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Annual Report on Health
Information Technology and
Health Information Exchange
in Connecticut

2022

A Report Pursuant to Connecticut General Statute §17b-59a for the
Connecticut General Assembly

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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, is required to report annually to the joint standing committees of the General Assembly on matters relating to:

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

The submission of this report by OHS Executive Director Vicki 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, and there is plenty of good news to report.

- **The official launch of Connie,** Connecticut's long-awaited health information exchange, was held on May 3rd, 2021, and 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% of Connecticut's population).

- **The Statewide Health Information Technology Plan** is based on a rigorous sixteen-month process to evaluate the current environment of health IT and HIE across ten domains of healthcare sectors and 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, bringing a strong combination of technical knowledge around health information systems, deft people management skills, and large government agency project experience, to lead the state strategies for administration of the statewide Health Information Exchange (HIE), administration of the All-Payer Claims Database program (APCD); and development of implementation plans for the recently completed Five-Year Statewide Health Information Technology Plan. In the HITO role, with guidance from Connecticut's Health Information Technology Advisory Council, Sajnani will also be monitoring a myriad of federal, state, and local policies and programs for health IT and HIE implications and for regulatory changes or policies that may be needed over time.

This document is organized into five sections mapping to the General Assembly's mandate for annual reporting, with an overview of the past year's activities and accomplishments pertaining to each topic area, and additional background analysis to provide policymakers with the types of 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 trusted contractor to OHS and to the Health IT Advisory Council. 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 was an important decision that considered the value of engaging and understanding the technology needs and capabilities of community-based organizations, social service agencies, local health departments and local 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.

Process and Timeline for Statewide Health IT Plan

Develop Scope, Define Stakeholders → Create Charter, Establish Governance → Conduct Environmental Scan → Analyze and Synthesize Data → Draft Recommendations for Priorities and Strategies → Public Comments and Stakeholder Review → Revise Refine Finalize Plan

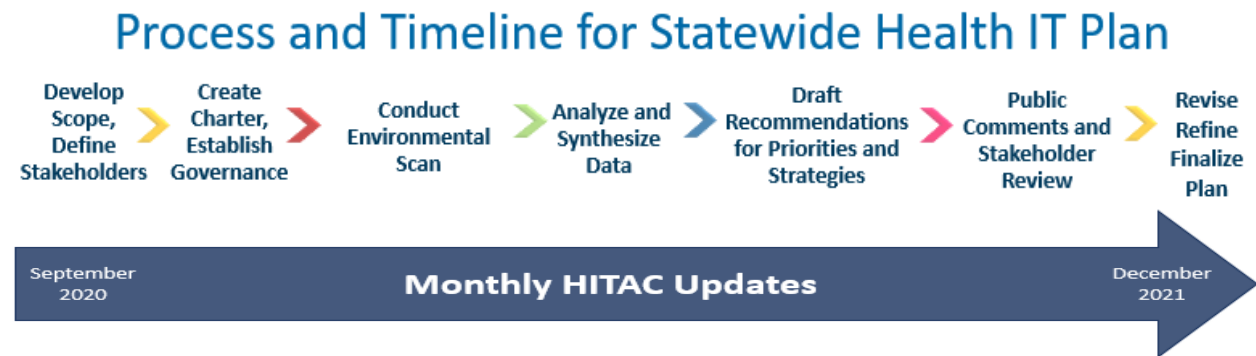September 2020 — **Monthly HITAC Updates** — December 2021

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

The project scope was defined and presented at the [February 18th, 2021, Health IT Advisory Council's meeting](). A detailed review of historical documents was a critical first step on the environmental scan process. A large number of individuals and stakeholder organizations from ten domains were identified for outreach to request participation in the environmental scan (see Table 1). Stakeholders weighed in from across state through a variety of engagement modalities.

Interactive virtual forums were conducted on Zoom with real-time participant polling capabilities. These forums were organized

Stakeholder Domains Represented in Environmental Scan Research	
Hospitals and Health Systems	Health Plans and Payers
Behavioral Health Providers	Public Health
Community-Based Organizations	Ambulatory Provider Practices
Consumers (Patients, Clients, Caregivers)	Long-Term Post-Acute Care Providers
Emergency Services Providers	Associations and Advocacy Groups
HIE and Health IT Organizations and Vendors	State Agencies and Advisory Groups

Table 1: Stakeholder Domains Included in Environmental Scan

around discussion topics and use case scenarios (see Table 2) and were open to any member of the public, in compliance with Connecticut's requirements for public meetings.

Electronic surveys were customized with domain-specific questions for eight of the ten domains (see Figure 2), and surveys were disseminated through list serves managed by state agencies and through state associations. For those domains where survey response rates were low, likely due to the pandemic, additional methods for engaging organizations and collecting data were added to the eScan tasks.

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: Topics of Interactive Forums Conducted as Part of the Environmental Scan

Small virtual focus groups were held with domain representatives (e.g., Connecticut Hospital Association members, the 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 - May 2021 from 126 unique organizations and over 1,200 individual stakeholders, more than 500 of whom identified as consumers.
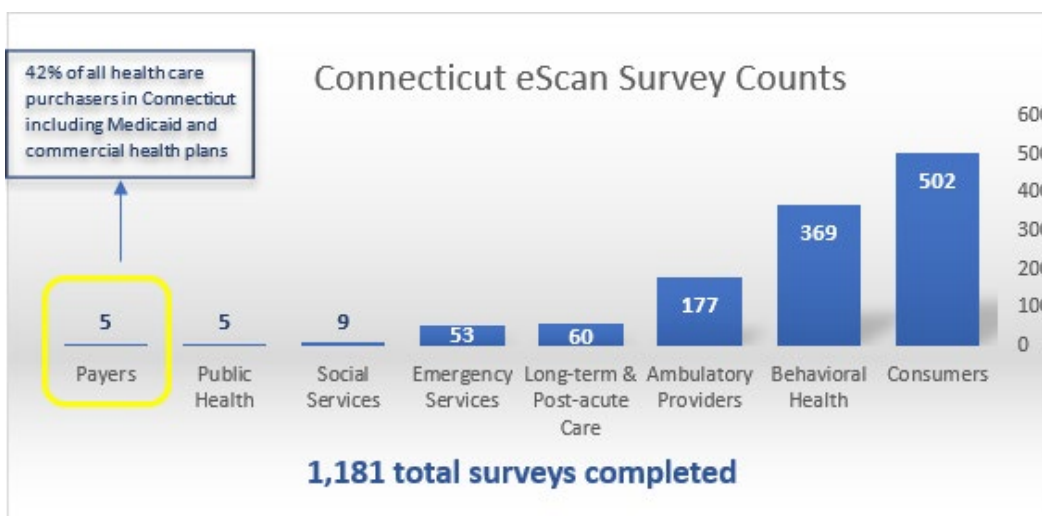

Figure 2: Customized Electronic Surveys for Data Collection in Each of These Domains

2021 Environmental Scan

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

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

- **Goal 2**: Identify critical data needs and gaps, and potential opportunities for improving the delivery of healthcare and social service programs through data integration and data sharing between existing systems in use by state health and human service agencies.

