



2025 Health Information Technology Report

Pursuant to Connecticut General Statute §17b-59a

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Table of Contents

Office of Health Strategy	5
History, Mission, and Responsibilities.....	5
Executive Summary	7
Section 1: The Statewide Health IT Plan	13
Focus Area 1: Sustain and Increase the Use of Statewide HIE Services.....	14
Focus Area 2: Implement Systems to Improve Health Equity, Address Health-Related So- cial Needs.....	16
Focus Area 3: Improve Service Coordination and Data Sharing Across HHS Agencies.....	17
Focus Area 4: Support Behavioral Health Providers with Adoption of EHR and HIE Services	19
Focus Area 5: Protect Individuals’ Health Information Privacy	19
Focus Area 6: Establish Electronic Data Standards to Facilitate Development of Integrated Electronic Health Information Systems.....	20
Section 2: Establishment of Data Standards	22
REL-D Standards for Connecticut Agencies and Providers.....	22
Section 3: Programmatic Updates	33
Connecticut’s Statewide Health Information Exchange.....	33
All-Payer Claims Database	58
Section 4: Recommendations for Policy, Regulatory or Legislative Changes	67
Advancing Health Equity in Connecticut Through Data-Driven Strategies	67
Recommendations for Maximizing Impact	67
Section 5: Other Initiatives Supporting Health IT	69
DSS & OHS Joint Steering Committee	69
Healthcare Benchmark Initiative.....	72
Data Compendium	72
Appendix A	73
Partial List of Health Information Technology Acronyms.....	73
Appendix B	74
Federal Health IT Strategic Plan Goals and Objectives	74
Federal Health IT Rules	76

Index of Tables and Figures

- Table 1: Statewide Health IT Plan..... 13
- Table 2: Connie's Core Technology Components..... 34
- Figure 1: Connie Data Quality Model & Plan 40
- Figure 2: Facilities Connected through December 2024..... 42
- Table 3: EHR Hub Connections..... 44
- Figure 3: 2024 Connie In-Bound Data Statistics..... 45
- Figure 4: Connie Service Usage Statistics..... 47
- Table 4: Summary Table of Connie Use Case Services and Supporting Functions..... 52
- Figure 5: Process for Activating a Consumer App for Accessing Patient Records..... 53
- Table 5: APCD Data Contributors, Data Types, and Years of Data Available..... 60
- Table 6: APCD Strategic Priorities, Activities and Status: Data Enhancements & Utilization..... 61
- Table 7: APCD Strategic Priorities, Activities and Status - Operational Enhancements..... 62
- Table 8: Summary of IAPD-U DDI Funding Request..... 71
- Table 9: OAPD Summary of Operations Budget Request 71
- Table 10: Combined IAPD and OAPD Funding Request..... 71
- Table 11: Partial List of Health IT Acronyms **Error! Bookmark not defined.**
- Figure 6: TEFCA Governance Framework..... 81

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Office of Health Strategy

History, Mission, and Responsibilities

The Office of Health Strategy (OHS) was established by the Connecticut General Assembly (CGA) on January 1, 2018, through Special Session [Public Act 17-2 §164](#). OHS develops programs, policies, and regulations through authorities granted by the CGA and duties defined in various sections of the [General Statutes of Connecticut](#).

OHS Mission

To implement comprehensive data-driven strategies that promote equal access to high-quality healthcare, control costs, and ensure better health for the people of Connecticut

OHS plays a pivotal role in advancing health Information Technology (health IT) initiatives in Connecticut. Key responsibilities include:

- 1) **Developing and Implementing a [Statewide Health IT Plan \(Health IT Plan\)](#):** OHS creates and executes a comprehensive Health IT strategy that prioritizes better health outcomes, cost containment, and equity.
- 2) **Coordinating Health IT Initiatives:** OHS serves as the central body to align and integrate the state's various Health IT projects and programs.
- 3) **Overseeing the All-Payer Claims Database (APCD):** OHS directs and manages the APCD program, which collects and analyzes healthcare claims data to inform policy and improve healthcare outcomes.
- 4) **Establishing and oversight of the Statewide Health Information Exchange (HIE) program:** OHS is responsible for creating and overseeing the Statewide HIE to enable secure and efficient sharing of health information among providers, payers, and patients.
- 5) **Patient Data Collection and Reporting:** OHS collects, analyzes, and reports on inpatient, outpatient, and emergency department visit data from healthcare providers to identify trends, assess healthcare utilization, and support data-driven policy development.
- 6) **Hospital Reporting System:** OHS oversees the collection, analysis, and reporting of hospital operating results, including financial data such as facility fees, audited financial statements, and detailed information about corporate structures, officers, and directors, to ensure transparency and accountability.

- 7) **Developing Data Standards:** OHS leads efforts to establish robust data standards, including those for Race, Ethnicity, Language, and Disability (REL-D) status, to ensure data consistency and support equitable healthcare delivery.
- 8) **Engaging Stakeholders:** OHS convenes forums, advisory councils, and stakeholder groups to discuss healthcare challenges and collaboratively develop effective strategies for improving cost, quality, and equity.

OHS collects, analyzes, and synthesizes critical datasets from diverse sources to achieve these goals. Insights are disseminated through reports, presentations, guidebooks, briefs, environmental scans, spreadsheets, and interactive dashboards.

OHS facilitates a robust network of advisory groups to inform legislative initiatives, and guide agency objectives and program needs. OHS managed 15 active advisory groups, comprising members from a wide range of stakeholder organizations to ensure diverse representation and informed decision-making throughout the report period.

Executive Summary

The 2025 Health IT Annual Report is respectfully submitted to the joint standing committees of the CGA having cognizance of matters relating to human services and public health, by Deidre Gifford, MD, MPH, Commissioner of OHS, and Sumit Sajnani, the Health Information Technology Officer (HITO), in consultation with Connecticut's Health Information Technology Advisory Council (HITAC).

The Health IT Report is developed to provide a comprehensive update on Connecticut's health IT initiatives and complies with statutory requirements of [C.G.S. 17b-59a\(f\)](#) which mandates the following:

- 1) **Development and Implementation:** Progress on the Health IT plan and data standards established and implemented by OHS.
- 2) **Statewide Health Information Exchange (HIE):** Updates on the establishment and advancement of the HIE.
- 3) **Recommendations:** Policy, regulatory, and legislative recommendations, as well as initiatives to promote Connecticut's health IT and exchange goals.

Navigating Uncertainty and Adapting Connecticut's Health IT Strategy and Road Map Amid Federal Policy Shifts

The federal landscape is experiencing significant shifts with the change in administration. A number of regulations, policies and guidance issued by the Centers for Medicare and Medicaid Services (CMS), the Office of the National Coordinator for Health Information Technology (ONC), and other federal agencies in 2024—many of which are cited in this report—may be subject to change under a new administration. These developments could have a substantial impact on health IT initiatives in Connecticut.

Federal policies on the collection and use of data such as race, ethnicity, sexual orientation, and gender identity may also be subject to changes. These standards, critical to addressing health disparities, may be reevaluated under the new federal administration, potentially limiting how states like Connecticut structure their health IT initiatives.

OHS will continue to monitor federal policy changes and assess their impact on Connecticut's health IT programs, plans, and regulations. Adjustments will be made as necessary to ensure compliance with federal requirements while advancing Connecticut's health IT goals.

Given this fluid federal environment, this report should be interpreted with an understanding of the potential for significant regulatory and policy shifts. As the landscape evolves, OHS remains committed to proactively adapting to these changes and ensuring Connecticut remains at the forefront of health IT innovation and implementation.

Report Structure and Purposeful Overlap

The report is divided into sections that reflect the interconnected nature of Connecticut's health IT efforts, including:

1) **Statewide Health IT Plan:**

- a. Details progress on the Health IT Plan, initially submitted to the CGA on February 1, 2022.
- b. Highlights updates and milestones achieved in implementing the plan's six focus areas, foundational to achieving the state's health HIT objectives and making progress on key health IT initiatives such as HIE and REL-D.

2) **Data Standards Development:**

- a. Describes progress in enhancing REL-D data reporting and analytics to support transparency and quality improvement.

3) **Programmatic Updates:**

- a. Highlights the operational progress and implementation activities of two key OHS health IT programs:
 - i. **Health Information Exchange:** Updates on functionality, stakeholder engagement, data-sharing capabilities, key operational policies and roadmap.
 - ii. **All-Payer Claims Database:** Achievements in expanding data collection and usage to inform healthcare cost, quality, and equity initiatives.

The report also contains an overview within Appendix B of significant statutory and policy changes at the federal level that influence Connecticut's health IT landscape and key policies, regulations, and federal initiatives in relation to their potential impact on the Health IT Plan and its associated programs.

The sections are designed to overlap by intention, reflecting the dynamic and interconnected nature of Connecticut's health IT initiatives. The Health IT Plan primarily focuses on strategic, policy, administrative, and oversight responsibilities. The programmatic updates outline operational progress and implementation activities. By integrating state progress, federal context, and specific program updates, the report provides a cohesive narrative of the state's efforts to build a robust and interoperable health IT ecosystem.

Key Health IT Achievements in Connecticut – 2024

Launch and Implementation of Connecticut REL-D 4.0 Standards

The collection and reporting of Race, Ethnicity, Language, and Disability data helps state agencies, researchers, policy makers, and legislators develop targeted plans to reduce racial disparities, and to help healthcare providers provide high-quality, patient-centered, equitable care. In 2024, OHS made progress in supporting agencies and provider organizations in collecting this data through several key activities:

- Successfully published and operationalized the [Connecticut REL-D 4.0 data collection standards](#), aligning it with the updated U.S. Federal Register revisions to Office of Management and Budget (OMB) Statistical Policy Directive No. 15 (SPD-15). These advanced standards enhance granularity in capturing REL-D data, equipping policymakers and providers with critical tools to perform equity-driven analyses and craft impactful health policies.
- Empowered provider organizations statewide to comply with REL-D 4.0 by delivering comprehensive resources, including detailed requirements, implementation plans, and best practices. These initiatives are aimed at advanced equitable healthcare delivery. OHS actively engages with a network of CT providers through monthly convenings. This learning collaborative is sponsored by the [Connecticut Health Foundation](#) (CT Health) and run by the [Yale School of Medicine Equity Research and Innovation Center](#) (Yale ERIC).
- Modernized statewide health and human services systems and processes in alignment with REL-D 4.0 standards. OHS provided strategic guidance, fostered collaboration, and facilitated learning environment, driving significant equity-focused system improvements through monthly convenings.

Development of a Health Equity Dashboard

- Initiated the development of a Health Equity Dashboard to integrate demographic, claims and clinical data, offering actionable insights into racial and health disparities. This dashboard, funded through the American Rescue Plan Act (ARPA), will be operational in 2025, further supporting the state’s health equity goals.

Advancements in the All-Payer Claims Database (APCD)

- Updated the [APCD Data Submission Guide](#) to incorporate dental and denied claims data and to fully integrate REL-D 4.0 standards. Health plans have started submitting data under the new guidelines, enabling more comprehensive and equity-focused data analyses.
- Began efforts to expand voluntary APCD participation for Employee Retirement Income Security Act (ERISA) self-insured employers and third-party administrators, modeled on successful programs in other states such as Colorado. This initiative enhances the breadth of Connecticut’s healthcare data landscape and will inform actionable insights on cost and quality.

Progress in Statewide Health Information Exchange (HIE) Connectivity

- Expanded [Connie, Connecticut’s Statewide HIE](#), which now represents over 5 million unique patients and connects more than 3,000 provider organization locations. Connie processes approximately 1.7 million clinical summary documents and 14 million lab results monthly, driving interoperability and seamless data sharing.
- Introduced transformative enhancements solidifying the HIE’s role as a cornerstone of Connecticut’s health IT infrastructure. The new [Population Explorer](#) empowers providers with streamlined access to patient encounter details across care settings, enabling seamless transitions from high-level patient panels to in-depth clinical records. Connie also launched an allergy list feature and enhanced medication management by integrating pharmacy data to display filled and dispensed medications, providing clarity on prescription adherence. For dental providers, a new “problems” display allows tailored views of patient health conditions relevant to their specialty, improving patient safety and outcomes. These advancements mark a significant step toward improving interoperability, data accessibility, and informed decision-making, ultimately driving better health outcomes across Connecticut.

- Overcame interoperability challenges by resolving Electronic Health Record (EHR) vendor issues, supporting providers with non-interoperable systems, and implementing secure direct messaging solutions.
- Strengthened Connie's infrastructure, enabling it to function as a Health Data Utility (HDU) and advancing statewide data accessibility, security, and quality.
- Enhanced Connie's offerings with patient-centric tools, such as a patient portal as a free service available to all CT residents to see their medical history within Connie.

Increased Federal Funding for Health IT Initiatives

- Successfully negotiated an increase in CMS-approved cost allocation for the Implementation and Advance Planning Document (IAPD) and Operational Advance Planning Document (OAPD) budgets from 41% to 56%, marking a substantial rise from 26% in 2021. This achievement unlocked additional federal resources to advance health IT initiatives.

Collaborative Efforts to Strengthen Data Governance and Equity Initiatives

- Convened the [Public Act 24-19 Recommendations Workgroup](#) (PA 24-19 Workgroup) and [HIE Regulations Advisory Subcommittee](#), which held four meetings respectively throughout 2024 to provide input on statewide HIE regulations and policies. The work of the PA 24-19 Workgroup culminated in a [comprehensive HIE Recommendations Report](#) that was delivered to the CGA on January 1, 2025.
- Curated and synthesized insights on federal health IT activities from 2024, including national data exchange networks and governance frameworks, ensuring alignment with Connecticut's HIE vision while addressing emerging privacy concerns and advancing healthcare interoperability.

Significant Health IT Achievements Led by Health and Human Services Partners

- DSS launched an Opportunity Centers Pre-Pilot in July 2024 at the DSS Greater Hartford Office, showcasing an innovative partnership between DSS, the Department of Housing, the Office of Early Childhood, and other agencies. This transformative cross-agency collaboration to streamline service delivery integrates advanced technology via Health.CT to enhance service delivery, providing families with equitable access to coordinated care and resources. By streamlining communication, scheduling, and data evaluation, the program has significantly improved client services and agency

collaboration. Its success in advancing health equity and economic mobility has paved the way for expansion in 2025.

Impactful Health IT Transformation in Connecticut

The ongoing efforts of OHS, with guidance from HITAC have driven transformative advancements in health IT and HIE initiatives, fostering improved care coordination, data interoperability, and equity-focused policymaking. These accomplishments underscore Connecticut's leadership in leveraging health IT to deliver equitable, high-quality, and cost-effective healthcare to its residents.

The OHS team, along with state agencies and stakeholders, remains committed to these efforts and appreciates the support of the CGA. The annual report reflects the dedication to advancing innovative and impactful health IT strategies for the state.

Section 1: The Statewide Health IT Plan

Connecticut’s Health IT Plan was developed by OHS with guidance from HITAC. HITAC voted to endorse the plan on December 16, 2021. It reflects a comprehensive assessment of the state’s health IT and HIE infrastructure. Through an extensive environmental scan, including stakeholder interviews, surveys and focus groups, the plan identified strengths and critical gaps.

