health providers, provider associations and other stakeholders and were designed to learn more about maintaining patient confidentiality where health information exchange is an important tool for care coordination. Behavioral health providers expressed reservations and concerns, including the following feedback:

- Concerns about client privacy when behavioral health providers’ EHR data is required to be shared with the statewide HIE (unless clients have expressly opted in);
- Concerns of the potential burdens on behavioral health providers to inform their clients about the HIE’s opt-out process and with supporting their clients with the opt out process;
- Concerns of potential risks for diminished trust from clients due to data-sharing requirements and limited options for providing consent at a granular level so individuals could choose the types of records they would like shared;
- Privacy concerns about the limited data segmentation options within the HIE so individuals can choose which medical data is shared or not shared through the HIE;

- Privacy concerns on the limitations of the HIPAA Privacy Rule to prevent uses of client data beyond for treatment only;
- Concerns issued that Connecticut HIE statute does not provide adequate clarity on how providers are required to connect to the HIE technology and does not effectively define what participation in the statewide HIE entails;
- Concerns about the lack of technical resources available to assist small organizations; and
- Concerns about the costs from EHR vendors for connecting to the statewide HIE.

Following the listening sessions, OHS posted a frequently asked questions section on its website to provide clarity and address some of the concerns listed above. OHS continues to have productive conversations and engagements with the behavioral health providers, associations, and stakeholders.

### Connie Activities

Following the listening sessions, Connie organized town hall meetings to share information about the connection requirements to the Statewide HIE and offered additional resources to behavioral health providers for onboarding support.

Connie also developed an educational campaign for behavioral health providers and patients on the benefits and risks of health information exchange.

## Focus Area 5: Protect Individuals' Health Information Privacy

### Connie Activities

In the last quarter of 2023, Connie's technology vendor, CRISP Shared Services, enabled the **Provider-Mediated Affirmative eConsent** service for organizations providing substance use disorder (SUD) treatment services to share data through the HIE with an individual's consent. Connie's eConsent tool follows state and federal laws for disclosing confidential data protected under federal confidentiality regulations [42 CFR Part 2](#) (Part 2). Part 2 generally requires a patient's written consent before making a disclosure of protected records – SUD treatment records. Using Connie to facilitate consent for the release of information allows care to be coordinated between SUD providers and other health care providers. Any provider with a treatment relationship with the patient can facilitate consent and view the patient's consent history. The system supports electronic signatures for patient consent and allows flexible expiration dates. Connie can also support an individual's request for an accounting of disclosures of Part 2 SUD data, as required by federal law.

### OHS Activities

OHS presented an introductory overview on electronic consent management to the HITAC during the Council's October 2023 monthly meeting. Key points from the presentation included:

- The medical records of many vulnerable individuals are locked up in EHR systems with data-sharing governed by all-or-nothing consent policies (to opt-out or opt-in of sharing health information with

an HIE or with a national network (e.g., [Carequality](#), [CommonWell Health Alliance](#), [eHealth Exchange](#), and newly designated Qualified Health Information Networks [[QHINs](#) under the [TEFCA Framework](#)])

- The all-or-nothing approach to data-sharing has been almost universally true for health records of individuals except for substance use disorder (SUD) treatment data, due to federal confidentiality regulations requiring consent for disclosures and redisclosures of Part 2 data.
- All-or-nothing is also true for the health records of all adolescents in many states (including Connecticut), and for individuals identifying as transgender or nonbinary
- Laws protecting health data privacy differ substantially between states
  - Healthcare organizations that operate in multiple states must deal with a patchwork of rapidly changing health data privacy laws
  - 13 states have enacted laws to protect online data privacy
  - Washington, Nevada, Maryland, California, and Connecticut passed legislation in 2023 with health data privacy protections
- Consent decisions are often collected as static documents that are not easily viewed or retrieved from an EHR
  - Scanned documents are often difficult to find in an EHR system, causing duplicates to be created
  - Many health care practices require patients to make an in-person visit simply to sign a consent for Release-of Information form

**Table 4** Comparison of States with eConsent Initiatives

Approaches	Washington	California	Michigan
A Standard Consent Form	For SUD	State-Funded Pilots with HIEs	For Behavioral Health
A Statewide Source of Truth Registry	✓		
Pilots and Solution Implementations Planned or Underway	✓	✓	✓
Federal and/or State Funding Approved	✓ Fed. and State	✓ State	✓ Fed. and State

## Focus Area 6: Establish Electronic Data Standards to Facilitate Development of Integrated Electronic Health Information Systems

### OHS Activities

OHS is statutorily required by [Connecticut General Statute §19a-754d](#) to develop and publish standards for the collection of Race, Ethnicity and Language (REL) data and make the standards available to all provider

organizations using electronic health record systems (EHRs) and by state agencies, boards, commissions, and contractors. The statute also required OHS to develop an implementation plan and periodically review census data and update the REL categories.

In addition to complying with all statutory requirements, OHS has also developed additional resources to support the implementation of REL data collection by health care provider organizations and state agencies impacted by the mandate. [Connecticut's Master Implementation Toolkit for Race, Ethnicity, and Language \(REL\) Data Collection](#) (REL Toolkit) includes guidance to provider organizations and state agencies to support implementation of REL standards in data systems and integration of the collection of REL data into workflows. The REL Toolkit includes an updated REL Implementation Plan (Version 3.0) and an updated REL Data Collection Standards Document (Version 3.0) along with several informational resources intended to be an overarching framework for implementers of the REL data collection standards.

Each section of the REL Toolkit is a stand-alone resource document in the OHS REL Online Resource Library maintained on the OHS website as a collection of informational materials on REL data collection, in pursuit of health equity and the elimination of racial and ethnic health disparities.

Provider feedback has been facilitated by Yale's Equity Research and Innovation Center (Yale ERIC) and feedback was also sought from state agencies with data systems that must be updated to comply with the REL data collection mandate.

The Master REL Toolkit includes the following information for organizations implementing the REL standards and collecting REL data from patients and clients:

- Purpose and history of collecting data to help address racial health-related disparities
- Roles and responsibilities of state agencies, provider organizations, and the Commission on Racial Equity in Public Health
- Guidance for implementors of the REL data collection standards
- Sample formats of REL questions and responses
- Frequently Asked Questions (FAQs) for providers and agency staff or contractors to inform clear, kind, and accurate dialogue with patients/clients about the collection of REL data
  - The FAQs have been developed as a resource for provider organizations and state agencies to share with patients and clients about the collection of race, ethnicity, and language data as part of an intake or patient registration process
  - The FAQs are intended a stand-alone communication tool for provider organizations that have implemented REL data collection processes as a common practice within the EHR patient registration workflows

### **The REL Implementation Plan Version 3.0**

The REL Implementation Plan V.3.0 is a component of the Master REL Toolkit. Every organization will have differing availability and capacity of staff or contractors to support the implementation of the REL standards

in an EHR system or in other data systems that will be required to meet the requirements for REL standards. Many organizations will be dependent on an EHR vendor or an industry consultant to make the technical changes to their IT system to facilitate the collection of REL data in standard formats, and to implement the necessary prompts, scripts, screens, and reports that will be needed to support the collection of the REL information from the individuals they are serving.

The REL Implementation Plan V.3.0 provides implementers (e.g., provider organizations or state agency programs) with a structure for planning and executing during each of the five-implementation activity domains:

- **Planning** for the technology implementation of the REL standards
- **Designing** the workflows for collecting REL data
- **Building and Testing** the REL data collection capability
- **Training** staff to use the tools effectively to collect REL data and **Deployment** of the REL workflows
- **Monitoring, Maintenance, and Reporting** of REL data collection to address health-related racial disparities
  - C.G.S. §19a-754d Section 11 which codifies the REL data standards is included as a resource
  - The REL Standards version 3.0 for Race, Ethnicity, and Language

OHS facilitates cross-agency, monthly convenings, among state agencies with data systems subject to the state’s mandate for Race Ethnicity and Language data collection standards. The meetings provide a learning collaborative to share ideas and support for working with system vendors, training staff, and communicating with clients and patients about the importance of REL data in addressing health-related racial and ethnic disparities. Agency staff with responsibilities for implementing the REL data standards have provided feedback on the OHS-created REL Master Toolkit of implementation resources; the REL Toolkit resources are described in detail in the section below on focus area 6. More information about state agency progress implementing the REL standards in state agency data systems is provided in Section 2 of this report.

OHS is planning to conduct stakeholder outreach and engagement in coming months to inform and educate health care providers about their obligation to implement the REL data standards and collect REL data if their practice is using a certified EHR system. OHS plans to expand awareness of the REL standards by continuing to work with Yale ERIC and by partnering with provider associations and other agencies when possible.

## Section 2: Establishment of Data Standards

### Federal and State Standards for Interoperable Health IT and HIE

The OHS Executive Director, the Commissioner of DSS, and the Health Information Technology Advisory Council are statutorily obligated to establish electronic data standards to facilitate the development of

integrated electronic health information systems for use by healthcare providers and institutions that receive state funding. This mandate includes provisions related to security, privacy, data content, structures and format, vocabulary, and transmission protocols.

The federal government works closely with standards development organizations (SDOs) to create guidance and develop regulations to improve the interoperability of health IT systems and the usability of data collected in those systems. Section 4003 of the [21<sup>st</sup> Century Cures Act](#) (Cures Act) delineates the federal regulations that aim to improve the interoperability of health information technology systems and that set penalties for blocking electronic data access by individuals to their own health records, or intentionally blocking electronic data exchange except with defined exceptions. The Act defines “interoperability” as health information technology that enables or allows,

1. “the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user.
2. “complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law;” and
3. “does not constitute information blocking as defined in section 3022(a).”
4. The Office of the National Coordinator for Health Information Technology (ONC) publishes the [Interoperability Standards Advisory](#) (ISA) as a way of recognizing interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. The ISA is issued annually, but because standards are frequently being added or changed, the website version of the ISA is regularly updated and is always considered the current version by the ONC. The [Standards Version Advancement Process](#) (SVAP) permits health IT developers to voluntarily update health IT products certified under the ONC Health IT Certification Program to newer versions of adopted standards and implementation specifications. ONC has established an annual process to receive public input on eligible standards and implementation specifications that could be adopted through SVAP.

The Cures Act introduced the United States Core Data for Interoperability (USCDI) as the nation’s defined baseline for the data elements and data formats that must be included in every CMS-certified EHR system. The USCDI is expected to be perpetually reviewed and updated, with approved versions being released by the ONC at least a few years in advance of the required version for certification, giving health IT developers a common roadmap for adding additional data elements in future system releases. The current federal standard for EHR certification by CMS is the USCDI Version 2 (v.2); the data elements for USCDI v.2 are listed with links in Appendix D.

The most significant change in health care standards is the adoption and expanded uses of the [FHIR](#)<sup>®</sup> standards. Fast Healthcare Interoperability Resources is a next generation standards framework created by HL7. FHIR combines the best features of other HL7 product lines while leveraging the latest web standards and applying a tight focus on ease of implementation.

FHIR solutions are built from a set of modular components called "Resources". These resources can easily be assembled into working systems that solve real-world clinical and administrative problems at a fraction of the price of existing alternatives. FHIR is suitable for use in a wide variety of contexts – mobile phone apps, cloud communications, EHR-based data sharing, server communication in large institutional healthcare providers, and much more.

On December 13th, 2023, the U.S. Department of Health and Human Services (HHS) released the final requirements and operational dates for the [Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing \(HTI-1\) rule](#). The federal government has now published definitive system requirements for compliance with USCDI Version 3. The HTI-1 final rule states that USCDI v.3 will replace USCDI v.2 as of January 1, 2026, however developers of certified EHR technology are encouraged to adopt the more complete data sets in the USCDI v.3 sooner, if feasible.

The HTI-1 final rule also advances patient access, interoperability, and [standards for algorithm transparency](#) by establishing first of its kind transparency requirements for the artificial intelligence (AI) and other predictive algorithms that are part of certified health IT. ONC-certified health IT supports the care delivered by more than 96% of hospitals and 78% of office-based physicians around the country. HHS' leading-edge regulatory approach will promote responsible AI and make it possible for clinical users to access a consistent, baseline set of information about the algorithms they use to support their decision making and to assess such algorithms for fairness, appropriateness, validity, effectiveness, and safety. It should be noted that ONC has a proposed HTI-2 rule that will likely update health IT certification standards further than the 916-page HTI-1 Final Rule.

## Trusted Exchange Framework and Common Agreement (TEFCA)

*The information in this section is sourced from the ONC website ([HealthIT.gov](https://www.healthit.gov)).*

The Trusted Exchange Framework and Common Agreement (TEFCA<sup>SM</sup>) has 3 goals: (1) to establish a universal governance, policy, and technical floor for nationwide interoperability; (2) to simplify connectivity for organizations to securely exchange information to improve patient care, enhance the welfare of populations, and generate health care value; and (3) to enable individuals to gather their health care information.

### TEFCA Components

#### Common Agreement

The [Common Agreement](#) is the legal contract that the Recognized Coordinating Entity<sup>®</sup> (RCE<sup>TM</sup>) will sign with each QHIN. It defines the baseline legal and technical requirements for secure information sharing on a nationwide scale. The Common Agreement also establishes the infrastructure model and governing approach to enable users in different health information networks (HINs) to securely share information with each other—all under commonly agreed-to expectations and regardless of which network they happen to be in.

#### Trusted Exchange Framework

The [Trusted Exchange Framework](#) is a common set of principles designed to facilitate trust between HINs and by which HINs voluntarily elect to abide to enable widespread information exchange. These principles

are standardization; openness and transparency; cooperation and non-discrimination; privacy, security, and safety; access; equity; and public health.

### **QHIN Technical Framework (QTF)**

The [QTF \[PDF - 1034KB\]](#) focuses on the technical components for exchange among QHINs, including patient identity resolution, authentication, and performance measurement. The QTF requirements are incorporated by reference into the Common Agreement. An updated version of the QTF will be made available soon to accompany Common Agreement Version 1.1.

### **Privacy and Security**

The Common Agreement requires strong privacy and security protections for all entities who elect to participate in TEFCAs, including entities not covered by HIPAA. Most connected entities will be HIPAA Covered Entities or Business Associates of Covered Entities and thus will already be required to comply with HIPAA privacy and security requirements. The Common Agreement requires each non-HIPAA entity that participates in TEFCAs to protect individually identifiable information that it reasonably believes is TEFCAs Information in substantially the same manner that HIPAA Covered Entities protect Protected Health Information (PHI), including having to comply with the HIPAA Security Rule and most provisions of the HIPAA Privacy Rule as if they were covered by the HIPAA Rules.

