2022

Annual Report: State Health IT & Health Information Exchange

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CONNECTICUT
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Introduction and Background

In accordance with section 17b-59a of the Connecticut General Statutes, the Executive Director of the Office of Health Strategy (OHS), in consultation with the State Health Information Technology Advisory Council (HITAC), is required to report annually to the joint standing committees of the General Assembly on matters relating to:

❖ the development and implementation of a statewide health information technology plan,
❖ the establishment of electronic data standards,
❖ the establishment and implementation of the statewide Health Information Exchange (HIE),
❖ recommendations for policy, regulatory and legislative changes, and
❖ other initiatives to promote the state's health information technology and exchange goals.

The submission of this report by OHS Executive Director Victoria Veltri marks the third report delivered to the joint standing committees of the General Assembly on OHS health IT initiatives, including the establishment of a statewide HIE in Connecticut. There is plenty of good news to report.

▪ **The official launch of Connie,** Connecticut's long-awaited health information exchange, was held on May 3, 2021. By the end of December 2021, Connie's Executive Director, Jenn Searls, announced that 273 organizations had officially signed Connie's participation agreement; this represents approximately 2.79M unique patients (76 percent of Connecticut's population).

▪ **The Statewide Health Information Technology Plan** (Health IT Plan) is based on a rigorous, 16-month process to evaluate the current environment of health IT and HIE across 10 domains of healthcare sectors, as well as to identify the most critical data needs and gaps and potential opportunities for improving health and healthcare in Connecticut through information technology and exchange.

▪ After an exhaustive process to identify and recruit the right individual to serve as **Connecticut's Health Information Technology Officer (HITO), Sumit Sajnani** joined the OHS team in October 2021. He brings a strong combination of technical knowledge about health information systems, deft people management skills, and large government agency project experience. His strategic leadership encompasses administration of the statewide Health Information Exchange (HIE); administration of the All-Payer Claims Database (APCD) program; and development of implementation plans for the recently completed Statewide Health Information Technology Plan. With guidance from Connecticut's Health Information Technology Advisory Council, Sajnani will also monitor a myriad of federal, state, and local policies and programs for health IT and HIE implications and for regulatory changes or policies needed over time.

This document is organized into five sections mapping to the General Assembly's mandate for annual reporting. It provides an overview of the past year's activities and accomplishments pertaining to each topic area, along with additional background analysis to provide policymakers with details and context needed for making future investments and ensuring existing investments are accountably managed.

Section 1. Development and Implementation of Statewide Health Information Technology Plan

Activities and Accomplishments

In September 2020, OHS launched a process to develop a five-year Statewide Health Information Technology Plan, led by the consulting firm CedarBridge Group, a contractor to OHS. Executive Director Veltri approved a comprehensive scope of research and stakeholder engagement to inform the development of a multi-year statewide health IT plan. This important decision considered the value of engaging and understanding the technology needs and capabilities of community-based organizations, social service agencies, local health and mental health departments, long-term care facilities, corrections facilities, and other service providers that are contributing to improving health outcomes for individuals and communities in Connecticut.
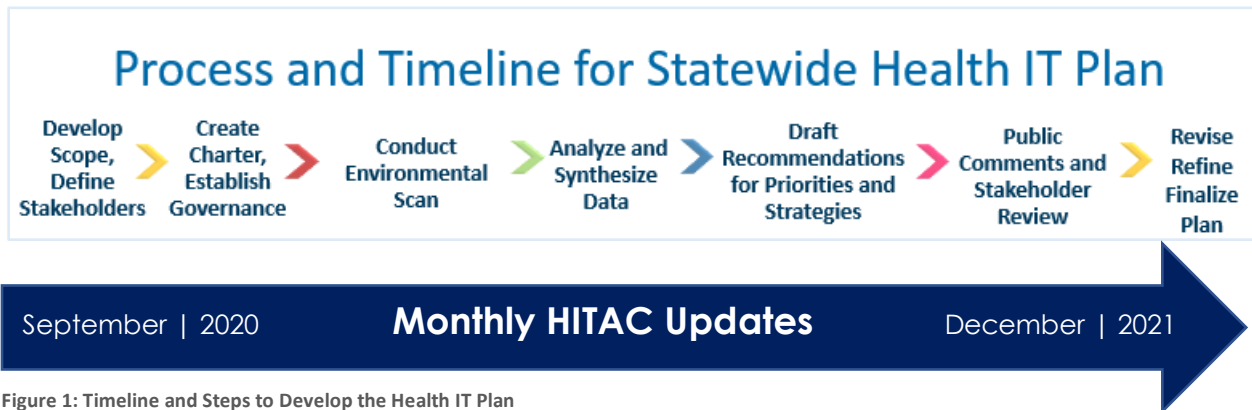

Figure 1: Timeline and Steps to Develop the Health IT Plan

2021 Environmental Scan | Project Scope

The project scope was defined and presented at the February 18, 2021, Health IT Advisory Council meeting. A detailed review of historical documents was a critical first step of the environmental scan process. A large number of individuals and stakeholder organizations from

Environmental Scan Stakeholder Domains	
Hospitals and Health Systems	Health Plans and Payers
Behavioral Health Providers	Associations and Advocacy Groups
Community-Based Organizations	Ambulatory Provider Practices
HIE and Health IT Organizations and Vendors	Long-Term Post-Acute Care Providers
Emergency Services Providers	Public Health
State Agencies and Advisory Groups	

Table 1: Stakeholder Domains

11 domains were identified for outreach to request participation in the environmental scan (Table 1).

Stakeholders weighed in from across the state through a variety of engagement modalities. Interactive virtual forums (see Table 2) were conducted on Zoom, with real-time participant polling capabilities

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organized around discussion and were open to any member of the public, in compliance with Connecticut's regulations for public meetings. Electronic surveys were customized with domain specific questions for eight of the ten domains (see Figure 2); those were disseminated through listservs managed by state agencies and through state associations. For the domains with low survey response rates, possibly due to the pandemic, additional methods for engaging organizations and collecting data were

Virtual Interactive Forums
Behavioral Health & Everyone Else: Sharing Sensitive Data Without Compromising Privacy
Integrating Social Needs Data: Knowing the Person Really Matters When Delivering Person-Centered Care
Prepare, Care, Protect, Measure, and Monitor: Technology and Data Needs for a Strong Public Health System
Connecting the Dots to Improve Outcomes: Eliminating Barriers to Protect and Care for Children in Need
Timely Information Moving Between Long-Term Care, EMS, Hospitals, and Primary Care
Prioritizing and Governing Investments: Secure, Person- Centered Health IT for Residents of Connecticut

Table 2: Virtual Forum Topics

added to the environmental scan tasks. Small virtual focus groups were held with domain representatives (e.g., Connecticut Hospital Association members, Medication Reconciliation and Polypharmacy Committee members, OHS Consumer Advisory Council members), and individual key informant interviews were conducted with each of the Health IT Advisory Council members, with subject matter experts in specific topic areas, and with individuals representing an organization or agency viewpoint.

In total, input was received during the months of February through May 2021 from 126 unique organizations and over 1,200 individuals, with over 500 of those identifying as consumers.
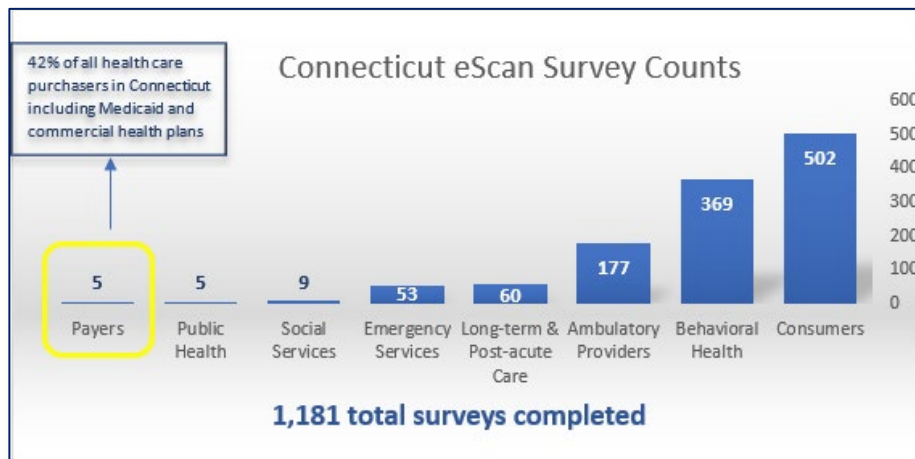

Figure 2: Survey Responses by Domain

There were four primary goals for the environmental scan process, as part of developing Connecticut's Health IT Plan.

- ❖ **Goal 1**: Identify opportunities and stakeholder support for improving health equity and addressing social determinants of health (SDoH) through health IT and HIE services.

- ❖ **Goal 2**: Identify critical data needs and gaps, along with potential opportunities to improve the delivery of healthcare and social service programs through data integration and data sharing between existing systems used by state health and human service agencies.

- ❖ **Goal 3**: Identify opportunities and multisector stakeholder support for health information exchange use cases that will add value to Connie's HIE services.

- ❖ **Goal 4:** Identify the highest acuity pain points, where improving data availability could improve outcomes, reduce inequities, address gaps in care, and advance care coordination for individuals needing care and services in Connecticut.

All data collected through the multiple environmental scan activities was analyzed by a small group of subject matter experts with specialty knowledge in different areas, and with extensive experience working with Connecticut stakeholders. CedarBridge Group was supported by an analytics consulting firm with decades of survey design experience and analytic tools for the electronic survey data. Key findings were organized and synthesized by CedarBridge into the [Environmental Scan Report and Draft Recommendations](#) for Connecticut's Five-Year Statewide Health Information Technology Plan, which was presented to the Health IT Advisory Council at the June 17, 2021 Council meeting, and discussed in more detail at the July 15, 2021 Council meeting.

Nearly all the data collection for the scan was completed prior to the official launch of Connie on May 3, 2021. Significant work had been accomplished by Connie staff and contractors prior to launch. This included the announcement of Jenn Searls as Connie's Executive Director and the selection of the [Chesapeake Regional Information System for our Patients](#) (CRISP) as Connie's technical vendor. During the period of time that the environmental scan was undertaken there was rapid progress of onboarding participants and receiving empanelment data into Connie's HIE platform.

Key Findings

- ❖ Stakeholders are cautiously optimistic about the future of **Connie** and about the interoperability of healthcare data in the state more generally. There was consensus during the 2021 environmental scan that Connie should establish interoperability fundamentals first - with the empanelment use case for attributed patient-to-provider data. Connie should make admittance, discharge, and transfer (ADT) data more useful by adding clinical information to notifications. It should also prioritize improvements to the reporting and querying processes to high value public health systems (e.g., CT Wiz for immunizations, syndromic surveillance, a real-time death registry, and vital records).

- ❖ Advocates and consumers remain concerned about the **security and privacy** of their data and about **consent**. As new infrastructure is developed, leaders at the state level and throughout the delivery system must pay close attention to protecting privacy and maintaining security. Building the confidence and trust of consumers will be essential to the success of future technology and interoperability endeavors.

❖ **State data systems** are siloed and difficult to use, whether sending or querying for information. Significant investments of time, money, and leadership will be required to enable a more seamless flow of data to inform programs, policymaking, and research, as well as to support improvements in care delivery.

❖ Stakeholders are very enthusiastic about the potential for more **social needs data** to be available for healthcare and social services providers. This can improve screening and assessments of social needs and health risks, increase referrals among disparate organizations, and improve the efficiency and effectiveness of service delivery. Although substantial investments have been made, additional outlays will be required to bring community-based organizations the core IT resources, and training needed to provide coordinated, whole-person care.

❖ **Increased utilization of Telehealth** is here to stay. The public health emergency of COVID-19 provided the impetus for Governor Ned Lamont's Executive Order 7G on March 10, 2020, expanding flexibility to healthcare organizations for the provision of technology-aided healthcare services. On May 10, 2021, Governor Lamont extended those provisions through June 30, 2023, by signing House Bill 5596 into law.

❖ **Public health** information technology infrastructure lags well behind other parts of the health and healthcare system. A once-in-a-generation infusion of federal funds is coming from the federal government to state and local governments through the CARES Act, the American Rescue Plan Act (ARPA), the Infrastructure Investments and Jobs Act, and other funding streams. With the development of a cohesive strategic vision for streamlining public health data systems, Connecticut could leverage technology to improve the lives of its citizens while strengthening the public health infrastructure. Technology investments could help bring greater uniformity in reporting, surveillance, and population health improvements across local public health departments.