- **Goal 3**: Identify opportunities and multi-sector 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 the availability of data could improve outcomes, reduce inequities, address gaps in care, and improve care coordination for individuals needing care and services in Connecticut.

All of the data collected through the multiple eScan 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 16, 2021 Council meeting, and discussed in more detail at the June 17, 2021 Council meeting.

It is important to note that nearly all the 2021 data collection was completed prior to the official launch of Connie on May 3rd, 2021. This timing could have had the result of a slightly muted enthusiasm from some highly engaged stakeholders who held some skepticism and frustration about the length of time the state had spent on legal agreements and funding plans for Connecticut's third go at a statewide HIE. However, because there was also significant forward movement during this time, in the selection of CRISP as Connie's technical vendor, and the announcement of Jenn Searls as Connie's Executive Director, the overarching mood of stakeholders who were "in the know" about the HIE efforts underway, indicated an air of optimism for the improvements that could come about with HIE services available in Connecticut.

Key Findings

❖ Stakeholders are cautiously optimistic about the future of Connie, the statewide health information exchange (HIE), and 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, make admit, discharge, and transfer data more useful by adding clinical information to notifications, and 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 consent. As new infrastructure is developed, leaders at the state and throughout the delivery system must pay heed 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 data. Significant investments of time, money, and leadership will be required to enable more seamless flow of data to inform programs, policymaking, research, and support improvements in care delivery.

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

❖ 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 government, with the CARES Act, the American Rescue Plan Act (ARPA), and 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

Analysis of data collected through the environmental scan produced the following major themes for the Statewide Health IT Plan to address.

- Strategies for Widespread Use and Sustainability of Connie
- Systems and Strategies to Support Needs Related to Social Determinants of Health
- Service Coordination and Data Integration Across State Agencies
- Support Adoption of EHRs and HIE Services by Behavioral Health Providers
- A Best Possible Medication History HIE Service, Connected Through Connie
- 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 Statewide 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 public and private sector for action. 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 availability of data to support better care, more coordinated services, and more accurate measurement of healthcare cost and quality, and creating efficiencies and cost savings through better coordination of care and services.

The six focus areas of the Statewide Health IT Plan are based on the major themes from the environmental scan, and they 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, strategies, and drive implementation of innovative technology and systems of care for improving health outcomes for individuals and communities.

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

Table 3: Focus Areas in Statewide Health IT Plan

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

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 the organizations 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 to Connecticut consumers with centralized access to their health records, to clinicians with timely access to information about their patients, to city,

Work Underway at Connie

→ The team at Connie is accelerating work to design, develop, and implement a patient access solution, to ensure 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). Lawmakers should explore changes to the administration and access regulations of the Prescription Monitoring and Reporting System (CPMRS) to maximize the use of the PDMP as a medication history data source.

county, and state officials in public health crises, and to community-based organizations for 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 evaluate technology for a statewide shared services infrastructure that can accelerate innovation.

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

Most primary care and specialty providers, and the vast majority of hospitals in the U.S, have received incentives for adopting and using electronic health record systems. Meanwhile, community-based organizations (CBOs) are resource-starved, without adequate resources to acquire and maintain the types of IT systems that will reliably track clients and manage referrals. Many healthcare delivery systems are motivated by value-based payments

Key Considerations for Legislators

→ Funding is needed for social service agencies, and community partner organizations participating in the Health Enhancement Communities (HECs) program to support implementation, training, and technical assistance for using care coordination data systems.

→ Funding is needed for Behavioral Health providers to hire staff with technical skills for support, train users, manage vendors, and operate technology systems.

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 few examples where healthcare and social service organizations are effectively coordinating services with health IT for consent management, person/provider attributions, closed-loop referrals, shared care plans across organizations, and analytics. Connecticut must support CBOs with resources to acquire, implement, and train staff to use IT systems. In addition to expansion of referral management platforms, OHS should explore the use of Connie as a centralized community information exchange (CIE) to capture longitudinal social risk data and coordinate care and services across Connecticut's communities. The state will build on the extensive work under way with Health Enhancement Communities, and standardize collection of Race Ethnicity and Language (REL) data in coordination with the Commission on Racial Equity in Public Health to ensure standards for the collection and storage of race, ethnicity, and language (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) initiative and Two Generational (2Gen) Initiative 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

Key Considerations for Legislators

→ The pandemic has led to a large influx of one-time public health funding for modernization of public health registries. The General Assembly should ensure funding is distributed that leverages modernization initiatives .

→ Previous legislation fostering data sharing across agencies have laid significant groundwork. The focus moving forward will be on implementation and evaluation of data sharing initiatives.

federal and state regulations around data use within and among agencies. Connecticut's Office of Policy Management (OPM) has established a toolkit for agreements between state agencies for data sharing and a Data Sharing Playbook; these assets should be shared with the leaders of Connie and plans should be set forth to evaluate the HIE's readiness to act as a hub for certain state HHS data systems to connect through. 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. Better training of state program field workers and home health aides around the importance of careful data entry and 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

Key Considerations for Legislators

→ Behavioral health provider incentives should leverage federal funding sources and ensure adequate privacy and security protocols for building client/patient trust.

→ Consider the growth that has occurred in behavioral health telehealth services and include requirements and funding for auditing telehealth providers and practices if included in any incentive or discounted technology programs offered by the state.