Priority areas included behavioral health EHR adoption, closed-loop referrals between primary care and community-based organizations, public health system data access, APCD utilization for policy planning, and use case development for the Statewide HIE (Connie). The result is a strategic, balanced roadmap of pilot projects, policy recommendations, and partnerships validated by OHS leadership and HITAC, as outlined in the [February 2022 Annual Health IT Report](#) to the CGA.

The **six priority focus areas** identified in the Statewide Health IT/HIE Plan are listed below in [Table 1](#), and [Section 1: The Statewide Health IT Plan](#) of this Report provides a summary of work done during 2024, specific to each of the focus areas. For the key initiatives of 2024, there are additional details in other sections of this report.

OHS plans to update the Health IT Plan beginning in Spring 2025 to address current challenges, assess stakeholders’ evolving needs, and incorporate ongoing health IT advancements and national trends. This comprehensive update will aim to deliver a forward-looking strategy that effectively meets the needs of Connecticut’s healthcare landscape.

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 Area 1	Sustain and increase use of Statewide HIE services
Focus Area 2	Implement systems to improve health equity and address health-related social needs
Focus Area 3	Improve service coordination and data sharing across state HHS agencies
Focus Area 4	Support behavioral health providers with the adoption of EHR and HIE services
Focus Area 5	Protect individual’s health information privacy

**Focus
Area 6**

Establish electronic data standards to facilitate the development of integrated electronic health information systems

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

The dedicated team behind Connecticut's Statewide HIE, Connie, made significant strides throughout 2024. They worked to expand the Use Case Services and Supporting Functions offered by their technology infrastructure vendor, CRISP Shared Services. In addition, they successfully increased both the number and variety of organizations participating in Connie's HIE services. For a comprehensive overview of Connie's Use Case Services, Supporting Functions, users, and current policies, please refer to [Section 3: Programmatic Updates](#) of the annual report.

OHS concentrated on Focus Area 1 of the Health IT Plan in 2024 to fulfill the requirements outlined first in [C.G.S. Chapter 319 Section 17b-59\(e-g\)](#) and amended by Senate Bill 1 ([PA 24-19](#)) as of July 1, 2024, to develop the necessary regulations, and policies and procedures for Connecticut's Statewide HIE services. HITAC approved a charter for the establishment of a HIE Regulations Advisory Subcommittee in 2023, followed by research for a comparative analysis of the legal and regulatory frameworks in states with similar statutory requirements to Connecticut's for hospitals, clinical labs, and ambulatory providers to connect and participate in state-supported HIE services. OHS did this work in preparation for the subcommittee meetings, where input and advice for the regulatory criteria for hospitals, clinical labs, and provider organizations with certified EHR systems capable of connecting to Connie was planned.

The HIE Regulations Advisory Subcommittee met four times in 2024; their work, which will be ongoing, has focused on topics that include:

- patient health information; complete medical record; healthcare provider; connecting to and participating in the Statewide HIE
- data use policies; interoperability requirements; data sharing and privacy protections
- administrative, physical and technical security safeguards; breach prevention, mitigation, notification and response
- sharing and access to sensitive information; data disclosure and release; patient access to Statewide HIE; patient complaint process

Public Act 24-19 Passage

The establishment of the HIE Regulations Advisory Subcommittee was supported by the passage of PA 24-19 on May 21, 2024. The amendments to Connecticut's enabling HIE legislation clarified provider participation requirements, provided liability protections for participating providers, and set clear timelines for connection and active participation in HIE services. Specifically, PA 24-19 mandates that providers must be not only connected but also actively participating in the HIE within eighteen months of policy implementation.

Clarity on Provider Participation Requirements

Public Act 24-19 amended C.G.S. §17b-59e to include the following regarding limitations to provider participation requirements: "...a healthcare provider shall not be required to connect with the Statewide Health Information Exchange if the provider (A) possesses no patient medical records, or (B) is an individual licensed by the state that exclusively practices as an employee of a covered entity, as defined by the Health Insurance Portability and Accountability Act, as amended from time to time, and such covered entity is legally responsible for decisions regarding the safeguarding, release or exchange of health information and medical records, in which case such covered entity is responsible for compliance with the provisions of this section."

Assurances of Liability Protections to Providers

Public Act 24-19 amended C.G.S. §17b-59e to include the following guidance related to provider liability: "(e) No healthcare provider shall be liable for any private or public claim related directly to a data breach, ransomware or hacking experienced by the Statewide Health Information Exchange, provided a healthcare provider shall be liable for any failure to comply with applicable state and federal data privacy and security laws and regulations in sharing information with and connecting to the exchange. Any healthcare provider that would violate any other law by sharing information with or connecting to the exchange shall not be required to share such information with or connect to the exchange."

Stipulations for Connecting and Participating in the Statewide HIE

Public Act 24-19 stipulates that, "(1) "connection" includes, but is not limited to, onboarding with the exchange, and (2) "participation" means the active sharing of medical records with the exchange in accordance with applicable law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and 42 CFR 2".

Enhancements to the Enabling HIE Statutes and Recommendations from PA 24-19 Recommendations Workgroup

The PA 24-19 Workgroup was established to provide strategic recommendations regarding the policies and procedures that govern HIE systems within the state. The workgroup was tasked with providing OHS with recommendations on HIE policies and procedures.

Topics of focus identified in PA 24-19 included:

- (1) privacy of protected healthcare information,
- (2) cybersecurity,
- (3) healthcare provider liability, and
- (4) any contract required of healthcare providers to participate in the Statewide Health Information Exchange.

Additional topics were later identified by stakeholders and included:

- Scope of “active sharing of medical records”, inclusive of out of state patients
- Patient Rights and Education
- Cost to Small Businesses
- Reproductive Health

A report of recommendations by the PA 24-19 Workgroup was compiled by OHS and submitted to the CGA on January 1, 2025. The workgroup’s recommendations will help OHS make strategic decisions to improve the state’s HIE infrastructure, while ensuring patient trust and fostering healthcare innovation. OHS anticipates completion of draft Statewide HIE Policies and Procedures for public comment by late Spring, 2025.

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

Connie plans to enhance the Connie Clinical Information application in Connie’s Provider Portal for Health-Related Social Needs (HRSN)/Social Determinants of Health (SDOH) Assessments. Formerly known as “SDOH Assessment”, the HRSN Assessments follow national standards set by healthcare quality organizations, including the National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set (HEDIS), CMS, and the Joint Commission, for requirements related to completing HRSN/SDOH Assessments for patients at the point of care, and providing information or resources to clients indicating needs. Connie will ingest and display HRSN/SDOH screening and assessment data and disseminate identified social needs to providers. This requires mapping assessment questionnaires to the

[Fast Healthcare Interoperability Resources \(FHIR\) Questionnaire](#) and the [FHIR Questionnaire/Response](#) resources for participating systems.

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

[Public Act 23-137 §13](#) put forth a requirement for the Office of Policy and Management (OPM), in collaboration with other state agencies, to develop a plan for a “Secure Online Portal” to facilitate cross-agency data sharing and improve service delivery for individuals with intellectual and developmental disabilities. In addition to OPM, the following agencies are also named in the legislation:

- Department of Developmental Services
- Office of Early Childhood
- State Department of Education
- Department of Children and Families
- Department of Aging and Disability Services
- Department of Social Services
- Department of Mental Health and Addiction Services
- Department of Correction
- Department of Administrative Services

OPM contracted with a consulting firm to explore the possibilities for a Secure Online Portal, as described [PA 23-137 §13](#). A rigorous process was undertaken to conduct a landscape analysis, looking at similar initiatives where a Secure Online Portal had been attempted or implemented. Agency discussions were held to consider data-sharing use cases, and stakeholder interviews and surveys were conducted to gather additional input.

Based on the landscape analysis and agency feedback findings, the consultant’s report recommended an alternative approach to a Secure Online Portal for facilitating cross-agency data sharing. The recommendations propose developing a “people-powered coordinating body” empowered to develop and implement shared governance and technology standards (i.e., policies, processes, technical tools, and templates) that improve service delivery not only for individuals with intellectual and developmental disabilities but also broadly for most state residents via a Data Enablement Service (DES).

A DES can leverage modular technical tools and reusable governance templates for scalability and flexibility, meeting agencies where they are. DES utilization can generate quick wins where tangible results are achieved by prioritizing low-complexity, high-impact use cases that demonstrate the value of the data-sharing framework.

With similarities to the “Person-Centered Services Collaborative” concept described in the [2023 Health IT/HIE Annual Report](#) to the CGA, the DES would take stock of current data-sharing initiatives, technical tools, and governance structures to understand what resources can be leveraged. The DES would establish a coordinating group responsible for overseeing the implementation of standards, coordinating agency requests, and facilitating collaboration; develop shared governance and technology standards; establish clear policies, processes, and tools that guide how agencies can securely share and manage data; and measure progress with process metrics, identifying lessons learned, and refining processes. OHS and OPM will work collaboratively with DSS, DDS, DMHAS, DPH, and other state agencies to advance the concepts of cross-agency data sharing with some tangible results in 2025.

Transformative Cross-Agency Collaboration to Streamline Service Delivery: In 2024, Connecticut unveiled its innovative **Opportunity Centers** initiative, a transformative cross-agency collaboration spearheaded by the Office of the Governor and the Department of Social Services (DSS) under Commissioner Andrea Barton Reeves. This shared resources model, developed in partnership with the Departments of Labor, Housing, and Early Childhood, aims to ensure equitable access to integrated services that support the health and economic mobility of individuals and families across the state.

The first Opportunity Center Pre-Pilot launched on July 16, 2024, at the DSS Greater Hartford office, adopting a rapid test-and-learn approach. Over four iterative sprints, the Pre-Pilot engaged families with young children through virtual and in-person services, leveraging technology to streamline appointment scheduling, intake processes, and care coordination via Health.CT. Strong outcomes have prompted the continuation of the Pre-Pilot into 2025, with plans to expand to a second location early this year.

Key successes stem from robust cross-agency collaboration and technological integration. Agencies co-designed a client profile system summarizing key information across programs, along with a shared release of information form approved by multiple legal departments. A templated visit summary ensures data-driven evaluation and enhanced customer service, as noted by a partner agency: *“The process and collaboration with other agencies made the process easier, demonstrating a complete partnership.”*

Technology has been pivotal, with tools like Microsoft Teams, SharePoint, Power BI dashboards, and a text messaging system supporting operations and client engagement. This innovative model showcases Connecticut's commitment to fostering health equity, streamlining service delivery, and driving positive outcomes through collaboration and integrated technology solutions.

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

Upon the conclusion of a previous outreach and engagement effort to support behavioral health providers with adoption of EHR and HIE services, OHS has continued to engage a broad range of stakeholders as it develops regulations for the HIE. The original engagement sought to share the value of HIE participation in supporting data-enriched care coordination and to learn about the complexities and challenges faced by these specialty providers in sharing/handling sensitive health data.

Focus Area 5: Protect Individuals' Health Information Privacy

Connie is implementing the Patient Mediated Affirmative Consent functionality, which will reflect the patient perspective associated with Provider Mediated Affirmative Consent that became operational in Q3 of 2023. Patient Mediated Affirmative Consent will be accessed through the Patient Portal, leveraging the patient ID verification process required for Patient Portal Access. The eConsent functionality will support the interactive participation of patients and their authorized representatives to manage their consent choices for data that could be shared through the HIE. The consent tool is configurable and enables patients to register consent to allow their substance use disorder (SUD) data to be shared through the HIE with members of their care team. Features that will be further vetted for consideration as part of the tool will include, but are not limited to:

- Electronic signatures for patient consent,
- Designation of programs or individuals authorized to disclose SUD data and access it under HIPAA's Treatment, Payment, and Operations provisions.
- Flexible expiration dates for consent registration
 - Consents made through the patient portal will be tracked in the provider portal consent history and providers accessing the SUD data will be appropriately tracked.

Currently, patients cannot register their preferences in terms of which types of providers the patient wishes to limit disclosures to. A granular consent approach would enable patients to identify additional limitations to their affirmative consent preferences. Connie will be conducting further analysis in terms of technical limitations, patient preferences, and impact on care coordination during the planning process for granular consent capabilities.

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

The Commissioners of OHS and DSS, and HITAC 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.

OHS is also required by [C.G.S. §19a-754d](#) to develop and publish standards for collecting Race, Ethnicity and Language (REL) data and make the standards available to all provider organizations using EHRs and by state agencies, boards, commissions, and contractors. The statute directs OHS to develop an implementation plan and periodically review census data and update the REL categories.

Federal Developments and OHS Progress

The Federal OMB is the U.S. agency responsible for executing the vision of the U.S. President across the executive branches of government. On March 29, 2024, OMB announced in the U.S. Federal Register Revisions to the OMB's SPD-15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. The announcement marked the first changes to federal race and ethnicity data standards since 1997.

OHS had published version 3.0 of Connecticut's Master Implementation Toolkit for REL Data Collection in December 2023, just three months before the OMB announcement. The revised OMB standards for race and ethnicity prioritize the voluntary collection of more granular data beyond the minimum race and ethnicity categories that had been the basic standard for nearly three decades.

Subsequently, OHS updated Connecticut's REL standards in September 2024 to align with SPD-15 and published its [Connecticut's Master Implementation Toolkit for Race, Ethnicity, Language, and Disability \(REL-D\) version 4.0](#) (REL-D 4.0 Master Toolkit). Additionally, in

response to requests made by Connecticut providers, OHS incorporated guidance on collecting self-reported **disability status data** in the toolkit. Sections 2-4 of this report includes additional details on Connecticut's progress to establish and support the adoption of data standards for health IT and HIE technologies.

Section 2: Establishment of Data Standards

REL-D Standards for Connecticut Agencies and Providers

In 2021, Connecticut declared racism a public health emergency and enacted Public Act 21-35 (now C.G.S. §19a-754d) as part of its response. The law requires healthcare providers “capable of connecting to and participating in the Statewide Health Information Exchange,” along with state agencies, boards, and commissions collecting demographic data in the context of healthcare or public health, to standardize their collection of REL data. OHS is required to develop and maintain Connecticut’s REL standards and to publish an implementation plan for system users subject to this mandate.

REL data serves as a critical resource for stakeholders such as the Commission on Racial Equity in Public Health, state agencies, researchers, policymakers, and legislators. It enables the development of targeted strategies to reduce racial disparities and helps healthcare providers deliver high-quality, patient-centered, and equitable care to Connecticut residents.

Development of Connecticut’s REL Standards

OHS published its first REL Data Collection Standards Implementation Guide in 2021, with subsequent updates incorporating stakeholder feedback and evolving best practices. By March 2024, when the OMB released updates to SPD-15, Connecticut had already established a robust framework for REL data collection, setting the stage for seamless integration of the new federal guidance.

Key SPD-15 Revisions and OHS Alignment

The OMB’s revisions to SPD-15 introduced significant changes to the collection of race and ethnicity data, including:

- **A Combined Race and Ethnicity Question:** A single question now asks, “*What is your race and/or ethnicity?*” Respondents can select multiple groups and provide additional details.
- **New Categories:** Inclusion of the Middle Eastern and North African (MENA) category.
- **Updated Terminology:** Removal and revision of certain terms in race and ethnicity categories.