Major Themes Emerged from the Research

The following major themes emerged from analysis of the environmental scan data, which resulted in the development of the Health IT Plan:

❖ Encourage widespread use of Connie's health information exchange services
❖ Encourage data-sharing between healthcare providers and community-based organizations (CBOs) to address social determinants of health and improve health equity
❖ Encourage interagency data sharing to improve coordination of benefits and services
❖ Encourage behavioral health providers to adopt Electronic Health Record (EHR) systems and/or care coordination software along with technical support to onboard with Connie for HIE services
❖ Support the development of a Best Possible Medication History service, connected through Connie
❖ Further enhance health information privacy to protect individuals and families

Health IT Plan Strategic Focus Areas

Numerous initiatives and action steps could be implemented through the construct of the Health IT Plan to address challenges and barriers to a connected system of care in Connecticut, as identified during the environmental scan. However, the purpose of this type of roadmap is to synthesize the major themes from the environmental scan research and provide structure to guide multi-stakeholder decision making and collaboration between the public and private sectors.

Focus Area 1	Sustain and increase use of statewide HIE services
Focus Area 2	Implement systems to address health equity and health-related social needs
Focus Area 3	Improve service coordination and data sharing across state Health and Human Services (HHS) agencies
Focus Area 4	Support behavioral health providers with the adoption of EHR and HIE services
Focus Area 5	Protect individuals' health information privacy
Focus Area 6	Establish electronic data standards to facilitate development of integrated electronic health information systems

Table 3: Priority Focus Areas for Health IT Plan

The resulting alignment of investments and policies will maximize the impacts of the initiatives undertaken individually and, together, will contribute to improvements in healthcare delivery and population health by increasing the availability of data to support better care, more coordinated services, and more accurate measurement of healthcare cost and quality; and will create efficiencies and cost savings through better coordination of care and services.

The six focus areas of the Health IT Plan (see Table 3) include an intentional concentration on systems, supports, and technologies that help address health equity for marginalized communities. The focus areas are designed to guide Connecticut's investments, governance, and strategies, as well as to drive implementation of innovative technologies and systems of care for improving health outcomes for individuals and communities.

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

The sustainability of Connie must be a top priority for Connecticut healthcare leaders and policymakers. While HIE sustainability is often thought of as a plan for comprehensive funding strategies, in truth sustainability means ensuring HIE organizations like Connie have the technical and business capabilities to provide services with tangible value to those they serve (i.e., healthcare providers, consumers, state

programs, payers, researchers, and policymakers) on an ongoing basis. Connie must position its suite of HIE services as a critical public utility for Connecticut consumers by providing centralized access to their health records; for clinicians by providing timely access to information about their patients; to city, county, and state officials by supporting public health crisis response; and CBOs by streamlining and coordinating healthcare and social services. Connecticut's HITAC members can apply their individual and shared expertise to support Connie's strategic plan and further evaluate technology for a statewide shared services infrastructure that will accelerate innovation.

> **Work Underway at Connie**
>
> ❖ The team at Connie is accelerating work to design, develop, and implement a patient access solution to ensure that Connecticut residents have ready access to their health information through the HIE.
>
> ❖ Connie has established a *Best Possible Medication History Workgroup* to leverage previous work by the Medication Reconciliation and Polypharmacy Committee (MRPC).

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

Most U.S. primary care and specialty providers, and the vast majority of hospitals, have received incentives for adopting and using electronic health record systems. Meanwhile, CBOs are resource starved, without adequate finances to acquire and maintain the types of IT systems that will reliably track clients and manage referrals. Healthcare delivery systems are increasingly motivated by value-based payments and to look closely at how substance use, environmental factors, traumatic experiences, race, ethnicity, language barriers, and poverty contribute to higher lifetime healthcare costs and poor health outcomes. There are currently very few examples of healthcare and social services organizations effectively coordinating services with technology for consent management, person/ provider attributions, closed-loop referrals, shared care plans across organizations, and analytics.

Connecticut will explore opportunities to provide CBOs with resources to acquire, implement, and train staff to use IT systems. In addition to expansion of referral management platforms, OHS will explore the use of Connie as a centralized community information exchange (CIE) to capture longitudinal social risk data and to coordinate care and services across communities. The state will build on the extensive work underway with Health Enhancement Communities (HEC), and will standardize the collection of Race Ethnicity and Language (REL) data in coordination with the Commission on Racial Equity in Public Health to ensure that standards for the collection and storage of REL data are incorporated with other initiatives.

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

There are significant opportunities to improve health outcomes for Connecticut residents by advancing electronic data sharing between agencies serving different needs of the same people. State agency officials recognize the importance of providing user friendly Digital Government Services (DGS) and are actively planning interagency data integration to effectively "hide the seams" for end users of state systems and services. Connecticut's Preschool Through Twenty Workforce Information Network (P20 WIN) and Two Generational (2Gen) initiatives have demonstrated early successes in interagency data integration and data sharing. Despite recognition of the need for appropriate and secure integration of data within state systems, the primary barrier communicated by state officials is the complex environment of federal and state regulations around data use within and among agencies.

Connecticut's Office of Policy Management (OPM) has established a toolkit for data-sharing agreements between state agencies and a Data Sharing Playbook; these assets should be provided to the leaders of Connie and plans should be set forth to evaluate the HIE's readiness to act as a hub for connecting certain state HHS data systems. Benefits can accrue quickly from improving point-to-point data sharing between systems, and from standardizing data fields such as individual demographic data at the time of data collection. Training of state program field workers and home health aides around the importance of careful data entry, while building a culture of collaborative care, will also help break down data silos.

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

Some sectors of the healthcare delivery system were lagging in the adoption of electronic health records prior to the pandemic, and the high prevalence of reported mental health concerns during the past two years has highlighted the issue for behavioral health providers. Compared to other stakeholder groups, many behavioral health providers expressed a strong desire to exchange data with other behavioral health providers, and to a lesser extent, with other types of medical care providers. During the environmental scan in the first half of 2021, approximately a quarter of the respondents indicated – with similar fervor – strong opposition to any type of data sharing, citing patient confidentiality as the primary reason. Given the diverse opinions of behavioral health providers, more research and outreach will be required to understand the opportunities and challenges related to the use of information technology and electronic information exchange in this specialty area.

In recent years, EHR and care coordination platform vendors have made huge strides in product support for behavioral health providers. However, because this specialty was left out of the Medicare and Medicaid EHR Incentive Programs, there are a significant number of independent and small-practice providers who generally are not documenting care outside of their handwritten visit notes. There is strong

push for primary care and behavioral health integration to provide whole-person care and to address high rates of comorbidities such as anxiety and depression disorders. Thus, it is imperative for behavioral health providers to receive additional education, technical assistance, mentorship, and support for the use of EHR technology and/or care coordination platforms to fully engage as partners in whole-person health care.

Focus Area 5:
Protect Individuals' Health Information Privacy

In Connecticut and around the country, there are legitimate concerns about personal information being at risk when data is stored and shared in electronic systems. Critical for establishing trust among consumers are practices to ensure that privacy wishes are respected, and that every individual's protected health information is kept secure, whether at rest (within a system) or in transit (between systems). Providing individuals with ways to have agency around the use of their personal health information – with easy ways to provide, deny, and revoke consent – will be one of the most important activities the state, Connie, and organizations participating in data exchange can undertake. Connie has done significant work in this area, including implementation of an opt-out provision. Taking additional steps in person-focused ways will build trust and buy-in for participation in whole-person coordinated care models because individuals would not have to release all personal information to all organizations.

Focus Area 6:
Establish Electronic Data Standards

The Health IT Advisory Council will establish a HITAC Standards Advisory Committee to review changes to federal standards and assess alignment with current Connecticut General Statutes. Recommendations will be made to the Governor's office, as needed, for updates to state statutes and/or to create new regulations. The Standards Advisory Committee will deliver annual recommendations to the OHS Executive Director on any necessary revisions to General Statutes relative to data standards and will monitor the regulatory environment and policy guidance development at the national level.

Summary for Policymakers

The Statewide Health Information Technology Plan provides a roadmap to enable better health outcomes across Connecticut's population, with healthcare providers having the right information at the right time to deliver informed care, and with supportive social services being appropriately coordinated across a network of community organizations. The HIE that Connecticut worked for so long to establish is now a

reality with Connie, and state agencies are moving toward more integrated information systems to support data informed government services.

HITAC was established as a collaboration between public and private sector organizations to provide guidance to the OHS Executive Director and the Health Information Technology Officer around health IT and HIE initiatives. As the Health IT Plan's implementation activities kick off in 2022, imperatives for HITAC include the following:

❖ Continuity as an advisory body, with attention to filling open positions with engaged individuals and additional representation of CBOs and consumers;

❖ Increased active participation in its work by public and private sector leaders who have decision making authority for their organizations or agencies;

❖ Examination of appropriate governance and oversight of public benefit technology assets and evaluation of shared technology services, managed and supported as a public utility asset.

HIE Sustainability Strategies

HIE organizations such as Connie are challenged to position themselves to provide unique services and supports that contribute to information exchange and improved health outcomes, while remaining viable/sustainable. The environmental scan for the Health IT Plan confirmed strong stakeholder support for a statewide HIE.

❖ Local needs are not all met by national exchange or vendor-driven solutions. Health systems with large geographical footprints do not yet include all types of providers involved in patient care. Connie can address these gaps in care networks through connected information exchange.

❖ Community health records that require integration of other data sources can be served by Connie. This tool would allow community healthcare providers to access aggregated patient records from multiple hospitals and medical labs throughout a community.

❖ Connie can serve public utility applications, including electronic case reporting and participation in disaster response. One example of the latter is the Patient Unified Lookup System for Emergencies (PULSE), which can support the information needs of an emergency field hospital when patients are remote from their normal provider systems. In a PULSE implementation, the HIE would participate with a national exchange entity to support this service.

❖ Incorporating SDoH data into care coordination models requires local interactions with a wide variety of social agencies and community organizations. Solutions may be varied, but they will require close coordination of integration and connections with a wide variety of organizations with varying levels of technical capabilities.

❖ Connie can provide or facilitate normalized, curated repositories of regional data. While the data may come from several different systems and may not reside at the HIE, the HIE nevertheless is a natural hub for the receipt and processing of such data.

❖ Connie could participate in a Health Data Utility (HDU) model. HDUs overlay public and population health with HIE organizing principles. HDUs address the exchange, curation, and analysis of data not typically provided by an HIE, such as – for example – a combination of data from an HIE, a Prescription Drug Monitoring Program (PDMP), a public health agency, and syndromic surveillance.

Interagency Data Sharing

Working with individual agencies to explore their needs – and working across agencies to bring multiple data sources to bear on unique problems or applications – is similar to the process of developing use cases, as practiced by Connie and other HIE organizations. The Health IT Plan envisions the Patient-Centered Services Collaborative (PCSC) as a long-term interagency workgroup guided by common agreements developed for sharing data among programs serving overlapping populations. The PCSC's primary goal will be to support and oversee details of connecting state agency data systems to Connie.

The Health IT Plan outlines several sustainability ideas for Connie to provide additional value around the state's health IT priorities. Value-add services could include the provision of a quality measurement and reporting system to support value-based payment models, with a master data management hub to enable care coordination and community information exchange efforts. The Health IT Plan sees Connie as a conduit for other efficiencies as well, such as serving as a public health gateway to DPH priority systems and aligning with other data-sharing initiatives including the State CIO's Information and Telecommunications Strategic Plan for FY 2021 and the State Data Officer's Data Plan for 2021-2022.

The Health IT Plan is intended to be a living roadmap that is adjusted and adapted over time as federal and state priorities evolve to meet foreseeable and unforeseeable circumstances in the future.

Anticipated Implementation Activities for the Statewide Health IT Plan

	Description	Activities
Focus Area 1	Sustain and increase use of statewide HIE services	❖ Charter a sustainability support workgroup for Connie ❖ Create patient access to Connie ❖ Evaluate centralized quality measurement ❖ Evaluate in-house resources to support central quality measurement ❖ Offer HIE onboarding payment incentives and technical assistance ❖ Determine funding sources for statewide quality measurement and reporting ❖ Offer provider education on ONC Information Blocking Rule
Focus Area 2	Implement systems to address health equity and health-related social needs	❖ Social Services Design Group ❖ CIE Feasibility Planning Committee ❖ Health Equity Dashboard ❖ IT infrastructure, staffing, and training ❖ Statewide CIE Shared Services
Focus Area 3	Improve service coordination and data sharing across state HHS agencies	❖ Public Health Gateway assessment ❖ HHS Person-Centered Services Collaborative ❖ IT workforce planning and investments ❖ Connecting HHS data systems to Connie ❖ Technical HHS Interoperability Workgroup
Focus Area 4	Support behavioral health providers with the adoption of EHR and HIE services	❖ Behavioral health provider listening sessions on EHR / HIE concerns ❖ Provider and patient educational campaign ❖ Provider EHR / HIE technical assistance and training ❖ Provider financial incentive program or hosted technology system providing care coordination capabilities
Focus Area 5	Protect individuals' health information privacy	❖ Hold citizen town halls on HIE and health data rights ❖ Issue RFI/RFP for state agency consent management solution ❖ Make recommendations on standardized statewide HIE consent protocols ❖ Establish a Patient Health Information Protection Office ❖ Support the development of educational resources for consumers
Focus Area 6	Establish Electronic Health Data Standards	❖ Establish a Health Data Standards Workgroup ❖ Make workgroup recommendations on health data standards ❖ Propose legislative concepts on health data standards, as needed ❖ Monitor and assess national and federal data standards policy developments

Table 4: Action Steps for Implementing Statewide Health IT Plan

Section 2. Establishment of Data Standards

Activities and Accomplishments

Connecticut General Statute 17b-59a distributes responsibilities for establishing electronic data standards for health information exchange among the OHS Executive Director, the DSS Commissioner, and the Health Information Technology Advisory Council (see Table 5). While the DSS Commissioner has primary responsibility (in consultation with the OHS Executive Director) for the development of standards across state agencies, the OHS Executive Director (in consultation with the DSS Commissioner and HITAC) has primary responsibility for developing standards for health information exchange for use by healthcare providers and institutions.