2021, a considerable number of survey respondents – about a quarter -- indicated with similar fervor, strong opposition to any type of data sharing, citing patient confidentiality as the reason. Given the diverse opinions of behavioral health providers, more research and outreach will be required to understand the opportunities and the 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, but because this domain 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. With the strong push for primary care and behavioral health care integration, in large part due to the common occurrence of comorbidities such as depression and chronic disease, it is imperative for practitioners of this specialty to receive support in the form of education, technical assistance, mentorship, and support for the use of EHR technology and/or care coordination technology.

Focus Area 5: Protecting Individuals' Health Information Privacy

In Connecticut and around the country, concerns about personal information being at risk when data is being shared and stored in electronic systems. Critical for establishing trust among consumers are practices to ensure privacy wishes are respected, and 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 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, in order to receive care.

Key Considerations for Legislators

→ Lawmakers should consider holding hearings with invited testimony on developing appropriate safeguards and ensuring those are in place to protect consumers.

→ Creating a neutral office for consumers' digital privacy rights and/or expanding the role of Connecticut's Office of the Healthcare Advocate would position Connecticut as a national leader in addressing patient privacy concerns. Such an office could provide consumer protection services for other types of personal data at risk everyday of being improperly captured through digital activities.

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 as needed to update state statute and/or create new regulations.

The Council's Standards Advisory Committee will deliver annual recommendations to the OHS Executive Director on any necessary revisions to Connecticut General Statutes relative to data standards and will monitor regulatory environment and policy guidance development at the national level.

Key Considerations for Legislators & Agency Leaders

→ Strong coordination between the Health IT Advisory Council's Standards Advisory Committee, OHS, and the General Assembly to ensure ongoing alignment between federal and state data standards. The HITAC Standards Advisory Committee can serve in a coordination function as federal standards evolve, along with OHS staff assigned to the committee.

→ Federal agencies are beginning to include interoperability requirements in funding opportunity announcements (FOAs); these types of actions can begin to drive vendors to move develop solutions using standard application program interfaces (APIs), for example, rather than building proprietary interfaces that are more costly to maintain or connect to.

Summary for Policymakers

The Statewide Health Information Technology Plan provides Connecticut with a roadmap to enable better health outcomes across the state's population, where healthcare providers have the right information at the right time to deliver informed care, and supportive social services can be appropriately coordinated across a network of community organizations. The statewide health information exchange 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.

Connecticut's Health IT Advisory Council was established as an organized 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 Statewide Health IT Plan implementation activities kick off in 2022, imperatives for the Council include the following:

1. Continuity of the Council as an advisory body, with attention placed on filling open positions with engaged individuals and additional representation of community-based organizations and consumers;

2. Increased, active participation in the Council's work by public and private sector leaders who have decision-making authority for their organization or agency;

3. 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 organizations. The environmental scan for the Statewide Health IT Plan confirmed strong stakeholder support for a statewide HIE, and the following information regarding potential strategies for HIE sustainability is a subset of an Appendix in the Plan, summarizing financial sustainability strategies gathered during the environmental scan.

→ Local needs are not all met by national exchange or vendor-driven solutions. Health systems with large geographical footprints still do not include all types of providers who may be involved in patient care. These are gaps in care networks that Connie can address through connected information.

→ Community health records integrating other data sources can be served by Connie. This tool would allow community health care 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 system for emergency response is the Patient Unified Lookup System for Emergencies (PULSE) which can support the information needs of a field hospital set up in an emergency, when the patients are remote from their normal hospitals and provider systems. In

a PULSE implementation the HIE would be participating 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. The data may come from several different systems and while the data may not reside at the HIE, the HIE is a natural hub for receipt and processing of such data.

→ Connie could participate in a Health Data Utility model (HDU). 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. For example, a combination of HIE, PDMP, All Payer Claims Database (APCD), syndromic surveillance, public health registries, etc.

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 Statewide Health IT Plan envisions the Patient-Centered Services Collaborative (PCSC) as a long-term interagency workgroup that will be guided by common agreements developed for sharing data between programs serving overlapping populations. The primary goal of the PCSC will be to support and oversee the details of connecting state agency data systems to Connie.

To help ensure sustainability of Connie, the Statewide Health IT Plan outlines several ways for Connie to provide additional value around health IT priorities of the state. 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, the State CIO's Information and Telecommunications Strategic Plan for Fiscal Year 2021, and in the State Data Officer's State Data Plan 2021-2022.

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

Some Anticipated Implementation Activities

	Description	Activities
Focus Area 1	**Sustain and increase use of statewide HIE services**	Charter a sustainability support workgroup for Connie
		Connie patient access portal
		Evaluate centralized quality measurement
		Evaluation of in-house resources to support central quality measurement
		HIE onboarding payment incentives and technical assistance
		Determine funding sources for statewide quality measurement and reporting
		Provider education on ONC Information Blocking Rule
Focus Area 2	**Implement systems to improve health equity and address 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
		Behavioral health provider EHR/HIE technical assistance and training
		Behavioral health provider financial incentive program or hosted technology system providing care coordination capabilities
Focus Area 5	**Protecting individuals' health information privacy**	Citizen town halls on HIE and health data rights
		RFI/RFP for state agency consent management solution
		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
		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

The OHS Executive Director is statutorily obligated, with the Commissioner of the Department of Social Services and the Health Information Technology Advisory Council, to establish electronic data standards to facilitate development of integrated electronic health information systems for use by healthcare providers and institutions that receive state funding. This includes provisions related to security, privacy, data content, structures and format, vocabulary, and transmission protocols. The statute requires limitation on the use and dissemination of an individual's social security number, require encryption of any social security number, and require privacy standards no less stringent than HIPAA. Protected Health Information (PHI) must be traceable by an electronic audit trail, be compatible with any national data standards, and permit the collection of health information in a standard electronic format.

The Statewide Health IT Plan provides a framework to establish processes for examining and addressing the legislative requirements for electronic data standards codified in Connecticut General Statute 17b-59a (3)(d) and 17b-59 (3)(e). It is expected that, in addition to the DSS Commissioner and OHS Executive Director, the State CIO or designee will need to have a leadership stake in the establishment of the standards requirements in CGS 17b-59a (3)(b).