The full list of changes was published in the Federal Register on March 29, 2024.

In response, OHS promptly aligned its REL standards with the updated SPD-15, working collaboratively with sister agencies and providers. Stakeholder convenings, led by **Yale** University's Equity Research and Innovation Center (Yale ERIC), played a pivotal role in shaping these updates. Providers requested the addition of disability standards, leading to the enhancement of the REL 3.0 Toolkit into the REL-D Master Toolkit 4.0.

Impact of Enhanced REL Standards

The incorporation of federal SPD-15 changes, combined with Connecticut's ongoing stakeholder engagement and toolkit updates, ensures:

- **Improved Data Accuracy:** Enhanced demographic granularity supports actionable insights.
- **Equity-Focused Policy Development:** Comprehensive REL-D data enables targeted strategies to address systemic disparities.
- **Provider Empowerment:** Standardized guidance equips healthcare organizations to deliver equitable and patient-centered care effectively.

Connecticut's proactive approach in aligning REL standards with federal updates underscores its commitment to addressing racial disparities in healthcare and fostering health equity for all residents.

Planning for REL-D Data Collection in 2025 and Beyond

REL-D Data Collection and Implementation: Summary and Recommendations

A key priority for OHS and Connecticut's OPM Data and Policy Analytics Unit is enhancing provider awareness of REL-D data collection standards and engaging EHR vendors to facilitate necessary system changes. These changes aim to ensure accurate capture of structured REL-D data in patients' electronic medical records (EMRs).

Provider and System Challenges

Many provider organizations will need EHR coding updates and workflow adaptations to comply with REL-D mandates. While self-service training resources, such as the REL-D 4.0 Master Toolkit, provide valuable guidance, they may not fully address the complexity of consistent data collection. Additional agency-specific communications and training resources are critical to support compliance, particularly for integrating REL-D data into state agency systems.

Connecticut's diverse EHR landscape presents adoption challenges, despite most systems meeting criteria for connection to the Statewide HIE. A coordinated communication and technical assistance plan are essential to mitigate frustrations, streamline implementation, and build long-term support for the initiative.

Progress and Future Directions

OHS is conducting research to assess the feasibility of adding Sexual Orientation and Gender Identity (SOGI) and insurance status data to future versions of the REL-D toolkit. Stakeholder engagement will continue through 2025 to refine these efforts. By aligning these initiatives with statutory requirements under C.G.S. §19a-754d, OHS is ensuring a unified communication strategy to prevent conflicting messages and support provider organizations.

Operational and Strategic Coordination

The report delineates strategic, policy, and oversight elements (covered in the Health IT Plan) from operational progress (addressed in program updates). Strategic coordination ensures clear objectives, while programmatic updates focus on implementation milestones.

Key Benefits and Long-Term Impact

The implementation of REL-D 4.0 standards will provide unprecedented insights into race-related disparities across populations served by ten state agencies. The data will support:

- **Policymaking:** Timely and targeted interventions to address systemic inequities.
- **Programmatic Linkages:** Integration of demographic data with specific services.
- **Broad Applications:** Insights for researchers, policymakers, social service organizations, and other stakeholders.

Provider Engagement and Burnout Considerations

Establishing provider support is critical for the initiative's success. Agencies must address challenges posed by varying schedules and technological capabilities across providers. Communication strategies should also consider efficiency improvements using digital tools to reduce administrative burdens, contributing to provider burnout.

Census Reevaluation and Data Monitoring

Per C.G.S. § 19a-754d, OHS will review U.S. Census Bureau data and other sources to reevaluate race and ethnicity categories as demographics shift. Anticipating delays in census updates, interim data sources like the American Community Survey will inform proactive adjustments.

Conclusion

The coordinated implementation of REL-D standards will empower Connecticut to address systemic disparities with precision, creating a foundation for equitable health outcomes. A robust, unified communication strategy across agencies, coupled with sustained provider engagement, will be instrumental in achieving these transformative goals.

State Agency Progress Implementing REL Data Collection Standards

Currently, 10 state agencies are actively working to implement the REL-D 4.0 data collection standards. This includes updating existing data systems and integrating REL-D 4.0 standards into procurement documents, such as requests for proposals and requests for quotations, for new health IT systems. The following section provides the status, progress, and activities of each of the 10 agencies with data systems subject to the mandates outlined in C.G.S. §19a-754d.

Department of Aging and Disability Services (ADS)

ADS previously reported the completion of initial phases toward compliance with REL-D data collection standards. Currently, the agency's Bureau of Aging (BOA) is reviewing several forms—such as the **CHOICES Secure Referral Form, UPC-DDC online form, NEAT-DDC online form, and Consumer Registration Form 5** (available in both paper and fillable PDF versions)—to ensure alignment with legislative requirements for data collection and reporting.

BOA anticipates that the **WellSky Aging and Disability system**, used to report aging and disability services data to the federal government, will implement the necessary adaptations in 2025 to comply with OMB standards for race and/or ethnicity data, ensuring consistency with Connecticut's REL-D 4.0 standards.

Other ADS bureaus and offices do not currently collect data related to healthcare, the provision or receipt of healthcare services, or public health purposes. Furthermore, the agency has not yet requested or secured funding to support initiatives in these areas.

Department of Children and Families (DCF)

In 2022, DCF identified two key systems affected by the REL legislation: the **legacy Statewide Automated Child Welfare Information System (SACWIS)**, also known as **LINK**, and the **Provider Information Exchange (PIE)** system.

In October 2023, DCF successfully implemented the REL standards in the **LINK system**. Implementation of these standards in the **PIE system** is on track for completion during the first

quarter of 2024. To meet federal requirements for a Comprehensive Child Welfare Information System (CCWIS), DCF is in the process of replacing the **LINK system** with a modern solution known as **CT-KIND (Kid's Information Network Database)**. LINK, a 22-year-old legacy system identified as outdated by the federal Administration for Children and Families (ACF), will be decommissioned, and **CT-KIND** is scheduled to go live in **August 2025** with REL 3.0 standards fully integrated. DCF anticipates the solution vendor will have the capacity to begin implementing REL 4.0 standards as a system upgrade within six months of the CT-KIND go-live date.

For the **PIE system**, DCF successfully updated it to **REL 3.0 standards** effective **June 15, 2024**. The agency plans to further develop and release updates to the PIE system that incorporate **REL-D 4.0 standards** by the end of calendar year 2025.

Department of Correction (DOC)

DOC has reported that the agency's EHR is the application by which the department maintains race and ethnicity data. DOC is aware of and has reviewed the standards for the REL-D 4.0 toolkit. The REL-D specification design changes are in progress for DOC EHR User Acceptance Testing (UAT) domain to be followed by build activities in early 2025. Outside of resource allocation, there are no observed challenges with the design and implementation. Changes regarding software and database design is not of concern as DOC maintains control over the systems. Configuration will ultimately be made in DOC's production environment to mirror UAT. A brief training will be developed for the end-user to inform on changes and guide in their use. It is DOC's expectation that by Q2 of 2025 the agency will be in full compliance with the REL-D 4.0 toolkit.

Department of Developmental Services (DDS)

DDS reported one system, eCAMRIS, requires modifications to adhere to the mandate. The agency plans to release an updated Eligibility Application form to collect new REL data in the future. The release of the new form would complete the Design Activity Domain of the REL implementation for DDS at which time system testing would commence. As of January 2024, DDS completed its first set of updates to the eCAMRIS system based on the REL Data Collection Standards Document Version 3.0 and CCIP recommendations. DSS data was ingested into eCAMRIS to populate the new race and ethnicity fields for individuals served by DDS and having Medicaid records. Additional updates to eCAMRIS will be made to incorporate the REL 4.0 standards once more granular data is available.

Department of Mental Health and Addiction Services (DMHAS)

DMHAS originally identified two systems impacted by the REL mandate—including its Admission/Discharge/Transfer (ADT) systems (WITS) and the DMHAS Data Program (DDaP). Both required extensive modifications to comply with the REL standards. DMHAS originally intended to retire the WITS system when the agency's new EHR system went online with the REL Standards integrated at the time of the system launch.

As of 2024, the **WITS system** remained active and serves as the ADT system only (not classified as an EHR due to its limited functionality), for DMHAS' eight state-operated facilities. DMHAS is actively working with DAS, OPM and other sister agencies to procure a fully integrated EHR for the agency's eight facilities. Due to budget restrictions and the priority of the EHR implementation for DMHAS, the WITS system is not being upgraded with the REL data collection standards. However, the REL 4.0 standards will be included as functional requirements for the selected EHR vendor, and the new EHR technology will be expected to comply with the REL 4.0 standards upon go-live.

EHR implementation Timeline: There are a number of dependencies involved with the multi-agency EHR system procurement and implementation that could have impacts on the timeline estimates for the new EHR system to be online. With what is known as of December 2024, DMHAS estimates that the new EHR will go live sometime between late 2026 to mid-year 2027.

The **DDaP** is a data collection system used by the DMHAS-funded private, non-profit providers (PNPs). The DDaP collects client and program utilization, and outcomes measures to track the PNPs' contractually obligated requirements. The DDaP was designed and built by the DMHAS IT team, and the system continues to be supported by DAS Bureau of Information Technology Solutions (BITS) and DMHAS IT. The DMHAS IT team and DMHAS program management personnel are meeting twice monthly to map out the upgrades to the DDaP that will be required to collect the REL 4.0 data elements. As of December 2024, current internal discussions foresee an implementation strategy with two phases for REL 4.0 data collection. Phase One is considered the "transition phase" when it is anticipated that some of the 130+ PNPs will have updated their EHR technology to comply with the REL 4.0 standards for data collection. It is not expected that PNP compliance with the REL 4.0 standards will occur simultaneously. The PNPs are using a variety of EHR platforms and DMHAS anticipates that vendor support for upgrading to REL 4.0 will be variable. Consequently, DMHAS is planning for technical challenges while some PNPs will be submitting REL 4.0 data elements to the DDaP, and at the same time other PNPs will not be ready to comply with REL 4.0. This will require the DDaP system to accept and incorporate REL data in multiple formats during Phase One.

Phase Two is planned to be the permanent state of maintaining REL 4.0 updates and having all the DMHAS funded PNPs submit these new data elements. The IT team is scoping that scenario as well, with a projected timeline when the DDaP will solely accept REL data in the 4.0 standard formats.

DMHAS Technical Note: DMHAS has asked their DAS BITS team to reach out to the IT support staff working with other REL-impacted state agencies to learn about their technical strategies for implementation.

DMHAS Operational Notes: DMHAS plans to work with OHS and other state agencies collecting REL data to identify additional strategies for communicating to providers who will be required to collect and submit REL data under the legislative mandate. The early provider convenings and communications about the REL standards have been led by OHS on behalf of all state agencies with REL integrations underway or planned, using a single unified message. With the REL-D 4.0 standards finalized now by OHS, additional communications from agencies to affected providers will be important to ensure compliance with Connecticut's law.

DMHAS Timeline Notes: The estimated timeline for the DDaP implementation has several dependencies, including:

- 1) the provider communication strategies, as noted above;
- 2) the resolution of technical challenges related to the DDaP system accepting data in older REL formats and in REL 4.0 formats simultaneously; and
- 3) having the DDaP fully modified to accept all of the REL 4.0 data elements.

Considering these dependencies, DMHAS is estimating the timeline for full DDaP REL 4.0 implementation to be the end of CY2026.

Department of Public Health (DPH)

DPH reported the following:

- **Connecticut's Electronic Death Registry System (EDRS or CT-Vitals) and Fetal Death System:** DPH is working on getting the REL implementation tasks into an updated workplan with the EDRS vendor.
- [Connecticut's Birth Registry](#) is on track for 2025 implementation of REL data standards.
- [Syndromic Surveillance](#) has been in transition with the [new system](#) being [HMS EpiCenter](#). The **Connecticut Electronic Disease Surveillance System (CTEDSS)** is also the primary surveillance and case management system for reportable diseases, emergency illnesses, and health conditions, and other non-disease activities. As part of the modernization effort for updating DPH technology systems, the primary disease

surveillance system has been assessed and options are being developed for consideration by DPH Leadership. The disease surveillance modernization project will include implementation of the REL 4.0 standards.

- [Behavioral Risk Factor Surveillance System](#) (BRFSS) and the [Youth Behavioral Risk Surveillance System](#) (YBRSS) are maintained by the U.S. Centers for Disease Control and Prevention (CDC). DPH will collect REL data from the BRFSS and YBRSS data submitters in REL 4.0 standards when the CDC systems are updated to meet OMB standards.
- [Connecticut's Tumor Registry](#): DPH has long used the National Cancer Institute's (NCI) population-based cancer registry system known as the Surveillance, Epidemiology, and End Results ([SEER](#)) Program. The SEER program uses cancer statistics collected by population-based registries to monitor the distribution of cancer cases by sex, race/ethnicity, age, and other demographic factors. The SEER registry is supported by the [Surveillance Research Program](#) (SRP) in NCI's [Division of Cancer Control and Population Sciences](#) (DCCPS). It is assumed that the SEER data model for race/ethnicity will be updated to reflect OMB's changes to SPD-15. However, the timing for making that type of change is not known.
- **Data Modernization Initiative (DMI)**: DPH has completed an inventory of 491 manual forms used across the agency; the forms are being assessed and prioritized for modernization within the JotForm platform. Once a form is identified as a candidate for self-reported REL data collection, the REL 4.0 standard will be applied and the form published as an online form using the REL 4.0 standards.
- DPH has also identified over **20 Microsoft Access databases** used as a primary data collection system which are in the process of being prioritized and modernized using the Microsoft Power Platform. The REL 4.0 standard will be applied when the application is migrated to the Power Platform. Updating 50% of the manual forms to on-line forms is estimated to be completed in CY2025; the remaining forms will be completed in CY2026. Modernizing the Access applications and other modernization efforts will take considerably longer; there is not an estimated completion date at this time.

Given the extensive scope of the agency's responsibilities and systems, DPH has identified securing adequate resources as a significant challenge in effectively fulfilling its mandate.

Department of Social Services (DSS)

DSS conducted a REL Feasibility Study, which concluded in September 2024, to determine its current state of compliance with the OHS REL data standards. This study reviewed the DSS

systems, applications and forms that collect REL and gender data and identified the needed changes and potential approaches to comply with C.G.S §19a-754d (PA-21-35).

Using the REL ARPA funds, DSS is entering into a contract with a vendor to support implementation of the needed changes for the ImpaCT system. These changes will allow for needed updates to how DSS reports REL and gender data, including in its People Served Dashboard.

During 2025, DSS will be focusing on building and testing the required REL changes for ImpaCT, in-scope federal reporting and updating associated forms. In addition, refinements to Social Work Administrative Network will occur to align it with the 4.0 REL Standards.

DSS will continue to socialize the REL collection and reporting requirements. This has included making “REL Data” a standing agenda item at the monthly DSS Data Governance Committee meetings. In addition, on December 16, 2024, DSS launched an “Introduction to Data Literacy” course. The courses curriculum includes a section on C.G.S §19a-754d (PA-21-35) and the REL reporting standards.