The OHS Executive Director also has primary responsibility for the Health IT Plan, which is intended to enhance interoperability to support optimal health outcomes, supported by electronic data standards. OHS and DSS both recognize Connie's statutory charge as statewide HIE, as well as the authority and fiduciary responsibility of DSS as the Single State Agency administering the Medicaid program.

OHS and DSS have been working collaboratively to ensure that the HIE services being offered by Connie will provide value throughout the state, with more complete information in the hands of clinicians at the point of care, more reliable data for measuring health outcomes and monitoring disease outbreaks, and more efficient, coordinated services by all HHS agencies to Connecticut residents. All the objectives listed above, and others on a growing list of HIE use cases, will require technology systems that, at a minimum, meet standards for interoperability, security, and privacy.

While Connecticut has set statutory requirements to develop electronic data standards, the federal government has been working for the past seven years with standards development organizations (SDOs) to create guidance and develop regulations to improve the interoperability of health IT systems and the usability of data collected in those systems. Section 4003 of the 21st Century Cures Act spells out the federal regulations that aim to improve the interoperability of health information technology systems and that set penalties for blocking electronic data access by individuals to their own health records, or intentionally blocking electronic data exchange except with defined exceptions. The Act defines "interoperability" as such health information technology that enables or allows:

(A) "the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; "

(B) "complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law;" and

(C) "does not constitute information blocking as defined in section 3022(a)."

To meet the provisions of Connecticut's statute, and in accordance with the Health IT Plan, a standing HITAC subgroup will be formed of stakeholders representing a cross section of relevant expertise in clinical care and healthcare delivery, digital health technologies, health analytics, health policy, and data privacy

and security, with state and federal regulations and reporting requirements for the healthcare and social services sectors. It will be critical for a member or members of this group to have strong familiarity with national and international healthcare standards development and standards implementation organizations (e.g., HL7, ISO, DirectTrust, Sequoia Project, Argonauts, CARIN Alliance, and others) and with the ONC's Interoperability Standards Advisory (ISA) and Standards Version Advancement Process (SVAP).

The Standards Advisory Committee should meet on a quarterly basis to weigh options and provide guidance to the OHS Executive Director, DSS Commissioner, and HITAC members, ensuring that the responsible parties named in statute have the information they need to provide relevant guidance, set appropriate policies, and communicate knowledgeably with members of the General Assembly and the Executive Branch on the challenges and opportunities inherent in these state requirements.

Initial Implementation Activities

❖ Establish a HITAC Standards Advisory Committee to review changes to federal standards and assess alignment with current Connecticut General Statutes.
❖ Make recommendations to update state statutes and/or file new legislation, as needed.
❖ Deliver annual recommendations to the OHS Executive Director on any necessary revisions to Connecticut General Statutes relating to data standards.
❖ Monitor the regulatory environment and policy guidance development at the national level.

Requirements in Connecticut General Statute for electronic health IT and HIE standards

Owners	Requirements
DSS Commissioner with OHS Executive Director	**CGS 17b-59a (3)(b)** Develop uniform management information, statistical information, terminology for similar facilities, electronic health-information standards, and uniform regulations for the Departments of Developmental Services, Public Health, Corrections, Children and Families, Veterans Affairs, and Mental Health and Addiction Services.
OHS Executive Director with DSS Commissioner and HITAC	**CGS 17b-59a (3)(c)** Establish electronic data standards to facilitate development of integrated electronic health-information systems for use by healthcare providers and institutions that receive state funding. Include provisions related to security, privacy, data content, structures and format, vocabulary, and transmission protocols. **Include requirements to:** • Be compatible with any national data standards to allow for interstate interoperability • Be compatible with the requirements for an electronic health-information system • Limit the use and dissemination of an individual's Social Security number (SSN) • Permit the collection of health information in a standard electronic format • Require the encryption of any SSN

	• Require privacy standards no less stringent than those in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) • Require that Protected Health Information (PHI) be secure • Require that access to PHI be traceable by an electronic audit trail
Statewide Health Information Technology Plan	**CGS 17b-59a (3)(c)** Include general standards and protocols for HIE, as well as national data standards to support secure data exchange to facilitate the development of a statewide, integrated electronic health-information system. Standards shall include provisions relating to security, privacy, content, structures and format, vocabulary, and transmission protocols. **Include requirements to:** • Be compatible with any national data standards to allow for interstate interoperability • Permit the collection of health information in a standard electronic format • Be compatible with the requirements for an electronic health-information system

Table 5: CGA Statute on Standards Development

There is substantial activity in Connecticut and nationally related to all the topics mentioned above. Providers and hospitals are using EHR systems that incorporate a number of standards required for their certification. HIPAA and security standards in the area of information technology are widely practiced. Connie is operating and has implemented its standards to support operations and safeguard data exchange with participants. Major health systems exchange data across scores of participating entities in large geographical areas.

OHS and DSS are working collaboratively with Connie to design, develop, and implement use cases that will enhance Connecticut's statewide HIE services, tapping the expertise of Connie's technology vendor, CRISP, and incorporating advancements made in EHR systems, care coordination platforms, and digital health solutions in use by hospitals, health systems, provider groups, payers, CBOs (e.g., 211 Connecticut), and others.

Summary for Policymakers and Protocols for Health Information Exchange

General Standards and Protocols for Health Information Exchange

The Office of the National Coordinator for Health Information Technology (ONC) publishes the Interoperability Standards Advisory (ISA) as a way of recognizing interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. The ISA is issued annually, but because standards are frequently being added or changed, the website version of the ISA is regularly updated and is always considered the current version by the ONC.

During 2020, HITAC established the Consent Design Group to consider approaches for creating consent policies for Connie as various use cases for data sharing are implemented. The Consent Design Group

developed a set of principles for applying consent management to electronic data exchange, which can inform future consent policy and subsequent implementation standards. A similar process can be applied to the other topics to support standards development activity.

Security

The ISA identifies security standards found in the following publications as relevant to health information security:

ASTM	International – American Society for Testing and Materials
ISO	Information Organization for Standardization
NIST	National Institute for Standards and Technology
Open ID Connect 1.0	identity layer for the OAUTH protocol
OAUTH 2.0	protocol for identity authorization
IHE	International – Integrating the Healthcare Enterprise
HL7	International – Health Level 7

Privacy

Two primary federal regulations address the privacy needs of individuals with respect to PHI:

HIPAA, or the HIPAA Privacy Rule

42 CFR Part 2, which is the abbreviation for Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records.

Connecticut also has state-specific regulations in statute relating to permitted disclosures of personal health information.

Sec. 52-146h regarding the transfer or disclosure of information to the Commissioner of the Department of Mental Health and Addiction Services (DMHAS).

Sec. 17b-225 regarding the availability of patient information to certain agencies.

Demographic Data Standards

Connecticut Public Act 21-35, which became law in 2021, requires providers "capable of connecting to and participating in Statewide Health Information Exchange" to collect the demographic data of race, ethnicity, and language (REL). OHS has developed an implementation plan and REL data standards in consultation with key stakeholders.

Data Content; Structures and Format

No single standard applies to the structures and formats of healthcare data content. The HL7 2.5.1 (or later) standard is widely adopted, and there is a strong emphasis today on the HL7 FHIR standard (Fast Healthcare Interoperability Resources). Connecticut can utilize the ISA to identify and explore current and emerging standards across the spectrum of data types and structures.

Vocabulary

The vocabulary and coding of observations, diagnoses, treatment, and results is covered by a number of maintained code sets. The ISA vocabulary tab includes details, and a few of the code sets that are widely used are listed here:

- ❖ SNOMED CT – Systematized Nomenclature of Medicine – Clinical Terms
- ❖ LOINC – Logical Observation Identifiers, Names, Codes
- ❖ CPT – Current Procedural Terminology

The Healthcare Information Management and Systems Society (HIMSS) offers a brief overview with links to some of the common terminology standards used in health information and technology.

The 21st Century Cures Act introduced the USCDI, the United States Core Data for Interoperability. Health IT developers will use the USCDI as a standard for defining data elements within their systems. Following such a standard approach will support the interoperable use of exchanged data.

Transmission Protocols

The Admit, Discharge, Transfer (ADT) standard is a widely implemented protocol for transmitting messages with health information. The FHIR standard is emerging and is the focus of many current implementations. Other transmission protocols may apply to specific situations, such as public health reporting to the Centers for Disease Control (CDC). The DIRECT protocol is also available for secure messaging similar to email, with encryption.

DSS & OHS Joint Steering Committee

On December 2, 2019, the DSS Commissioner and OHS Executive Director established the Department of Social Services (DSS) & Office of Health Strategy (OHS) Joint Steering Committee. The purpose of the Joint Steering Committee is to provide recommendations 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. DSS and OHS agree that a successful collaboration recognizes both OHS' statutory charge for overseeing the statewide HIE and DSS' authority and fiduciary responsibility as the Single State Medicaid Agency for administering federal funding from the Centers for Medicare and Medicaid Services (CMS) to support the HIE. The agreement describes the joint vision of OHS and DSS working together and sets forth

its understanding of the steps and processes that will be used for the mutual benefit of both agencies, the HIE Entity, and other Connecticut stakeholders. The structure and position list for the committee are included in Appendix E.

Current collaborative activities include the development of CMS funding proposals for HIE implementation and operations. In addition, DSS and OHS are working together to obtain CMS certification of HIE functionalities as they become operational.

Section 3. Establishment and Implementation of Statewide Health Information Exchange

Activities and Accomplishments

With gratitude for the staunch dedication of many believers in the value of health information exchange – and for the support of Governor Lamont and the General Assembly – Connecticut's HIE, Health Information Alliance, Inc. (Connie), was officially opened for data exchange services on May 3, 2021[1] with the mission to enhance the health and well-being of state residents through the provision of health information technology services.

In 2020, following a Request for Quotes (RFQ) to potential HIE service providers, the Connie Board of Directors selected CRISP, Maryland's successful HIE, to support Connecticut's technical needs. CRISP also provides HIE technology services to West Virginia, the District of Columbia, and Alaska.

Connie services are designed to enable providers and physicians to:

❖ Better share clinical information across all healthcare settings.
❖ Assist in care coordination.
❖ Reduce preventable costs associated with readmissions, duplicative testing, and errors.
❖ Support public health reporting, research, and population health analytics.
❖ Adhere to and promote standards and interoperability.
❖ Provide patients with access to their own health information.

In addition to CRISP's technical services, DSS' existing encounter notification service, Project Notify, was transferred to Connie. Project Notify's participating organizations receive near-real-time alerts when their Medicaid patients are admitted or discharged from Yale New Haven Health System or Hartford Healthcare hospitals. The service enables providers and organizations to coordinate care for their patients as they transition to and from the acute care setting. In December 2021, almost 77,000 alerts were sent to

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https://conniect.org/secure-clinical-data-exchange-comes-to-connecticut/
https://conniect.org/connie-launched-and-building-momentum-countdown-begins-for-connection-deadline-and-ta-assistance-funds-2/
Connecticut Launches Long-Awaited Health Information Exchange

approximately 25 organizations participating in Project Notify. Figure 3 shows many potential uses of Project Notify alerts by Medicaid stakeholders; it is taken from a presentation made by DSS and Connie to CMS in support of Connie's certification requests for initial use cases to receive ongoing federal funding for the Medicaid share of operations.

Figure 3: Page from a Joint Presentation to CMS by Connie and DSS

Use Case Development

In addition to the transition of Project Notify, Connie implemented two additional use cases in 2021, the Empanelment Use Case and the Clinical Data Use Case.

Empanelment Use Case

This serves as one of two foundational use case for promoting care coordination by creating linkages between care teams and their patients. It enables organizations to send files containing patient information and health provider data in order to establish an active care relationship between the patient and the provider. Once this patient-provider attribution is made, it can be used to promote better transitions of care and care coordination through the Care Coordination use case. The Empanelment Use Case is essential to the master provider registry, master person index (MPI), and person-provider relationship service, which drive matching processes in a health information network.

Clinical Data Use Case

The Clinical Data Use Case serves as the second foundational use case for Connie. It enables participating organizations to send clinical data for improving care and transitions of care. Organizations send and receive clinical information such as patient care summaries, labs, or ADT messages to improve patient and provider encounters at the point of care, facilitate care coordination efforts, and result in better outcomes for patients, providers, and organizations alike.