To meet the provisions of the statute a standing committee to the Health IT Advisory Council will be formed of stakeholders with a cross-section of relevant expertise in clinical care and healthcare delivery, digital health technologies, health analytics, health policy, data privacy and security, and 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 international and national 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). This Standards Advisory Committee should meet quarterly to weigh options and provide guidance to the OHS Executive Director, DSS Commissioner, and Health IT Advisory Council members, ensuring the responsible parties named in statute have the information they need to provide relevant guidance, set appropriate policies, and can communicate knowledgeably with members of the Connecticut General Assembly and the executive branch of government on the challenges and opportunities inherent in these state requirements.

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	**CGS 17b-59a (3)(c)** Establish electronic data standards to facilitate development of integrated electronic health information systems for use by health care providers and institutions that

DSS Commissioner and **HITAC**	receive state funding. Include provisions related to security, privacy, data content, structures and format, vocabulary, and transmission protocols. **Includes 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 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 HIPAA • Require that PHI be secure • Require access to PHI be traceable by an electronic audit trail
Statewide Health Information Technology Plan	**CGS 17b-59a (3)(e)** Include general standards and protocols for HIE; include national data standards to support secure data exchange data standards to facilitate the development of a state-wide, integrated electronic health information system. Standards shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols. **Includes 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: Connecticut Requirements for Standards Development

Background for Policymakers

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 available as an annual document but because standards are frequently being added or changed, the website version of the ISA is always considered the current version by ONC.

The Health Information Management and Systems Society (HIMSS) has a brief overview with links of 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 Connecticut's goals for the interoperable use of exchanged data.

Data Content; Structures and Format

There is not a single standard that 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 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.

Demographic Data Standards

Connecticut Public Act 21-35, passed into 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 is in the process of developing an implementation plan and working to validate selected standards with key stakeholders at the time of this report.

Security Standards

The ISA identifies the following organizations as having published relevant security standards for health data. OHS expects to closely track with the work of these nationally recognized standards development organizations (SDOs) as applies to each data type and each use of data the security standard(s) will address.

- 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 Standards

There are two primary federal regulations addressing the privacy needs of individuals with respect to personal health information (PHI). They are:

- The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, or the HIPAA Privacy Rule, and

- Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2), known as 42 CFR Part 2.

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 availability of patient information to certain agencies

Vocabulary Standards

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

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 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.

Section 3. The Establishment and Implementation of the 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 Connecticut's General Assembly, Connecticut's HIE, Health Information Alliance, Inc. (dba Connie), was officially opened for data exchange services on May 3, 2021[1] with the mission to enhance the health and well-being of Connecticut 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 the state's technical needs in Connecticut. CRISP also provides the 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 patient access to their own health information

In addition to the CRISP technical services, the Department of Social Services (DSS) transferred their existing encounter notification service, Project Notify, to Connie. Project Notify participating

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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

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 affords providers and organizations to coordinate care for their patients as they transition to and from the acute care setting. In December of 2021, almost 77,000 alerts were sent to approximately 25 organizations participating in Project Notify. The image below showing many potential uses of Project Notify alerts by Medicaid stakeholders, 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.

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.

Empanelment Use Case

The Empanelment use case serves as one of two foundational use case to promoting care coordination by creating linkages between care teams and their patients. The Empanelment use case 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. The clinical data use case 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 admit, discharge, and transfer (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.

Connie Statistics in 2021

237	2.79M	267K	999K	1.47M	1,456
Organizations have signed Connie's legal agreements	Unique Patients Represented	Clinical summary documents received	Lab results received from Quest Labs	ADT messages received weekly	Opt-out Forms Received from Patients
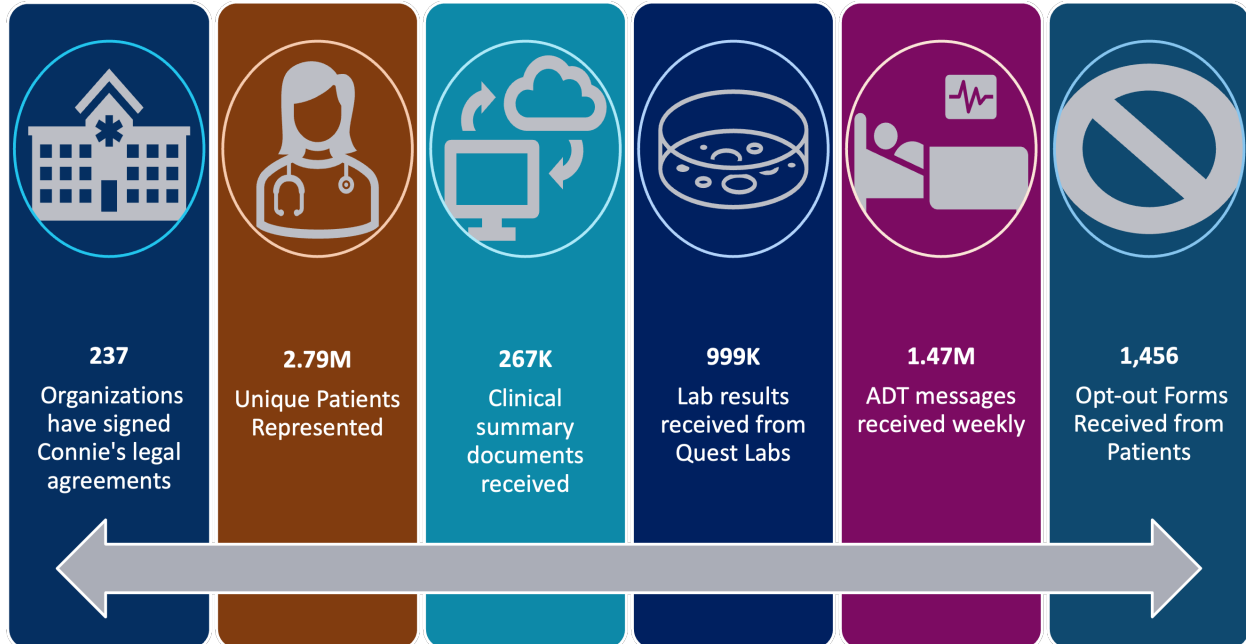
Figure 3: Connie's Transaction Numbers through 12/31/21

Connie Milestones for Federal Fiscal Year 2021

Oct. 20 - Dec. 20
- ED hired
- CRISP selected
- Project Notify transferred from DSS
- Empanelment & EncounterUse Case established
- 21 organizations signed on to Connie

Jan.21-Mar.21
- 4 new staff
- OHS contract signed
- 40 organizations signed

Apr.21-June 21
- Connie is operational
- Connie website live
- Opt-out process developed
- 70 organizations signed on to Connie

July 21-Sept. 21
- Sustainability plan
- CMS Certification
- 4 new staff
- 273 organizations signed on
- 1.54M unique patients *(43% of CT population)*

Figure 4: Connie's First Year Milestones

Connie's Achievement on 2021 Goals

In January of 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 including goals focused on connectivity, financial sustainability, use cases, and governance and staffing.