In addition, DSS will partner with its Office of Skill Development (OSD) to ensure that the analytic and other related training includes information about C.G.S §19a-754d (PA-21-35), and the REL collection and reporting standards. Similarly, DSS will explore mechanisms to improve the quality and completeness of REL data, including better explaining why these data are collected, how they are protected and how they are used to improve services and outcomes.

Potential challenges to implementing Connecticut’s REL standards include aligning the timing with reporting requirements across various Federal agencies, and for contractors who may provide services across multiple CT health and human services agencies. DSS has been meeting with its Administrative Service Organizations (ASOs) to plan and coordinate implementation of the REL standards. Also, a recommendation from DSS’ REL Feasibility Study is to convene an internal workgroup to support alignment with Federal REL and gender reporting requirements.

Department of Veterans Affairs (DVA)

The DVA originally reported that the agency’s ADL EHR system was impacted by the mandate and would require modifications to meet new REL standards. DVA later reported that the existing EHR system was determined not capable of accepting updated REL requirements. As of 2024, DVA shared that the existing EHR application cannot adapt to the data collection field specifications outlined by the REL-D initiative. DVA applied and was awarded IT Capital

Investment funding earlier this calendar year. DVA is in the process of signing the scope of work and issuing a contract to replace the current EHR. This project is projected for completion in Fall of 2025. The new solution allows customization of data collection fields to align with the specific requirements of the race/ethnicity, language, and disability data collection mandated by PA 21-35 §11. This ensures all necessary demographic information is captured accurately and comprehensively.

Office of the Chief Medical Examiner (OCME)

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). As of 2024, the EDRS project is anticipated to be completed early in 2025.

Office of Health Strategy (OHS)

OHS identified four systems impacted by the REL mandate: the APCD, Inpatient Database, Outpatient Database, and Emergency Department Database. Each required updates to meet the new REL standards. The APCD was prioritized for initial implementation.

The APCD Data Submission Guide was updated in October 2023 to support the collection of self-identified demographic data, allowing health plans to report:

- Up to three races (including "other"),
- Three ethnicities (including "other"), and
- Two language preferences (including "other"), aligned with Connecticut's REL 3.0 standards.

Starting in 2024, health plans began submitting claims data conforming to REL 3.0 standards. Following the publication of REL-D 4.0 standards in September 2024 (aligned with SPD-15), OHS updated the APCD DSG to incorporate more granular REL 4.0-D standards.

- System Enhancements:

As of December 2024, OHS is:

- Retooling its reporting portal to accept REL 4.0-D submissions,
- Updating databases to house expanded data fields, and
- Restructuring data tables in the inpatient, outpatient, and emergency department reporting modules to support:
 - The new Minimum Category for Middle Eastern or North African (MENA) race/ethnicities, and
 - Combined race/ethnicity categories and subcategories per SPD-15.

OHS has begun receiving early test data and anticipates completing development and testing of these systems by July 2025.

- **Funding and Collaboration:** These updates were funded through ARPA funds. OHS also allocated funds to the DSS to enhance its ImpaCT system.
- **Future Initiatives:** OHS is developing a Health Equity Dashboard, which will be published in 2025. This will further support the agency's mission to advance health equity in Connecticut.

Section 3: Programmatic Updates

Connecticut's Statewide Health Information Exchange

The statewide HIE, Connie, is created by OHS in accordance with C.G.S. §17b-59d to empower consumers to make effective healthcare decisions; promote patient-centered care; improve the quality, safety and value of healthcare; 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 are listed in the enabling legislation for the Statewide HIE, as follows:

- Allow real-time, secure access to patient health information and complete medical records across all healthcare provider settings;
- Provide patients with secure electronic access to their health information;
- Allow voluntary participation by patients to access their health information at no cost;
- Support care coordination through real-time alerts and timely access to clinical information; Reduce costs associated with preventable readmissions, duplicative testing and medical errors;
- Promote the highest level of interoperability;
- Meet all state and federal privacy and security requirements;
- Support public health reporting, quality improvement, academic research and healthcare delivery and payment reform through data aggregation and analytics;
- Support population health analytics;
- Be standards-based; and
- Provide for broad local governance that includes stakeholders, including. representatives of DSS, hospitals, physicians, behavioral health and 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 HIE.

OHS designated Health Information Alliance, Inc. (HIA) as the official operating entity for Connie.

Connie's Role in Provider Connections and Emerging as Connecticut's Health Data Utility

In many respects, Connie has been operating as Connecticut's de facto HDU—a model gaining traction in several states. HDUs are often nonprofit HIEs formally designated through

Statewide Health Information Exchange

statute or Governor’s Executive Order. They provide data services under strict accountability frameworks defined by statutory requirements and/or contractual obligations.

While the technology services offered by an HDU are largely like those of an HIE, the HDU model distinguishes itself through its governance structure, which is more closely aligned with state policymakers. This alignment enables the use of policy levers, such as incentives or mandates, to:

- Drive increased provider participation in data exchange,
- Strengthen connections with state agencies, and
- Enhance collaboration with public health and other sectors to advance data-sharing initiatives.

Advantages of the HDU Model

1. **Policy Integration:** Tight governance ties with state leadership enable effective implementation of policies that promote data exchange.
2. **Public Sector Collaboration:** HDUs are better positioned to form partnerships with state agencies, advancing data exchange with public health and other entities.
3. **Financial Sustainability:** HDUs often receive increased financial support from state Medicaid agencies and other sources, unlocking federal funding streams to bolster long-term sustainability.

Connie’s evolution towards this HDU model underscores its importance in fostering comprehensive and equitable data-sharing infrastructure across Connecticut.

Table 1: Connie’s Core Technology Components

Core Component	Description of Connie’s Core Technology
Master Patient Index (MPI)	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"> ▪ Edit and transform data ▪ Map data to national standard code sets ▪ Map data between differing formats
Application Program Interface (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
Consolidated Clinical Document Architecture Federator	Federates queries to one or more disparate backend document repositories – whether internal, external, or over national networks

Statewide Health Information Exchange

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
Conne Provider Portal	Connie's secure web-based portal where authorized users may query for patient data
Connie Patient Connect	Connie's secure web-based patient portal where CT residents may access their own health information from participating Connie providers.
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

It is expected that some changes to Connie's policies will be necessary following the finalization of the Statewide HIE regulations, currently in process.

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 PHI. 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

Statewide Health Information Exchange

purposes. Connie uses a privacy tool for additional monitoring of all Participant User activities regarding PHI access patterns to ensure all provisioned accounts are being used appropriately and to protect the confidentiality of PHI; however, it is ultimately the Participant's obligation to ensure the appropriate use of Connie Services by the Participant and the Participant's Users.

Patient Access and Rights Policies

Accounting of Disclosure Requests: Patients can request an accounting of disclosure report of Participant access to the patient's information.

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 its technology, such as the Prescription Monitoring Program or public health reportable conditions.

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 healthcare 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. Due to the above consent considerations, and because parents or legal guardians are unable demonstrate their custodial relationship, at this time, ***Connie is not able to make any information available for individuals aged 17 and under.***

Statewide Health Information Exchange

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 healthcare 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 in accordance with Connie's Data Release Policy (link and more information [here](#)).

Participating Data Providers Policies

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

Statewide Health Information Exchange

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 SUD 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 Healthcare 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.

Statewide Health Information Exchange

It is anticipated that the Connie Data Release Policy will be updated as part of the process to finalize the Statewide HIE regulations, and policies and procedures, as required in statute.

It is important to note that Connie has not yet operationalized the Research Disclosure use case and, accordingly, has not approved any research disclosures.

Activities and Accomplishments

In January of 2024, Connie's Board of Directors approved Connie's three-year strategic Plan. For FFY24, the priorities and goals were:

Priority 1: Enhance the Utility of Health Data

- Define, develop, and implement a process to monitor Connie's data quality, establish baseline, and define improvement targets
- Connie will continue progress towards achieving critical mass, defined as *95% hospitals + 75% ambulatory medical providers [pediatricians, primary care, FQHC, urgent care, specialty care] + 75% pharmacies + 75% SNFs + 1 state-private connection through Connie*
- Develop plan to measure stakeholder awareness and trust

Priority 2: Empower Patients

- Connie's first Patient and Family Advisory Council has been established and begun to provide feedback on Connie's patient-facing activities
- By October 1, 2024, Connie's patient portal will be ready to go-live

Priority 3: Optimize Care Team Tools

- Monitor and improve the use of core care team tools (Connie Portal/InContext app) across at least two industry types from Dec 2023 levels (tentative measure: median searches/active users/month and tentative industry types: hospital and ambulatory medical)

Priority 4: Advance Population Health

- Define a set of Connie population health and analytics tools and develop a plan for implementation
- At least one project in place connecting private sector to public sector

Priority 5: Maintain Operational Excellence

- Develop revised three-year financial strategy
- Create Leadership Development Plan

By the Numbers: Connie's 2024 Results

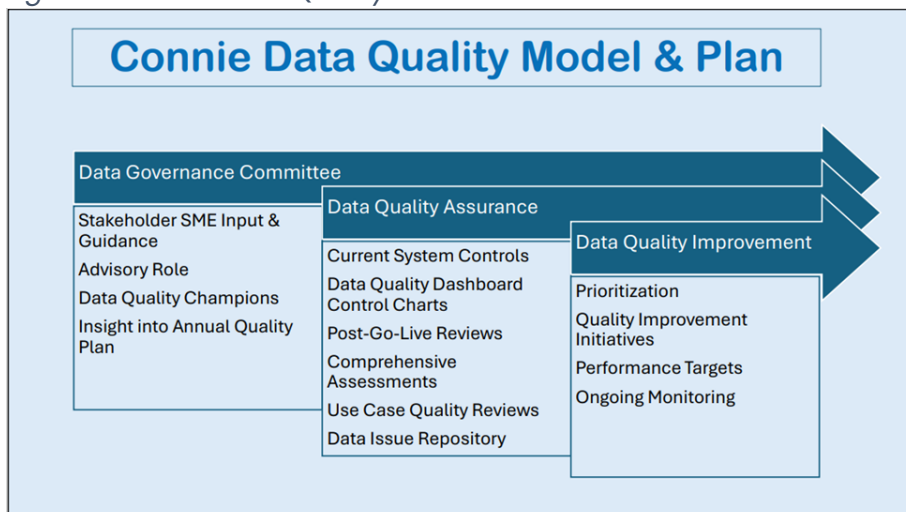
In 2024, Connie made significant progress on working to measure, monitor, and improve its data quality.

Priority 1: Enhance the Utility of Health Data

Data Quality Program

Connie made significant progress on working to measure, monitor, and improve its data quality. Connie hired a Director of Analytics and Data Quality in April and created a data quality plan. As illustrated in the graphic below, the data quality plan contains three interrelated components that work synergistically to implement a continuous improvement model for data quality. The first component is the Data Governance Committee, which is comprised of twenty-one representatives from sixteen different organizations that utilize Connie services. The primary purpose of this committee is to incorporate the “voice of the customer” into its quality work by providing guidance, support, and oversight for quality improvement activities. The second component, Data Quality Assurance, includes activities focused on assessing the quality of data and identifying opportunities for improvement. The third component, Data Quality Improvement, includes those activities associated with prioritizing improvement opportunities and implementing projects to improve quality.

Figure 1: Connie Data Quality Model & Plan



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Implementation of the plan commenced during the second half of 2024, beginning with the recruitment of Data Governance Committee members. The inaugural meeting was held in September, followed by a second meeting in November. During the November meeting, members recommended Connie prioritize four data elements for quality improvements in 2025: diagnosis, diagnosis description, discharge disposition, and discharge location.

Connie established a cross-functional project team to carry out the improvement work. The team has set target performance ranges for each data element, identified specific organizations or facilities that require improvement, and established baseline performance metrics for each entity. The project team will continue its efforts into next year and will report on outcomes during the second half of the year.

To support data quality assurance, Connie documented all data quality controls for the processes of ingesting, transforming, aggregating and reporting data. Statistical process control charts were also implemented to monitor the quality performance of key data elements. Additionally, post-go-live reviews were implemented to assess data for newly onboarded skilled nursing facilities, ensuring no degradation in data quality during the transition from test to production environments.

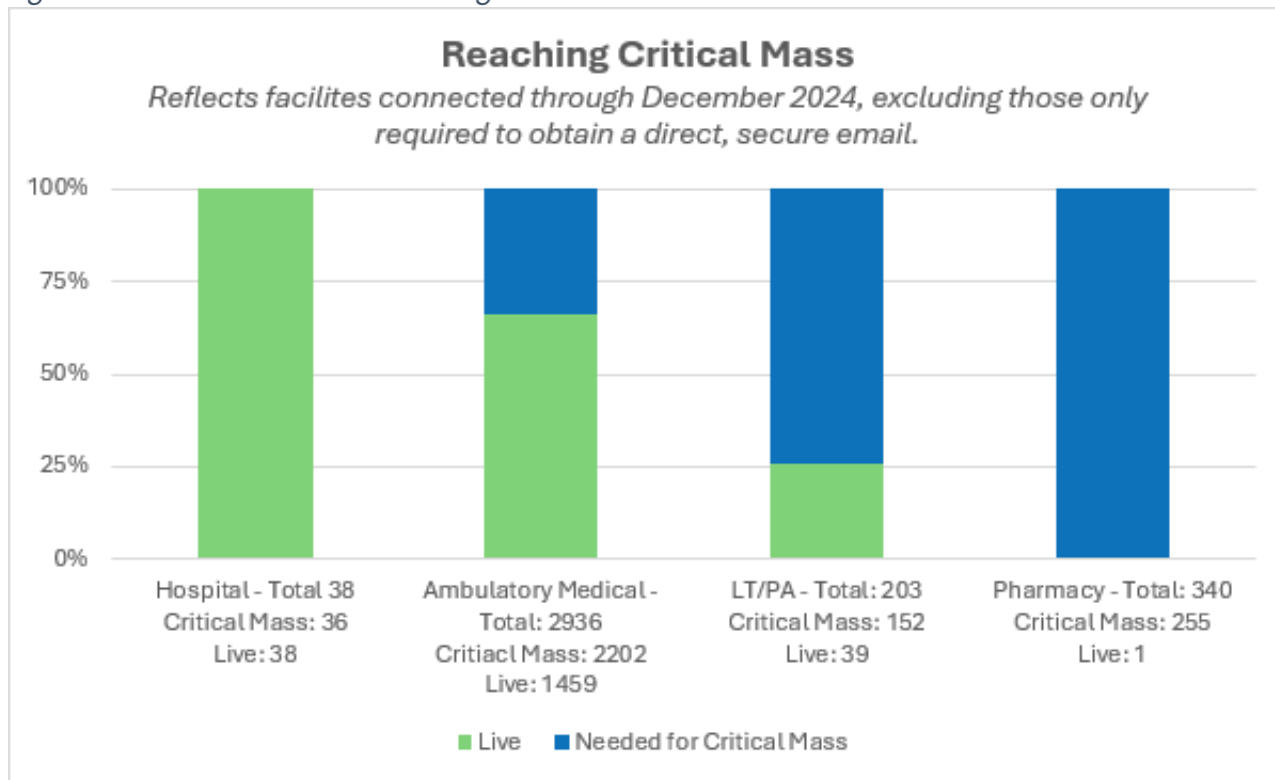
A process for reporting data quality issues was established, along with a central repository for the information. Centralizing data quality issues will allow Connie and the Data Governance Committee to better understand potential issues with the data and prioritize resolution. The focus next year will be to continue planned data quality improvement work and to operationalize all elements of the data quality plan.