By the Numbers: Connie's 2021 Results

273	2.79M	267K	999K	1.47M	1,456
Organizations have signed legal agreements	Unique patients represented	Clinical summary documents received	Lab results received from Quest Labs	ADT messages received weekly	Opt-out forms have been received from patients
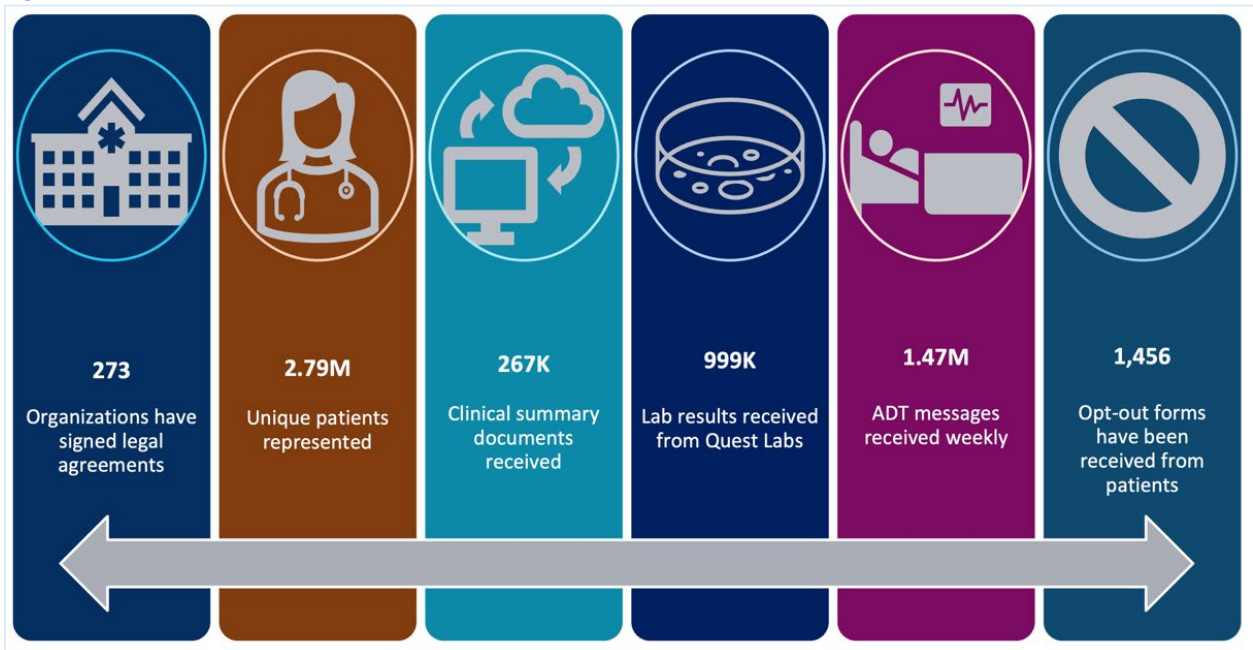
Figure 4: Connie's Transaction Numbers through 12/31/21

Connie Milestones for Federal Fiscal Year 2021

October - December 2020	ED hired; CRISP selected as tech partner	21 organizations signed	Project Notify transferred from DSS	Established Empanelment Use Case	Established Encounter Use Case
January-March 2021	4 new staff hired	Contract executed with OHS	40 organizations signed		
April - June 2021	Connie is operational	Connie website live	Opt-out process developed	70 organizations signed	
July - September 2021	Sustainability Plan drafted	CMS Certification submitted	4 new staff hired	273 organizations signed	1.54M unique patients; 43% of CT population)

Figure 5: Connie's First Year Milestones

Connie's Achievements of 2021 Goals

In January 2021, Connie's Board of Directors approved a set of goals for the organization to achieve for the calendar year. As highlighted in Figure 6, the board approved goals in four domains focused on connectivity, financial sustainability, use cases, and governance and staffing.

Figure 6: Connie's 2021 Goals

In January 2022, Connie management reported on the organization's achievement of the approved goals. As shown in Figure 7, they reported receiving clinical data from 20 of the 39 acute care hospitals in the state, exceeding its goal of connectivity to 50 percent of those hospitals. While Connie is receiving "copy forward" lab data from Quest, as authorized by participating organizations, it has not yet established connectivity to any laboratories in the state.
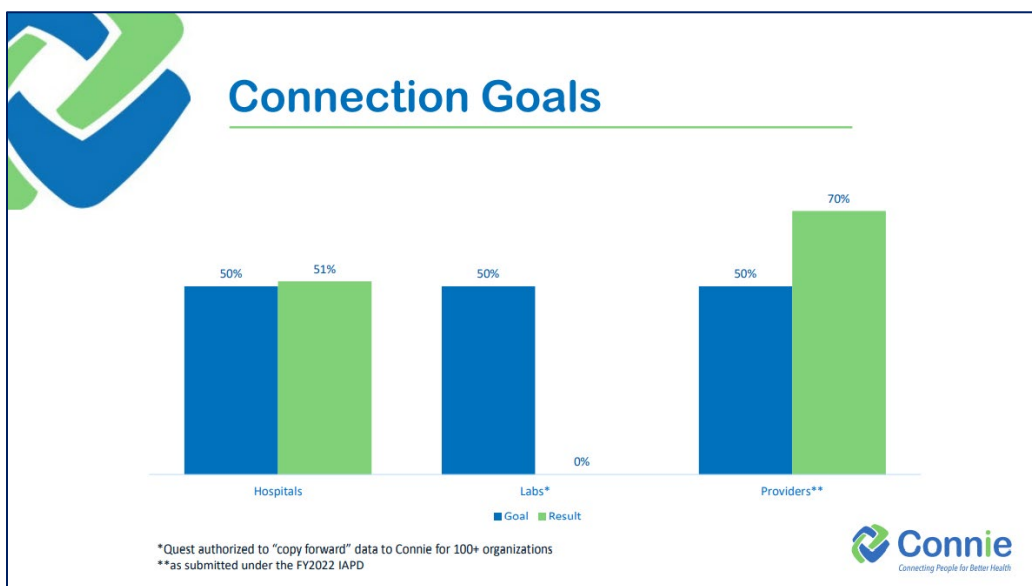
Figure 7: Connection Goals and Results

In addition to meeting Connie's connectivity goals, management reported favorable achievement of the remaining domains, including the development of a sustainability plan approved by the Connie Board of Directors, illustrated in Figure 8. In addition, they reported 17,924 unique National Provider Identifier numbers (NPI) in the data, representing 70 percent of active licensed providers in the state.

Other Goals

Financial Goal
- Sustainability plan presented and approved at August 2021 Board Meeting

Use Case Goals
- Three initial use cases approved and implemented
  - Empanelment, Encounter Notification, eConsent, Clinical Data
- Two additional uses cases in development
  - PDMP, Best Possible Medication History, Image Exchange

Governance and Staffing
- Board fully appointed by November 2021
- Connie fully staffed

Figure 8: Additional 2021 Performance Goals

Connie's 2022 Goals and Future Plans

FY 2022 Goals: Promoting Interoperability

Stakeholder Value
- Design, develop, and implement 3 new services/use cases
- Design and develop utilization measures to assess effectiveness of Connie

Connectivity
- Enable processes for hospitals to meet statutory mandate for connectivity
- Enable processes for labs to meet statutory mandate for connectivity

Operational Excellence
- Develop and implement fee structure for Connie
- Develop and implement consumer facing communications strategy

Figure 9: Connie's 2022 Goals

Use Cases, Services, and Tool Development for 2022

❖ **Connie Portal:** Develop a stand-alone website to provide authorized participating organizations with the ability to review clinical data about a patient at the point of care; to search for additional members of the patient's care team to help coordinate care; and to review the patient's NarxCare Report via integration to Connecticut's Prescription Monitoring and Reporting System (CPMRS), as required by law.

❖ **Connie Patient Access:** Consistent with its mission to empower consumers and to meet one of its mandated goals of providing real-time, secure access to data, Connie is developing an Application Programming Interface (API) based solution to allow patients to access their data using their preferred tool or platform. Using applications such as Apple Health or CommonHealth, consumers can securely access their data while using familiar tools. For consumers preferring a web-based solution, Connie will be exploring a solution that will validate users and allow them to view and download their data.

❖ **InContext App:** Embed a SMART-on-FHIR app to enable users of certain electronic health records (EHRs) to securely access clinical data about their patients in the context of their workflow. SMART is the acronym for Substitutable Medical Applications and Reusable Technologies, a standards-based, interoperable apps platform for EHRs.

❖ **Image Exchange:** Devise an Image Exchange Use Case that will enable organizations to electronically share digital radiologic images through Connie. This will enable providers to access and view diagnostic-quality images for their patient in Connie without needing to have a Picture Archiving and Communication System (PACS). This use case will improve the quality and efficiency of healthcare by giving providers ready access to images where and when they are needed. Additionally, with the ability to download images to PACS, unnecessary/redundant testing can be reduced or eliminated. Future planned functionality includes the development of an emergent use case to facilitate the exchange of emergent images to stroke centers.

❖ **Prescription Monitoring Program Access:** Early in 2022, Connie plans to roll out access to the state's CPMRS through an integration with the Department of Consumer Protection's gateway product. Access to the CPMRS enables providers to quickly look up a patient's history of prescribed scheduled drugs. This information helps providers assess the risk of substance use disorders and doctor shopping, and it offers the potential to intervene with high-risk patients. Alignment between the state designated HIE and prescription monitoring programs (PMP) is a recognized best practice.

❖ **Provider Directory:** This service allows healthcare staff to look up a provider in Connecticut to enable referrals and improve transitions of care for their patients. It also enables users to search for a specific provider and find detailed and accurate information on that provider, including languages spoken, facility locations, contact information, and specialties. Conversely, searches can be based on desired qualifications (ex., a specific specialty or language spoken). The Connie Master Provider Directory would serve as a source of truth for Connecticut provider information across numerous, previously disparate systems, including information on state-specific identifiers

to support Medicaid and other programs. An attribution service linking organizations/providers to patients/clients would provide the foundational backbone for value-based payment models and whole-person care coordination and would serve as the underpinnings of ADT notification services.

❖ ***Additional Use Cases:*** Planned for development are the eReferral, Best Possible Medication History, Advanced Directives, Immunization Reporting and Querying, Patient Access, and Consent Management use cases.

❖ ***Workgroups****:* Beginning in 2022, Connie will convene a Clinical Advisory Council to provide clinical insight and feedback on Connie functionality development and current tools.

❖ ***Projects****:* Connie is working with DSS to connect organizations providing Long-Term Care Services and Supports with connectivity to Connie to enable data-driven, member-based outcome care. Connie will also support Medicaid to meet its CMS requirements for interoperability.

Summary for Policymakers

Connecticut is positioned to have a high functioning HIE organization supporting improved health outcomes in the state through HIE services. Health Information Alliance, Inc., d/b/a Connie:

❖ Has state designated entity (SDE) status.
❖ Is integrated into a governance model that ensures relationships with both DSS and OHS.
❖ Has established a position in the Medicaid Enterprise as a component that DSS will employ for several anticipated use cases.
❖ Has a path to funding for the next two years through the OHS budget.

Exploration of investments in Connie's HIE services and upgrades to state data systems will enable more efficient care and more effective programs, which will save the state money, lower employer costs, and lead to a healthier, more productive population. General Statute Sec. 17b-59e, which sets legislative mandates for hospitals and provider organizations to participate in Connecticut's health information exchange, is a powerful driver that will accelerate the value that a connected system of care can bring to a state or region.

The sustainability of HIE services must be a top priority not only for government leaders, but also for the broad healthcare leadership across the state. Sustainability includes comprehensive funding strategies; however, it must also rapidly ensure there is tangible value to clinicians through user friendly interfaces that can be readily and efficiently incorporated into clinical workflows. Connie must position its suite of HIE services as a critical public utility for clinicians, public health crises response, and coordination of community support services. HITAC is appointing an ad hoc Sustainability Support Workgroup, with weekly meetings expected to begin by March 2022. The Workgroup will bring additional stakeholder engagement and insights in the evaluation of sustainability options and will work collaboratively with Connie's Board of Directors and staff on the outputs for OHS and the Council.

Approved Implementation Advanced Planned Document (IAPD) Funding

Medicaid Federal Funding Requests to Support HIE Services

Connecticut received federal approval of its Medicaid Enterprise System (MES) Implementation Advanced Planning Document (IAPD) from CMS for Design, Development, and Implementation (DDI) activities to continue building out Connie. Federal financial participation by Medicaid for HIE services was substantially reduced at the start of federal fiscal year 2022 (on October 1), down from 90 percent to 26 percent. Connecticut submitted its initial IAPD following a series of Health Information Technology for Economic and Clinical Health (HITECH) Act APDs for HIE planning and design, development, and implementation (DDI) activities, dating back to 2011. HITECH funding supported strategic planning for health information exchange services the establishment of a governance structure, and most recently, the establishment of a state designated entity for health information exchange. Recent HITECH IAPDs included funding to establish the technical infrastructure of the HIE, to onboard providers to the HIE, and to begin developing use case services and additional supportive critical infrastructure or foundational components. A separate Operations APD will be submitted for a service that has operated since May of 2021, after the service receives outcomes-based certification from CMS.