### **Recognized Coordinating Entity (RCE)**

The [RCE](#) developed, updates, implements, and maintains the Common Agreement. It is also responsible for soliciting and reviewing applications from HINs seeking QHIN status and administering the QHIN designation and monitoring processes. [The Sequoia Project](#) serves as the RCE under a contract with ONC.

### **Qualified Health Information Network (QHIN)**

A QHIN is a health information network that is a U.S. Entity that has completed the [QHIN application, onboarding, and designation process](#) and is a party to the Common Agreement countersigned by the RCE. QHINs have the technical capabilities and organizational attributes to connect HINs on a nationwide scale. Participants and Sub-participants will be able to choose their QHIN and will be able to share information with all other connected entities regardless of which QHIN organization they choose.

Currently, TEFCAs will support exchange for the following Exchange Purposes: Treatment; Payment; Health Care Operations; Public Health; Government Benefits Determination; and Individual Access Services (IAS). This means organizations connected to TEFCAs are optionally allowed to request for or respond to any of these purposes. As a starting point, TEFCAs only requires responses for Treatment and IAS. Over time, responses will be required for the remaining Exchange Purposes and other Exchange Purposes may be added.

On December 12, 2023, HHS Secretary Xavier Becerra, HHS Deputy Secretary Andrea Palm, National Coordinator for Health Information Technology Micky Tripathi, and other federal leaders celebrated TEFCAs exchange becoming operational at a Common Agreement signing event at HHS headquarters. At the event, the following five organizations that completed the rigorous TEFCAs onboarding process were officially designated as QHINs:

- [eHealth Exchange](#)
- [Epic Nexus](#)
- [Health Gorilla](#)
- [KONZA](#)
- [MedAllies](#)

## Other Data Standards Trends to Watch

Portions of the following section have been sourced from the online publication [EHR Intelligence](#) “AI, Semantic Interoperability Top Health IT Trends for Next Year” published on December 28, 2023

### Artificial Intelligence

According to Scott Stuewe, president and CEO of healthcare industry alliance DirectTrust, AI could help advance semantic interoperability across the care continuum in 2024.

[Semantic interoperability](#) "provides for common underlying models and codification of the data including the use of data elements with standardized definitions from publicly available value sets and coding vocabularies, providing shared understanding and meaning to the user," according to HIMMS.

One way that AI is advancing interoperability is by transforming unstructured text received via fax or in free text notes into the standard formats of the Consolidated Clinical Document Architecture (C-CDA).

"We're going to need to really pay attention to AI because it may change the requirements for a lot of the standards that we have in place," Stuewe said. "It may make the need for data to be reliably coded less important, which I think would be, on the one hand, very disruptive. On the other hand, probably a pretty good thing."

### Enforcement of Information Blocking Regulations

ONC's 2020 [Cures Act Final Rule](#) implemented key provisions of the 21st Century Cures Act, including the prohibition of information blocking, which refers to preventing or interfering with the access, exchange, or use of electronic health information (EHI).

There hasn't been a practical enforcement mechanism for the regulation until recently when the HHS Office of Inspector General (OIG) released a [final rule](#) with information blocking enforcement policies.

Effective September 1, 2023, OIG has the authority to investigate reports of information blocking across certified health IT developers, companies that resell certified health IT, health information networks, and [HIEs](#). Stakeholders could be subject to up to a [\\$1 million penalty](#) per instance of information blocking, however, it should be noted that OIG has not begun.

### Consent Management

[SHIFT](#) is an independent health care task force for equitable interoperability with over 200 engaged OHS 2024 Health IT Annual Report to CGA (covering 2023 activities)

stakeholders taking part in SHIFT’s vendor-neutral planning work. SHIFT’s primary goal is to advance national standards for data segmentation for privacy (DS4P FHIR) with security labels for sensitive health data mapped to the USCDI v.3 data elements.

## Connecticut’s Leadership in Advancing Health Data Standards

The Connecticut General Assembly is increasingly seen as a national leader in advancing the adoption of interoperable health IT standards. State lawmakers declared racism as a public health emergency in 2021 and passed sweeping legislation to help address the crisis. One [section of the law](#) requires providers “capable of connecting to and participating in Statewide Health Information Exchange” and “any state agency, board or commission that directly, or by contract with another entity, collects demographic data concerning the ancestry or ethnic origin, ethnicity, race or primary language of residents of the state in the context of health care or for the provision or receipt of health care services or for any public health purpose.” to collect the demographic data of race, ethnicity, and language (REL) in standard formats. OHS is directed in statute to develop and maintain Connecticut’s REL Standards, and to publish an Implementation Plan for system users and developers subject to the new mandate. Listed below are the state agency progress reports for the implementation of the Connecticut REL Standards in state systems.

## State Agency Progress Toward Systems Compliance with REL Standards

### Department of Social Services (DSS)

**2022 DSS REL Report:** In 2022, DSS identified three IT systems impacted by C.G.S. § 19a-754d that will require modifications to comply with new REL standards. Those are:

1. The Integrated eligibility system (ImpaCT)
2. The Medicaid Management Information System (MMIS)
3. The Social Work Services System (SWSS)

DSS prioritized the SWSS system and targeted the REL system updates to be completed by October 2023. Other DSS initiatives pertaining to REL include:

- Use of REL standards to expand the way it represents race + ethnicity on its public facing, interactive People Served dashboard
- Partnering with the Office of Policy and Management (OPM) and OHS under a [grant from Actionable Intelligence for Social Policy](#) (AISP) to advance equity within the State’s [P20 WIN](#) initiative.

**2023 DSS REL Report:** DSS reports being in the process of executing a Memorandum of Agreement (MOA) with OHS to support a feasibility study on the requirements of the Department’s compliance with C.G.S. § 19a-754d. The analysis will be used by DSS to inform the Department’s strategy for updating REL impacted systems. DSS also reports using the new Social Work Division’s system as a model for the collection of REL data. That system is now known as SWAN instead of SWSS. The SWAN system will comply with the REL data collection requirements when the system launches in early 2024.

### Office of Health Strategy

**2022 OHS REL Report:** OHS has identified four systems impacted by the REL mandate,

1. The APCD
2. Inpatient Database
3. Outpatient Database
4. Emergency Department Database

All four systems require modifications to meet new REL standards and OHS prioritized the APCD system to complete the REL implementation first. In the previous year's report, OHS targeted completion of the APCD enhancement with system compliance by October 2023.

**2023 Progress Report:** The APCD data submission guide was updated on October 1, 2023, with functionality that enables collection of self-identified three races (two and "other"), three ethnicities (two and "other") and two language preferences (one and "other"), each utilizing the latest version of the Connecticut REL Standards. Data collection begins in January 2024. OHS has a business analyst resource assigned to propose updates to the three other data systems which fall under the REL mandate. This work includes mapping old REL data to the new Connecticut REL Standards and enabling collection and validation of new REL data in alignment with the latest version of the Standards.

### Office of the Chief Medical Examiner (OCME)

**2022 OCME REL Report:** The executive leadership at OCME reported being aware of and committed to the REL standards requirements for state agency data systems. At the time, OCME stated the agency was in the process of connecting its system with DPH's Electronic Death Registry System (EDRS), a project that was expected to be completed before October 2023.

### Department of Children and Families (DCF)

**2022 DCF REL Report:** In 2022, DCF identified two systems in use that are impacted by the REL requirements in C.G.S. § 19a-754d. Those systems are the SACWIS (also known as LINK) the DCF legacy Statewide Automated Child Welfare Information **System**, and the Provider Information Exchange (PIE) system.

**2023 DCF REL Report:** In their update to OHS for the Annual Health IT/HIE Report, 2023 DCF reported that the Connecticut REL Standards were successfully implemented in the SACWIS system in October 2023 and that the implementation of the REL Standards in the Provider Information Exchange (PIE) system is expected to be completed and in compliance in first quarter 2024.

### Department of Veterans Affairs (DVA)

**2022 DVA REL Report:** In 2022, DVA identified the agency's ADL electronic health record system as impacted by C.G.S. §19a-754d. DVA confirmed that the system would require modifications to meet new REL standards. At the time, DVA was targeting completion of its enhancement and compliance by October 2023.

**2023 DVA REL Report:** DVA is currently in the contracting process for a new electronic health records (EHR) system. The current version is not capable of accepting updated race, equity, and language (REL) requirements. The new version includes in the scope of work, the requirement to accommodate all current

and reasonably forecasted REL requirements. The new EHR system is expected to begin full operational status in the June-July 2024 timeframe.

## Department of Mental Health and Addiction Services (DMHAS)

**2022 DMHAS REL Report:** In the previous year, DMHAS identified two systems impacted by Connecticut's REL mandate for state agency health-related data systems. Those are:

1. The Admission/Discharge/Transfer system (WITS)
2. The DMHAS Data Program (DDaP)

Both systems will require modifications to comply with new REL standards, and due to the extent of the modifications needed, DMHAS reported that neither of the system updates would be completed by October 2023. DMHAS also reported at that time the plan to retire the WITS system when the agency's new Electronic Health Record (EHR) system goes online with the REL Standards integrated at the time of the system launch.

**2023 DMHAS REL Report:** DMHAS, in collaboration with the Department of Administrative Services (DAS) Procurement Services, continues to work on EHR vendor contract negotiations. If the project continues as currently planned, the timeline is to have the new EHR go live by July 1, 2026. The new EHR will have the REL changes incorporated when it is implemented.

The DMHAS Data Program (DDaP) is an internal data system that captures all client utilization data for all DMHAS-funded providers throughout the state. Internal IT resources will be used to update the DDaP to meet the REL standards for data collection. DMHAS reports that the target start date to begin changes is March 1, 2024, and it is expected to take 24 months to update the DDaP system to be fully compliant with the REL changes.

## Department of Public Health (DPH)

**2022 DPH REL Report:** DPH has over 30 systems undergoing assessment to determine if they are impacted by PA 21-35. One of these, the Electronic Death Registry System (EDRS) has completed assessment and has been identified as needing modifications to comply with new REL standards. DPH has periodized enhancing this system by October 2023.

DPH is currently engaged in an interoperability project to support automated data exchange between the OCME Management system and the EDRS. This project will support the transfer of REL-related data from the EDRS to the OCME, bringing the OCME into compliance by the October 2023 timeframe.

DPH is in the beginning stages of a federally funded Data Modernization Initiative (DMI), which is an agency-wide effort to modernize its data systems and data-related policies and practices, bringing agency data strategy and management into alignment with industry standards and emerging expectations of the CDC. Full compliance with REL will be part of this initiative; however, this initiative will take considerable time to unfold as it is far-reaching in scope and deliverables, and it addresses agency systems and processes systematically and holistically.

**2023 DPH REL Report:** DPH has over 30 systems that are undergoing assessment to determine if they are impacted by PA 21-35.

1. The Electronic Death Registry System (EDRS) has completed the assessment and has been identified as needing modifications to comply with new REL standards. DPH has periodized enhancing this system by the second quarter, 2024. The estimated cost of the REL standards upgrade is \$38,000.
2. The Fetal Death systems is currently under development and is scheduled to be completed the second quarter, 2024. The Fetal Death system will be implemented as a module of the Electronic Death Registry System (EDRS). It will comply with the REL standards as part of its initial development and DPH does not anticipate any additional costs above the EDRS expenditure.
3. The Birth Registry is scheduled to be replaced in 2025, and the REL standards will be implemented as part of that project.
4. Other systems currently being assessed for the implementation of REL data collection standards are the Tumor Registry and the two surveillance systems, the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Behavioral Risk Surveillance System (YBRSS)

DPH is continuing its work on the federally funded Data Modernization Initiative (DMI), which is an agency-wide effort to modernize its data systems and data-related policies and practices. Full compliance with REL will be part of this initiative. For systems that DPH are planning to replace, or for systems that may be replaced, the upgrade to REL standards will occur as part of the modernization process.

### Department of Development Services (DDS)

**2022 DDS REL Report:** DDS reported in 2022 that the eCAMRIS system would need modifications to adhere to the mandate. The agency targeted completion of system enhancement and compliance by October 2023.

**2023 DDS REL Report:** The DDS IT unit reported to OHS in December 2023 that the Department is finalizing updates to the eCAMRIS system and is expecting to complete those by mid-January. DDS plans to populate eCAMRIS with data transferred from the old system; however, data from an external source would significantly improve the quality of data since there is a lot of missing information in the old system. Once IT updates are complete, DDS plans to release an updated Eligibility Application form to collect new REL data in the future. The release of the new form will complete the Design Activity Domain of the REL implementation for DDS at which time system testing will commence.

### Department of Correction (DOC)

**2022 DOC REL Report:** DOC reported in 2022 that the inmate EHR system was following the new REL standards and no other systems in that agency are impacted by the mandate.

**2023 DOC REL Report:** The DOC EHR system remains in compliance with the REL data collection standards.

### Department of Aging and Disability Services (ADS)

**2022 ADS REL Report:** In the prior year's annual report, the Department of Aging and Disability Services shared that the agency's legal counsel along with staff from the IT units were assessing whether any of the agency systems would be impacted by the mandate.

**2023 ADS REL Report:** ADS has completed the initial phases of the REL compliance project, including a project charter, thorough technology inventory, and impacted systems. Next, ADS will conduct a gap analysis and prepare foundational requirements documents for all applications requiring compliance.

## Section 3: Statewide Health Information Exchange

### Background

Connecticut's General Assembly designated Health Information Alliance, Inc. (dba Connie) as the statewide Health Information Exchange through [CGS Sec.17b-59d](#) to empower consumers to make effective health care decisions; promote patient-centered care; improve the quality, safety and value of health care; reduce waste and duplication of services; support clinical decision-making; keep confidential health information secure; and make progress toward the state's public health goals.

Eleven goals for the statewide HIE are listed in the enabling legislation. Those are:

1. Allow real-time, secure access to patient health information and complete medical records across all health care provider settings;
2. Provide patients with secure electronic access to their health information;
3. Allow voluntary participation by patients to access their health information at no cost;
4. Support care coordination through real-time alerts and timely access to clinical information; Reduce costs associated with preventable readmissions, duplicative testing and medical errors;
5. Promote the highest level of interoperability;
6. Meet all state and federal privacy and security requirements;
7. Support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics;
8. Support population health analytics;
9. Be standards-based; and
10. Provide for broad local governance that includes stakeholders, including, but not limited to, representatives of DSS, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and is committed to the successful development and implementation of the Statewide Health Information Exchange.