Figure 5: Connie's 2021 Goals

In January of 2022, Connie management reported on the organization's achievement of the approved goals. As shown in Figure 7, Connie management reported receiving clinical data from 20 of the 39 acute hospitals in the state, exceeding its goal of connectivity to 50% of the state's 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.
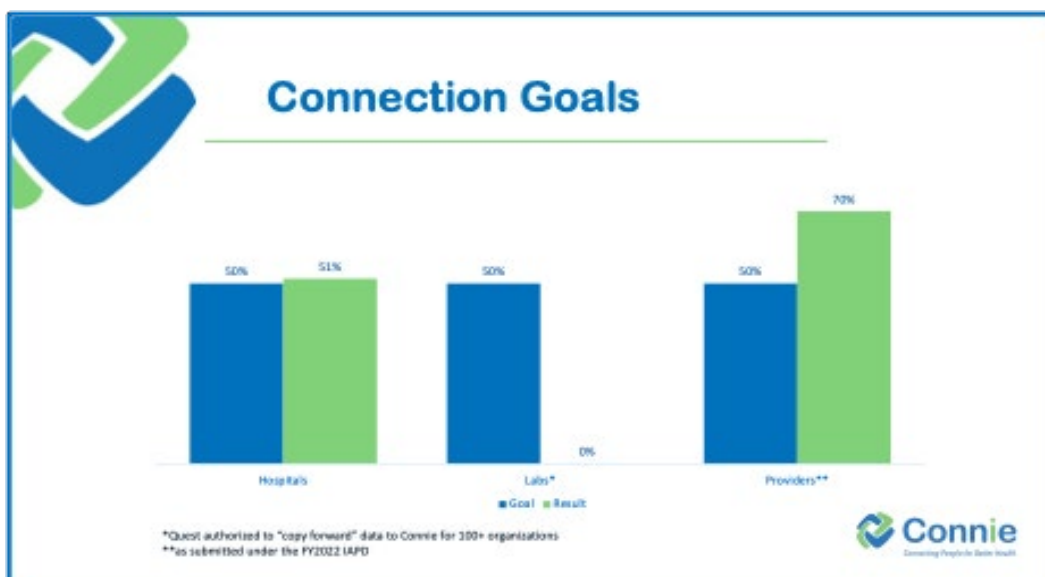
Figure 6: Connie's 2021 Connection Goals and Results

In addition to its achievement on its connectivity goals, Connie 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 to the other Connie management reported 17,924 unique NPIs in its data representing 70% of active licensed providers in the state.
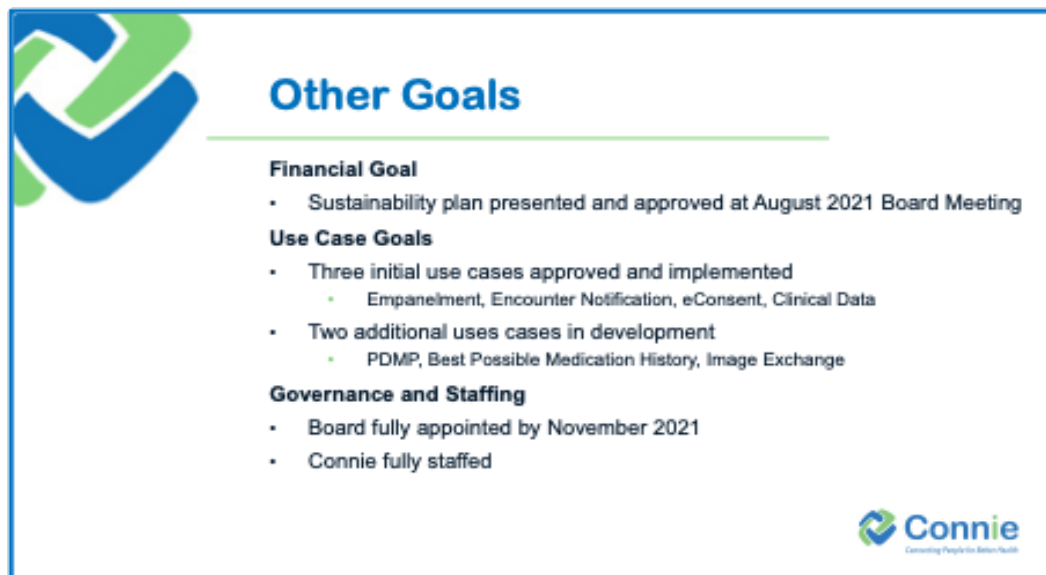
Figure 7: Additional 2021 Performance Goals

Connie 2022 Goals and Future Plans

Use Cases, Services, and Tool Development for 2022

Connie Portal: Stand-alone website for authorized Connie users to securely access clinical data on their patients.

InContext App: Embedded SMART on FHIR app to enable users in certain EMRs to securely access clinical data on their patients while in the context of their workflow in their electronic medical record.

Image Exchange: The Image Exchange Use Case 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 PACS (Picture Archiving and Communication System). 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 Connecticut's Prescription Monitoring and Reporting System (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, doctor shopping, and 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: Provider Directory allows healthcare staff to look up a provider in Connecticut to enable referrals and improve transitions of care for their patients. This enables users to search for specific providers and find detailed and accurate information on that provider, including languages spoken, facility locations, contact information, and specialties. Conversely, searches can be made based on desired qualifications (i.e., search for a specific specialty or language spoken). Provider Directory through Connie would allow providers to search the Connie Master Provider Directory as a source of truth for Connecticut provider information across numerous previously disparate systems, including information on Connecticut-specific identifiers to support Medicaid and other programs.