Onboarding and Data Exchange Progress

Although Connie did not reach their 25% increase target, they made significant progress towards reaching Critical Mass. They reached a 13% increase in ambulatory practices, and specifically increasing the percent of skilled nursing facilities (SNFs) connected to and participating in Connie by 88%.

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Figure 2: Facilities Connected through December 2024



Industries (Subindustries) Represented in Chart above:

- Hospital** (Hospital)
- Ambulatory Medical** (FQHC, Pediatric, Primary Care, Specialty Medical Practice, Urgent Care)
- Long Term/Post Acute "LT/PA"** (Skilled Nursing Facility)
- Pharmacy** (Clinical Pharmacy)

To support both onboarding and data quality, Connie developed a revised [Use Case Implementation Guide](#) and made that publicly available along with detailed specifications and sample messages.

Stakeholder Outreach

Over the past year, the Connie team has continued to build strong connections within the healthcare community, actively participating in outreach efforts to promote the use and benefits of the Connie Portal. These initiatives have included attending key conferences across Connecticut, delivering educational sessions, and hosting a range of webinars. Beginning in January of 2024, the team shifted focus towards more in-person community practice visits to provide hands-on training and education about the Connie Portal and its care management tool.

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These engagements have allowed the Connie team to:

- Educate providers on how to connect with Connie and integrate its services into their workflows.
- Conduct live demonstrations of the Connie Provider Portal and its features.
- Showcase Connie’s progress and evolving capabilities.
- Address questions and provide tailored support to healthcare professionals.

Through these interactions, Connie has empowered providers to fully utilize the Connie Portal as a critical tool for improving care coordination and patient outcomes. By demonstrating its real-time data-sharing capabilities, customizable care management tool, and streamlined access to vital health information, the team has helped practices and organizations across Connecticut integrate the Connie Portal into their daily workflows. These efforts have not only enhanced provider utilization but also reinforced the value of the portal as a cornerstone of connected, patient-centered care.

Connie’s outreach and engagement over the past year included collaboration with a diverse range of professional organizations and networks, such as:

- Medical Associations:
 - Fairfield County Medical Association
 - Hartford County Medical Association
 - Greater Bridgeport Medical Association
 - New Haven Medical Association
 - Specialized Societies and Groups:
 - Radiological Society of Connecticut
 - Connecticut Podiatric Medical Association
 - Connecticut Association of Addiction Professionals
 - Connecticut Association of Family Physicians’ Board Meeting Presentation
 - Academy of Audiology
- Health-Focused Initiatives:
 - Connecticut Oral Health Initiative
- Webinars and Partner Collaborations:
 - Office Ally Customer Webinar
 - PointClickCare Customer Webinar
 - SoNE Member Webinar
 - Pharmacy EMR Webinar
 - Skilled Nursing Facility Webinar

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- Federally Qualified Health Center Webinar Series
- Local and Statewide Meetings:
 - Bristol Area Provider Dinner
 - Connecticut Association of Family Physicians (CAFP) Board Meeting
 - CT Department of Correction Medical Staff Meeting
 - iCan Conference Sponsorship and Booth
 - Public Health Association Sponsorship and Member Presentation

These focused efforts have significantly expanded the adoption and effective utilization of the Connie Portal, enabling providers to deliver better-coordinated, more efficient, and informed care for their patients.

Electronic Health Record Hub Connections

Connie has adopted a strategic approach to maximize its capacity for rapidly onboarding provider organizations to Statewide HIE services. By focusing on cloud-based EHR vendors with the highest concentration of Connecticut-based provider practices, Connie has established "connectivity hubs" that streamline the process of linking multiple practices to the HIE through a single integration point for each vendor.

In 2024, 15 EHR hubs successfully completed connections to Connie, resulting in 166 provider locations or organizations going live. This scalable strategy accelerates adoption and enhances the value of Connie’s HIE services across the state.

The following specialty EHR vendors established new hub connections to Connie during that time, enabling seamless onboarding for participating providers:

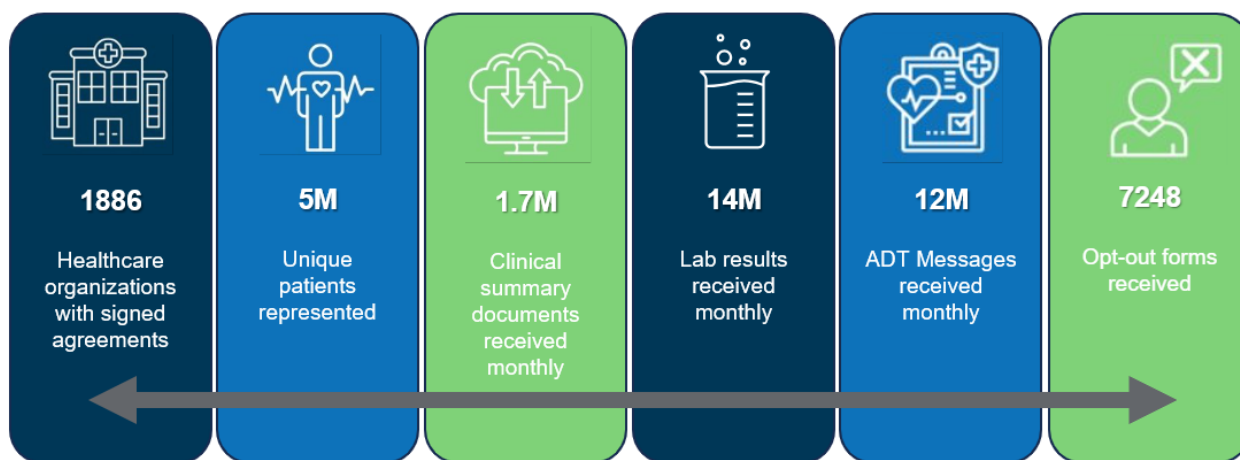
Table 2: EHR Hub Connections

EHR Name	EHR Specialty
Athena (Privia)	Multispecialty
DBC - ChiroQuickCharts	Chiropractic
eClinical Works	Multispecialty
Elation	Primary Care
Experity DocuTAP	Urgent Care
HST Pathways (eChart)	Surgery
MatrixCare SNF	Long-Term/Post-Acute
MEDENT	Multispecialty
Modernizing Medicine	Multispecialty
NextGen HealthFusion	Multispecialty
Physician's Computer Company	Pediatric

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Point Click Care	Long-Term/Post-Acute
Qualifacts	Behavioral Health
Surgical Information Systems	Surgery
Surgical Information Systems - Amkai	Surgery
Surgical Information Systems - SIS Complete	Surgery

Figure 3: 2024 Connie In-Bound Data Statistics



Data Service Integrations

In 2024, Connie facilitated the delivery of over **32 million outbound messages**, providing transformative data services to stakeholders across various industries.

- **Key Stakeholders and Impact**

- **Care Coordination/Management Organizations:** Community Health Network of Connecticut (CHNCT) leveraged Connie's enriched lab results data from participating hospitals and health systems. This enabled CHNCT to close care gaps, facilitate referrals to care management programs, and enhance reporting accuracy for HEDIS measures. Currently, **70% of CHNCT's lab results** are delivered through Connie, underscoring the substantial impact of this collaboration.
- **Payers:** Organizations like Cigna utilized tailored data streams, including Admission, Discharge, Transfer (ADT) notifications, to improve operational efficiency and support quality initiatives.
- **Ambulatory Providers:** Ambulatory care providers such as ProHealth benefited from Connie's ability to deliver real-time clinical data, including lab results, ADT notifications, and care summaries. This empowers providers to monitor patient

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health transitions in real time, address care gaps effectively through timely interventions, and enhance overall patient care.

These milestones highlight Connie's growing role in delivering actionable and timely data to its stakeholders. Moving forward, its efforts will focus on addressing remaining care gaps and expanding data services to further enhance the quality of care across the healthcare ecosystem.

Priority 2: Empower Patients

Patient Access: To support ONC interoperability compliance, Connie 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. This service was made available as of September 2023. In 2024, Selfii was the first web-based application connected through the Carequality framework.

Patient Portal: Connie has developed 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, multi-factor authentication, with patient ID verification and validation, patients who are 18 years or older will be able to view their health information available within Connie's infrastructure. The patient portal is 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. Connie and Medicasoft completed testing in August and began piloting the Patient Portal in October 2024.

Patient and Family Advisory Committee: Connie recognizes that meaningful patient and family engagement is essential to delivering quality healthcare, and this extends to how organizations securely exchange information to inform a patient's care team. Connie's Patient and Family Advisory Committee (PFAC) demonstrates this commitment to patients and families and facilitates ongoing conversation and learning. The PFAC works collaboratively with Connie leadership to ensure that the patient and family perspective is integrated into

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all aspects of the HIE. In 2024, Connie completed recruitment for the initial five PFAC members, held three virtual meetings, and one in-person meeting, and began recruiting for the 2025 cohort. PFAC members are recruited and selected based on their diversity of experience with the healthcare system—race and ethnicity, age, sex, primary language, private vs. publicly insured, supporting the care of a loved one, and/or diagnoses with chronic illnesses or experience with behavioral health treatment.

Priority 3: Optimize Care Team Tools

Service Usage Statistics

Connie has had a 200% increase in active users during 2024. Active users are defined as having at least one log in during the recorded month. More importantly, Connie experienced a 279% increase in the number of repeat users during the same period. Repeat users must use the portal for two months in a row to be included in the metric. Not surprisingly, the number of queries for patient records increased five-fold during the year as Connie continued onboarding organizations.

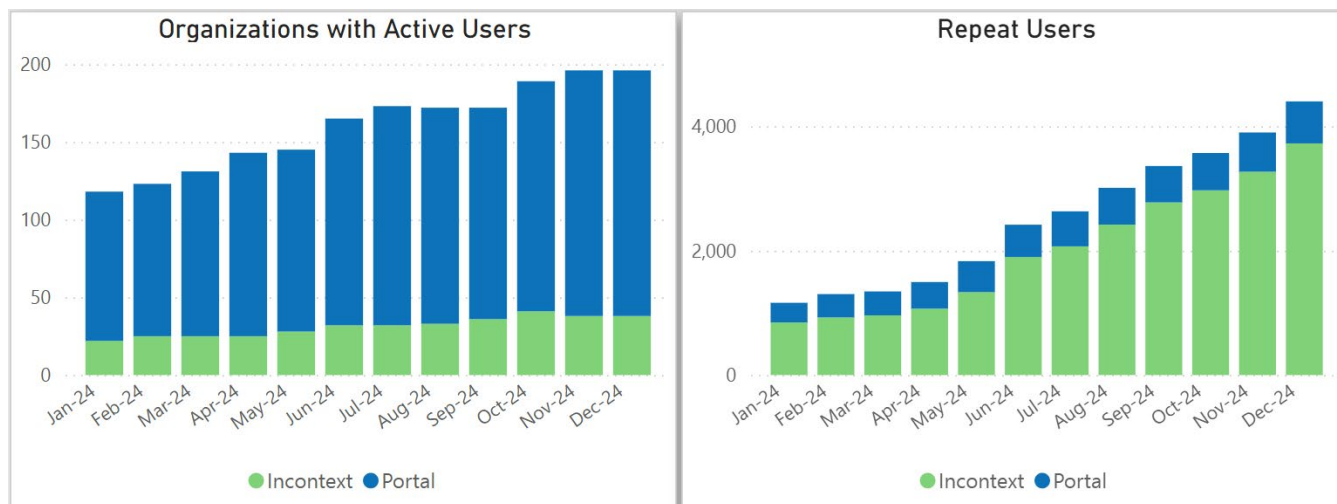


Figure 4: Connie Service Usage Statistics

New Use Cases in Production in 2024:

Alert Enhancement – Connie Encounters Worklist: Connie added a powerful new alerts worklist feature directly into the Clinical Information application called Population Health Explorer. Explorer enables 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 directly to encounter detail or directly to the patient’s

Statewide Health Information Exchange

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

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.

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. Who prescribed the medication and if the medication prescribed is being taken is not clear. Through this enhancement, Connie incorporates 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.

Problem Filters: Connie developed 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 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.

CCD eConsent Filter: Connie's eConsent tool requires participating organizations 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 enables Connie to screen incoming CCDs from organizations that have indicated that they have SUD treatment programs among other healthcare services. When a CCD contains sensitive data, the CCD is 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 data consent policies to be effectively implemented and operated across patient and provider populations.

Statewide Health Information Exchange

Referral Enhancement- 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 has pivoted to utilize 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 need 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.

Priority 4: Advance Population Health

Population Health Reports: Connie is developing aggregated population health reports with rich patient-level data that will give stakeholders insight into their patient's health trends. Connie initial patient roster-based reports leverage encounter and clinical information from participating organizations. Provider organizations could access the reports to analyze how their patients are doing related to statewide health improvement priorities, target priorities and strategies better tailored to their patient population's health status. Initial reports will focus on:

1. Patient demographics, specifically population health reports that provide REL breakdowns using national standards, with table views that support organizations' state standards analysis.
2. Hospital readmissions related to long-term/skilled nursing/post-acute care. The report would show patients with hospital admission, if they were admitted to a SNF, then returned to a hospital for an ED Visit, Observation or Inpatient stay within 30 days.
3. Connie will also work on developing a post-acute care in-patient length of stay report. The report will show the frequency for lengths of stay at any hospital or LTC facility at

Statewide Health Information Exchange

specified intervals. Length of stay is regardless of whether the patient was first admitted to the hospital or not.

Connie's Integration Work with State Agencies

- **Department of Correction:** DOC has signed a data sharing agreement with Connie, and DOC's medical team has onboarded to Connie's secure portal through single sign-on capabilities. 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:** In 2020, CMS passed a rule to improve quality and access to health information, allowing Medicaid participants and their providers to make informed healthcare decisions. The CMS rule requires DSS to develop patient access and provider directory application programming interfaces (API). In 2022, Connie facilitated DSS's development of these APIs, meeting the CMS interoperability requirements. Throughout 2024, Connie continued to support DSS in the operations and maintenance of the APIs.

Additionally, Connie is supporting DSS's Medicaid Home and Community Based Services (HCBS) Waiver program three-year initiative to track outcomes for a value-based care model. The initiative provides funding for community Long-Term Services and Supports (LTSS) organizations to connect to Connie. Participating home and community base service 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:

- decrease avoidable hospitalizations,
- increase in probability of discharge from hospital to community in lieu of nursing home,
- increase the number of members meeting their personal goals; and
- decrease health inequities among members served by participating organizations.

Statewide Health Information Exchange

- **Department of Public Health:** The Connecticut 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 25,927 cases in SFY2023. Of those cases, 3,103 required autopsies, 531 needed 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. HIPAA includes special disclosure provisions relevant to deceased individuals.