Connie's role in facilitating provider connections includes knowing who needs to be connected, ensuring the resources are available to communicate about connecting, troubleshooting EHR vendor issues for providers as they onboard, and providing alternatives to those provider groups that do not have an EHR system capable of connecting. In those cases, Connie sets up a [Direct](#) address for secure messaging. In many ways, Connie has been serving as Connecticut's de facto [health data utility](#) (HDU), a concept that has been spreading in some states, where nonprofit health information exchange entities are designated in statute or by an Executive Order to provide various data services, with accountability through statutory requirements and/or contract

terms. While most technology services offered by an HDU are identical to the services of an HIE, the governance of an HDU is likely to be more tightly connected to state policymakers with authority to implement policy levers, including incentives and/or mandates aimed at increasing provider participation in data exchange activities. A health data utility may have advantages in forging connections with state agencies that could advance data exchange with public health and other agencies, and health data utilities may end up receiving increased financial support from the state’s Medicaid agency and/or other sources of funding that may be leveraged for increased federal funding to support sustainability.

**Table 5** *Connie’s Core Technology Components*

Core Component	Description of Connie’s Core Technology
Master Patient Index	A database that maintains a unique index (or identifier) for every patient whose information has been received by Connie
Integration Engine	An interoperability platform that receives all connections and moves clinical and demographic data to Connie; provides the capabilities to: <ul style="list-style-type: none"> <li>▪ Edit and transform data</li> <li>▪ Map data to national standard code sets</li> <li>▪ Map data between differing formats</li> </ul>
API Gateway	The API Gateway handles API orchestration (including with consent and MPI), throttling, telemetry, and general API security as an external access point to the HIE infrastructure
C-CDA Federator	Federates queries to one or more disparate backend document repositories - whether internal, external, or over national networks
FHIR-based Repositories	Use case specific secure data repositories to store minimally necessary, intelligently curated, tagged, clinical encounter, and care team information to enable efficient queries
Connie Portal	Connie's secure web-based portal where authorized users may query for patient data
HIE InContext App	A SMART-on- FHIR application launched from EHRs designed to present HIE data within the context of the provider workflow
DNS Responder Server	Enables Direct subscribers to securely exchange information with other Direct subscribers on the network.

## Connie’s Policies

### User Access Policies

All Participants are required to develop, or have in place, written requirements that govern Participants’ and Participant Users’ access to information systems and use of protected health information. Such policies should be consistent with the permitted purposes in the Connie published Participation Agreement and Operating Policies and Procedures, and the organizations should make those available to Connie management upon request.

Participants must appoint an Authorized Individual to implement and ensure compliance with all policies related to Connie Participant Users. The Authorized Individual will be responsible for implementing policies

that appropriately grant Participant Users access to clinical data on behalf of the Participant. The Authorized Individual may also act as the designated point of contact for Connie correspondence and user verification and updates.

**Minimum Necessary:** Participant Users agree to view, use, and/or disclose the minimum amount of information necessary for the purpose of such use. Participant Users should only have access to the minimum amount of information required to perform their job function. Minimum necessary does not apply to use of data for treatment or purposes required by law. It is the Participant's obligation to ensure the appropriate use of Connie Services by Participant and Participant Users.

**Data Misuse:** Health information available through Connie is to be accessed, viewed, and used only by Connie Participants and authorized Participant Users, and only for permitted purposes. Connie uses a privacy tool for additional monitoring of all Participant User activities regarding protected health information access to ensure all provisioned accounts are being used appropriately and to protect the confidentiality of protected health information; however, it is ultimately the Participant's obligation to ensure the appropriate use of Connie Services by Participant and Participant Users.

## Patient Access and Rights

**Accounting of Disclosure Requests:** Patients can request an accounting of disclosure of a Participant's access of the patient's information. Connie requires the patient request to include first name, last name, date of birth, address, and a copy of a government-issued photo ID.

**Opting Out of Connie Services:** Unless otherwise required by Applicable Law, Connie's default patient consent policy is opt-out. This means that a patient must proactively, and explicitly, declare their desire to opt out of the exchange. Opting out means that a patient's health information will no longer be returned as the result of a query or sent as an encounter notification. Opting out does not apply to point-to-point secure messaging (e.g., Direct messaging). For example, if a primary care physician uses Direct messaging to communicate with a specialty physician about a patient's care, the communication will not be available to other physicians who query the exchange. It also does not apply to any state-mandated program that Connie facilitates through our technology, such as the Prescription Monitoring Program or public health reportable conditions.

The opting out of patients is handled by Connie. It is the Participant's (provider's) responsibility to adequately educate patients on the opt-out process and to ensure that its Notice of Privacy Practices is updated accordingly, if and to the extent necessary. Patients can opt out by completing a paper form and mailing or faxing it to Connie, calling a toll-free number, or via online form submission.

**Access to Health Information:** As discussed below, patient access is a Permitted Purpose and is required, in most cases, under Applicable Law. Patients can find the types of information Connie stores as part of its routine operations on the Connie website. Connie will facilitate multiple methods for patient information access, including through third party applications and accessing information directly from Connie.

**Access to Information for Minors:** State or Federal law may prohibit health care providers from disclosing certain health related information about a minor patient to anyone, including parents, without the express consent of the minor. It is technically infeasible for Connie to segment or remove data from encounters or clinical documents to avoid disclosing specific types of information that Applicable Law prohibits being disclosed. Parents or legal guardians who can demonstrate their custodial relationship may have access to information for their children aged 0-11, however at this time, ***Connie is not able to make any information available for individuals aged 12-17.***

**Support and Education:** Connie will make available educational materials about best practices and methods for patients accessing their information, including privacy and security risks. In addition, the materials will remind patients that their healthcare providers will likely have more robust information and are the appropriate contact if they have questions or concerns with the information shared. The Connie Customer Support team will answer patient questions about how to access their Connie information, but patients who have questions about their information will be directed to the health care provider who shared or created the information.

## Permitted Purposes

Participants and Participant Users may access and use data through Connie Services for Permitted Purposes only. Current Permitted Purposes for data use are listed below:

1. For Treatment, Payment, and Healthcare operations, as those terms are defined in the Health Insurance and Portability and Accountability Act of 1996 ([HIPAA](#)), and except as set forth below.
2. For public health activities as permitted or required by Applicable Law and consistent with the mission of Connie to advance the health and wellness of patients.
3. For participation in federal programs, such as [Medicare Access and CHIP Reauthorization Act](#) (MACRA) [Quality Payment Program](#) (QPP), including [Merit-Based Incentive Payment System](#) (MIPS), and the [Medicare Shared Savings Program](#) (MSSP).
4. For transacting with External HIEs, including the eHealth Exchange, in accordance with the applicable use case.
5. For responding to requests for individual access in accordance with Section 4.
6. All other allowed purposes as determined by Connie to be required or permitted under the Applicable Law.

Permitted Purposes may be expanded or restricted through use cases. The use cases are approved and amended by the applicable Committee before their incorporation into a Permitted Purpose. According to the Agreements, Connie may add Permitted Purposes.

## Participating Data Providers

Participants must complete testing and other onboarding activities prior to going live with connectivity to Connie. These testing and onboarding activities are tailored to the type of data being provided and accessed

and typically include a patient or member panel. Connie communicates these requirements during the onboarding process. Participants should notify Connie of any changes prior to system changes or upgrades being made. Data validation should be completed by comparing the data in Connie's system to that in the Participant's source system. Connie will provide guidance on testing, but it is the Participant's responsibility to execute a complete test plan in accordance with their own testing policies and procedures. Following successful completion of participant testing, Participants must confirm that they are ready to go live.

**Data Contributors:** Participants will make data available that is necessary to engage Connie Services. For each Participant, information made available to the Connie Services will be subject to appropriateness and technical readiness. For a Participant to be connected to and remain connected to Connie Services, it must submit at least one defined data type. Contribution of data must occur over a secure connection configured by Connie and the Participant.

**Sensitive Health Information:** Participants are responsible for complying with Applicable Laws and for filtering any information that must not be disclosed to or through Connie. Data contributors of Participating Organizations must refrain from sending certain sensitive health information unless they have obtained patient consent, including substance use disorder treatment, and may refrain from sending other sensitive health information.

## Data Release Policy

On January 11, 2023, the Connie Board of Directors approved the organization's [Data Release Policy](#) with the purpose of giving governance authorities to Connie management for the appropriate and secure disclosure of Data to third party data requesters, consistent with applicable state and Federal law. The Data Release Policy sets forth the process and procedures by which Connie management will consider data release programs and accept, review, evaluate, and decide upon requests from third parties to access data for disclosures related to the categories of Health Care Provider Access Disclosure, Service Disclosure, and Research Disclosure.

The Data Release Policy includes a requirement for Connie to designate an existing committee or establish a new committee to serve the function of the Research Evaluation Committee to review Research Disclosure Applications and determine the adequacy of applicants' privacy and security infrastructure and safeguards; if applicable, consider whether an applicant has sufficiently justified the need for identifiable data rather than de-identified data or a limited data set; and any other factor or consideration deemed by Connie management or the Research Evaluation Committee to be relevant to the Research Disclosure Application or the research proposed by the applicant. Additional data release criteria, procedural requirements, policies, and processes are specified in the Data Release Policy, posted on Connie's website.

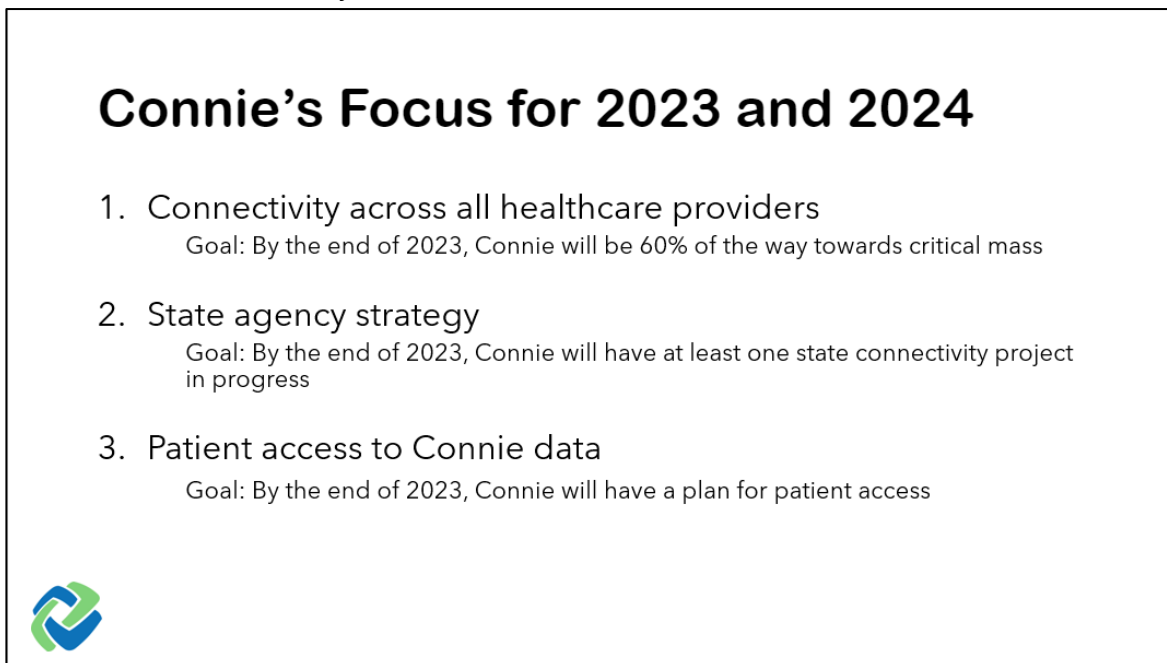
## Activities and Accomplishments

In January of 2022, Connie's Board of Directors approved a set of goals the organization to achieve for the fiscal year. Connie's Board approved goals in three domains focused on stakeholder value, connectivity, and operational excellence.