HIE Activities Previously Approved under HITECH

Connecticut's most recent HITECH Implementation APD update (IAPD-U) was approved by CMS on January 12, 2021, back-dated to be effective as of November 25, 2020. The following table shows high-level activities that were funded under the HITECH IAPD-U.

HIE Activities under HITECH

Activity Description	Status
Governance Framework	❖ Several steps were completed, including development of a stainability plan, approved by DSS, OHS, and Connie Board of Directors
Stakeholder Outreach and Workgroups	❖ Support for Health IT Advisory Council and workgroups is ongoing
HIE Foundational Services Components and Use Cases	❖ CRISP procured for HIE services ❖ Use Case Factory established. ❖ Process for Use Case funding and MES certification established.
HIE Support Services and Onboarding Activities	❖ Funding assistance ended on 9/30/2021 for this program.
Immunization Information System (CT-Wiz)	❖ DPH has made significant progress with this program's promotion and onboarding support.
SUPPORT Act-Related HIE Initiatives	❖ A connection with the PDMP has been established. ❖ Connie plans to go live in 2nd quarter of 2022.

Table 6: Examples of HITECH-Funded Activities Prior to Program's End

HIE Activities Requested for Approval Under MES IAPD

This initial MES IAPD will support continued funding for DDI of Connie services. As the HITECH Program ends, the options and requirements for ongoing Federal Financial Participation (FFP) for HIE activities are transitioning to MES funding. Separately, DSS is requesting certification of critical infrastructure and an Empanelment and Alerts Service and will submit an Operations APD for related funding once certified.

Connecticut seeks funding for HIE use case services (UCS), along with supporting functions (SF) and data sources. The following table lists the UCS and SF for which funding is requested in this IAPD.

HIE Use Cases and Supporting Functions and Data Sources

IAPD Initiatives: Critical Infrastructure, Use Case Services, and Foundational Data Sources				
ID	Name	Type	Status	Certification Required
UCS 01	Web-Based Portal (LogOnce Technology)	UCS	DDI	Yes
UCS 02	InContext App (Smart on FHIR Portal)	UCS	DDI	Yes
SF 01	Clinical Data	SF	DDI	No
SF 02	PDMP access	SF	DDI	No
SF 03	Best Possible Medication History	SF	DDI	No
SF 04	Advance Directives	SF	DDI	No
SF 05	Immunizations	SF	DDI	No
SF 06	eConsent (Provider Mediated Affirmative Consent)	SF	DDI	No
SF 07	eConsent (Patient Mediated Affirmative Consent)	SF	DDI	No
SF 08	Image Exchange	UCS	DDI	Yes
UCS 03	eReferral	UCS	DDI	Yes
UCS 04	Provider Directory	UCS	DDI	Yes
UCS 05	Electronic Case Reporting	UCS	Plan	Yes
USC 06	eConsult	UCS	Plan	Yes
USC 07	Quality Measurement	UCS	Plan	Yes
UCS 08	SDOH (screening, referral, resource directory, analytics)	UCS	Plan	TBD
UCS 09	Dental Health Records	UCS	Plan	TBD
UCS 10	Durable Medical Equipment Order Tracking	UCS	Plan	TBD
UCS 11	Stroke Registry / Network	UCS	Plan	TBD

Table 7: Use Case Status Chart for Medicaid Certification Planning

CRISP is contracted to provide a complete, bundled technology solution including software, hosting, and support for all of Connie's technical needs. OHS, Connie, and CRISP have estimated the incremental costs associated with each of the listed use cases and supporting functions. Connie has provided a budget

estimate that includes personnel and administrative needs, as well as contracted services from CRISP and other vendors. OHS and DSS have also estimated the associated personnel and contracting needs to meet the statutory and Medicaid agency requirements associated with the proposals presented in this IAPD. This IAPD presents Connecticut's HIE MES funding request for DDI for Federal Fiscal Year (FFY) 22 and FFY 23. The funding details are summarized in the table below (subject to change upon CMS review).

HIE MES IAPD-U funding request for the period from October 1, 2021, through September 30, 2023

DDI	Total Costs	Costs Allocated to Medicaid	90% Federal Share	10% State Share	50% Federal Share	50% State Share	Total Federal Share	State Share Total
FFY 22	$ 9,812,616	$ 8,943,644	$ 6,228,865	$ 692,096	$ 1,011,341	$ 1,011,341	$ 7,240,206	$ 1,703,437
FFY 23	$ 8,210,723	$ 7,430,188	$ 5,104,131	$ 567,126	$ 879,465	$ 879,465	$ 5,983,597	$ 1,446,591
Grand Total:	$18,023,339	$16,373,831	$ 11,332,996	$ 1,259,222	$ 1,890,807	$ 1,890,807	$ 13,223,803	$ 3,150,028

Table 8: Summary of FFY 22 and FFY 23 Funding Request

Section 4. Recommendations for Policy Changes

OHS is not proposing any policy changes related to health information technology or health information exchange, as part of the February 2022 Submission of Annual Health IT and HIE Report to Connecticut's General Assembly.

Section 5. Other Initiatives Promoting Health IT

Activities and Accomplishments

Current Office of Health Strategy Technology Initiatives

In addition to the strategic guidance and shepherding of statewide HIE services through Connie, and the development of the Health IT Plan, OHS leads or supports numerous initiatives to improve healthcare quality and efficiency, drive cost savings, and bring 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.

❖ Governor Lamont signed Executive Order (EO) #5 in January 2020, charging OHS to create a Cost Growth Benchmark (CGB) for total healthcare expenditures growth in the state. OHS, in consultation with a technical team and advisory committees, will create a per annum rate-of-growth for healthcare spending. Once calculated, Connecticut will be the fifth state to have a statewide cost growth benchmark. EO #5 also requires OHS to establish targets for increases in primary care spending, which will be advised by the OHS Primary Care and Community Health Reforms (PCCHR) Workgroup.

❖ The Health Systems Planning (HSP) office administers the Certificate of Need (CON) program, prepares the Statewide Healthcare Facilities and Services Plan, and conducts hospital financial reviews and reporting. CON promotes appropriate health facilities and service development to address a public need. CON strives to ensure accessibility to needed services while limiting duplication or excess capacity of facilities and services. HSP has statutory authority to gather and analyze significant amounts of hospital financial, billing, and discharge data. Information collected, verified, analyzed, and reported on includes hospital expenses and revenues, uncompensated care volumes, and other financial data, as well as hospital utilization, demographic, clinical, charge, payer, and provider statistics. OHS produces an annual acute-care hospital financial stability report and a biennial utilization study.

❖ In the 2021 legislative session, the General Assembly passed Connecticut Public Act 21-35, with the goal of addressing racism as a public health crisis. Among other things, it will establish a Commission on Racial Equity in Public Health and will require the collection of REL data for providers "capable of connecting to and participating in Statewide Health Information Exchange." OHS has published the standards for REL and an Implementation Guide.

❖ In April 2021, Governor Lamont proposed initial allocations of the Coronavirus State Fiscal Recovery Fund under Subtitle M of the American Rescue Plan Act of 2021 (ARPA) that included $73 million to be allocated in 2022 to "support the breadth of Local Health Department operations" and $15 million to enable low income residents to connect to broadband or replace outdated wiring.

Office of Health Strategy Executive Director
Vicki Veltri

Health Information Technology Officer
Sumit Sajnani

Health Information Technology Advisory Council

APCD Advisory Group

APCD Data Release Committee

Figure 10: Organizational Roles of APCD Governance

All-Payer Claims Database (APCD)

Created in 2012 by Public Act 12-166, Connecticut's All Payer Claims Database (APCD) was established as a program to receive, store, and analyze health insurance claims data. The Act requires health insurers to submit medical and pharmacy claims data, as well as information on providers and eligibility. The state's APCD was transferred from Access Health CT to OHS in 2019 as a result of the passage of C.G.S. § 19a-755. OHS has utilized the approximately 950 million claims records in the APCD for policy development and research that improves health outcomes, ensures better access to healthcare, identifies and addresses health inequities, reduces high per-capita healthcare spending, stabilizes consumer costs across all sectors of healthcare; and supports multipayer healthcare payment and service delivery reforms that improve population health, focus on the root causes of health conditions, and prevent those conditions from occurring. Nationally, federal law prevents APCDs from mandating the collection of claims data from self-insured employers; in Connecticut, however, one of the largest self-insured employers, the State of Connecticut, is voluntarily submitting claims data to the APCD.

The APCD Advisory Group and APCD Data Release Committee are conduits for input to be received from stakeholder organizations on APCD policies and operations. They also provide guidance to the APCD program within OHS through the members' expertise. The APCD Advisory Group is chartered under the Health IT Advisory Council; the governance structure is illustrated in Figure 10.

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

During this reporting period, the advisory group met on a quarterly basis.

Date	Meeting Focus
5/13/2021	APCD use case update, internal versus external APCD application process, Health IT Plan
8/12/2021	Medicaid data integration, Medicare data use agreement extension, denied claims use cases and data collection, healthcare cost growth benchmarks, and primary care spending targets
11/4/2021	Denied claims collection feedback and discussion, federal grant funding for state APCDs, State APCD Advisory Committee (SAPCDAC) Final Report, discussion on recommendations

Table 9: 2021 APCD Advisory Council Meetings

The APCD Data Release Committee (DRC) reviews and deliberates on each data release application submitted to the APCD. The committee has 10 members. The DRC reviewed and approved three research

studies to receive APCD data sets during 2021; no requests were denied over the timeframe. Studies were submitted by the following organizations:

- ❖ APPERTURE LLC
- ❖ Yale HPV-General Warts Study
- ❖ The UCONN Phenotype Suicide Algorithm Study

In 2021, 23 health insurance plans contributed data to the Connecticut APCD.

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

Table 10: 2021 Health Plans Contributing Data to APCD

OHS-Sponsored Initiatives Using the APCD

A Quality Scorecard was launched in 2019 and continued to be maintained and updated in 2021 to increase transparency related to healthcare cost and quality. The Scorecard was designed to allow healthcare organizations access to information on their performance relative to peers to drive quality improvement through transparency; by providing policymakers, payers, and employers with information to assess the state's healthcare performance; and by giving consumers access to healthcare quality information. The Scorecard compares quality of care using Connecticut's Multi-Payer Measures Set, determined by the multistakeholder Quality Council.

In 2022, healthcare organizations will be held to certain healthcare quality benchmarks, which will help ensure high quality healthcare and access to primary care for Connecticut residents. Benchmarks can include items such as clinical quality, patient safety, and over/under utilization of resources. The Quality

Council is currently working to determine which measures to include in the Quality Benchmark. Progress can be tracked at the OHS Quality Council webpage.

A consumer webpage that was launched in June 2021, the Connecticut Healthcare Affordability Index (CHAI), measures the impact of healthcare costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs (e.g., housing, transportation, childcare, and groceries). CHAI starts with the 2019 Self-Sufficiency Standard for Connecticut and adds in details that influence healthcare costs, such as type of insurance coverage, age, health risk, and family composition. The index calculates healthcare costs and affordability for 19 different household types across the state.

OHS and the Office of State Comptroller (OSC) collaborated on this project to create a tool that will help policymakers understand the real costs of healthcare and the challenges that Connecticut residents face in meeting their basic expenses. The goal of the project is to provide a tool for providing data and analysis to inform policies and practices that will make quality, reliable healthcare affordable to all.

OHS calculated the average percentage of household budget spent on healthcare for households that can afford their basic expenses in Connecticut, based on the 2019 CT Self-Sufficiency Standard. Depending on composition, households spend between 6 percent and 10 percent of their budgets on healthcare costs, including premiums and out-of- pocket expenses. When these expenses exceed their targets, households are unable to meet their costs for healthcare and other needs, such as housing, food, childcare, and transportation. Healthcare expenses over this target are generally unaffordable.

Based on the 2019 CT Self-Sufficiency Standard, OHS calculated the average percentage of budget spent on healthcare for households that can afford their basic expenses in Connecticut. Depending on composition, research showed that households that can afford their basic expenses spend 7-11 percent of their budgets on healthcare costs, including premiums and out-of-pocket expenses.[2]

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[2] The calculations reflect costs and subsidies available in June 2021, including new subsidies provided by the American Rescue Plan Act (ARPA). They do not include additional subsidies approved by the General Assembly in the FY22/23 Connecticut Biennial Budget.