Priority 5: Maintain Operational Excellence

New website launched: In 2024, Connie's redesigned their website with a new, modern look. The new and improved site is full of new information tailored to both [providers](#) and [patients](#), including a Progress Display bar to show the status of healthcare organizations connected with Connie, patient-facing services, revamped [FAQ](#) sections, and a chatbot to answer other common questions. The site also features a brand-new [services page](#), designed to demonstrate how Connie can help solve real-life challenges and improve patient outcomes.

The site also contains [Connie University](#), an evolving, interactive hub for training materials, tools, and resources. User guides, service overviews, webinars, podcasts, walkthrough video tutorials, news, and newsletters are all available through the University, so organizations can stay informed and master Connie tools. As Connie continues to grow, more will continue to be added to the website for the benefit of patients and organizations.

HITRUST certification: Throughout CT FY24, Connie has been working diligently to submit the required documentation for HITRUST certification. Connie submitted its validated

Statewide Health Information Exchange

assessment ahead of schedule (September 2024) and received confirmation in October that it is HITRUST certified. HITRUST certification is a gold-standard certification that demonstrates an organization’s commitment and compliance to rigorous security and privacy requirements.

Connie’s Services

Table 3: Summary Table of Connie Use Case Services and Supporting Functions

Implementation FFY	Use Case Service
2021	Empanelment and Alerts MPI
2022	Provider Portals Provider Directory eReferrals Clinical Data PMP Access Best Possible Medication History (BPMH) Image Exchange
2023	Advanced Healthcare Directives (AHCD) Immunizations Provider Mediated eConsent Emergent Imaging Dental Health Records Connie Patient Access API
2024	Patient Portal Empanelment and Alerts Enhancement <ul style="list-style-type: none"> • Connie Encounters Worklist Referral Enhancement <ul style="list-style-type: none"> • Health Related Social Needs/Social Determinants of Health (HRSN/ SDOH) referrals Provider Portal Enhancements <ul style="list-style-type: none"> • Problem List Filters • Allergy Lists • BPMH – Pharmacy data Consent Enhancements <ul style="list-style-type: none"> • Continuity of Care Document (CCD) Sensitive Data Filters – Provider Mediated Affirmative (PrMA)
2025	Patient Portal Enhancement <ul style="list-style-type: none"> • Patient Mediated Affirmative Consent (PrMA)

Statewide Health Information Exchange

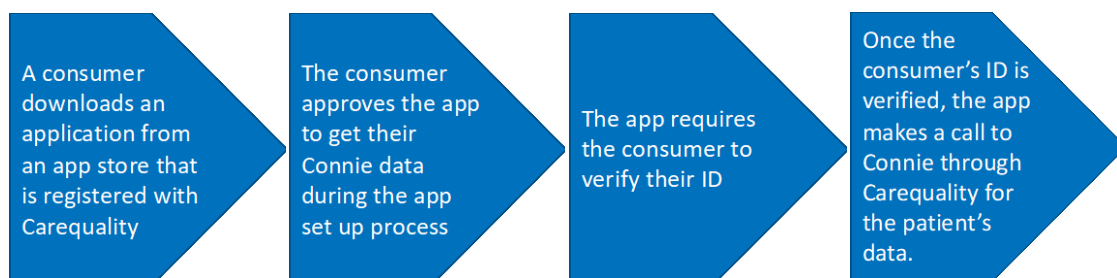
Implementa- tion FFY	Use Case Service
	Provider Portal Enhancements <ul style="list-style-type: none"> ▪ HRSN/SDOH Assessment ▪ Medicaid Redetermination ▪ Data in the Workflow ▪ Population Health Reports Empanelment and Encounter Notification Service Enhancement <ul style="list-style-type: none"> ▪ Logic-based Alerts

Descriptions of Connie Use Cases and Functionality

Use Cases in Production in 2024:

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.

Figure 5: Process for Activating a Consumer App for Accessing Patient Records



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

Statewide Health Information Exchange

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.

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.

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, allergies** and **problems**. Problems are able to be filtered to focus on issues important for oral health.
- **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, deduplicating 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 SUDs 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.

Statewide Health Information Exchange

- **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 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 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 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.

Statewide Health Information Exchange

Use Cases in Development for 2025:

Data in the Workflow: Connie is continuously focused on improving access to HIE data within the provider workflow. Connie's next iteration of workflow improvement will be to seamlessly incorporate pieces of HIE data within their EHR at the right point in the clinical workflow. For example, a user could enter an order for a CT scan within their EHR and a clinical decision support rule would alert the user that the same CT scan image had recently been captured and is available within Connie for viewing. Implementation of data-in-the-workflow can be flexible based on the capability and preferences of the participant. Some variables that can impact the scope of the implementation include:

HRSN/SDOH Assessment: Connie will ingest and display HRSN/SDOH screening and assessment data in the Connie Clinical Information application to disseminate identified social needs to providers. This requires mapping assessment questionnaires to the FHIR questionnaire and response model for participating systems.

Logic-Based Alerts: A logic-based alert is a highly actionable alert that follows pre-defined rules designed for a specific purpose that only trigger when all conditions are met. For example, Connie could provide real-time alerts that notify a patient's care team when their high-risk patients have hospital encounters for specific conditions (e.g. COVID-19, Congestive Heart Failure [CHF], Asthma), procedures (e.g. Mammography, Joint Replacement) or key lab tests results (e.g. COVID-19, Pregnancy, Pre-Diabetes). Flagging specific situations where the provider can intervene to provide preventative care, identify certain patients that would benefit from case management, or enroll patients in state-led programs is critical for improved patient outcomes. Connie will work to identify, develop, and implement Logic-Based Alerts, which will be delivered within a provider's workflow through the Connie Portal, or available at the point-of-service for providers.

Medicaid Redetermination: To streamline and provide more targeted outreach using Medicaid member rosters with member redetermination dates on an ongoing basis, Connie will be able to flag patients who are coming up on redetermination in the next 90 days for their provider. Providers and/or care managers could then encourage their patients to update DSS on their contact information to ensure they do not lose eligibility. Streamlining outreach using a more ongoing and targeted mechanism is expected to decrease time and effort for both DSS and participating provider organizations in ensuring eligible members retain their benefits.

Statewide Health Information Exchange

Patient Mediated Affirmative Consent: Patient Mediated Affirmative Consent enables patients to register consent to allow their SUD data to be shared through the HIE with members of their care team, without having to go through their provider. They will access their own consent tool through the Patient Portal, leveraging the patient ID verification process required for Patient Portal access. The eConsent functionality will support the interactive participation of patients to manage their consent choices for data that could be shared through the HIE.

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 their patient care gap, trends in their patient's needs, assess their success related to statewide health improvement priorities, and better target strategies tailored to their patient population's health status.

All-Payer Claims Database

Created in 2012 by Public Act 12-166 (codified as [C.G.S. §19a-755a](#)), the Connecticut's APCD program receives, stores, and analyzes health insurance claims data to promote research addressing safety, quality, transparency, access, and efficiency at all levels of healthcare delivery to improve the health of Connecticut residents. The statute requires health insurers to submit medical, pharmacy and dental claims, and provider and eligibility data from commercial, Medicare, and Medicaid payers. The [OHS website](#) contains information about the database, oversight, governance, policies and procedures.

Program Administration

The CGA transferred the APCD program administration responsibilities to OHS in 2018. OHS makes APCD data available to state agencies, payers, providers, consumers or researchers through a formal Data Release review and approval process. The CGA authorized the release of an APCD limited data set to Connecticut hospitals for specific purposes outlined in [C.G.S. §19a-127k\(f\)](#) to support hospitals' community benefit program planning and implementation.

Stakeholder Advisement

OHS provides staff support and oversight of the [APCD Advisory Group](#) (APCD-AG), a subcommittee of the [Health Information Technology Advisory Council](#) (HITAC), and the [APCD Data Release Committee](#) (DRC). The APCD-AG meets quarterly and provides strategic guidance and recommendations related to the program, to OHS and the HITAC. The DRC meets to review external APCD data requests and to make recommendations that ensure the protection of Connecticut residents' health data. In late 2024, OHS reactivated an APCD Data Release Application Workgroup to update and enhance the application (not including hospital community benefit) as part of the agency's APCD strategic planning goals. The updated application and related data use agreement will incorporate protections related to the new HIPAA privacy rules on the sharing and use of reproductive data.

All APCD advisory body meetings are open to the public and meeting materials including recordings are published on the OHS website.

APCD Data Enhancements

The APCD currently contains more than a billion records spanning from 2012 through September 2024; data is refreshed quarterly. [Table 5](#) illustrates all current APCD data contributors, types, and years available.

Employee Retirement Income Security Act (ERISA) data collection: In alignment with OHS's strategic goal of enhancing data quality and completeness, efforts are underway to engage Connecticut's self-insured employers to encourage the voluntary submission of commercial health plan data through their third-party administrators (TPAs) or insurers. Due to ERISA's federal preemption, states cannot mandate participation of ERISA self-insured employers, their contracted TPAs or commercial health plans in the APCD.

However, health benefit plans administered by the Office of the State Comptroller for Connecticut's public employees and retirees—including those offered to municipalities through the CT Partnership Plan 2.0—actively contribute data to the APCD. Building on this framework, OHS is collaborating with insurance carriers to explore opportunities for self-insured employers to voluntarily opt-in to submit claims data to the CT APCD.

As part of these efforts, OHS is considering introducing an opt-in form, modeled after successful examples from other APCD programs, such as Colorado. This form would provide a clear, standardized mechanism for employers to participate voluntarily and contribute to the state's comprehensive health data collection initiative.

Medicare Data: To improve data completeness of the existing Medicare data set in the APCD, OHS requested and received 2019 through 2022 Medicare data. This data will be available within the APCD by spring 2025.

2024 Data Releases

In 2024, OHS fulfilled approximately 20 data requests, including applications for limited data sets submitted by the Connecticut Hospital Association on behalf of seven hospitals and hospital systems. Six (6) additional inquiries for data extracts are pending further information from the requestors.

All Payer Claims Database

Table 4: APCD Data Contributors, Data Types, and Years of Data Available

Payer	Population	Claim Type	Years Available (From)	Years Available (To)
Commercial**	Fully insured (individual, small and large group plans)	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2012	9/30/2024
Commercial**	Self-insured (individual, small and large group plans) including State Employees/Retirees Plan & Municipalities in State Partnership Plan, and some employer sponsored Plans	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2012	9/30/2024
Medicaid/HUSKY Health	All ages***	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2015	9/30/2024
Medicare (Fee for Service)	Ages 65 and older, and under 65 with certain disabilities/conditions	Eligibility/Enrollment Medical Claims	1/1/2012	12/31/2019
Medicare (Part D)	Drug Plan (Fee for service/Medicare Advantage)	Pharmacy Claims	1/1/2012	12/31/2018
Medicare (Medicare Advantage)	Health plans provided by private companies contracted by Medicare. Most plans include Part D	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2012	9/30/2024

**Anthem (Elevance Health), Aetna, Cigna East, Cigna West, ConnectiCare, UnitedHealthcare, HealthyCT, Harvard Pilgrim, Optum Health, Oxford, WellCare Health, eviCORE Healthcare, Express Scripts, Caremark. Dental carriers: UnitedHealthcare, Ameritas, Elevance Health, Aetna, Cigna, Unum

Reporting threshold – 3,000 members

***HUSKY A – children, teens, parent, pregnant women, & relative caregivers. HUSKY B or Children’s health insurance program (CHIP) for children and teens up to age 19. HUSKY C for adults 65 and older, and adults with disabilities, HUSKY D for low-income adults without dependent children.

APCD Strategic Priorities

The two tables below provide an update on the APCD program’s strategic priorities by category as presented during the November 2024 APCD-AG meeting: Category 1 – APCD Data Enhancements and Utilization, Category 2 – Operational Enhancements.

Table 5: APCD Strategic Priorities, Activities and Status: Data Enhancements & Utilization

STRATEGIC PRIORITY	SPECIFIC ACTIVITIES	STATUS	2024 PRIORITY
Produce and publish data visualizations with APCD data	<ul style="list-style-type: none"> Select 3 from 13 proposed cost, utilization and performance use cases that align with OHS priorities 	In process	Yes
Enhance and enrich APCD data	<ul style="list-style-type: none"> Convene a data quality workgroup to identify how to improve data quality for field of value that supports policy development and evaluation of CT healthcare utilization, cost, and quality 	Pending	Preliminary discussion
Pursue ERISA plan involvement	<ul style="list-style-type: none"> Convene virtual stakeholder listening sessions with ERISA plan sponsors 	In process	Yes
Increase CT State agencies and external use of APCD data	<ul style="list-style-type: none"> Website redesign to make APCD information more accessibility for data requests, and publish approved uses Create e-marketing campaign to users Create public use file for research Update healthcare cost estimator tool to support consumer/purchaser decision-making 	Phase 1 Completed Pending In process Completed	Yes Yes Yes Yes

All Payer Claims Database

Table 6: APCD Strategic Priorities, Activities and Status - Operational Enhancements

STRATEGIC PRIORITY	SPECIFIC ACTIVITIES	STATUS	2024 PRIORITY
Explore fee structure changes	<ul style="list-style-type: none"> ▪ OHS to prepare report on pricing models across nation, fee structure, and fee waivers; solicit feedback and consult with HITAC and APCD advisory bodies to create new fee schedule 	Pending	
Refine APCD data request application and process	<ul style="list-style-type: none"> ▪ OHS to work with APCD Data Release Committee to revamp data release application and develop more efficient requirement fulfillment workflow 	In process	Yes
Enact new APCD policies and procedures	<ul style="list-style-type: none"> ▪ As part of ongoing process improvement, update policies and procedures to delineate data request process for state agencies versus external (non-state agencies) process ▪ Add a data question assessment for the release requirements ▪ Consult with HITAC and APCD advisory bodies 	Pending	
Fill APCD Advisory Group and Data Release Committee vacancies	<ul style="list-style-type: none"> ▪ Fill 1 vacancy on APCD Advisory Group ▪ Fill 2 vacancies on APCD DRC 	In process	Yes

2024 APCD Program Achievements, Initiatives, and Contributions

2024 List of Costliest Drugs in the State

The [list of costliest drugs in the State](#) was completed in accordance with C.G.S. § 19a-754b (d). The list provides transparency on the state's most expensive outpatient prescription drugs in Connecticut between January 1, 2020, and December 31, 2022. The data for this list was pulled from the following sources:

- Connecticut's All Payer Claims Database
- Connecticut Insurance Department Managed Care Enrollment files
- The Redbook Micromedex Wholesale Acquisition Cost

Access Health CT Plan Utilization Review

The state's Insurance Exchange market reviews benefit information annually, to determine the standard plan offerings for the upcoming plan year. APCD information used in conjunction with other data to help make benefit recommendations for plan year 2025.

APCD Snapshot Dashboard

An online [APCD Snapshot dashboard](#) overview of data available in the APCD. Updated on quarterly basis to include current data. Available data is for ten-year periods, currently 2014 through September 2024.