Figure 2 Connie's Organizational Goals

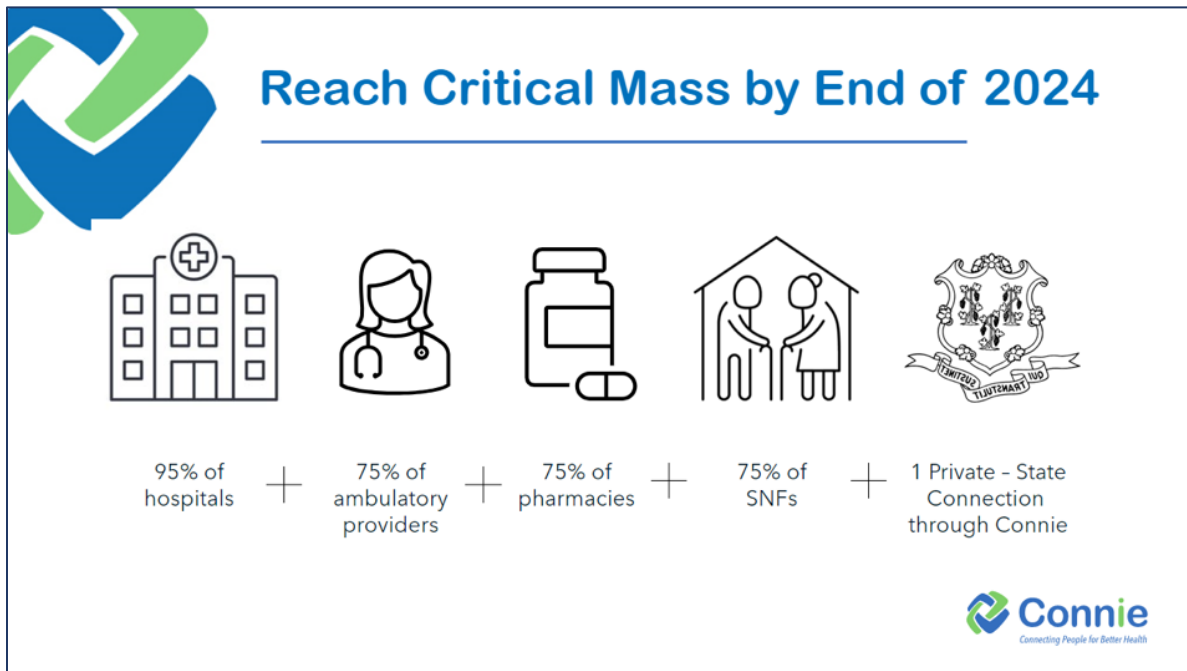


Figure 3 Connie's 2023 and 2024 Areas of Focus



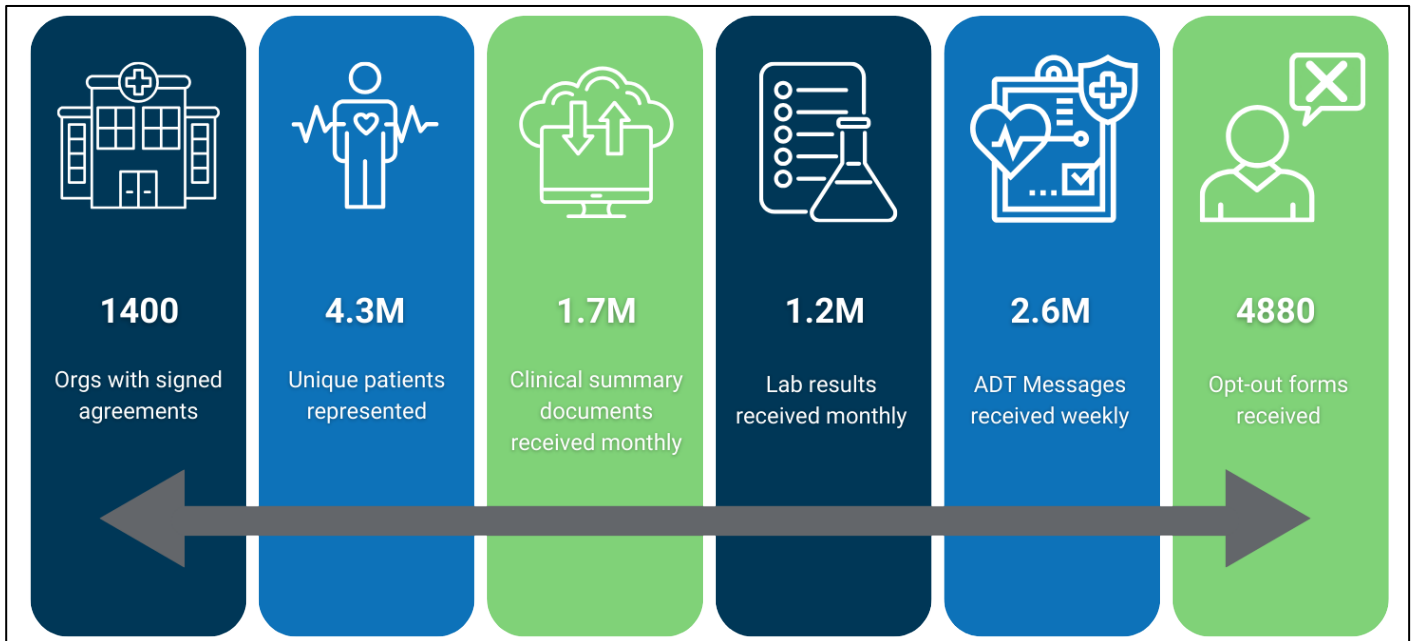
Connie's Board approved ambitious goals of reaching critical mass by the end of 2024.

Figure 4 Connie's Goals to Reach Critical Mass



**By the Numbers: Connie's Connecticut FY2023 Results**

Figure 5 Connie Stats for 2023



**Connie Services**

**New Use Cases in Production in 2023**

- **Advance Directives:** Advance Health Care Directives (AHCD) are stored in disparate systems across healthcare providers. Many can be found in EHRs, hard copy files, patient homes, third-party vendors etc. Connie's AHCD Service allows third-party vendors that hold patient directives to display those directives within the patient's clinical information section. At this time directives registered with ADVault using their MyDirectives service are being displayed within Connie. Directives present in Connie may not reflect the most recent or complete directive for a patient. Nevertheless, it does improve access to directives registered through connected third-party organizations and allows a patient's treating providers to follow internal protocols related to the use of outside directives to support health care decisions for patients.
- **Emergent Imaging:** Hospitals currently have the capability to push images to larger systems in emergent situations to comprehensive stroke/trauma centers, however each receiving hospital utilizes a different infrastructure for sending and receiving emergent images. This approach is cumbersome for small hospitals, so Connie is augmenting the Image Share service with Emergent Imaging. When an ED provider is presented with a stroke patient and does not have the expertise in-house, they can open the imaging study and push it to Connie for the stroke specialist at the Level 1 Trauma Center to view in advance of the patient arriving. The Emergent Images tab sits on top of the core Image Exchange feature within the Connie portals and provides the user with the ability to share wet (unread) images. Connie's approach can be implemented by Level 1 Trauma Center in a way that will not deviate from their current workflows while streamlining workflows for smaller hospitals, decreasing administrative burdens, and saving precious time in emergencies. Connie has implemented this capability and is working to onboard hospitals in order to make the service available to providers.
- **eReferral:** Tracking patient information across providers is difficult and can lead to incomplete information needed for clinical decision making. Communication of patient health information between primary care providers and specialists is a key factor in correct diagnosis, treatment, and positive patient outcomes. Inadequate communication can result in duplicate testing, missing information, higher costs, and increased patient risk. eReferral support through Connie will improve care coordination by improving the amount, quality, and timeliness of information available to providers serving patients with multiple needs and caregivers. In the first year of implementation, eReferral was developed to support primary care to homecare and hospice referrals in places where faxes are typically used to facilitate referrals. The eReferral service is accessible from both the web-based portal and the InContext app. The service is driven by a Program Directory with contact information and details about the program.
- **Medication Management:** Sources of medication data are numerous but generally incomplete and sometimes inaccurate. Patients with multiple chronic conditions often have several different types of specialty providers who may each be prescribing medications without knowledge of other duplicative or perhaps contraindicated drugs. Medication Management is a compilation of medication data from various sources including Continuity of Care Documents (CCDs) sent to Connie from connected provider clinics and hospitals. Data aggregates at the patient-level facilitates medication

reconciliation and deprescribing, supports collaborative care, reduces medication costs and errors, and improves clinical outcomes.

- **Problem List:** Connie has developed a display of clinical data that enables providers to easily view their patients' health conditions. The health conditions list pulls data from patient health issues parsed from CCDs submitted to Connie. Connie is enhancing this service to enable a quick filtered view of conditions relevant to specific provider types. The initial filter will be developed for dental providers to easily identify whether their patient has a condition that may require preventive care or impact the treatment approach, or treatment outcomes.
- **Provider-Mediated Affirmative eConsent:** enables SUD treatment providers to share data protected by 42 CFR Part 2 through the HIE with patient consent. Connie's eConsent tool follows both state and federal SUD data disclosure rules. Enabling SUD data to be shared through Connie improves care coordination between SUD providers and other healthcare providers and strengthens continuity of care for patients when transitioning between SUD treatment programs. Using Connie to facilitate consent and data sharing eases the SUD workflow burden when obtaining consent and disclosing confidential information to other treating providers.
- **Snapshot** provides a summary of key patient data and enables providers to quickly identify potential issues that need to be reviewed and/or discussed with their patient. Additionally, the user will be able to see the patient's care team and review any healthcare encounters they have had in the past year. Snapshot saves time for both patients and providers, allowing for a more holistic view of the patient's history, and helps providers deliver a more prepared and informed patient experience.

Today, participating organizations with access to **Connie's Provider Portal** benefit from the following applications, tools and features to support patient treatment and care coordination.

- **Connie Alerts:** Connie's encounter notification tools, also known as Connie Alerts, provides alerts when patients are admitted, discharged or transferred from inpatient or outpatient services, giving providers the ability to determine the next right step in their patient's care. The initial service was limited to hospital encounter notifications to select behavioral health providers via secure, direct email. The service will be expanded to include inpatient and outpatient encounters. Any Connie participating healthcare organization receives the notification as an alert in the Connie Portal through a filterable worklist feature.
- A **Snapshot** summary of key patient data, including demographics, medical encounters, care team information, and next of kin.
- **Clinical Information** includes patient-specific point-of-care clinical tools:
  - **Care Coordination** includes the patient's care team, a history of referrals made for the patient through Connie, and any **Advanced Directives** available from MyDirectives.
  - **Clinical Data** including overdose alerts, in-patient and outpatient encounters, labs and radiology reports, summaries of care, and separate, consolidated lists of the patient's **immunizations** and **problems**.

- **Image Share** allows authorized users access to view, compare, download, and import diagnostic quality images seamlessly in near real-time.
- **Emergent Imaging** enables Connie to push images associated with emergency situations, such as a patient presenting with stroke symptoms in an emergency department.
- **Medication Management** is a consolidated medication history created using a systematic process of gathering medication information from multiple sources, de-duplicating and standardizing the data, and displaying it in a single resource, saving time and making comparative viewing much easier.
- **Prescription Monitoring Program:** Providers have access using Single Sign On (SSO) to the Connecticut Department of Consumer Protection’s Prescription Monitoring and Reporting System’s (CPMRS) Narx report. Access to the CPMRS enables providers to quickly look up a patient’s history of prescribed scheduled drugs. This information helps providers assess the risk of substance use disorders and doctor shopping, and it offers the potential to intervene with high-risk patients. Alignment between a state’s prescription monitoring programs (PMP) and a state or regional is a recognized best practice.
- **Social Needs Data** highlights when a patient has reported to a provider that they experience problems related to social issues known to impact health using Z-codes, a standard for coding social needs in EHR systems.
- A **Consent** tool with two features:
  - The **Prevention of Harm form**, enabling providers to submit written notice to Connie that the patient’s electronic health information (EHI) should not be shared with that patient because it is reasonably likely to cause substantial harm to or endanger the life or physical safety of the patient or another person.
  - A **Provider-Mediated Patient Consent** form to support care coordination between substance use disorder (SUD) treatment and medical providers for patients enrolled in SUD treatment programs.
  - **eReferral** supports care coordination with home-based care and social needs services. This tool provides a list of referrals made through Connie from providers to home and community-based provider organizations.
- **Provider Directory** This service allows healthcare staff to look up a provider in Connecticut to enable referrals and improve transitions of care for their patients. It also enables users to search for a specific provider and find detailed and accurate information on that provider, including facility locations, contact information, and specialties.
- **InContext Application** is an embedded [SMART-on-FHIR](#) app enabling users of certain electronic health records (EHRs) to securely access clinical data about their patients in the context of their workflow. SMART is the acronym for Substitutable Medical Applications and Reusable Technologies, a standards-based, interoperable apps platform for EHRs. Using the application within their EHR, users

can access additional patient clinical information from providers outside of their health system. The InContext application also enables access to eReferral and Consent tools.

- **Connie Connect Gateway** supports a variety of outbound, curated data feeds, including ADTs, labs, and (in the future) parsed CCDs—separate, curated lists of immunizations, medications, problems, allergies, and vital records sourced from CCDs. Curated data feeds combine, deduplicate, and normalize data from disparate sources to deliver a more complete list of patient clinical and encounter information to participating organizations. Data can be hydrated to add important details that might be missing from providers’ records but available from other participating organizations—like specific or updated patient demographic information—or filtered to deliver information for a specific subset of a population—like labs results for patients with elevated Hemoglobin A1C levels to support targeted diabetes management programs.

## Service Enhancements in Development for 2024

**Allergy List:** An allergy list derived from CCDs will be made available to the patient’s care team through the InContext/Clinical Information applications. It will consist of a new tab or table that displays the extracted allergies from the CCD.

**CCD eConsent Filter:** Connie’s eConsent tool requires participating organization to be able to send Connie sensitive data (data required affirmative patient consent before being shared for treatment purposes) independently from other patient information. One critical limitation is the ability of providers who may provide both SUD treatment services and other healthcare services to filter their data so that sensitive data can be sent independently of non-sensitive data. The CCD Consent filter will enable Connie to screen incoming CCDs from organizations that have indicated that they have SUD treatment programs among other health care services. When a CCD contains sensitive data, the CCD will be tagged as Affirmative Consent Required (ACR), to await patient affirmative consent before being made available to the patient’s treating providers. The consent filters ensure a patients’ rights and privileges regarding data sharing are respected and able to be fulfilled; assists users in complying with 42 CFR Part 2 requirements; and enables policies for managing consent for data sharing to be effectively implemented and operated across patient and provider populations.

**Connie Alerts:** Connie is adding the Connie Alerts Worklist feature directly into the Clinical Information application, enabling providers to review a list of their patients’ encounters at emergency rooms, inpatient or outpatient settings with a more streamlined access to the patient’s clinical record. Providers can launch the Alerts Worklist directly to see the encounter detail or directly to view the patient’s clinical information. Each message is rolled up as an update to the encounter. Providers can toggle between patient panels or filter encounters based on select encounter information.

**Dental Records – Care Team Enhancement:** Dental health information is an essential part of overall patient information and can inform other health care diagnoses and treatments. Conversely, health information related to acute and chronic conditions can inform dental treatment. Medication information is an essential

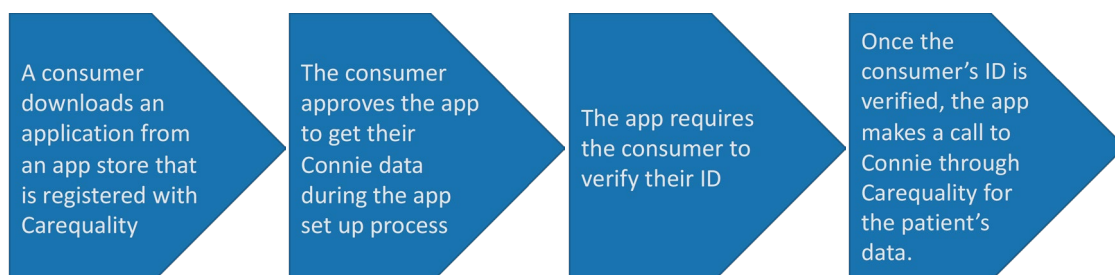
part of the information to be shared. To address data exchange needs and near-term opportunities, Connie is enhancing the patient care team display to include dental providers, leveraging dental provider submission of patient panels. This service was made available as of September 2023. The patient panel will also enable dental providers access to medication history and patient encounters. As dental data is shared with Connie, dental records display enhancements will be added to Connie's use cases.

**Medication Management Enhanced with Pharmacy Data:** Medications from CCDs indicate either what has been prescribed and/or what a patient has indicated they are taking. Often missing from the CCD is information about who prescribed the medication and if the prescribed medication is being taken. Through this enhancement, Connie will incorporate pharmacy data into the current Medication Management display to show medications filled, and, if possible, medications dispensed, as well as who prescribed the medication. Connie is currently in the process of onboarding pharmacies, which will supply the data necessary to support the design, development and implementation (DDI) required for this use case.