Connecticut Healthcare Spending Target, June 2021

CT HEALTHCARE SPENDING TARGET, JUNE 2021					
Household Type		**Percentage of Total Income Needed to Meet Basic Needs**			**Healthcare Net Costs as % of Total Income Needed to Meet Basic Needs**
		Premium	**Out-of-pocket**	**Premium Tax Credit**	
Adults	**Children**				
1	0	8.06%	2.04%	-3%	7.3%
	1	9.10%	1.93%	-2%	8.8%
	2	9.86%	2.03%	-2%	9.5%
	3	8.15%	1.93%	-2%	7.9%
	4	7.05%	2.01%	-2%	6.8%
Adults	**Children**				
2	0	12.51%	3.05%	-5%	10.8%
	1	11.46%	2.64%	-4%	10.2%
	2	10.35%	2.65%	-4%	9.1%
	3	8.88%	2.48%	-3%	8.1%
	4	7.84%	2.51%	-3%	7.1%

Table 11: Spending Targets by Household Size

As of June 2021, approximately 18 percent (165,684) of households in Connecticut with working adults faced costs that exceeded the target for affordability.[3] The percentage of households with access to health insurance costs below the affordability target varied by the source of coverage. Forty-two percent (60,906) of households purchasing insurance through Access Health CT faced healthcare cost that exceeded the target for affordability, while only 16 percent (104,788) of households with employer-sponsored insurance faced healthcare costs that exceeded the target for affordability. Households covered by HUSKY (Medicaid) are all presumed to have affordable healthcare.

OHS and OSC worked with researchers from the Center for Women's Welfare at the University of Washington School of Social Work and from the University of Connecticut Analytics and Information Management Solutions (UCONN AIMS) to develop this tool. The project was partially funded and guided by the Connecticut Health Foundation and the Universal Healthcare Foundation of Connecticut. OHS and OSC also convened a public advisory committee to review and provide input as the tool was developed.

CHAI is a living tool, so as costs and conditions change, OHS and OSC will use it to measure impacts on the marketplace or to model policy ideas and alternatives. The figures in this summary have been adjusted to reflect the changes to the Affordable Care Act included in the ARPA, enacted in March 2021.

Also in 2021, OHS redesigned and relaunched HealthScoreCT, a webpage that is now fully hosted by the Department of Administrative Services, Bureau Information Technology Solutions (BITS). As part of this

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[3] To estimate the number of Connecticut households with unaffordable healthcare, we utilized the 2017 American Community Survey (ACS) 1-Year PUMS dataset previously coded with the Self-Sufficiency Standard and the CHAI adequate income calculations. Because the costs in the Self-Sufficiency Standard assume that adults work, this ACS dataset excludes adults not expected to work, such as seniors and adults with work-limiting disabilities.

project, OHS is in the process of updating, and will relaunch in 2022, the consumer health information webpage; it will include the Cost Estimator, which provides information on the cost and quality of health services to support consumer decision-making.

OHS partnered with the RAND Corporation to provide commercial claims data for the RAND Hospital Price Transparency Study 3.0, a national hospital price transparency project. It measured and reported prices paid for hospital care benchmarked against Medicare-charged amounts. In 2021, OHS provided an additional APCD data extract for inclusion in the RAND Hospital Price Transparency Study 4.0.

OHS participated in an award winning, six-state initiative led by the New England States Consortium Systems Organization (NESCSO) that utilizes APCD data, defines and evaluates primary care investments, and enables comparisons among payers and populations across the region. Estimates for Connecticut will also in part, provide baseline information and inform the process for increasing primary care spending annually to 10 percent by 2025, in support of Governor Lamont's Executive Order #5.

OHS is partnering with Bailit Health and Mathematica to examine drivers of commercially insured healthcare costs utilizing APCD data. The analyses also include identifying high-cost, high-volume medical services, and those with wide price variations among providers at the state, payer, and provider network levels, to identify opportunities to reduce cost growth, improve quality and promote equity. The analyses also support the benchmarks work authorized by Executive Order #5.

In addition, OHS provided APCD with data extracts and analyses to support state initiated projects such as, but not limited to: a project by the Office of the Comptroller to evaluate healthcare options for small employer groups; medical services pricing and availability to support Certificate of Need decision-making; evaluation of facility fee legislation on evaluation and management codes, and assessment and management codes as they relate to surprise billing; and measurement of the impact of COVID-19 on adult immunizations, at risk populations and hospitals' operations to support related policy development. Policy development has included identifying the towns and locations of at-risk populations to support decision-making on reopening; and providing trend analyses for select healthcare providers showing the impact of COVID on operations (commercial revenue) to support decision-making on providing state financial support for hospitals and health systems.

Medication Reconciliation and Polypharmacy Committee

The General Assembly enacted Special Act 18-6 on June 1, 2018, requiring the Health Information Technology Officer to establish a working group under the purview of HITAC to evaluate issues concerning polypharmacy[4] and medication reconciliation[5]. The major output of the Medication Reconciliation

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[4] "Polypharmacy" means the simultaneous use of multiple drugs by a patient to treat one or more ailments or conditions.

[5] "Medication reconciliation" means the process of comparing a patient's admission, discharge, and transfer medication orders to all of the medications the patient has been taking for the purpose of avoiding medication errors, including omission, duplication, dosing errors and drug interactions.

Polypharmacy Working Group (MRPW) was a report, published in early 2020, with 11 recommendations related to medication reconciliation and polypharmacy.

Following the submission of the MRPW report to the General Assembly in 2019, HITAC chartered a standing Medication Reconciliation and Polypharmacy Committee (MRPC) for a two-year term as a standing committee of the Council to develop recommendations and explore solutions for improving the flow of medication data between health IT vendor systems, including when medications are discontinued (deprescribed), with the goal of having Connecticut's HIE advance the use case for a Best Possible Medications History service.

The MRPC demonstrated dedicated leadership through its two-year lifespan as a standing Council committee. In its first year, the MRPC distinguished itself by helping drive adoption of CancelRx as a national standard for electronic medication discontinuation, and by developing a robust set of business and functional requirements for a BPMH, captured in the MRPC 2020 Annual Report.

The committee began its second year with five goals identified in the January 2021 report.

❖ **Goal 1**: Develop a detailed strategic approach for the creation of a BPMH, supported by active patient engagement, which results in near-term value for stakeholders while laying the foundation for a longer-term, more extensive, and integrated solution.

❖ **Goal 2**: Create an online directory of evidence-based medication management and medication reconciliation tools and solutions, with patient engagement strategies; technical advisories; subject matter experts; and policy and regulatory guidance documents.

❖ **Goal 3**: Serve as a resource to OHS, Connie, DSS, and the Department of Consumer Protection to support development and implementation related to technical solutions and use cases; workflow integration; medication reconciliation pilot activities; stakeholder engagement; and measurement and evaluation.

❖ **Goal 4**: Develop an implementation plan for recommendations related to deprescribing transaction standards, including CancelRx, developed by the MRPC.

❖ **Goal 5**: Support the Implementation Advance Planning Document (IAPD) and initiatives funded by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act; and actively monitor funding opportunities related to the stated purpose and goals of MRPC.

In April 2021, in recognition of available time and funding constraints, the committee narrowed its focus to accomplishing two initiatives prior to September 2021:

Initiative 1: An environmental scan of relevant policy and technological implications of medication data sources for a Best Possible Medication History.

Before Connie could consider a BPMH use case, more information was needed about the availability, quality, and cost of medication history data to HIEs from various electronic data sources. With guidance from the MRPC members and with resources allocated as part of the work on the Health IT Plan, CedarBridge Group conducted an environmental scan to research questions around medication fill data

sources, including access and release policies in other states, consent requirements, data standards and formats used in different systems, and where it was possible, costs associated with data feeds from source systems. Interviews were conducted with representatives from HIEs, state PDMPs, other state and federal government agencies, technology vendors, and subject matter experts in relevant domains, including:

- ❖ Health Information Exchange organizations (seven total)
- ❖ Prescription Drug Monitoring Programs (four total)
- ❖ Connecticut Department of Social Services
- ❖ Connecticut Office of the Healthcare Advocate
- ❖ The Pharmacy Health Information Technology Collaborative
- ❖ The U.S. Department of Veterans Affairs
- ❖ Health information technology vendors (four total)

Additional information was gathered through informal interviews and conversations with subject matter experts in the fields of medicine, pharmacy, medical terminology and informatics, technology and data standards, patient privacy, state and federal regulations and policies for PDMPs, and value-based care models. MRPC members contributed significantly to the detailed information in this report, as did staff and physician leaders from University of Connecticut (UConn) Health, UConn School of Pharmacy, and Yale New Haven Health. An online scan for published literature was conducted, and relevant sources are cited as footnotes in the MRPC final report.

The goal of this research is to provide a foundation of objective information for policymakers, regulators, state agency program administrators, Connie's management, and Board of Directors, and HITAC advisors as they engage stakeholders in planning and implementation of the Health IT Plan. While many stakeholders have indicated strong support for Connie to offer a BPMH service, access to affordable medication data sources is a well-known problem for HIEs across the country. Some interest has been expressed in exploring expanded use of the technology platform used by Connecticut's CPMRS as a source of connectivity to medication data sources (retail and specialty pharmacies, hospitals, clinics) for medication reconciliation and BPMH services; the MRPC final report provides information to inform further discussion on medication data sources.

HIEs are uniquely positioned to facilitate more effective and comprehensive medication reconciliation, and to present a consolidated view of the current and past medications that have been prescribed, dispensed, and refilled as part of a longitudinal summary of a person's health record. This report provides an overview of the potential sources for medication data, the use cases those data can potentially support, and potential technological and regulatory implications that may be relevant to the use cases and future services.

Initiative 2: User interface requirements for feedback and analysis of BPMH data by patients and through clinician-facing tools.

Accurate medication lists are essential data needed to inform clinicians' decision-making. Ideally, a medication list would comprise a 360-degree view of all prescribed, dispensed, and purchased medications, and would seamlessly connect patients and providers to medication data from multiple sources. While it is ideal to capture every aspect of medication management, in reality a BPMH has been identified as a more achievable goal.

To help envision how a BPMH could be graphically represented, two students from UConn's Computer Science and Engineering Department created "wireframe" diagrams, or visual representations, of a user interface. They modelled two prototypes, one patient-facing and the other clinician-facing. The UConn Health team showcased these mockups to stakeholder representatives, collecting and incorporating feedback into subsequent design iterations.

Type of Participant	(n=70)
Clinicians	34
MRPC Members	6
Patients (in-person)	15
Patients (survey)	15
Type of Clinician	(n=34)
Physicians	6
Medical Residents	13
Pharmacists	4
Home Care Nurses	5
Primary Care Nurses	2
Nurse Care Managers	2
Medical Students	1
Medical Assistants	1

Table 12: Participants in Prototype Feedback

In an effort to realize a BPMH and to facilitate the goals of the Office of Health Strategy, the MRPC members, supported by the UConn Health consulting team, engaged stakeholders (patients, clinicians, advocates) in focus groups and interviews to solicit feedback on the user interface requirements for a BPMH (see Table 12). Feedback was obtained via facilitated discussions that occurred in person, via virtual WebEx meetings, and through online surveys.

The following themes emerged from the feedback sessions:

❖ **Existing Gaps**. Currently it is challenging to accurately perform medication reconciliation given the gaps that exist in medication data. There is also a lack of communication between providers and EHRs.

❖ **User Interface Optimization**. Participants recognized the wireframe mockups as prototypes. They appreciated the intent and provided recommendations to enhance the user experience, for example by simplifying the collaboration code process, adding a menu of options on the home screen, and having the ability to filter medications in different ways (alphabetically, chronologically, by medication class, etc.). There were suggestions to optimize the Medication History calendar by enabling reminder alerts. Recommendations to enhance visual appearance included adjusting the font size and color and adding pictures of medications.

❖ **Safety Considerations**. Both clinicians and patients expressed concerns regarding patient autonomy over prescription medications. Most felt that patients should be able to modify OTC medications only (not prescriptions), and that they should be able to add comments on all medications. Clinicians raised concerns regarding alert fatigue since they might be notified in real time of updates to their patients' medication list. Also, it was suggested to simplify the language in order to accommodate patients with lower literacy levels.

❖ **Data**. A recurring theme was the need to seamlessly incorporate data from many sources, including electronic medical records, insurance dispense records, health systems, pharmacies, and others. Clinicians felt this functionality should be integrated into their EHR.

❖ **Best Use Considerations**. This could be valuable for health systems, pharmacies, and health plans. Clinicians recognized the expanding capabilities of existing EHRs to pull data from multiple sources and questioned what this could add. Patients felt this could facilitate bidirectional communication with their providers and enhance their autonomy.

❖ **Value Proposition**. Many felt this would improve patient care across the healthcare landscape and would facilitate patient autonomy over their medications. This could also be used in population health to close gaps in care such as adherence gaps, which could ultimately improve plans' star ratings.

❖ **Problematic Status Quo**. All stakeholders suggested that the current mechanisms in place to perform medication reconciliation and determine a BPMH are woefully inadequate, time consuming and create undue risks for patients and providers. There was strong support for development of an effective, efficient, and workflow friendly alternative.

Two major sources provided funding for this project. The Computer Science and Engineering students were funded through UConn summer research internships. The feedback sessions and other elements were funded through contracts with UConn Health, supported by OHS with 90/10 APD funding. Existing funding from other sources was provided to carry out the qualitative research.