Additional Use Cases planned for development include eReferral, Best Possible Medication History, Advanced Directives, Consent Management for capturing affirmative consent, immunizations, and patient access.

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

Projects: To support DSS and the Medicaid program, Connie will be working with DSS to connect Long Term Services and Supports organizations with connectivity to Connie to enable data driven member-based outcome care. Additionally, Connie will be supporting Medicaid meet its CMS requirements for interoperability

Figure 8: Connie's 2022 Goals

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., dba Connie:

a. Has state-designated entity (SDE) status
b. Is integrated into a governance model that ensures relationships with both the Department of Social Services (DSS) and the Office of Health Strategy (OHS)
c. Has established a position in the Medicaid Enterprise as a component that DSS will employ for several anticipated use cases
d. Has a path to funding for the next two years through the OHS budget

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. Connecticut General Statute Sec. 17b-59e setting 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 of region.

Sustainability of HIE services must be a top priority for Connecticut leaders. 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 for coordination of community support services. The Health IT Advisory Council 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 Advance Planning Document Funding

Medicaid Federal Funding Requests to Support HIE Services

Connecticut is currently seeking federal approval of its Medicaid Enterprise System (MES) Implementation Advanced Planning Document (IAPD) by the Centers for Medicare and Medicaid Services (CMS) for Design, Development, and Implementation (DDI) activities to continue building out Connecticut's new Statewide Health Information Exchange known as Connie. Federal financial participation by Medicaid for HIE services was substantially reduced at the start of federal fiscal year 2022 (on October 1st), down from 90 percent to somewhere between 26-42% percent (at the time this report was written, the percentage was under review by CMS). Connecticut submitted its initial HIE MES Implementation Advanced Planning Document (APD) 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, 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 supporting critical infrastructure or foundational components. A separate Operations APD will be submitted for a service that has been in operation 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, 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
Establish Governance Framework	Several steps completed including development of a stainability plan, approved by DSS, OHS, and Connie board
Stakeholder Outreach and Workgroups	Support for Health IT Advisory Council and its 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	DPH has made significant progress with the IIS program promotion and onboarding support
SUPPORT Act related HIE initiatives	A connection with the Prescription Drug Monitoring Program (PDMP) has been established. Connie has planned 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 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

The HIE technology provided by CRISP is an integrated technology stack. 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 consulting 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 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, Regulatory, Legislative Changes

No recommendations for policy, regulatory, or legislative changes are being purposed relating to health information technology or health information exchange, as part of the 2021 Annual Health IT and HIE Report to the General Assembly.

Section 5. Other Initiatives Promoting the State's 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 developing the Statewide 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 around the following policy priorities; over time, each of these initiatives will be directly impacted by improvements to Connecticut's health IT infrastructure and 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 health care 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 Health Care Facilities and Services Plan, and conducts hospital financial reviews and reporting. The CON program promotes appropriate health facility and service development that addresses a public need. The CON program strives to ensure accessibility for 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 biennial utilization study reflective of these data analyses.

❖ In the 2021 legislative session, the Connecticut 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 requires the collection of race, ethnicity, and language (REL) data for providers "capable of connecting to and participating in Statewide Health Information Exchange". OHS has responsibility for standards development and an implementation plan for the collection of REL data.

❖ 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. With ARPA funding currently slated to expire at the end of the calendar year 2024, Governor Lamont in December requested proposals from state agencies for other projects permitted under ARPA that would advance Connecticut's economic recovery agenda. Four health IT-related projects were submitted by OHS for consideration by the Governor's Office:

1. **COMMUNITY INFORMATION EXCHANGE (CIE) FEASIBILITY**

CIE feasibility planning includes appointing a Social Risk Data Design Group as a subgroup to the HITAC to analyze social determinants of health (SDoH) screening processes, referral management options, community-based organizations' (CBOs) data sharing capabilities, and social risk data standards. ARPA funding will also support the exploration of resources for CBOs and social service agencies to adopt IT systems that help track and coordinate care. Stakeholders will convene to consider a statewide CIE shared services hub for governance and management needs, including establishment of statewide shared CIE services.

2. **RACE, ETHNICITY, AND LANGUAGE (REL) DATA**

OHS proposes funding a state data infrastructure to allow for the uniform collection of ethnicity, race, and primary language data to meet the statutory requirements of Connecticut Public Act 21-35. This will allow effective target interventions that will address health disparities exacerbated by the COVID-19 pandemic and promote equity in the provision of needed social and government services. DSS and OHS have a collaboratively identified systems for a pilot. The one-time funding over 12 months would fund consultants to develop REL standards and an implementation roadmap for system upgrades at OHS and DSS, and also update the HIE to provide REL data to the

state. Upon successful execution, OHS would look for funding for systems at additional state agencies to be in compliance with REL standards mandated by state statute.

3. OUTREACH FOR BEHAVIORAL HEALTH CARE SERVICES AND USE OF TECHNOLOGY

The pandemic has created an even greater need for behavioral health services due to isolation. OHS proposes town hall listening sessions with behavioral health providers and their patients around the use of information technology and HIE services while maintaining confidentiality. This outreach aims to characterize and better understand the needs of behavioral health providers to achieve a coordinated, whole person care model.   Health equity is the foundation for this initiative, which further aligns with each of the key pillars in the Governor's plan. This proposal includes planning a financial incentive program for behavioral health providers, conducting an analysis of cloud-hosted behavioral health EHR systems and to review eScan survey data to understand current EHR adoption rates for this specialty. The proposal may also consider procuring a cloud-hosted Behavioral Health Care Coordination Platform (BHCCP) to support all behavioral health providers.