**Immunizations:** Connie's immunization services provide access to a compilation of immunization data from participating organizations including vaccines administered by providers, and vaccines reported by patients or between providers. The immunizations listed are deduplicated across data sources when the vaccine date and name are the same, leaving a consolidated list of a patient's vaccine history. The state's immunization information system, CT Wiz should continue to be regarded as the source of truth for scheduling vaccines for a patient. Nevertheless, immunization data from CCDs can supplement the information provided through CT Wiz and enables providers who do not have access to CT Wiz to have knowledge of a patient's vaccine status. This service was made available as of September 2023.

**Patient Access:** To support compliance with federal interoperability requirements, Connie has enabled a secure way for consumers to access their health information in Connie through a third party, personal health application (PHA). Patients aged 18+ may have access to their information once they have appropriately validated their identity. Consumers make the decision on which PHA they will use to view their data. PHAs use secure API connections to Connie through Carequality, a national data exchange framework. Carequality provides a high level of security as PHAs must sign the Carequality Agreement to participate. Connie was the first HIE to participate in this newly enabled permitted purpose through Carequality, made available as of September 2023. As of the drafting of this document, no apps are yet available, however Connie is actively testing connectivity with one application and two additional PHAs considering Carequality connections are currently also connected to the DSS Interoperability API.

***Process for Activating a Consumer App for Accessing Patient Records***



**Patient Portal:** Connie’s Operating Policies and Procedures include a [Patient Access Principles Policy](#) which articulates that Connie will provide patients timely and direct access to their electronic health information within Connie to align with federal and state information blocking and interoperability rules. Connie will create a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an internet connection. Using a secure username, password, multifactor authentication, with patient ID verification and validation, individuals who are 18 years or older will be able to view their health information available within Connie’s infrastructure. The patient portal will be designed to support a patient’s need to have a single source of information about their health record, assist a patient in identifying information discrepancies and directing a patient to where they can address inaccuracies and manage the information they have consented to sharing. A Request for Quotations ([RFQ](#)) was posted on October 2, 2023. Connie is looking for a partner to implement the initial iteration of the Patient Portal, expected to be available for patients to access in October 2024.

**Population Health Reports:** Leveraging clinical information across participating organizations, Connie is developing population level reports to support provider organizations, clinically integrated networks, payers, and state agencies identify gaps in patient care, trends in their patient’s needs, assess their success related to statewide health improvement priorities, and better target strategies tailored to their patient population.

**Problem Filters:** Connie is developing a display of clinical data that enables dental providers to easily view their patients’ health conditions relevant to dental patient safety, preventive care, and treatment outcomes. The health conditions list pulls data from patient health issues parsed from CCDs submitted to Connie. Dental providers can then filter this list to the conditions relevant to their specialty to quickly identify any issues that need to be accommodated during the patient’s appointment.

**Social Determinants of Health eReferrals:** Social Determinants of Health (SDOH) data is valuable for providers to have at the point of care. In the context of individual patient needs, Connie is using the term Health Related Social Needs (HRSN) to describe individual needs that could be a result of SDOH factors contributing to a patient’s overall health. Social Determinants are now widely accepted as having significant influence on an individual’s overall health and on the probability of a desired health outcome when treatment is needed. SDOH data is fragmented across numerous social service agencies and non-profit organizations and is not normalized or in common formats. Capturing this data and making it available in conjunction with other clinical health data will result in more informed treatment and care coordination. Care coordination may involve the subsequent referral of a patient to an appropriate social service provider. HRSN referrals will be able to build a more complete picture of patient needs by integrating with third-party referral platforms. Referrals in the SDOH environment are more complex due to disparate systems used by social service agencies and community-based organizations, which are typically not connected to an HIE. Providing feedback to referring providers or “closing the loop” on such referrals will decrease duplication in referrals and reduce the provider’s time spent on creating referrals.

## Connie’s Integration Work with State Agencies

**Department of Correction:** DOC has signed a data sharing agreement with Connie, and DOC's medical team is currently in the process of onboarding with Connie. This connection will allow the DOC medical team to have a much more complete view of an inmate's health at the time of incarceration with medications, lab tests, images, prior conditions, and other elements of an individual's health history available. When incarcerated individuals are released back in the community, data exchange between DOC and Connie supports the continuity of their healthcare to an FQHC or other clinic where a primary care provider relationship can be established, and timely service referrals can be made to give individuals the best chance at a successful re-entry, care and support.

**Department of Social Services:** The Centers for Medicare and Medicaid Services (CMS) published the [Interoperability and Patient Access Final Rule](#) on May 1, 2020, to improve quality and access to health information, allowing Medicaid participants and their providers to make informed health care decisions. The CMS rule requires the DSS to develop patient access and provider directory application programming interfaces (APIs). In 2022, Connie facilitated DSS's development of these APIs, meeting the CMS interoperability requirements. Throughout 2023, Connie continued to support DSS in the operations and maintenance of the APIs.

Additionally, Connie is supporting the DSS Medicaid Home and Community Based Services ([HCBS](#)) Waiver program, a 3-year initiative to track outcomes for a value-based care model. The initiative provides funding for community-based, long-term services and supports (LTSS) organizations to connect to Connie. Participating home and community-based organizations will have access to clinical information on their clients as allowed by applicable laws to improve care coordination, reduce preventable costs, and improve patient care, health, and wellbeing. Program goals include:

- Decreasing avoidable hospitalizations;
- Decreasing Medicaid members' length of stay in skilled nursing facilities to under 100 days;
- Increasing probability of discharge from hospital to HCBS in lieu of a nursing home or SNF;
- Increasing the number of Medicaid members meeting their personal goals; and
- Decreasing health inequities among Medicaid members served by participating organizations.

**Department of Public Health:** DPH is replacing its current laboratory information system (LIMS). Through this project, Connie will serve as the message router between hospitals and DPH. This represents an efficiency for hospitals as they would utilize an existing connection to interface with the state lab rather than having to maintain a new connection to DPH. This is an efficiency for DPH as they will only need to support the maintenance of one interface from Connie to their LIMS instead of multiple connections and interfaces with each hospital system and provider organization required to connect, which could had up to hundreds of individual connections.

**Office of the Chief Medical Examiner:** OCME reviewed 27,480 cases in FY2021. Of those cases 3,103 required autopsies, 531 required external exams, and 2,085 death certificates were issued. Each of these actions and cases may require a review of the decedent's medical history as part of the death investigation. OCME has approximately 34 staff involved in performing aspects of these investigations, including

doctors, investigators and fellows. Since December of 2022, OCME permitted staff have been able to access data contributed to Connie from multiple EHRs through the Connie Portal to streamline the death investigation process.

## Connecting and Onboarding Progress

### EHR Hub Connections

To the degree possible, Connie is taking an approach to maximize their capacity to rapidly onboard as many provider organizations to statewide HIE services as possible. Connie is doing this by identifying cloud-based EHR vendors with the largest numbers of Connecticut-based provider practices using their system and setting up a “connectivity hub” to each EHR vendor for all their Connecticut practices to connect to Connie through. Over 280 EHR vendors have been contacted by Connie staff, with 22 EHR hubs having completed connections to Connie, and nine EHR hubs in development as of November 2023. This strategy provides a much faster scalability to demonstrate value from Connie’s HIE services.

**Table 6**

Hub	Specialty
American Health Tech	Long-Term Care
CureMD	Multispecialty
Thornberry	Home Care
Medinformatix	Radiology
Triarq Health	Multispecialty
Homecare Homebase (HCHB)	Home Care
Meridian (Vertex)	Multispecialty
Elation	Primary Care
TriMed	Pediatric

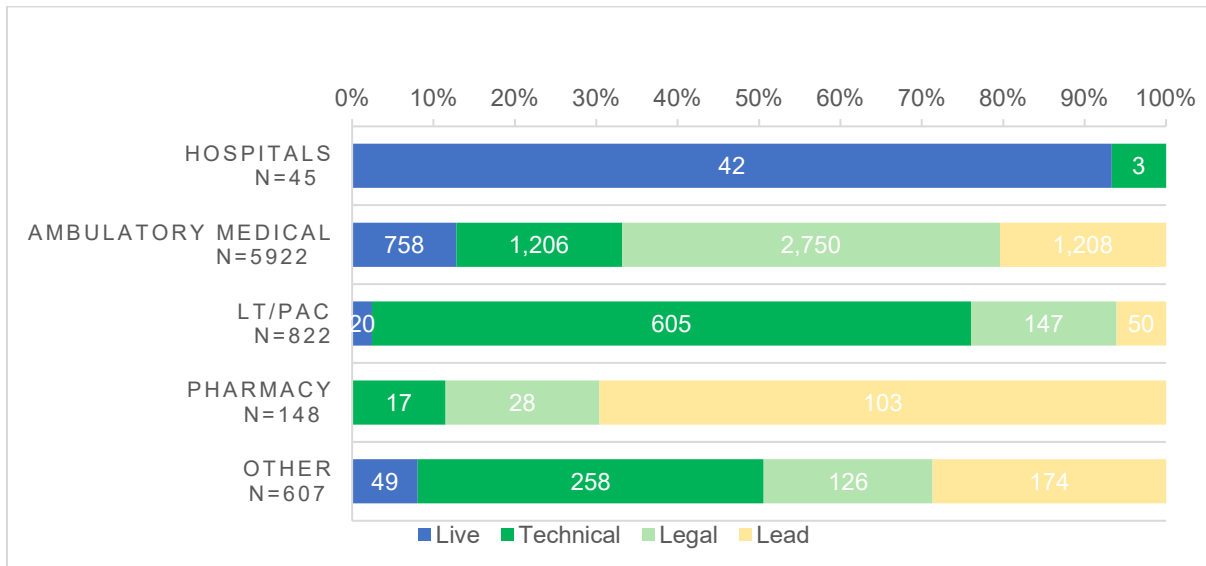
**Table 7**

Hub	Specialty
Experity	Urgent Care
MEDENT	Multispecialty
Physician's Computer Company	Pediatric
Surgical Information Systems	Surgery
UnifiMD	Multispecialty
Yardi	Long-Term Care
eClinicalWorks	Multispecialty
Veradigm Allscripts	Multispecialty

### Onboarding and Data Exchange Progress

The specialty EHR vendors in Table 6 were connected to Connie during FY2023 and can onboard participating providers through their hub connection to Connie.

Work was underway by Connie to connect the specialty EHR vendors in Table 7 at the time this report was published.



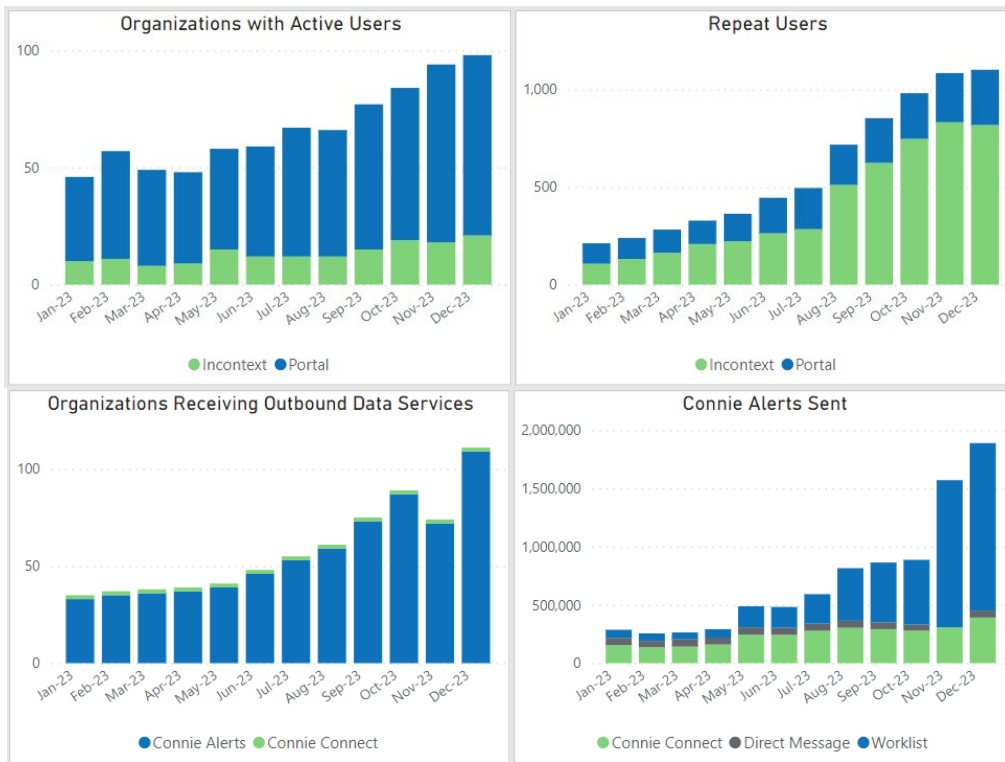
**Note: reflects onboarding through July 31, 2023, as reported to HITAC on August 17, 2023**

### Connie Outreach to Stakeholders

The Connie team has been actively engaging in outreach efforts, attending conferences across Connecticut to educate the healthcare community about Connie and its services. Some meetings were in person, others virtual. These engagements enable Connie staff to educate providers about the state mandate to begin the process of connecting to Connie, provide updates on how to connect with Connie, offer demonstrations of Connie’s Provider Portal, showcase Connie’s progress, and answer questions. Connie’s engagement over the past year included conversations with:

- Connecticut Academy of Family Physicians 2022 Scientific Symposium
- CMGMA’s Best Practices Symposium
- Connecticut Association of Optometrists
- Academy of Audiology
- Fairfield County, Hartford County, and Greater Bridgeport Medical Associations
- New Haven Medical Association
- Radiological Society of Connecticut
- Connecticut Podiatric Medical Association
- Connecticut Chiropractic Association
- Connecticut Association of Addiction Professionals
- LeadingAge Conference for Skilled Nursing Facilities
- Meeting series with behavioral health providers

### Service Usage



## Section 4: Recommendations for Policy, Regulatory or Legislative Changes

Connecticut [Public Act 22-58](#) amended CGS §17b-59d(g) and §17b-59e(d) to direct the OHS Executive Director to develop regulations related to 1) administration of the Statewide Health Information Exchange and 2) the mandatory participation of hospitals, clinical labs, and health care providers in the Statewide Health Information Exchange. Prior to final adoption of regulations, in accordance with the Connecticut Uniform Administrative Procedure Act ([CGS Chapter 54](#)), the following actions will be taken.