The MRPC final report was submitted to OHS in October 2021, and was presented to the Health IT Advisory Council at its meeting on November 18, 2021. After the final report was submitted, the work of the MRPC was rolled into a new Connie workgroup focused on the BPMH Use Case. Two meetings of the BPMH Workgroup were held, in November and December 2021.

Appendix A

Connecticut Statute Relating to Health IT and HIE

Connecticut General Statute Relating to Regulatory Authorities and Requirements for a Statewide Health Information Technology Plan, the Statewide Health Information Exchange, the All-Payer Claims Database, the Health Information Technology Advisory Council, Uniform Interagency Data Standards and Policies, and Electronic Data Standards (Current as of 1/7/2021)

Sec. 17b-59a. (Formerly Sec. 4-60i). Development of uniform information and technology standards and regulations. Health information technology plan. Electronic data standards. Statewide Health Information Exchange. Report. (a) As used in this section:

(1) "Electronic health information system" means an information processing system, involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data and knowledge for communication and decision making, and includes: (A) An electronic health record that provides access in real time to a patient's complete medical record; (B) a personal health record through which an individual, and anyone authorized by such individual, can maintain and manage such individual's health information; (C) computerized order entry technology that permits a health care provider to order diagnostic and treatment services, including prescription drugs electronically; (D) electronic alerts and reminders to health care providers to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments; (E) error notification procedures that generate a warning if an order is entered that is likely to lead to a significant adverse outcome for a patient; and (F) tools to allow for the collection, analysis and reporting of data on adverse events, near misses, the quality and efficiency of care, patient satisfaction and other healthcare-related performance measures.

(2) "Interoperability" means the ability of two or more systems or components to exchange information and to use the information that has been exchanged and includes: (A) The capacity to physically connect to a network for the purpose of exchanging data with other users; and (B) the capacity of a connected user to access, transmit, receive, and exchange usable information with other users.

(3) "Standard electronic format" means a format using open electronic standards that: (A) Enable health information technology to be used for the collection of clinically specific data; (B) promote the interoperability of healthcare information across healthcare settings, including reporting to local, state, and federal agencies; and (C) facilitate clinical decision support.

(b) The Commissioner of Social Services, in consultation with the executive director of the Office of Health Strategy, established under section 19a-754a, shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families, Veterans Affairs and Mental Health and Addiction Services, uniform management information, uniform statistical information, uniform terminology for similar facilities, uniform electronic health information technology standards and uniform regulations for the licensing of human services facilities, (2) plan for increased participation of the private sector in the delivery of human services, (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to facilitate shared services and eliminate duplication.

(c) The executive director of the Office of Health Strategy shall, in consultation with the Commissioner of Social Services and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, implement and periodically revise the state-wide health information technology plan established pursuant to this section and shall 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. Such electronic data standards shall: (1) Include provisions relating

to security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) limit the use and dissemination of an individual's Social Security number and require the encryption of any Social Security number provided by an individual; (3) require privacy standards no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and contained in 45 CFR 160, 164; (4) require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail; (5) be compatible with any national data standards in order to allow for interstate interoperability; (6) permit the collection of health information in a standard electronic format; and (7) be compatible with the requirements for an electronic health information system.

(d) The executive director of the Office of Health Strategy shall, within existing resources and in consultation with the State Health Information Technology Advisory Council: (1) Oversee the development and implementation of the Statewide Health Information Exchange in conformance with section 17b-59d; (2) coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation; and (3) serve as the state liaison to, and work collaboratively with, the Statewide Health Information Exchange established pursuant to section 17b-59d to ensure consistency between the state-wide health information technology plan and the Statewide Health Information Exchange and to support the state's health information technology and exchange goals.

(e) The statewide health information technology plan, implemented and periodically revised pursuant to subsection (c) of this section, shall enhance interoperability to support optimal health outcomes and include, but not be limited to (1) general standards and protocols for health information exchange, and (2) national data standards to support secure data exchange data standards to facilitate the development of a state-wide, integrated electronic health information system for use by healthcare providers and institutions that are licensed by the state. Such electronic data standards shall (A) include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols, (B) be compatible with any national data standards in order to allow for interstate interoperability, (C) permit the collection of health information in a standard electronic format, and (D) be compatible with the requirements for an electronic health information system.

(f) Not later than February 1, 2017, and annually thereafter, the executive director of the Office of Health Strategy, in consultation with the State Health Information Technology Advisory Council, shall report in accordance with the provisions of section 11-4a to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health concerning: (1) The development and implementation of the state-wide health information technology plan and data standards, established and implemented by the executive director of the Office of Health Strategy pursuant to this section; (2) the establishment of the Statewide Health Information Exchange; and (3) recommendations for policy, regulatory and legislative changes and other initiatives to promote the state's health information technology and exchange goals.

Sec. 17b-59b. (Formerly Sec. 4-60j). Commissioner to consider advice of advisory boards and councils. In fulfilling his or her responsibilities under sections 17b-59a and 17b-59c and complying with the requirements of said sections, the Commissioner of Social Services shall take into consideration such advice as may be provided to the commissioner by advisory boards and councils in the human services areas.

Sec. 17b-59c. (Formerly Sec. 4-60l). Approval of agency policies, programs, and plans. (a) Matters of policy related to subsection (b) of section 17b-59a involving more than one of the agencies designated in said subsection shall be presented to the Commissioner of Social Services for his or her approval prior to implementation.

(b) Matters of program development related to subsection (b) of section 17b-59a involving more than one of the agencies designated in said subsection shall be presented to the commissioner for his or her approval prior to implementation.

(c) Any plan of any agency designated in subsection (b) of section 17b-59a for the future use or development of property or other resources for the purposes of said subsection shall be submitted to the commissioner for his or her approval prior to implementation.

Sec. 17b-59d. Statewide Health Information Exchange. Established. (a) There shall be established a Statewide Health Information Exchange 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.

(b) It shall be the goal of the Statewide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all healthcare provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and healthcare delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; and (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the Department of Social Services, hospitals, physicians, behavioral healthcare providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the Statewide Health Information Exchange.

(c) All contracts or agreements entered into by or on behalf of the state relating to health information technology or the exchange of health information shall be consistent with the goals articulated in subsection (b) of this section and shall utilize contractors, vendors, and other partners with a demonstrated commitment to such goals.

(d) (1) The executive director of the Office of Health Strategy, in consultation with the Secretary of the Office of Policy and Management and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, shall, upon the approval by the State Bond Commission of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, develop and issue a request for proposals for the development, management and operation of the State-wide Health Information Exchange. Such request shall promote the reuse of any and all enterprise health information technology assets, such as the existing Provider Directory, Enterprise Master Person Index, Direct Secure Messaging Health Information Service provider infrastructure, analytic capabilities and tools that exist in the state or are in the process of being deployed. Any enterprise health information exchange technology assets purchased after June 2, 2016, and prior to the implementation of the State-wide Health Information Exchange shall be capable of interoperability with a Statewide Health Information Exchange.

(2) Such request for proposals may require an eligible organization responding to the request to: (A) Have not less than three years of experience operating either a state-wide health information exchange in any state or a regional exchange serving a population of not less than one million that (i) enables the exchange of patient health information among healthcare providers, patients and other authorized users without regard to location, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time healthcare provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing or medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and operations; (C) be capable of providing consulting to ensure effective governance; (D) be regulated or administratively overseen by a state government agency; and (E) have sufficient staff and

appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the Statewide Health Information Exchange.

(e) Notwithstanding the provisions of subsection (d) of this section, if, on or before January 1, 2016, the Commissioner of Social Services, in consultation with the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, submits a plan to the Secretary of the Office of Policy and Management for the establishment of a Statewide Health Information Exchange consistent with subsections (a), (b) and (c) of this section, and such plan is approved by the secretary, the commissioner may implement such plan and enter into any contracts or agreements to implement such plan.

(f) The executive director of the Office of Health Strategy shall have administrative authority over the Statewide Health Information Exchange. The executive director shall be responsible for designating, and posting on its Internet web site, the list of systems, technologies, entities, and programs that shall constitute the State-wide Health Information Exchange. Systems, technologies, entities, and programs that have not been so designated shall not be considered part of said exchange.

Sec. 17b-59b. (Formerly Sec. 4-60j). Commissioner to consider advice of advisory boards and councils. In fulfilling his or her responsibilities under sections 17b-59a and 17b-59c and complying with the requirements of said sections, the Commissioner of Social Services shall take into consideration such advice as may be provided to the commissioner by advisory boards and councils in the human services areas.

Sec. 17b-59c. (Formerly Sec. 4-60l). Approval of agency policies, programs, and plans. (a) Matters of policy related to subsection (b) of section 17b-59a involving more than one of the agencies designated in said subsection shall be presented to the Commissioner of Social Services for his or her approval prior to implementation.

(b) Matters of program development related to subsection (b) of section 17b-59a involving more than one of the agencies designated in said subsection shall be presented to the commissioner for his or her approval prior to implementation.

(c) Any plan of any agency designated in subsection (b) of section 17b-59a for the future use or development of property or other resources for the purposes of said subsection shall be submitted to the commissioner for his or her approval prior to implementation.

Sec. 17b-59d. Statewide Health Information Exchange. Established. (a) There shall be established a Statewide Health Information Exchange 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.

(b) It shall be the goal of the Statewide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all healthcare provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and healthcare delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; and (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the Department of Social Services, hospitals, physicians, behavioral healthcare providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the Statewide Health Information Exchange.

(c) All contracts or agreements entered into by or on behalf of the state relating to health information technology or the exchange of health information shall be consistent with the goals articulated in

subsection (b) of this section and shall utilize contractors, vendors, and other partners with a demonstrated commitment to such goals.

(d) (1) The executive director of the Office of Health Strategy, in consultation with the Secretary of the Office of Policy and Management and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, shall, upon the approval by the State Bond Commission of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, develop and issue a request for proposals for the development, management and operation of the State-wide Health Information Exchange. Such request shall promote the reuse of any and all enterprise health information technology assets, such as the existing Provider Directory, Enterprise Master Person Index, Direct Secure Messaging Health Information Service provider infrastructure, analytic capabilities and tools that exist in the state or are in the process of being deployed. Any enterprise health information exchange technology assets purchased after June 2, 2016, and prior to the implementation of the State-wide Health Information Exchange shall be capable of interoperability with a Statewide Health Information Exchange.

(2) Such request for proposals may require an eligible organization responding to the request to: (A) Have not less than three years of experience operating either a state-wide health information exchange in any state or a regional exchange serving a population of not less than one million that (i) enables the exchange of patient health information among healthcare providers, patients and other authorized users without regard to location, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time healthcare provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing or medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and operations; (C) be capable of providing consulting to ensure effective governance; (D) be regulated or administratively overseen by a state government agency; and (E) have sufficient staff and appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the Statewide Health Information Exchange.

(e) Notwithstanding the provisions of subsection (d) of this section, if, on or before January 1, 2016, the Commissioner of Social Services, in consultation with the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, submits a plan to the Secretary of the Office of Policy and Management for the establishment of a Statewide Health Information Exchange consistent with subsections (a), (b) and (c) of this section, and such plan is approved by the secretary, the commissioner may implement such plan and enter into any contracts or agreements to implement such plan.

(f) The executive director of the Office of Health Strategy shall have administrative authority over the Statewide Health Information Exchange. The executive director shall be responsible for designating, and posting on its Internet web site, the list of systems, technologies, entities, and programs that shall constitute the State-wide Health Information Exchange. Systems, technologies, entities, and programs that have not been so designated shall not be considered part of said exchange.

Sec. 17b-59e. Electronic health record systems. Connection to Statewide Health Information Exchange.
For purposes of this section:
(1) "Healthcare provider" means any individual, corporation, facility, or institution licensed by the state to provide healthcare services; and
(2) "Electronic health record system" means a computer-based information system that is used to create, collect, store, manipulate, share, exchange or make available electronic health records for the purposes of the delivery of patient care.
(b) Not later than one year after commencement of the operation of the Statewide Health Information Exchange, each hospital licensed under chapter 368v 1 and clinical laboratory licensed under section 19a-30 shall maintain an electronic health record system capable of connecting to and participating in the

Statewide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the Statewide Health Information Exchange.

(c) Not later than two years after commencement of the operation of the Statewide Health Information Exchange, (1) each healthcare provider with an electronic health record system capable of connecting to, and participating in, the Statewide Health Information Exchange shall apply to begin the process of connecting to, and participating in, the Statewide Health Information Exchange, and (2) each healthcare provider without an electronic health record system capable of connecting to, and participating in, the Statewide Health Information Exchange shall be capable of sending and receiving secure messages that comply with the Direct Project specifications published by the federal Office of the National Coordinator for Health Information Technology.

Sec. 17b-59f. State Health Information Technology Advisory Council. Establishment of All-Payer Claims Database Advisory Group. (a) There shall be a State Health Information Technology Advisory Council to advise the executive director of the Office of Health Strategy and the health information technology officer, designated in accordance with section 19a-754a, in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts and goals and to advise the executive director and officer in the development and implementation of the state-wide health information technology plan and standards and the Statewide Health Information Exchange, established pursuant to section 17b-59d. The advisory council shall also advise the executive director and officer regarding the development of appropriate governance, oversight, and accountability measures to ensure success in achieving the state's health information technology and exchange goals.