Behavioral Health Insurance Coverage and Payment Parity in HUSKY, Private Insurance, and Medicare Advantage Report

Published in September 2024, the legislatively mandated [behavioral health parity study](#) was supported by a collaborative multi-agency workgroup comprised of staff from OHS, DMHAS, DSS, and DCF. APCD data supported the study in the following ways:

- Reimbursement rates were constructed for common behavioral health services for HUSKY, commercial insurance, and Medicare Advantage using 2022 professional claims data (i.e., claims for services billed by individual doctors or other practitioners) from Connecticut's APCD.
- Behavioral health services were identified in APCD claims data using Common Procedure Terminology (CPT) codes for office visits, psychiatric diagnostic evaluation, and psychotherapy, with each CPT code representing different behavioral health provider types, including physicians (psychiatrists, and neurologists) and non-physician providers (advanced practice nurses [APRNs], physician assistants [PAs], social workers, counselors, and psychologists).
 - The APCD claims data were used to identify health plan enrollees with a mental health disorder (MHD) or SUD.

Certificate of Need Evaluations

APCD data is leveraged for [evaluating healthcare services availability and pricing](#) to help guide community-based planning for health services and facilities.

Comparison of APCD Inpatient Data to hospital inpatient discharge data to assess the completeness and/or how representative the APCD was of hospital inpatient discharges.

Connecticut Healthcare Affordability Index (CHAI)

Co-created by OHS, the Office of the State Comptroller, the Connecticut Healthcare Foundation, and the University of Washington School of Social Work, Center for Women's Welfare, the [CHAI](#) defines what Connecticut households need to meet their healthcare costs without sacrificing other basic needs including housing, food, transportation, childcare, and taxes. The CHAI measure, updated in 2024, demonstrates how healthcare costs vary based factors that impact affordability, including differences in insurance coverage, age, and increased out-of-pocket costs based on health risk scores.

Connecticut Healthcare Cost Estimator

An upgraded [Healthcare Cost Estimator tool](#) was released in 2024 which includes paid amounts & out of pocket payments on 25+ commonly provided inpatient services, outpatient services/procedure and enhanced to include cost information on outpatient Rx drugs, and durable medical equipment (DME) in Connecticut.

Connecticut Statewide Healthcare Facilities and Services Plan

Published in June 2024, the [Connecticut Statewide Healthcare Facilities and Services Plan](#) uses numerous data sources including APCD and Hospital discharge data to analyze current capacity, utilization, and estimates of need for healthcare facilities and services in Connecticut. This report was supported through additional funding from the CGA and the CDC Health Disparities Grant.

Dental Carriers Reporting Data

In September 2023 dental claims and eligibility data collection went into effect and reporting began in February 2024.

- 25 dental policies in Connecticut and all 25 dental carriers registered during OHS annual registration
- Of the 25 carriers only 3 carriers (one has three subsidiaries) meet the 3,000 lives reporting threshold

[All Payer Claims Database](#)

Department of Public Health Flu Vaccine Statewide Coverage

Provided information on the name and identifying information for clinics that administer influenza vaccines to verify statewide coverage and/or need for intervention.

Department of Public Health Primary Care Shortage Designation

Provided primary care provider information to support DPH annual requests for federal health profession shortage area designations for geographic areas or population groups in CT that lack primary care providers.

Healthcare Benchmark Initiative Recommendations to the CGA

Published October 18, 2024, in accordance with *C.G.S. § 19a-754f*, the [Healthcare Benchmark Initiative Recommendations Report](#) summarizes the results of the OHS Healthcare Benchmark Initiative for the calendar years 2021-2022. The OHS Healthcare Benchmark Initiative includes:

- The healthcare cost growth benchmark
- Primary care spending target
- Quality benchmark

The Report uses APCD claims to identify high-cost, high-volume medical services, as well as services in Connecticut that show wide price variations. The report's recommendations identify opportunities to reduce cost growth in medical care, improve quality and promote equity. The analyses also included measuring the unintended consequences of the program on consumer medical and insurance premium out of pocket spending.

Home Health Services Costs

Provided average and total costs, and number of claims for home health skilled versus unskilled care to estimate cost and utilization for health insurance mandate bill.

Impacts of Connecticut Hospital and Healthcare System Consolidation (2016-2021)

Published in March 2024, this [legislatively mandated report](#) studied the impact of hospital and healthcare system consolidation in Connecticut between 2013 and 2019 on healthcare utilization, spending, and prices through review of hospital discharges and medical claims from the APCD and the Connecticut Hospital Discharge Database.

Paramedic Intercept Services Costs

Provided number and amount of claims, in the commercial market and state employee plan, made annually by enrollees and their share of the cost to estimate cost and utilization for a health insurance mandate bill.

[All Payer Claims Database](#)

Primary Care Spend Target Initiative – 2022 Performance

Published June 2024, this legislatively mandated [Primary Care Target Initiative Report](#) leveraged APCD data to study utilization management and provider payment practices of Medicare Advantage Plans study.

2024 APCD Program Reports, Analysis, and Initiatives

The following reports, analysis, and initiatives utilizing the APCD data program are published or in progress:

- Cost and Market Impact Review for Hospital Consolidation – in progress
- [Report of Pharmacy Benefit Manager Practices](#)
- [Healthcare Cost Growth Benchmark: Data Transparency Dashboards](#)
- OnPoint Collective Impact Behavioral Health Dashboard – in progress to be delivered in 2025
- Health Equity Dashboard – in progress to be delivered in 2025
- [Connecticut Insurance Department Utilization Management and Provider Payment Practices of Medicare Advantage Plans Study](#)

Section 4: Recommendations for Policy, Regulatory or Legislative Changes

Advancing Health Equity in Connecticut Through Data-Driven Strategies

The State of Connecticut is embarking on an ambitious path to reduce racial and ethnic disparities in health outcomes through data-informed policies, interventions, programs, and investments. Strategic decisions made by the CGA have significantly enhanced the potential for meaningful action by requiring most healthcare providers to collect standardized, machine-readable REL data, along with other health-related information, in EHR systems.

As organizations work toward full compliance with C.G.S. §19a-754d, Section 11, providers are collecting and managing data in EHRs—such as clinical information, race/ethnicity, primary language, and patient-reported disability data—with appropriate privacy protections. This data can be shared and integrated with agency-specific datasets to yield actionable insights. These insights will guide the Commission on Racial Equity in Public Health and state policymakers in identifying and addressing inherent racial health disparities across Connecticut.

Recommendations for Maximizing Impact

To fully leverage the potential of these efforts, OHS recommends exploring a **coordinated, cross-agency data sharing and technical assistance strategy** to support irrigation of REL data from provider organizations to state agencies. This strategy should include consent forms, tools, services, and resources to ensure seamless implementation and long-term success, such as:

- **Sample Vendor Resources:** Draft sample requirements documents and Statements-of-Work for providers to use when contracting with EHR vendors to implement REL 4.0 data collection standards.
- **Data-Sharing Agreements:** Develop template agreements to facilitate secure and consistent data exchange between providers and state agencies.
- **Consent-to-Share Forms:** Create standardized, legally compliant consent-to-share and release of information (ROI) forms.

- **Shared Services for Consent Management:** Provide shared services to collect, access, view, and manage electronic consent forms for sharing sensitive PHI between agencies and providers.
- **EHR Testing Support:** Assist providers in testing and validating EHR system changes to ensure compliance with data collection and reporting requirements.
- **Training Resources:** Develop and distribute training materials tailored to providers and agency staff to support ongoing education.
- **Additional Support Services:** Offer other tools and resources as needed to ensure sustained success of these initiatives.

Connecticut's proactive approach to collecting and utilizing REL data, combined with these recommended supports, positions the state as a leader in addressing racial health disparities through innovative, data-driven solutions.

Section 5: Other Initiatives Supporting 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. 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, Implement phase into an Operations and Maintenance phase.

Medicaid Federal Funding Requests to Support HIE Services

Implementation Advanced Planning Document Update

- 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) covers the period from October 1, 2024, through September 30, 2026. 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. The cost allocation percentage approved for this year is 56%. Before a use case or system module receives CMS certification the FFP is limited to **50%** of Medicaid program

- Once CMS certifies a use case or system module, the FFP increases to **75%** of Medicaid program costs

The Federal Share of the IAPD and OAPD budgets were calculated with the CMS-approved Cost Allocation Percentage of 56%.

Implementation Advanced Planning Document Update

Table 7: Summary of IAPD-U DDI Funding Request

FFY	Total DDI Costs	Costs Allocated to Medicaid	90% Federal Share	10% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25	\$ 8,258,058	\$ 5,827,758	\$ 5,244,982	\$ 582,776	\$ 5,244,982	\$ 582,776	\$ 2,430,300
FFY 26	\$ 8,433,199	\$ 5,632,217	\$ 5,068,995	\$ 563,222	\$ 5,068,995	\$ 563,222	\$ 2,800,982
Total	\$ 16,691,256	\$ 11,459,975	\$ 10,313,977	\$ 1,145,997	\$ 10,313,977	\$ 1,145,997	\$ 5,231,281

Operational Advanced Planning Document Update

Table 8: OAPD Summary of Operations Budget Request

FFY	Total Operations Costs	Costs Allocated to Medicaid	75% Federal Share	25% State Share	50% Federal Share	50% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25	\$ 4,252,312	\$ 2,381,295	\$ 1,169,807	\$ 389,936	\$ 410,776	\$ 410,776	\$ 1,580,583	\$ 800,712	\$ 1,871,017
FFY 26	\$ 4,569,774	\$ 2,559,074	\$ 1,192,307	\$ 397,436	\$ 484,666	\$ 484,666	\$ 1,676,972	\$ 882,101	\$ 2,010,701
Total	\$ 8,822,086	\$ 4,940,368	\$ 2,362,114	\$ 787,371	\$ 895,441	\$ 895,441	\$ 3,257,555	\$ 1,682,813	\$ 3,881,718

Combined Implementation / Operational Advanced Planning Document Update

Table 9: Combined IAPD and OAPD Funding Request

APD	Total Costs	Costs Allocated to Medicaid	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
IAPD	\$ 16,691,256	\$ 11,459,975	\$ 10,313,977	\$ 1,145,997	\$ 5,231,281
OAPD	\$ 8,822,086	\$ 4,940,368	\$ 3,257,555	\$ 1,682,813	\$ 3,881,718
Total	\$ 25,513,342	\$ 16,400,343	\$ 13,571,533	\$ 2,828,810	\$ 9,112,999

Healthcare Benchmark Initiative

In 2020, Governor Lamont signed [Executive Order No. 5](#) directing OHS to develop annual benchmarks for healthcare per capita cost growth for CY 2022–2025. Executive Order No. 5 was codified into law in C.G.S. §§19a–745f–g. To support the benchmark initiative, OHS collects and evaluates troves of health data as illustrated in the table linked here: [Summary of Connecticut OHS Healthcare Benchmark Initiative Spending Data Collection and Analysis](#).

Data Compendium

The OHS [Data Compendium](#) is a compilation of key databases maintained by OHS staff. Information in the compendium includes: a brief overview of the data source, website, links, and data fields related to the database.

The Data Compendium also provides comprehensive information about OHS databases, why each data set is collected, what is readily accessible, and what OHS makes available through the Freedom of Information (FOI) process or through a protected health information (PHI) data release process. OHS processes data requests through its [data request portal](#), where all FOI requests are documented and made publicly available.

Appendix A

Partial List of Health Information Technology Acronyms

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

HITRUST	Health Information Trust Alliance	2Gen	Two Generational Initiatives
IAPD	Implementation Advance Planning Document	UConn	University of Connecticut
IAPD-U	Implementation Advance Planning Document	VBPM	Value-Based Payment Model

Appendix B

Federal Health IT Strategic Plan Goals and Objectives

This summary is provided for reference to illustrate alignment between federal and state health IT strategies and roadmap.

As required by Section 3001(c)(3) of the Public Health Service Act, Assistant Secretary of Technology Policy (ASTP) and ONC updated the [Federal Health IT Strategic Plan](#) (Strategic Plan) in September 2024. The plan establishes goals, objectives, and strategies for federal health IT efforts and reflects input from over 25 federal organizations, public comments, and stakeholders, including healthcare systems, health IT developers, and patient advocates.

Goal 1: Promote Health and Wellness	
Objectives	Individuals are empowered to manage their health Individuals are empowered to manage
	Individuals and populations experience modern and equitable healthcare
	Communities are healthier and safer Communities are healthier and safer
Goal 2: Enhance the Delivery and Experience of Care	
Objectives	Providers deliver safe, equitable, high-quality, and improved care
	Patients experience expanded access to quality care and reduced or eliminated health disparities
	Healthcare is improved through greater competition and transparency
	Providers experience reduced regulatory and administrative burden
	The healthcare workforce uses health IT with confidence
Goal 3: Accelerate Research and Innovation	
Objectives	Researchers and other health IT users have appropriate access to high-quality health data to drive individual and population health improvement
	Individual and population-level research, analysis, and its application are enhanced by health IT
	Researchers advance health equity by using health data that includes underrepresented groups

Goal 4: Connect the Health System with Health Data	
Objectives	Development and use of health IT capabilities continues to advance
	Health IT users have clear and shared expectations for data sharing
	Underserved communities and populations have access to infrastructure that supports health IT use
	Individuals' EHI is protected, private, and secure
	Communities are supported by modern and integrated public health

ASTP/ONC prioritizes the following areas for measuring progress on the Strategic Plan's goals and objectives:

- **United States Core Data for Interoperability (USCDI):** Adoption and use of a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange
- **USCDI+:** Adoption and use of standardized sets of domain or program-specific data elements for federal quality measurement and public health interoperable data sharing
- **Certified Health IT:** Widespread use of modern health IT capabilities of Health IT
- Standard **Application Programming Interfaces (APIs)** for patient and population services
- **Electronic Health Information (EHI)** export for a single patient and for an entire patient population
- **Decision Support Interventions (DSI)** information to improve transparency on how a predictive DSI was designed, developed, trained, evaluated, and should be used
- **Trusted Exchange Framework and Common Agreement™ (TEFCA):** Qualified Health Information Network's (QHINs) support secure EHI exchange for the purposes of treatment, payment, healthcare operations, public health, government benefits determination, and individual access services
- **Information Sharing Consistent with the Information Blocking Regulations:** Health information is appropriately exchanged across care settings, and information blocking conduct is reduced or eliminated.
- **HHS Health IT Alignment:** HHS uses its spending power and regulatory authorities to drive alignment with and use of HHS adopted health IT standards

Federal Health IT Rules

Health Data, Technology, and Interoperability: Certification Program Updates, AI-Algorithm Transparency, and Information Sharing (HTI-1) Final Rule

Overview	The HTI-1 Final Rule updates the ONC Health IT Certification Program , advancing interoperability, transparency, and EHI exchange under the 21st Century Cures Act .
Key Updates	<p>AI Transparency: Requires certified health IT to provide baseline algorithm details for fairness, safety, and effectiveness.</p> <p>USCDI v3: Adopts new data standards by January 1, 2026, enhancing equity and public health data sharing.</p> <p>Information Blocking: Adds new exceptions to support secure, standards-based EHI exchange under TEFCAs.</p> <p>Usage Metrics: Introduces a certification requirement to report interoperability usage insights.</p>

Note: [Minor corrections](#) issued in early 2024.