**Figure 6:** Process for Finalizing Regulations for Statewide Health Information Exchange



## Section 5: Other Initiatives Supporting Health IT

### Office of Health Strategy Initiatives Supported by Health IT

OHS leads and supports numerous initiatives to improve healthcare quality and efficiency, drive cost savings, and provide transparency around healthcare costs. Major efforts are underway relating to the policy priorities below; over time, each of these initiatives will be directly impacted by improvements to Connecticut’s health IT infrastructure and to the availability of data.

## DSS & OHS Joint Steering Committee

DSS and OHS established the Joint Steering Committee in 2019 to provide recommendations to the leadership of both agencies on conceptual and strategic matters, as well as to make decisions on tactical and operational matters as defined through the DSS-OHS Memorandum of Agreement (MOA). DSS and OHS agree that a successful collaboration recognizes the OHS statutory charge for overseeing the statewide HIE and the authority and fiduciary responsibility of DSS as the Single State Medicaid Agency for administering federal funding from the and CMS to support the HIE. The MOA is an excellent example of inter-agency collaboration with shared accountability.

Current collaborative activities include the development of CMS funding proposals for HIE implementation and operations. In addition, DSS and OHS work together to support Connie in obtaining CMS certification of HIE functionalities as Use Cases move from the Design, Develop, Implementation and operational.

### Medicaid Federal Funding Requests to Support HIE Services

#### Implementation Advanced Planning Document Update (IAPD-U)

- 90% Federal Financial Participation (FFP) is available at a cost allocated percentage to support a planning phase for modules and HIE use cases to support the Medicaid Enterprise System
- 90% FFP (cost allocated) is also available to support the work to design, develop, and implement (DDI) modules and HIE use cases to support the Medicaid Enterprise System

The most recent IAPD-U (Update) was submitted in June 2023 for the timeframe from October 1, 2023, through September 30, 2025. Additional updates are permitted by CMS in the interim, if needed. As a recently formed HIE, transactional data is still insufficient for evaluating HIE utilization by payer, thus DSS continues to evaluate the per capita number of medical transactions (paid medical claims) in Connecticut by insurance coverage, calculated with data from Connecticut’s APCD. CMS approved this methodology on February 23, 2022.

The Federal Share of the IAPD and OAPD budgets were calculated with the CMS-approved Cost Allocation Percentage of 43%.

DDI	Total Costs	Costs Allocated to Medicaid	90% Federal Share	10% State Share	50% Federal Share	50% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 24	\$ 9,350,432	\$ 5,281,909	\$ 4,039,136	\$ 448,793	\$ 396,990	\$ 396,990	\$ 4,436,126	\$ 845,783	\$ 4,068,523
FFY 25	\$ 8,070,711	\$ 4,580,399	\$ 3,464,764	\$ 384,974	\$ 365,331	\$ 365,331	\$ 3,830,095	\$ 750,304	\$ 3,490,312
<b>Total</b>	<b>\$ 17,421,143</b>	<b>\$ 9,862,308</b>	<b>\$ 7,503,900</b>	<b>\$ 833,767</b>	<b>\$ 762,321</b>	<b>\$ 762,321</b>	<b>\$ 8,266,221</b>	<b>\$ 1,596,087</b>	<b>\$ 7,558,835</b>

#### Operational Advanced Planning Document Update (OAPD-U)

##### CMS Rules

- HIE modules and/or use cases must be **certified** as supporting the Medicaid Enterprise System (MES) to receive 75% Federal Share
- Certification is based on the **value propositions** specific to the Medicaid program, **anticipated outcomes**, and agreed upon **metrics**
- **Medicaid program costs** are determined by an approved CMS cost allocation methodology. As a recently formed HIE, transactional data is still insufficient for evaluating HIE utilization by payer, thus DSS continues to evaluate the per capita number of medical transactions (paid medical claims) in Connecticut by insurance coverage, calculated with date from Connecticut’s APCD. The cost allocation percentage approved for this year is 43%.
- Before a use case or system module receives CMS certification the FFP is limited to **50%** of Medicaid program
- Once a use case or system module is certified by CMS, the FFP increases to **75%** of Medicaid program costs

FFY	Total Operations Costs	Costs Allocated to Medicaid	75% Federal Share	25% State Share	50% Federal Share	50% State Share	Federal Share Total	State Share Total	Costs Not Allocated to Medicaid
2024	\$ 2,834,667	\$ 1,408,277	\$ 800,091	\$ 266,697	\$ 170,744	\$ 170,744	\$ 970,836	\$ 437,441	\$ 1,426,390
2025*	\$ 3,842,959	\$ 1,652,472	\$ 953,348	\$ 317,783	\$ 190,671	\$ 190,671	\$ 1,144,019	\$ 508,453	\$ 2,190,486
<b>Total</b>	<b>\$ 6,677,626</b>	<b>\$ 3,060,749</b>	<b>\$ 1,753,439</b>	<b>\$ 584,480</b>	<b>\$ 361,415</b>	<b>\$ 361,415</b>	<b>\$ 2,114,855</b>	<b>\$ 945,895</b>	<b>\$ 3,616,876</b>

\* DSS will only draw down 50/50 FFP for Patient Portal in FFY 25 until certified - included at 75/25 in this summary.

## Healthcare Benchmark Initiative Data Analytics Workgroup

The Healthcare Benchmark Initiative Data Analytics Workgroup’s charge includes designing and reviewing standard cost drivers, cost driver reports, and ad hoc analyses using available APCD data, identifying opportunities to reduce spending growth, and offering recommendations for areas of focus to the OHS Healthcare Benchmark Initiative Steering Committee on opportunities for reducing cost growth in the state. The Data Analytics workgroup members include designees from DSS and the Office of the State Comptroller and representatives of health care stakeholders including providers, insurance carriers, health equity advocate, health economists or actuarial experts and data analytics subject matter experts. The Workgroup’s advice follows guidance established by the Steering Committee’s endorsed Data Use Strategy which has been adopted and updated by the State.

The Workgroup provides advice on:

- Implementing the Data Use Strategy, including design and review of standard and ad hoc reports
- Benchmarking of Connecticut spending to other state benchmarks
- Identifying contributors to high spending, spending variation and spending growth
- Identifying opportunities for cost growth mitigation strategies
- Using analytic findings in an illustrative manner to make a compelling case to support policy change to ensure equitable, high-quality healthcare and improved population health

## Healthcare Cost Growth Benchmarks

In 2023, OHS published the first annual Healthcare Cost Growth Benchmark report and recommendations based on analyses of 2020 and 2021 data.

- [March 2023 Report](#): Healthcare cost growth benchmark and primary care spending target initiatives – 2020 and 2021 performance
- [October 2023 Report](#): Healthcare cost growth benchmark and primary care spending target recommendations to the general assembly

Additionally, OHS shared results with Healthcare Benchmark Initiative Steering Committee in March of 2023 and held a public hearing in June of 2023.

## Healthcare Quality Benchmarks

In 2020, Governor Lamont signed [Executive Order No. 5](#) directing OHS to develop annual Quality Benchmarks for CY 2022-2025. In 2022, Public Act 22-118 codified Executive Order No. 5 into law. Among other things, the new statute [C.G.S. § 19a-754g](#) requires OHS in certain circumstances and permits it in others to take certain measures including holding public hearings when seeking to adopt or modify Quality Benchmark measures or values.

The Quality Benchmarks are quality measures to which annual target values have been set, based on recommendations made by the Quality Council. In 2021, OHS selected seven Quality Benchmark measures and Benchmark values for phased implementation, per the Quality Council’s recommendation. For most of the Quality Benchmarks, separate values were established for the commercial insurance and Medicaid markets due to historical disparities in performance. For two measures, separate values were developed for the Medicare Advantage market as well.

## Data Compendium

The [Data Compendium](#) is a compilation of a current profile of key databases maintained by OHS its staff. For data sources, information includes: a brief overview of the data source, website, link and data fields related to the database. Information on public availability and access to the data are provided on the cover page of a Microsoft Excel workbook which has tabs for:

- APCD and data dictionary
- Certificate of Need (CON) database and data dictionary
- CON Notifications
- Consumer Engagement
- Hospital Reporting System (HRS) and data dictionary
- Acute care and specialty hospital Audited Financial Statements (AFS)
- State Health Care Facilities and Services Inventory and data dictionary
- Nonprofit Hospital IRS form 990 data
- Hospital Corporate Structure data

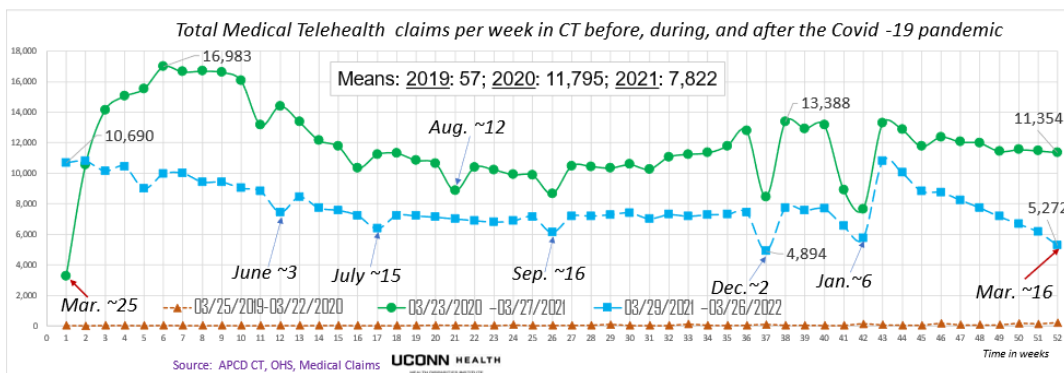
- Hospital Medicare Cost Reports
- Patient data and data dictionary from facilities, including:
  - Inpatient Discharge Database System (HIDDS)
  - Emergency Department Data
  - Surgery department and Outpatient Surgical Facility Data
- Other Required Filings – required of a variety of health care organizations and provider types
- Hospital Uncompensated Care Policies and Procedures filings required by statute

## Telehealth Study

Pursuant to [Public Act 22-81](#), OHS was required to conduct a study and report findings on 1) the feasibility and impact of expanding access to telehealth services, telehealth providers and coverage for telehealth services in this state beginning on July 1, 2024, and 2) any means available to reduce or eliminate obstacles to patient access to telehealth services, telehealth providers, and coverage for telehealth services in this state, including, but not limited to, any means available to reduce patient costs for telehealth services and coverage for telehealth services. OHS contracted UCONN Health Interoperability, Innovation and Learning Lab to conduct the study and develop the [report](#); that OHS submitted to the Public Health, Human Services, and Insurance and Real Estate Committees of Connecticut’s General Assembly on March 31, 2023.

Some notable findings in the Telehealth Study are illustrated in **Figure 7** below, and in **Table 10**, further down in this section of the Report show significant immediate growth in the use of telehealth services at the onset of the COVID-19 pandemic in the Spring of 2020, and only a modest decrease in the use of telehealth once health care practices returned to offering in-person visits in 2021. In 2019, the year before the COVID-19 virus swept around the globe, an average of 57 telehealth visits per week were conducted (over the entire year) in Connecticut. In contrast, the weekly average number of telehealth visits jumped to 11,795 in the peak COVID-19 year (2020) and remained around 7,822 in the post-COVID-19 year (2021).

**Figure 7** Weekly Rates of Telehealth Visits in Connecticut



## Telehealth Report Executive Summary

Telehealth rapidly became an indispensable tool in delivering healthcare to patients in Connecticut during the COVID-19 Pandemic. To better understand the impact of telehealth’s rapid implementation, as well as the opportunities, challenges, and future needs associated with its continued use, §41 of Public Act 22-81 required OHS to report on: (1) the feasibility and impact of expanding access to telehealth services, telehealth

providers and coverage for telehealth services in this state beginning on July 1, 2024, and (2) any means available to reduce or eliminate obstacles to patient access to telehealth services, telehealth providers, and coverage for telehealth services in this state, including, but not limited to, any means available to reduce patient costs for telehealth services and coverage for telehealth services in this state.

OHS engaged UConn Health to conduct a comprehensive study, including a literature review, surveys, and key informant interviews with patients and clinicians, an assessment of state and federal policies, and an analysis of available data from the APCD.

The findings of this study reveal that patients and clinicians strongly support telehealth as it facilitates the provision of convenient, high-quality care. For patients, telehealth provides continuity of care and reduces barriers associated with access, especially among hard-to-reach populations. Telehealth offers patients the ability to seek various primary care, behavioral health, and specialty care services in the comfort of their homes or workplaces. Providers report that telehealth facilitates their ability to provide timely patient care and mostly found the technology easy to implement.

While continued use of telehealth has robust, across-the-board support, there exists room for improvement. Several opportunities were identified to enhance telehealth services, including **payment, technology, and user support**. Several policy recommendations are made within this report to address the identified challenges. Recommendations include:

Creation of a telehealth advisory council, task force, or committee for OHS that continues to report to the legislature and state agencies.

Creation of rapid response multi-agency state agency task force to evaluate opportunities to use state and federal dollars to support infrastructure (i.e., broadband expansion, telehealth centers), and agency policy.

- Further assess the fiscal and operational feasibility of continuing payment parity for telehealth and remote patient monitoring with an examination of actual costs to provide services compared to in-person services.
- Creation of clear policy regarding telehealth definitions, reimbursement, and requirements regarding supervision of clinicians in training for Medicaid and other state payors with recommendations that the opportunity be extended to all payors.
- Funding and evaluation of the pilot testing of telehealth specifically focused on saving healthcare dollars, while maintaining or improving quality (i.e., in jails and prisons, schools, skilled nursing facilities, etc.).
- Designation and funding of an entity to continue to monitor the policy, practice, and healthcare outcomes in Connecticut and other states as well as at a federal level and to evaluate the clinical and cost outcomes of changes with policy, usage, and payment.
- Partnering with a team to develop and administer a training program for clinicians, staff and patients on the "best practices" in telehealth.

- Expansion of access to telehealth through ubiquitous broadband coverage, low or no cost highspeed internet, low-cost and easy-to-use technology and devices, telehealth-specific spaces or centers, and expansion of interstate licensing compacts.

There is a clear existing and demonstrated benefit to the continued reimbursement of telehealth services in the State beyond the Public Health Emergency. Clinicians and patients agree that telehealth offers a convenient, high-quality complement to in-person care. However, a need remains for further evaluation of its effectiveness and impact on cost savings and health outcomes. This further study may enumerate specific cost savings, quality improvement, and effectiveness outcomes.

## All-Payer Claims Database

Created in 2012 by Public Act 12-166, later codified as [CGS §19a-755a](#), the Connecticut [All-Payer Claims Database](#) (APCD) was established as a program to receive, store, and analyze health insurance claims data for the promotion of research addressing safety, quality, transparency, access, and efficiency at all levels of health care delivery. The statute requires health insurers to submit medical and pharmacy claims data, as well as information on providers and eligibility.