Sec. 17b-59g. Program to expedite development of Statewide Health Information Exchange. Entity to implement the program. Board of directors. (a) The state, acting by and through the Secretary of the Office of Policy and Management, in collaboration with the executive director of the Office of Health Strategy, shall establish a program to expedite the development of the State-wide Health Information Exchange, established under section 17b-59d, to assist the state, healthcare providers, insurance carriers, physicians and all stakeholders in empowering 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. The purposes of the program shall be to (1) assist the State-wide Health Information Exchange in establishing and maintaining itself as a neutral and trusted entity that serves the public good for the benefit of all Connecticut residents, including, but not limited to, Connecticut healthcare consumers and Connecticut healthcare providers and carriers, (2) perform, on behalf of the state, the role of intermediary between public and private stakeholders and customers of the Statewide Health Information Exchange, and (3) fulfill the responsibilities of the Office of Health Strategy, as described in section 19a-754a.

   (b) The executive director of the Office of Health Strategy, in consultation with the health information technology officer, designated in accordance with section 19a-754, shall design, and the Secretary of the Office of Policy and Management, in collaboration with said executive director, may establish or incorporate an entity to implement the program established under subsection (a) of this section. Such entity shall, without limitation, be owned and governed, in whole or in part, by a party or parties other than the state and may be organized as a nonprofit entity.

   (c) Any entity established or incorporated pursuant to subsection (b) of this section shall have its powers vested in and exercised by a board of directors. The board of directors shall be comprised of the following members who shall each serve for a term of two years:

   (1) One member who shall have expertise as an advocate for consumers of healthcare, appointed by the Governor;

   (2) One member who shall have expertise as a clinical medical doctor, appointed by the president pro tempore of the Senate;

(3) One member who shall have expertise in the area of hospital administration, appointed by the speaker of the House of Representatives;

(4) One member who shall have expertise in the area of corporate law or finance, appointed by the minority leader of the Senate;

(5) One member who shall have expertise in group health insurance coverage, appointed by the minority leader of the House of Representatives;

(6) The Chief Information Officer and the Secretary of the Office of Policy and Management, or their designees, who shall serve as ex-officio, voting members of the board; and

(7) The health information technology officer, designated in accordance with section 19a-754a, who shall serve as chairperson of the board.

(d) Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. If an appointing authority fails to make an initial appointment on or before sixty days after the establishment of such entity, or to fill a vacancy in an appointment on or before sixty days after the date of such vacancy, the Governor shall make such appointment or fill such vacancy.

(e) Any entity established or incorporated under subsection (b) of this section may (1) employ a staff and fix their duties, qualifications and compensation; (2) solicit, receive and accept aid or contributions, including money, property, labor and other things of value from any source; (3) receive, and manage on behalf of the state, funding from the federal government, other public sources or private sources to cover costs associated with the planning, implementation and administration of the Statewide Health Information Exchange; (4) collect and remit fees set by the Health Information Technology Officer charged to persons or entities for access to or interaction with said exchange; (5) retain outside consultants and technical experts; (6) maintain an office in the state at such place or places as such entity may designate; (7) procure insurance against loss in connection with such entity's property and other assets in such amounts and from such insurers as such entity deems desirable; (8) sue and be sued and plead and be impleaded; (9) borrow money for the purpose of obtaining working capital; and (10) subject to the powers, purposes and restrictions of sections 17b-59a, 17b-59d, and 17b-59f, do all acts and things necessary and convenient to carry out the purposes of this section and section 19a-754a.

Appendix B

Health IT Advisory Council Membership

	Appointment by	Name | Appointment Date	Represents
1.	Statute	Sumit Sajnani 10/22/2021	Health Information Technology Officer or designee
2.	Statute	Joe Stanford (designee) 5/11/2017	Commissioner of Social Services or designee
3.	Statute	Elizabeth Taylor (designee) 12/19/2019	Commissioner of Mental Health and Addiction Services or designee
4.	Statute	Cindy Butterfield (designee) 4/17/2017	Commissioner of Children and Families or designee
5.	Statute	Sharonda Carlos (designee) 1/19/2021	Commissioner of Correction or designee
6.	Statute	Vanessa Hinton (designee) 7/08/2016	Commissioner of Public Health or designee
7.	Statute	Dennis Mitchell (designee) 3/16/2017	Commissioner of Developmental Services or designee
8.	Statute	Sandra Czunas (designee) 12/21/2017	State Comptroller or designee
9.	Statute	Mark Raymond	CIO or designee
10.	Statute	Rob Blundo (designee) 3/22/2017	CEO of the CT Health Insurance Exchange or designee
11.	Statute	Kelly Sinko Steuber 12/20/2021	An expert in state healthcare reform initiatives appointed by the Exec. Dir. of Office of Health Strategy
12.	Statute	Chuck Podesta 3/19/2020	CIO of UConn Health or designee
13.	Statute	Ted Doolittle	Healthcare Advocate or designee
14.	Governor	Vacant	Representative of a health system that includes more than one hospital
15.	Governor	David Fusco 3/09/2016	Representative of the health insurance industry
16.	Governor	Nicolangelo Scibelli 1/19/2016	Expert in health information technology
17.	Governor	Patricia Checko 1/19/2016	Healthcare consumer or consumer advocate
18.	Governor	Cassandra Murphy 3/2/2020	An employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186
19.	President Pro Tempore of Senate	Robert Rioux 9/20/2016	Representative of a federally qualified health center
20.	President Pro Tempore of Senate	Jeannette DeJesus 7/31/2015	Provider of Behavioral Health Services

	Appointment by	Name | Appointment Date	Represents
21.	President Pro Tempore of Senate	Vacant	Representative of the Connecticut State Medical Society
22.	Speaker of the House of Representatives	Lisa Stump 11/22/2016	Technology expert who represents a hospital system
23.	Speaker of the House of Representatives	Vacant	Provider of home healthcare services
24.	Speaker of the House of Representatives	Vacant	Healthcare consumer or a healthcare consumer advocate
25.	Majority Leader of the Senate	Patrick Charmel 11/30/2015	Representative of an independent community hospital
26.	Majority Leader of the House of Representatives	Vacant	Physician who provides services in a multispecialty group and who is not employed by a hospital
27.	Minority Leader of the Senate	Joseph Quaranta, MD (Co-Chair) 7/22/2015	Primary care physician who provides services in a small independent practice
28.	Minority Leader of the House of Representatives	Alan D. Kaye, MD 8/24/2015	Expert in healthcare analytics and quality analysis
29.	President Pro Tempore of Senate	Dina Berlyn (designee)	President Pro Tempore of Senate or designee
30.	Speaker of the House of Representatives	Vacant	Speaker of the House of Representatives or designee
31.	Minority Leader of the Senate	Dr. Susan Israel (designee) 1/06/2021	Minority Leader of the Senate or designee
32.	Minority Leader of the House of Representatives	William Petit, MD 5/13/2019	Minority Leader of the House of Representatives or designee
33.	Health IT Advisory Council Co-Chairs	Stacy Beck 7/19/2018	Representative of a commercial health insurer
34.	Health IT Advisory Council Co-Chairs	Ken Ferrucci 5/18/2020	Representative of the CT State Medical Society
35.	Health IT Advisory Council Co-Chairs	Pareesa Charmchi Goodwin 10/29/2020	Consumer Advocate
36.	Health IT Advisory Council Co-Chairs	Vacant	Representation at the discretion of the Co-Chairs

Appendix C

Medication Reconciliation and Polypharmacy Committee Members

	Member Name	Organization	Membership Category
1.	Sean Jeffery, PharmD	Integrated Care Partners – Hartford Healthcare	Expert in medication reconciliation
2.	Nityu Kashyap, MD	Yale New Haven Health	Expert in medication reconciliation
3.	Kate Sacro, PharmD	Value Care Alliance	Expert in medication reconciliation
4.	Amy Justice, MD, PhD	Dept. of Veteran Affairs, Connecticut Healthcare System	Expert in Polypharmacy
5.	Janet Knecht, PhD, MSN	University of Saint Joseph	Expert in Polypharmacy
6.	Nathaniel Rickles, PharmD, PhD, BCPP	UConn School of Pharmacy	Expert in Polypharmacy
7.	Marghie Giuliano, RPh	Connecticut Pharmacists Association	Pharmacist
8.	Anne VanHaaren, PharmD	CVS Health	Pharmacist
9.	Thomas Agresta, MD, MBI	UConn Health	Prescribing practitioner
10.	Bruce Metz, PhD	UConn Health	Member of the Health IT Advisory Council
11.	R. Douglas Bruce, MD, MA, MSc	Cornell Scott-Hill Health Center	Prescribing practitioner
12.	Ece Tek, MD	Cornell Scott-Hill Health Center	Prescribing practitioner
13.	Lesley Bennett	Consumer / Patient Advocate	Represents consumers
14.	MJ McMullen	Surescripts	Represents expertise in CancelRx Workflow
15.	Jennifer Osowiecki, JD, RPh	Connecticut Hospital Association	Represents expertise in law
16.	Diana Mager, RN-BC	Connecticut Association of Healthcare at Home	Represents LTPAC / Hospice
17.	Jameson Reuter, PharmD, MBA, BCPS	ConnectiCare	Represents payers
18.	Jeremy Campbell, PharmD, MHI	Boehringer-Ingelheim	Represents pharmaceuticals
19.	Peter Tolisano, PsyD, ABPP	Connecticut Dept. of Developmental Services	Represents a state agency
20.	Rodrick Marriott, PharmD	Connecticut Dept. of Consumer Protection	Representative of the Dept. of Consumer Protection
21.	Barbara Bugella	Connecticut Dept. of Mental Health and Addiction Services	Represents a state agency

Appendix D

Acronyms

ACO	Accountable Care Organization	**IIS**	Immunization Information System
APCD	All-Payer Claims Database	**ISA**	Interoperability Standards Advisory
ARRA	American Recovery and Reinvestment Act	**LDS**	Limited Data Set
BPMH	Best Possible Medication History	**MES**	Medicaid Enterprise System
CBO	Community Based Organization	**MPI**	Master Person Index
CCIP	Community and Clinical Integration Program	**MRPC**	Medication Reconciliation and Polypharmacy committee
CDAS	Core Data Analytics Solution	**OHS**	Office of Health Strategy
CIE	Community Information Exchange	**ONC**	Office of the National Coordinator for Health Information Technology
CMMI	Center for Medicare and Medicaid Innovations	**OPM**	Office of Policy and Management
CMS	Centers for Medicare and Medicaid Services	**OSC**	Office of the State Comptroller
CQM	Clinical Quality Measure	**P20 WIN**	Preschool Through Twenty Workforce Information Network
CRISP	Chesapeake Regional Information System for our Patients	**PCMH**	Patient Centered Medical Home
DGS	Digital Government Services	**PCSC**	Patient Centered Services Collaborative
DPH	Department of Public Health	**PDMP**	Prescription Drug Monitoring Program
DSS	Department of Social Services	**PHI**	Protected Health Information
eCMS	Electronic Consent Management System	**PSI**	Prevention Service Initiative
eCQM	Electronic Clinical Quality Measure	**R & D**	Research and Development
EHR	Electronic Health Record	**REL**	Race Ethnicity and Language (REL)
FFP	Federal Financial Participation	**RFA**	Request for Applications
FFY	Federal Fiscal Year	**SDLC**	Systems Development Life Cycle
FQHC	Federally Qualified Health Center	**SIM**	State Innovation Model
Health IT	Health Information Technology	**SMHP**	State Medicaid Health IT Plan

HEC	Health Enhancement Communities	**SMMS**	Statewide Medication Management Services
HHS	Health and Human Services	**TA**	Technical Assistance
HIE	Health Information Exchange	**TEFCA**	Trusted Exchange Framework and Common Agreement
HIPAA	Health Insurance Portability and Accountability Act of 1996	**2Gen**	Two Generational Initiatives
HITECH	Health Information Technology for Economic and Clinical Health Act	**UCFM**	Use Case Factory Model
HITO	Health Information Technology Officer	**UConn**	University of Connecticut
HITRUST	Health Information Trust Alliance	**UConn AIMS**	UConn Analytics and Information Management Solutions
IAPD	Implementation Advance Planning Document	**VBID**	Value-based Insurance Design
IAPD-U	Implementation Advance Planning Document Update		

Appendix E

Membership Structure of DSS/OHS Joint Steering Committee

Section 1: Membership in the Joint Steering Committee shall represent individuals with appropriate subject matter expertise and decision-making authority. The members will include, at minimum, the following roles:

Department of Social Services	**Office of Health Strategy**
❖ CT METS Program Director	❖ Fiscal Lead
❖ Chief Innovation Officer	❖ Health Information Technology Officer
❖ Medicaid Director	❖ Health IT Program Manager
❖ Chief Financial Officer	❖ General Counsel