Confidentiality of Substance Use Disorder Patient Records Final Rule

Summary of [42 CFR Part 2 Final Rule](#) (Feb 16, 2024)

Overview	Aligns SUD privacy protections (42 CFR Part 2) with HIPAA rules, as required by the CARES Act .
Key Changes	<p>Patient Consent:</p> <ul style="list-style-type: none"> • Allows a single consent for treatment, payment, and healthcare operations. • Redisclosure allowed under HIPAA rules. • Separate consent required for SUD counseling notes. • Prohibits combining legal disclosure consent with other consents. • Disclosures must include consent details or explanation. <p>Other Uses/Disclosures:</p> <ul style="list-style-type: none"> • Public health authorities may receive de-identified data without consent. • Civil, criminal, or legislative use restricted without consent or court order. <p>Penalties: Aligns with HIPAA enforcement (civil/criminal).</p> <p>Breach Notification: Extends HIPAA breach rules to Part 2.</p> <p>Patient Notice: Updates Part 2 notices to match HIPAA requirements.</p>

	Safe Harbor: Limits liability for agencies following due diligence before requesting records.
Additional Updates	Segregation of Part 2 data is not required. Patients can file complaints with the Secretary and Part 2 program. SUD Counseling Notes: Defined separately, requiring specific consent akin to HIPAA psychotherapy notes. Fundraising: Patients may opt out of fundraising communications.
Compliance	Aligns with the 2024 HIPAA Privacy Rule; compliance date set for February 16, 2026.
Future Plans	HHS intends to implement CARES Act antidiscrimination provisions in future rulemaking.

21st Century Cures Act: Establishment of Disincentives for Healthcare Providers That Have Committed Information Blocking Final Rule

Overview	CMS finalized penalties for information blocking under the Medicare Promoting Interoperability Program, Merit-based Incentive Payment System (MIPS), and Medicare Shared Savings Program
Key Disincentives	<p>Promoting Interoperability Program: Hospitals and critical access hospitals (CAHs) committing information blocking (per OIG referral) lose status as meaningful EHR users. Results in loss of three-quarters of annual payment increase for hospitals or reduction of CAH payments to 100% of reasonable costs (from 101%).</p> <p>MIPS: MIPS-eligible clinicians committing information blocking lose meaningful EHR user status. Leads to a zero score in the Promoting Interoperability performance category (typically 25% of the final composite score).</p> <p>Medicare Shared Savings Program: Accountable Care Organizations (ACOs), participants, or providers committing information blocking face potential one-year program exclusion. CMS may take additional actions, such as denying participant additions, requiring remedial action, or terminating participation agreements.</p>

<p>Alternative Policy</p>	<p>CMS will consider factors like the severity, corrective efforts, and time elapsed before applying penalties.</p> <p>These measures aim to discourage information blocking and promote interoperability across healthcare systems.</p>
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Health Data, Technology, and Interoperability: Trusted Exchange Framework and Common Agreement (HTI-2) Final Rule

<p>Overview</p>	<p>Published in the Federal Register on December 16, 2024, ASTP/ONC’s HTI-2 Final Rule amends the information blocking regulations by including definitions related to the TEFCAs Manner Exception. It also implements provisions to support the reliability, privacy, security, and trust within TEFCAs.</p>
<p>Key Changes</p>	<p>The HTI-2 Final Rule finalizes a new part of the Code of Federal Regulations (CFR) for provisions related to TEFCAs in 45 CFR Part 172. These final provisions further implement the Public Health Service Act section 3001(c)(9) as added by the Cures Act and provide greater transparency of TEFCAs processes.</p> <p>The HTI-2 Final Rule makes no changes to the TEFCAs Manner Exception § 171.403 and adopts the TEFCAs-related definitions as proposed.</p>

Health Data, Technology, and Interoperability: Protecting Care Access (HTI-3) Final Rule

<p>Overview</p>	<p>Published in the Federal Register on December 17, 2024, the ASTP/ONC’s HTI-3 Final Rule aims to enhance information sharing while safeguarding patient privacy. It builds on the HTI-2 Proposed Rule by finalizing key updates to information blocking regulations.</p> <p>These updates reflect federal efforts to balance improved data exchange with protections for individuals’ privacy and legal safety, particularly in sensitive areas like reproductive healthcare.</p>
<p>Key Updates</p>	<p>Definition of “Reproductive Healthcare”: A new definition of “reproductive healthcare” was added to the information blocking regulations under 45 CFR 171.102.</p> <p>Revised Information Blocking Exceptions:</p> <p>Privacy Exception (§ 171.202): Expanded the sub-exception (§ 171.202(e)) for restricting the sharing of an individual’s Electronic Health Information (EHI) at their request by removing a prior limitation tied to other laws requiring disclosure. While the revision does not override laws compelling disclosure, it allows actors to restrict</p>

	<p>EHI sharing at an individual’s request without being considered information blocking, provided the requirements of the sub-exception are met.</p> <p>Infeasibility Exception (§ 171.204): Updated the segmentation condition to allow actors to withhold certain EHI that cannot be unambiguously segmented from other shareable data. This expansion applies to all sub-exceptions under the Privacy Exception, as well as the new Protecting Care Access Exception.</p> <p>Protecting Care Access Exception (§ 171.206): This exception provides assurance for actors who choose to limit information sharing in scenarios where doing so could protect individuals involved in lawful reproductive healthcare (e.g., patients, providers, or facilitators) from potential legal risks. It also allows for restricting the sharing of a patient’s EHI related to reproductive healthcare to prevent exposure to legal action.</p>
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More About the Defined Exceptions to the Information Blocking Rule

The **Protecting Care Access Exception** increases the number of Federal Information Blocking exceptions defined by ASTP/ONC to nine. These exceptions provide clear guidelines for actors (healthcare providers, health IT developers, HINs, and HIEs), ensuring that practices meeting exception conditions are not deemed information blocking.

Summary of Exceptions

In addition to the new Protecting Care Access Exception and the revised Privacy and Infeasibility Exceptions from the HTI-3 Final Rule, ASTP/ONC has previously defined [six other exceptions](#):

1. **[Preventing Harm Exception](#)**: Justifies practices likely to interfere with EHI access, exchange, or use when protecting patients and others from unreasonable risks of harm.
2. **[Security Exception](#)**: Protects all legitimate security practices without mandating a specific security standard, enabling flexibility for varying organizational needs.
3. **[Health IT Performance Exception](#)**: Allows for temporary unavailability or degraded performance of health IT systems when necessary for maintenance or improvements to overall system performance.
4. **[Content and Manner Exception](#)**: Provides clarity on the required EHI scope and the flexibility to fulfill requests. Supports innovation by permitting actors to establish market-negotiated terms for accessing, exchanging, or using EHI.

5. **Fees Exception:** Permits actors to charge fees for developing technologies and services that enhance interoperability while prohibiting opportunistic fees or practices that obstruct EHI access, exchange, or use.
6. **Licensing Exception:** Enables actors to protect their innovations and charge reasonable royalties to recoup investments made in developing, maintaining, and updating their technology.

These exceptions balance the need for robust information sharing with the protection of privacy, innovation, and security, ensuring that actors can operate within clear regulatory boundaries.

National Health Data Exchange Networks: Standards and Governance

Trusted Exchange Framework and Common Agreement (TEFCA)

The [TEFCA](#) is a [government-endorsed](#) approach for a nationwide network of networks to enable interstate data sharing of health information for specific Exchange Purposes. It is a contractual and operational framework for data sharing. It is not a network or standards body, technology, platform, or service and is not legally mandated. TEFCA is a non-binding policy document developed by the ONC that articulates foundational principles for trusted data exchange and enables the appropriate sharing of electronic health information between networks.

Common Agreement

The [Common Agreement](#) is a binding legal agreement to ensure the legal provenance, privacy, and security of the data for all organizations participating in TEFCA.

Recognized Coordinating Entity (RCE)

The Recognized Coordinating Entity ([RCE](#)) is the body charged with operationalizing, implementing, and administering TEFCA and monitoring QHINs.

TEFCA Governance Framework

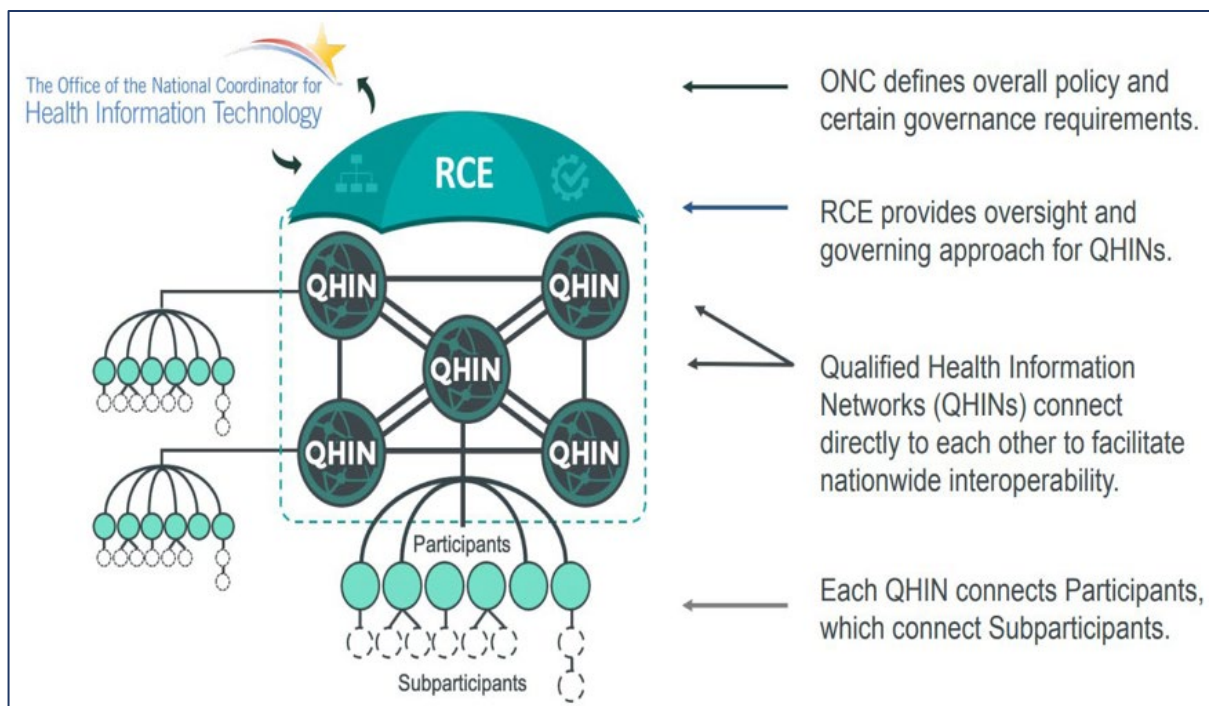


Figure 6: TEFCA Governance Framework

Source: <https://rce.sequoiaproject.org/wp-content/uploads/2023/03/Common-Agreement-Users-Guide-version-1.1-dated-3.22.2023.pdf>

TEFCA Permitted Purposes for Health Information Exchange

TEFCA currently supports electronic data exchange for six [exchange purposes](#): [Treatment](#), [Payment](#), [Healthcare Operations](#), [Public Health](#), [Government Benefits Determination](#), and [Individual Access Services](#) (IAS).

This means organizations participating in health data exchange through the services of a TEFCA QHIN are optionally allowed to request health information (query for data) or respond to queries for any of the listed purposes. TEFCA policies, however, require responses to queries for *TEFCA Required Treatment* (defined below) and *Individual Access Services*.

Defining “Treatment” and “TEFCA Required Treatment” in TEFCA

1. The [HIPAA Privacy Rule](#) has long permitted healthcare organizations that are “covered entities” and “business associates” to share—with few exceptions—a patient’s protected health information *without the patient’s affirmative consent* for the purposes of *Treatment, Payment, and Healthcare Operations* (known as HIPAA TPO). The term “Treatment” is defined in HIPAA regulations at <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.501> as “the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers

relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another”.

2. A query that meets the requirements of TEFCA Required Treatment can only be asserted by a QHIN, Participant, or Sub participant if the Query is in connection with or intended to inform healthcare services that an entity is providing or intends to provide to a patient through synchronous or asynchronous interaction (either in-person or virtual) with a Licensed Individual Provider.
 - a) This includes, but is not limited to, querying for records: upon receipt of a notification of admission to or discharge from a hospital, for medication reconciliation and medication management; in support of care management; and for identification of care gaps all for an individual patient.
 - b) Queries initiated using the TEFCA Required Treatment XP Code are intended to support healthcare services for individual patients.
 - c) If a query is made for a similar purpose at a population level, it is for the [\(SOP\) Exchange Purpose \(XP\) Implementation: Healthcare Operations](#).

Health Data Privacy Laws

The HIPAA [2024 Privacy Rule](#) went into effect on June 25, 2024, making the following changes to HIPAA’s privacy protections for Protected Health Information (PHI):

- Prohibits the use or disclosure of PHI when it is sought to investigate or impose liability on individuals, healthcare providers, or others who seek, obtain, provide, or facilitate reproductive healthcare that is lawful under the circumstances in which such healthcare is provided, or to identify persons for such activities.
- Requires a regulated healthcare provider, health plan, clearinghouse, or their business associates, to obtain a signed attestation that certain requests for PHI potentially related to reproductive healthcare are not for these prohibited purposes.
- Requires regulated healthcare providers, health plans, and clearinghouses to modify their Notice of Privacy Practices to support reproductive healthcare privacy and notify individuals of changes to consent requirements for sharing substance use data (described in an earlier section of the Annual Report).

Artificial Intelligence

In November 2022, a working version of ChatGPT was released by [OpenAI](#) for public use, launching an explosion of growth in the use of generative AI (GenAI) technology. Simultaneously, substantial thought is being applied to the considerations for effectively regulating the ongoing development of AI technology—often referred to as a technology arms race—and ensuring responsible use of GenAI technology. Governments around the globe, technology-focused think tanks, businesses using AI systems and tools, and technology companies building AI solutions have raced to create internal policies for using AI technology responsibly, while also contributing to the ongoing dialogue and rigorous debate about whether and/or how to apply regulatory guardrails to the AI technology domain.

Definition of Generative AI

Generative AI models are a category of deep-learning models that are “trained” on extensive datasets and that can then be directed to generate content based on the data on which they have been trained. GenAIs capable of generating new content for users in a variety of formats, including text, images, sounds, videos, and more. That being said, it is essential to precisely define and understand the various terms associated with generative AI.

[Regulating Under Uncertainty: Governance Options for Generative AI](#)

Stanford Cyber Policy Center

Federal Actions

In 2025, the ONC is enforcing new regulations requiring transparency and accountability for the use of AI in certified health IT systems, mandating that developers of health IT modules with predictive AI capabilities must disclose details about their algorithms, including risk management practices and data governance procedures, to ensure responsible and ethical AI implementation in healthcare.

Connecticut’s Responsible AI Framework

The "[Responsible AI Framework](#)" issued by Connecticut, effective February 1, 2024, outlines policies and procedures to ensure the ethical use of AI in state government. The framework emphasizes meaningful guardrails, workforce empowerment, and purposeful use to drive responsible AI innovation.