[Section 19a-755a](#) directs OHS to oversee planning, implementation, and administration of the APCD. OHS makes APCD data available to payers, providers, consumers or researchers of health and health care services through a data release process that delineates internal state data uses from external APCD data uses. The APCD program makes information about the database, its charter, oversight, governance, policies and procedures, available to the public on the [OHS website](#).

OHS provides staff support and oversight of the [APCD Advisory Group](#) and the [APCD Data Release Committee](#) (DRC). OHS releases data extracts from the APCD to any state agency, insurer, employer, health care provider, consumer of health care services, researcher, or the [Connecticut Health Insurance Exchange](#) for health care services utilization, costs or quality review. As required by the federal regulations [45 CFR 160.103](#), disclosures must protect the confidentiality of health information. For entities outside the State of Connecticut government, OHS releases a deidentified data extract containing commercial data only.

Commercial Insurance Plans
Aetna Life Insurance Co. – Traditional
Aetna Life Insurance Co. - Student Health
Aetna Health Insurance Co. - HMO administered by ACAS
Cigna East
Harvard Pilgrim Healthcare Insurance Co.
eviCore Healthcare
Anthem Health Plans, Inc. - G1800
ConnectiCare Insurance Co.
Caremark LLC
Medicaid Plans
CT Medicaid FFS Eligibility, Medical, ED, Outpatient, Pharm
CT Medicaid FFS Long Term Care
CT Medicaid FFS Inpatient Care
CT Medicaid FFS Telehealth Services
Medicare Advantage Plans
WellCare Health Plans, Inc.
Anthem Health Plans Inc
Caremark LLC
UnitedHealthcare Insurance Co.
Aetna - Next Gen
ERISA Plans (Voluntary Submission)
UnitedHealthcare Insurance Co.
ConnectiCare Insurance Co.
Cigna East
eviCore Healthcare

**Table 8** Health Plans Contributing to Connecticut’s APCD 2023

Each quarter, new data is released from the APCD with utilization and pricing information on commercial, Medicare, and Medicaid covered populations. Sources of data include medical and pharmacy claims, as well as eligibility, enrollment, and provider information. The APCD currently contains more than a billion records spanning data from 2012 through September 2023. The commercial insurance and Medicare eligibility and claims data are available from 2012 while Medicaid data is available from 2016. Federal law prevents APCDs from mandating the collection of claims data from self-insured employers. In Connecticut, however, one of the largest self-insured employers, the State of Connecticut and [CT Partnership Plan 2.0](#) for municipalities, voluntarily submit claims data to the APCD. A request for more complete Medicare data has been submitted to the CMS Research Data Assistance Center (ResDac). The timeline for the APCD program to receive ResDac data is between 5-9 months; the effort is being facilitated by OnPoint, Connecticut’s APCD vendor.

The APCD Advisory Group, composed of 20 advisors (see Appendix C), is charged with providing advice to OHS to enhance the state's use of healthcare data from multiple sources to increase efficiency, enhance outcomes, and improve understanding of healthcare expenditures in the public and private sectors.

During this reporting period, the Advisory Group met on a quarterly basis, with the following agenda topics at each of their 2023 meetings.

**Table 9** 2023 APCD Advisory Group Meetings

Date	APCD Advisory Group: Meeting Focus
2/9/23	APCD use case update, internal versus external APCD application process, Health IT Plan
4/26/23	Medicaid data integration, Medicare data use agreement extension, denied claims use cases and data collection, healthcare cost growth benchmarks, and primary care spending targets
5/11/23	Denied claims collection feedback and discussion, federal grant funding for state APCDs, State APCD Advisory Committee (SAPCDAC) Final Report, discussion on recommendations
8/10/23	State government update on artificial intelligence (AI), and APCD strategic prioritization update and data submission guide update
11/9/23	Approval of 2024 meeting schedule and updates on: APCD strategic activities, Snapshot on website, Healthcare Cost Estimator Consumer Tool, Statewide Facility Plan preliminary report for Phase 1, Behavioral Health Parity Study, and Hospital Community Benefit Data Release.

The APCD Data Release Committee (DRC) reviews and deliberates on each data release application submitted to the APCD. The DRC reviewed and approved three research studies to receive APCD data sets during 2023; no requests were denied over the timeframe. Studies were submitted by the following organizations:

- Planned Parenthood of Southern New England
- Humbi, LLC
- For provider commercial price comparisons for an alleged anti-competitive activities investigation (based on a subpoena to the state)

### Key APCD Initiatives in 2023

- In 2023, [CGS §19a-127k](#) authorized OHS to release limited datasets to CT hospitals for use in preparing Community Health Needs Assessments, preparing and executing community benefit implementation strategies; and meeting community benefit program reporting requirements.
- OHS continued to partner with Bailit Health and Mathematica in 2023 to examine drivers of commercially insured healthcare costs utilizing APCD data. The analyses also include identifying high-cost, high-volume medical services, and those with wide price variations among providers at the state, payer, and provider network levels, to identify opportunities to reduce cost growth, improve quality and promote equity. These analyses primarily support the Healthcare Benchmarks Initiative work authorized by Executive Order No. 5, codified as [C.G.S. §19a-754g](#), to work to slowdown the rising cost of healthcare to sustainable levels, increase primary care spending, and improve the quality of care. The analyses also included measuring the unintended consequences of the program on consumer medical and insurance premium out of pocket spending.

Using these APCD analyses, OHS identified insurers, healthcare providers and manufacturers of prescription drugs that exceeded the annual growth benchmark and/or were significant contributors to healthcare cost growth and held the first informational public hearing of the program in June 2023.

- Through a Data Use Agreement (DUA) with OHS, UConn Health acquired, and analyzed APCD data for the legislatively mandated Telehealth Study. The protocol and methodology strategies were reviewed and approved by the UConn Health Institutional Review Board as an expedited study (IRB #21-050-1). Access to the APCD data allowed the analysis of telehealth services versus face-to-face services by type in a time-series methodology, tracked against the COVID-19 outbreak, policy and payment changes.

The observational retrospective research design study was aimed at detecting time changes, differences by population groups and regions, and differential changes by population groups and region in medical care utilization and costs before and after telehealth became widely available in Connecticut. It is important to note that the APCD contains a subset of claims data from Connecticut for the timeframe evaluated, including Medicaid, commercially insured patients from the exchange, and non-self-insured employers, as well as self-insured employers who explicitly permit claims to be submitted to the APCD. While this has some limitations, it still represents the majority of healthcare delivered in Connecticut during this period between January 1, 2019, and March 31, 2022. Data from Medicare was not available for the entire timeframe and was not included in the analysis.

**Table 10** Comparative Telehealth Expenditures Based on APCD Data

Timeframe	Unique Patients	Total Count of Claims	Total Paid Amounts	Total Charged Amounts
Pre-COVID-19 3/25/2019 – 3/22/2020	5,361	6,191	\$440,926	\$884,302
Peak COVID-19 3/23/2020 – 3/21/2021	273,119	620,814	\$56,117,982	\$103,554,589

Post-COVID-19 3/29/2021 – 3/26/2022	184,628	399,371	\$35,065,691	\$70,476,750
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## APCD Strategic Planning

The year 2023 saw Connecticut’s APCD program engaged in a strategic planning process to ensure the program continues to provide value and achieve its aims. Seven strategic initiatives across two broad areas have been defined for action by the APCD program.

In the focus area of **Data Enhancements and Utilization** the strategic initiatives and proposed actions are:

### 1. Produce and publish data visualizations with APCD data

- OHS will select three of eleven proposals for cost, utilization and performance use cases that align with OHS priorities (underway)

### 2. Enhance and enrich APCD data

- The APCD program will convene a data quality workgroup to identify how to improve data quality that will support policy development and evaluation of Connecticut healthcare utilization, cost, and quality (pending)
- The APCD program will convene virtual stakeholder listening sessions with ERISA plan sponsors (underway)

### 3. Increase the external uses of APCD data

- The APCD program will initiate a website redesign to make APCD information more accessible for data requests and publish approved uses (underway)
- The APCD program will create an e-marketing campaign to attract users as such as educational, research, and non-profit organizations, state agencies, and other states (pending)
- The APCD program will create public use files for research (pending)
- The APCD program will update its healthcare cost estimator tool to support consumer and health care purchaser decision-making (complete)

In the focus area of **Operational Enhancements**, the strategic initiatives and proposed action steps are:

### 4. Explore fee structure changes

- The APCD program will prepare a report on pricing models for data release requests from other APCD programs across the nation, including fee structures and fee waivers. The APCD program staff will solicit feedback from the HITAC and APCD advisory bodies before developing a new fee schedule for Connecticut APCD data releases. (pending)

### 5. Refine APCD data request application and process

- The APCD program to work with the APCD Data Release Committee to revamp the data release application and develop more efficient request fulfillment workflow (underway)

### 6. Enact new APCD policies and procedures

- As part of ongoing process improvement, update policies and procedures to delineate data request process for state agencies versus external (non-state agencies) process (pending)
  - Add a data equity assessment for the release requirements
  - Consult with the HITAC and APCD advisory bodies

**7. Fill vacancies on the APCD Data Release Committee and APCD Advisory Group**

- Fill two vacancies in Advisory Group with representatives from DPH and from the Connecticut State Medical Society (underway)
- Fill three vacancies in Data Release Committee with the Medicaid Director/designee, OHS Executive Director/designee, and an attorney/healthcare professional (physician, nurse, social worker or psychologist) with experience in healthcare/data privacy or research matters (underway)

**Table 11** *Additional APCD Strategic Activities*

Activity	Tasks
<b><u>New Sources of Data Collection</u></b> Dental & denied claims  Race, Ethnicity & Language in compliance with CGS §19a-754d	<ul style="list-style-type: none"> <li>○ APCD Advisory Group approved an updated Data Submission Guide for new data collection (April '23)</li> <li>○ 30-day public review of the Data Submission Guide (May-June '23)</li> <li>○ New Data Submission Guide in effect (October '23)</li> <li>○ New submission requirements begin (February '24)</li> </ul>
New, improved <b>Cost Estimator</b> (consumer and health care purchaser decision tool)	<ul style="list-style-type: none"> <li>✓ Upgraded tool includes paid amounts &amp; out of pocket payments on 25+ commonly provided inpatient services, outpatient services/procedure, outpatient Rx drugs, durable medical equipment (DME)</li> <li>✓ Release (January '24)</li> </ul>
<b>ERISA Plan Stakeholder Engagement</b> campaign to encourage self-insured employers to submit to CT-APCD	<ul style="list-style-type: none"> <li>✓ Presentation to Connecticut large employers</li> <li>✓ Creation of opt-in form for employers' use to authorize TPA/insurer to submit</li> </ul>

**OHS & State-Initiated Projects That Are Supported by APCD Data**

1. Analysis of outpatient Rx drugs to support CGS 368dd 19a-754b transparency mandate
2. OHS provided an additional APCD data extract for inclusion in the [RAND Hospital Price Transparency Study 5.0](#)
3. Analysis of the hospital facility fee to support legislative updates
4. Analysis of health care cost and quality benchmarks & primary care target initiative (a legislatively mandated data use strategy to identify insurers and providers that exceed benchmarks)
5. Analysis of health care service pricing and availability to support decision-making in Certificate of Need evaluations

6. Analysis of hospital cost and market impact for a proposed hospital consolidation
7. Telehealth expansion and access improvement study (legislatively mandated)
8. Analysis of reproductive health service access for commercial population, to support legislation
9. Analysis of claims volume by product line to support Connie federal funding match rate (40% CMS cost share increased to 43%)
10. Analysis of autism services access and relative price comparisons between commercial insurance and Medicaid benefits for parity requirements
11. Development of the Cost Estimator, an improved healthcare consumer and purchaser tool (released in January 2024)
12. A price comparison of inpatient and outpatient services between state employees and other commercial insurance plans
13. APCD Snapshot – updated online dashboard of summary data available (e.g., data available, # of people insured from year to year, medical procedures performed, drugs prescribed, costs for health plans and consumers)
14. Analysis of payment parity and behavioral health coverage by private insurers (a required report by CMS, in progress, report due 2024)
15. Analysis of the impact of Connecticut hospital and health care system consolidations (a legislatively mandated study to be released in 2024)
16. A statewide health care utilization study to support a facilities and services plan (a legislative report is in progress)
17. Analysis of Connecticut’s expenditures on ten Medicare Rx drugs that are subject to negotiations
18. A market plan utilization review of Access Health CT- the state’s Insurance Exchange
19. Comparative analysis of APCD inpatient data vs. hospital inpatient discharge data
20. A review of chronic disease programs – pending
21. A review of primary care provider information to support decision-making for designations of health professional shortage areas- pending
22. Analysis to support an update to Connecticut’s healthcare affordability index dashboard pending

## APCD Funding Update

OHS requested and received in the 2024 budget cycle additional resources to manage Connecticut APCD and support analytics which include:

- Two additional positions
- Funding for data enhancement and ad hoc analytics - \$50,000

A federal funding opportunity through the No Surprises Act is slated to provide grants to state APCD programs of \$2.5m over three years for states to establish or enhance APCDs to support market transparency efforts and research. The grant program is expected to include provisions to make it easier for self-insured

employers to voluntarily participate in state APCD programs. Connecticut is still awaiting guidance from the Federal Department of Labor about grant requirements.