4. DEVELOP CAPABILITY FOR HHS AGENCIES TO CONNECT TO CONNIE TO PROMOTE PERSON CENTERED SERVICES COLLABORATIVE (PCSC)

The PCSC is envisioned as a multi-agency working group of state HHS program managers and IT staff who are unified in the shared objective of delivering more efficient and coordinated care and services. The mechanism by which this will be accomplished is through Connie, Connecticut's Health Information Exchange (HIE), a non-profit entity that is uniquely positioned to exponentially improve the speed and quality of health information accessibility. Project outcomes will focus on creating appropriate policies, consent requirements, system integration standards, and data sets to be shared. In so doing, the proposal will benefit multiple stakeholders (e.g., Connecticut residents, service providers, healthcare organizations, state HHS agencies, etc.) who can then better utilize, monitor, and analyze specific information critical to achieving whole-person health and mitigating future public health risks. The project will complement and further leverage the Connecticut resident-focused efforts underway through MyCT though targeted HHS Interagency collaboration on pilot project(s). These pilot projects will align around more accurate identity matching of vulnerable individuals and families receiving services from multiple agencies and programs. In addition, this effort will further enhance the emerging value that Connie offers the state of Connecticut through the rapidly developing use cases Connie has underway. Finally, the promotion of health equity is central to the goals of this project which further align with each of the key pillars in the Governor's plan.

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 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 approximate 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 multi-payer 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 collection of claims data from self-insured employers, however in Connecticut, one of the largest self-insured employers, the State of Connecticut, is voluntarily submitting claims data to the APCD.

Office of Health Strategy Executive Director
Vicki Veltry

Health Information Technology Officer
Sumit Sajnani

Health Informtion Technology Advisory Council

APCD Advisory Group

APCD Data Release Committee

The APCD Advisory Group and APCD Data Release Committee are conduits for input to be received from stakeholder organizations on APCD policies and operations, and they 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, which comprises of twenty 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 the understanding of health care expenditures in the public and private sectors.

Figure 9: Organizational Roles of APCD Governance

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

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

Table 9: 2021 APCD Advisory Council Meetings

The APCD Data Release Committee (DRC) reviews and deliberates on each data release application that is submitted to the APCD. The committee is comprised of ten members. The DRC reviewed and approved three research studies to receive APCD data sets during 2021; there were no requests denied over the timeframe. Studies were submitted by the following organizations:

1. Apperture Health

2. Yale HPV-Genital Warts Study

3. The UCONN Phenotype Suicide Algorithm Study

In 2021, there were 23 health insurance plans that 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 Health Care 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 Plan Contributing Data to APCD

OHS Sponsored Initiatives Using the APCD

The 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, provide policy makers, payers, and employers with information to assess the state's healthcare performance, and provide consumers access to healthcare quality information. The Quality Scorecard compares quality of care using Connecticut's Multi-Payer Measures Set determined by the multi-stakeholder Quality Council. In 2022, healthcare organizations will be held to certain healthcare quality benchmarks, which 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 quality measures to include in the Quality Benchmark. Progress can be tracked at the OHS Quality Council webpage.

A consumer webpage 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, like housing, transportation, childcare and groceries. The

CHAI starts with the 2019 Self-Sufficiency Standard for Connecticut and adds in additional 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 Connecticut.

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 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% and 10% of their budget on healthcare costs, including premiums and out-of- pocket expenses. When healthcare expenses exceed their household target, households are unable to meet their healthcare expenses 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 household 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 between 7% and 11% of their budget on healthcare costs, including premiums and out-of-pocket expenses.[2]

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 — 1	9.10%	1.93%	-2%	8.8%
1 — 2	9.86%	2.03%	-2%	9.5%
1 — 3	8.15%	1.93%	-2%	7.9%
1 — 4	7.05%	2.01%	-2%	6.8%
Adults — Children				
2 — 0	12.51%	3.05%	-5%	10.8%
2 — 1	11.46%	2.64%	-4%	10.2%
2 — 2	10.35%	2.65%	-4%	9.1%
2 — 3	8.88%	2.48%	-3%	8.1%
2 — 4	7.84%	2.51%	-3%	7.1%

Table 11: Spending Targets by Household Size

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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 just approved by the CT General Assembly in the FY22/23 Connecticut Biennial Budget.

As of June 2021, approximately 18% (165,684) of households in Connecticut with working adults face costs that exceed the target for affordability.[3] The percentage of households with access to health insurance costs below the affordability target varies by the source of coverage. 42% (60,906) of households purchasing insurance through Access Health CT face health care cost that exceed the target for affordability, while only 16% (104,788) of households with employer-sponsored insurance face healthcare costs that exceed 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 Health Care Foundation of Connecticut. OHS and OSC also convened a public advisory committee to review and provide input as the tool was developed.

The CHAI is a living tool and as costs and conditions change, OHS and OSC will use the tool 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 American Rescue Plan Act (ARPA) enacted in March 2021.

Also in 2021, OHS redesigned and relaunched the webpage, HealthScoreCT, which is now fully hosted by the Department of Administrative Services, Bureau Information Technology Solutions (BITS). As part of this project, OHS is in the process of updating and will relaunch in 2022, the consumer health information webpage including the Cost Estimator, which provides information on cost and quality of health services to support consumer decision-making.

OHS partnered with RAND to provide commercial claims data for the RAND Hospital Price Transparency Study 3.0 project, a national hospital price transparency study. This study measured and reported prices paid for hospital care benchmarked against Medicare charged amounts. In 2021, OHS provided an additional APCD data extract to the Rand Corporation 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 New England states. Estimates for Connecticut will also in part, provide baseline information and inform the process for increasing primary care spend annually to 10% 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 health care cost utilizing APCD data. The analyses also include identifying high cost, high volume medical

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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—seniors and adults with work-limiting disabilities.

services and those with wide price variation among providers at the state, payer, and provider network level, to identify opportunities to reduce health care cost growth, improve quality and promote equity. The analyses provided support the benchmarks initiative work authorized by Governor Lamont's Executive Order #5.

OHS also provided APCD 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 health care 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, and assessment and management as relates to surprise billing; and measuring the impact of COVID-19 on adult immunizations, at risk populations and hospitals' operation to support related policy development.

DSS & OHS Joint Steering Committee

On December 2nd, 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 decision on tactical and operational matters as defined through the Memorandum of Agreement. DSS and OHS agree that a successful collaboration recognizes both the HIE Entity's statutory charge for statewide HIE and DSS' authority and fiduciary responsibility as the Single State Agency administering the Medicaid and Promoting Interoperability programs. The agreement describes the joint vision of OHS and DSS working together and sets forth understanding of the steps and processes that will be used for the mutual benefit of both agencies, the HIE Entity, and other Connecticut stakeholders.