## APCD Fee Schedule for Data Releases

Data Fee Schedule

Types of Files	Commercial		Non-Profit/Educational		State Agencies		Assessed	
	Initial Extract	Additional Extract	Initial Extract	Additional Extract	Initial Extract	Additional Extract	Initial Extract	Additional Extract
Inpatient Facility	\$3,000	\$1,500	\$1,000	\$500	\$750	\$375	\$2,500	\$1,250
ER Facility	\$3,000	\$1,500	\$1,000	\$500	\$750	\$375	\$2,500	\$1,250
Outpatient Facility	\$3,000	\$1,500	\$1,000	\$500	\$750	\$375	\$2,500	\$1,250
Professional Claims	\$6,000	\$3,000	\$2,000	\$1,000	\$1,500	\$750	\$5,000	\$2,500
All Medical Claims	\$12,000	\$6,000	\$4,000	\$2,000	\$3,000	\$1,500	\$10,000	\$5,000
Pharmacy Claims	\$3,000	\$1,500	\$1,000	\$500	\$750	\$375	\$2,500	\$1,250
Member Eligibility	\$5,000	\$2,500	\$1,650	\$825	\$1,250	\$625	\$4,170	\$2,085

**Note:** Initial extract can be of multiple years. Additional Extract is for 1 year or less.

# Appendix A

## Health IT Advisory Council Member Roster

Appointing Authority	Name & Appointment Date	Represents
1. Statute	Sumit Sajjani** (Co-Chair) 10/22/2021	Health Information Technology Officer or designee
2. Statute	Gui Woolston (designee) 7/11/2022	Commissioner of Social Services or designee
3. Statute	Elizabeth Taylor (designee) 12/19/2019	Commissioner of Mental Health and Addiction Services or designee
4. Statute	Nicole Taylor (designee) 11/18/2021	Commissioner of Children and Families or designee
5. Statute	Sharonda Carlos (designee) 1/19/2021	Commissioner of Correction or designee
6. Statute	Gary Archambault (designee) 12/6/2023	Commissioner of Public Health or designee
7. Statute	Joshua Scalora (designee) 8/17/2022	Commissioner of Developmental Services or designee
8. Statute	Sandra Czunas (designee) 12/21/2017	Office of the State Comptroller or Designee
9. Statute	Mark Raymond	Chief Information Officer or designee
10. Statute	Rebekah McLearn (designee) 10/19/2022	CEO of the CT Health Insurance Exchange or designee
11. Statute	Thomas Woodruff 11/17/2023	An expert in state health care reform initiatives appointed by the Executive Director of Office of Health Strategy
12. Statute	Vacant	Chief Information Officer of UConn Health or designee
13. Statute	Adam Prizio (designee) 10/5/2023	Healthcare Advocate or designee
14. Governor	Geoffry Hook 1/5/2024	Representative of a health system that includes more than one hospital
15. Governor	David Fusco 3/0/2016	Representative of the health insurance industry
16. Governor	Nicolangelo Scibelli 1/19/2016	Expert in health information technology
17. Governor	Patricia Checko 1/19/2016	Health care consumer or consumer advocate
18. Governor	Cassandra Murphy 3/2/2020	An employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186
19. President Pro Tempore of Senate	Vacant	Representative of a federally qualified health center
20. President Pro Tempore of Senate	Vacant	Provider of Behavioral Health Services
21. President Pro Tempore of Senate	Vacant	A physician licensed under chapter 370
22. Speaker of the House of Rep.	Lisa Stump 11/22/2016	Technology expert who represents a hospital system
23. Speaker of the House of Rep.	Vacant	Provider of home health care services
24. Speaker of the House of Rep.	Vacant	Health care consumer or a health care consumer advocate
25. Majority Leader of the Senate	Patrick Charmel 11/30/2015	Representative of an independent community hospital
26. Majority Leader of the House of Rep.	Vacant	Physician who provides services in a multispecialty group and who is not employed by a hospital
27. Minority Leader of the Senate	Joe Quaranta, MD** (Co-Chair) 7/22/2015	Primary care physician who provides services in a small independent practice
28. Minority Leader of the House of Rep.	Alan Kaye, MD 8/24/2015	Expert in health care analytics and quality analysis
29. President Pro Tempore of Senate	Dina Berlyn (designee)	President Pro Tempore of Senate or designee
30. Speaker of the House of Rep.	Mark Gildea (designee) 9/8/2021	Speaker of the House of Representatives or designee
31. Minority Leader of the Senate	Dr. Susan Israel (designee) 1/6/2021	Minority Leader of the Senate or designee
32. Minority Leader of the House of Rep.	Michael Crain 3/13/2023	Minority Leader of the House of Representatives or designee

# Appendix B

## HITAC Meeting Schedule

### Health Information Technology Advisory Council 2024 Regularly Scheduled Meetings

Health Information Technology Advisory Council meetings are held on the third (3<sup>rd</sup>) Thursday of the month. In accordance with Public Act 22-3, OHS intends to hold all meetings solely by means of electronic equipment (remotely).

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**Meeting Location:** [Zoom](#)  
Dial In: +1 646 876 9923 US (New York)  
Meeting ID: 842 7294 5585  
Passcode: 807322

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Date (Thursday)	Time (EST)
January 18, 2024	1:00-3:00 pm
February 15, 2024	1:00-3:00 pm
March 21, 2024	1:00-3:00 pm
April 18, 2024	1:00-3:00 pm
May 16, 2024	1:00-3:00 pm
June 20, 2024	1:00-3:00 pm
July 18, 2024	1:00-3:00 pm
August 15, 2024	1:00-3:00 pm
September 19, 2024	1:00-3:00 pm
October 17, 2024	1:00-3:00 pm
November 21, 2024	1:00-3:00 pm
December 19, 2024	1:00-3:00 pm

Agendas, materials, and updated meeting information can be found on the Office of Health Strategy website: [HITAC Meeting Materials & Information](#)

Pursuant to Public Act 22-3, OHS will provide accommodations for members of the public who need access to electronic equipment. Please contact [OHS@ct.gov](mailto:OHS@ct.gov) no later than 24 hours in advance of the meeting to make a request.

# Appendix C

## APCD Advisory Group Member Roster

## Connecticut All Payer Claims Database Advisory Group\* | Membership Roster

Appointing Authority	Name & Appointment Date	Representation
1. Statute	Olga Armah, Chair (designee)	Health Information Technology Officer or designee
2. Statute	Scott Gaul (designee) (1/9/2020)	Secretary of Office of Policy and Management or designee
3. Statute	Josh Wojcik (designee) (6/25/2013)	State Comptroller or designee
4. Statute	Gary Archambault (designee) (12/6/2023)	Commissioner of Public Health or designee
5. Statute	William Halsey (designee) (11/9/2021)	Commissioner of Social Services or designee
6. Statute	Michael Giralmo (designee) (2/11/2019)	Commissioner of Mental Health and Addiction Services or designee
7. Statute	Paul Lombardo (designee) (11/8/2018)	Commissioner of Insurance or designee
8. Statute	Sarah Carr (designee) (10/3/2023)	Healthcare Advocate or designee
9. Statute	Robert Barry (designee) (9/1/2020)	State Chief information Officer or designee
10. Statute	Vacant	Representative of the Connecticut State Medical Society
11. Statute; affirmed by APCD Advisory Group	Bernie Inskeep (6/4/2015)	Representative of a Health Insurance Company
12. Statute; affirmed by APCD Advisory Group	Cassandra Murphy (3/2/2020)	Representative of a Health Insurance Purchaser
13. Statute; affirmed by APCD Advisory Group	James Iacobellis (4/29/2013)	Representative of Hospitals
14. Statute; affirmed by APCD Advisory Group	Patricia Checko (8/8/2019)	Representative of Consumer Advocates
15. Statute; affirmed by APCD Advisory Group	Robert Scalettar, MD (4/29/2013)	Representative of Health Care Providers
16. Health Information Technology Officer	Robert Aseltine (4/29/2013)	Health Care Expert from an Academic Institute
17. Health Information Technology Officer	Francois de Brantes (8/11/2016)	Expert in Payment Reform
18. Health Information Technology Officer	Michaela Dinan (5/10/2021)	Health Care Expert from an Academic Institute

\*The APCD Advisory Group is a subcommittee of the Health Information Technology Advisory Council in accordance with C.G.S. Sec. 17b-59f(e)(1)

# Appendix D

## USDI Version 2

### Allergies and Intolerances

Harmful or undesired physiological responses associated with exposure to a substance.

- [Substance \(Medication\)](#)
- [Substance \(Drug Class\)](#)
- [Reaction](#)

### Assessment and Plan of Treatment

Health professional's conclusions and working assumptions that will guide treatment of the patient.

- [Assessment and Plan of Treatment](#)
- [SDOH Assessment](#)

### Care Team Member(s)

Information on a person who participates or is expected to participate in the care of a patient.

- [Care Team Member Name](#)
- [Care Team Member Identifier](#)
- [Care Team Member Role](#)
- [Care Team Member Location](#)
- [Care Team Member Telecom](#)

### Clinical Notes

Narrative patient data relevant to the context identified by note types.

- [Consultation Note](#)
- [Discharge Summary Note](#)
- [History & Physical](#)
- [Procedure Note](#)
- [Progress Note](#)

### Clinical Tests

Non-imaging and non-laboratory tests performed that result in structured or unstructured findings specific to the patient to facilitate the diagnosis and management of conditions.

- [Clinical Test](#)
- [Clinical Test Result/Report](#)

### Diagnostic Imaging

Tests that result in visual images requiring interpretation by a credentialed professional.

- [Diagnostic Imaging Test](#)
- [Diagnostic Imaging Report](#)

### Encounter Information

Information related to interactions between healthcare providers and a patient.

- [Encounter Type](#)
- [Encounter Diagnosis](#)
- [Encounter Time](#)
- [Encounter Location](#)
- [Encounter Disposition](#)

## **Goals**

Desired state to be achieved by a patient.

- [Patient Goals](#)
- [SDOH Goals](#)

## **Immunizations**

Record of vaccine administration.

- [Immunizations](#)

## **Laboratory**

Analysis of clinical specimens to obtain information about the health of a patient.

- [Tests](#)
- [Values/Results](#)

## **Medications**

Pharmacologic agents used in the diagnosis, cure, mitigation, treatment, or prevention of disease.

- [Medications](#)

## **Patient Demographics/Information**

Data used to categorize individuals for identification, records matching, and other purposes.

- [First Name](#)
- [Last Name](#)
- [Middle Name \(including middle initial\)](#)
- [Suffix](#)
- [Previous Name](#)
- [Date of Birth](#)
- [Race](#)
- [Ethnicity](#)
- [Sex \(Assigned at Birth\)](#)
- [Sexual Orientation](#)
- [Gender Identity](#)
- [Preferred Language](#)
- [Current Address](#)
- [Previous Address](#)
- [Phone Number](#)
- [Phone Number Type](#)

- [Email Address](#)

## **Problems**

Condition, diagnosis, or reason for seeking medical attention

- [Problems](#)
- [SDOH Problems/Health Concerns](#)
- [Date of Diagnosis](#)
- [Date of Resolution](#)

## **Procedures**

Activity performed for or on a patient as part of the provision of care.

- [Procedures](#)
- [SDOH Interventions](#)

## **Provenance**

The metadata, or extra information about data, regarding who created the data and when it was created.

- [Author Time Stamp](#)
- [Author Organization](#)

## **Smoking Status**

Representing a patient's smoking behavior.

- [Smoking Status](#)

## **Unique Device Identifier(s) for a Patient's Implantable Device(s)**

Unique identifier(s) for a patient's implantable device(s).

- [Unique Device Identifier\(s\) for a patient's implantable device\(s\)](#)

## **Vital Signs**

Physiologic measurements of a patient that indicate the status of the body's life sustaining functions.

- [Systolic Blood Pressure](#)
- [Diastolic Blood Pressure](#)
- [Heart Rate](#)
- [Respiratory Rate](#)
- [Body Temperature](#)
- [Body Height](#)
- [Body Weight](#)
- [Pulse Oximetry](#)
- [Inhaled Oxygen Concentration](#)
- [BMI Percentile \(2 - 20 years\)](#)
- [Weight-for-length Percentile \(Birth - 36 Months\)](#)
- [Head Occipital-frontal Circumference Percentile \(Birth - 36 Months\)](#)

# Appendix E

## Partial List of Health Information Technology Acronyms

<b>ACO</b>	Accountable Care Organization	<b>IIS</b>	Immunization Information System
<b>APCD</b>	All-Payer Claims Database	<b>ISA</b>	Interoperability Standards Advisory
<b>ARRA</b>	American Recovery and Reinvestment Act	<b>ISO</b>	International Standards Organization
<b>BPMH</b>	Best Possible Medication History	<b>LDS</b>	Limited Data Set
<b>CBO</b>	Community Based Organization	<b>MES</b>	Medicaid Enterprise System
<b>CCIP</b>	Community and Clinical Integration Program	<b>MPI</b>	Master Person Index
<b>CIE</b>	Community Information Exchange	<b>MRPC</b>	Medication Reconciliation and Polypharmacy Committee
<b>CMMI</b>	Center for Medicare and Medicaid Innovations	<b>OHS</b>	Office of Health Strategy
<b>CMS</b>	Centers for Medicare and Medicaid Services	<b>OMB</b>	U.S. Office of Management and Budget
<b>CQM</b>	Clinical Quality Measure	<b>ONC</b>	Office of the National Coordinator for Health Information Technology
<b>CRISP</b>	Chesapeake Regional Information System for our Patients	<b>OPM</b>	Office of Policy and Management
<b>DGS</b>	Digital Government Services	<b>OSC</b>	Office of the State Comptroller
<b>DPH</b>	Department of Public Health	<b>P20 WIN</b>	Preschool Through Twenty Workforce Information Network
<b>DSS</b>	Department of Social Services	<b>PCMH</b>	Patient Centered Medical Home
<b>eCMS</b>	Electronic Consent Management System	<b>PCSC</b>	Patient Centered Services Collaborative
<b>eCQM</b>	Electronic Clinical Quality Measure	<b>PDMP</b>	Prescription Drug Monitoring Program
<b>EHR</b>	Electronic Health Record	<b>PHI</b>	Protected Health Information
<b>ERIC</b>	Equity Research and Innovation Center-Yale	<b>PSI</b>	Prevention Service Initiative
<b>FFP</b>	Federal Financial Participation	<b>R&amp;D</b>	Research and Development
<b>FFY</b>	Federal Fiscal Year	<b>REL</b>	Race Ethnicity and Language (REL)
<b>FQHC</b>	Federally Qualified Health Center	<b>RFA</b>	Request for Applications
<b>Health IT</b>	Health Information Technology	<b>SDLC</b>	Systems Development Life Cycle
<b>HEC</b>	Health Enhancement Communities	<b>SIM</b>	State Innovation Model
<b>HHS</b>	Health and Human Services	<b>SMHP</b>	State Medicaid Health IT Plan
<b>HIE</b>	Health Information Exchange	<b>SMMS</b>	Statewide Medication Management Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996	<b>TA</b>	Technical Assistance
<b>HITECH</b>	Health Information Technology for Economic and Clinical Health Act	<b>TEFCA</b>	Trusted Exchange Framework and Common Agreement
<b>HITO</b>	Health Information Technology Officer	<b>2Gen</b>	Two Generational Initiatives
<b>HITRUST</b>	Health Information Trust Alliance	<b>UConn</b>	University of Connecticut

<b>IAPD</b>	Implementation Advance Planning Document	<b>VBPM</b>	Value-Based Payment Model
<b>IAPD-U</b>	Implementation Advance Planning Document		