OHS and DSS acknowledge the importance of collaboration and orderly governance for the development and sustainability of the statewide HIE and the benefit of health information exchange to Connecticut stakeholders. An HIE to Medicaid Enterprise System (MES) Implementation Advance Planning Document (IAPD) was submitted to CMS in July 2021 and approved in December 2021. In the spirit of bi-directional collaboration and transparency, OHS and DSS have opened team and committee meetings to one another. These agencies, together with the HIE Entity (incorporated as the Health Information Alliance, Inc. on July 17, 2019, and dba Connie), are sharing technical and subject matter experts to inform decision-making in the interests of Connecticut stakeholders. OHS and DHS have agreed to make workspace available for the part-time co-location of workers at each other's office.

The Joint Steering Committee, which started December 2019 continues today. Meetings are conducted in a collaborative manner consistent with the intent of the Joint Steering Committee charter. The membership structure and position list for the committee are in **Appendix E**.

Medication Reconciliation and Polypharmacy Committee

The Connecticut 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 Health IT Advisory

Council to evaluate issues concerning polypharmacy[4] and medication reconciliation[5]. The major output of the Medication Reconciliation Polypharmacy Working Group (MRPW) was a [report](#) published in early 2020 with eleven recommendations related to medication reconciliation and polypharmacy.

Following the submission of the MRPW report to the General Assembly in 2019, the Health IT Advisory Council [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 Connie, Connecticut's HIE, advance the use case for a "best possible medications history" (BPMH) 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 developing a robust set of business and functional requirements for a BPMH, captured in the [MRPC 2020 Annual Report](#).

In its second year, the committee began 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, that 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 medication management and medication reconciliation tools and solutions for communication of evidence-based, best practice medication tools; patient engagement strategies; technical advisories; subject matter experts; and policy and regulatory guidance documents.

- Goal 3: Serve as a resource to OHS, Health Information Alliance, Inc., Department of Social Services, and 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 the Medication and Polypharmacy Work Group recommendations related to deprescribing transaction standards, including CancelRx.

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

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

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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.

1. **An environmental scan of relevant policy and technologic implications of medication data sources for a Best Possible Medication History**

Before Connie could begin to consider offering a best possible medication history service to providers for their patients, more information was needed about the availability, quality, and cost of medication history data from various electronic data sources. With guidance from the MRPC members and with resources allocated as part of the work on Connecticut's Statewide 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, the costs associated with data feeds from source systems. Interviews were conducted with representatives from Health Information Exchanges (HIEs), state Prescription Drug Monitoring Programs (PDMPs), other state and federal government agencies, technology vendors, and individuals who were identified as subject matter experts in relevant subject matter domains, including:

- Seven Health Information Exchange (HIEs) organizations
- Four Prescription Drug Monitoring Programs (PDMPs)
- The State of Connecticut, Department of Social Services
- The State of Connecticut, Office of the Healthcare Advocate
- The Pharmacy Health Information Technology Collaborative
- The U.S. Department of Veterans Affairs
- Four health information technology vendors

Additional information was gathered through informal interviews and conversations with subject matter experts across the fields of medicine, pharmacy, medical terminology and informatics, technology and data standards, patient privacy, state and federal regulations and policies for prescription drug monitoring programs, and value-based care models. The members of the MRPC were significant contributors to the detailed information in this report, as were 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 sources was done, and relevant sources are cited throughout the MRPC final report as footnotes.

The goal for this research is to provide a foundation of objective information for policymakers, regulators, state agency program administrators, the management of Connie and its Board of Directors, and the advisors on the Health IT Advisory Council, as they engage stakeholders in planning and implementation of the Statewide Health IT Plan. While strong support has been indicated by many stakeholders for Connie to offer a BPMH service, the 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 Prescription Drug Monitoring Database (CPMRS) as a source of medication data for medication

reconciliation and BPMH services; the MRPC final report provides information to inform further discussions on that and on other 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.

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, 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 Best-Possible Medication History (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 created "wireframe" diagrams, or visual representations of a user interface. They modelled two prototypes - a patient-facing prototype and a clinician-facing prototype. The UConn Health team showcased these mock-ups to stakeholder representatives, collecting and incorporating feedback into further design iterations.

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 9). Feedback was obtained via facilitated discussions that occurred in-person, via virtual WebEx meetings, and through online surveys.

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

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/EHRs.

- User Interface Optimization: Participants recognized the wireframe mockups are prototypes. They were able to appreciate the intent and provided recommendations to enhance the user experience. For example, simplifying the collaboration code process,

adding a hamburger 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 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 alerted to real-time updates made to their patients' medication list. Also, it was suggested to simplify the language in order to accommodate patients with low literacy levels.

- Data: A reoccurring theme was the need to seamlessly incorporate data from many sources including electronic medical records, insurance dispense records, health systems, pharmacies and other data banks. Clinicians felt this should be integrated into their EHR as well.

- Best Use Considerations: This could be valuable for health systems, pharmacies, and health plans. Clinicians recognized the expanding capabilities of already existing EHRs pulling 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.

- An additional key finding from across all stakeholders was the feedback 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 work-flow friendly alternative.

Funding for this project was from two major sources. The Computer Science Engineering students in this project were funded through UConn summer research internships. The project and these feedback sessions were also funded through contracts with UConn Health supported from the Office of Health Strategy. A set of additional funding was provided to carry out the qualitative research using funding that was already available.

The MRPC final report was submitted to OHS in October 2021, and was presented to the Health IT Advisory Council at its November 18, 2021 meeting. After the final report was submitted to OHS, the work of the MRPC was rolled into a new Connie workgroup focused on the Best Possible Medication History 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 health care information across health care 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 health care 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 health care 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 health care decisions, promote patient-centered care, improve the quality, safety, and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health goals.

(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 health care provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (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 health care 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 health care 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 health care 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 health care 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) "Health care provider" means any individual, corporation, facility or institution licensed by the state to provide health care 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 health care 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 health care 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, health care providers, insurance carriers, physicians and all stakeholders in empowering consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health goals. 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 health care consumers and Connecticut health care 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 health care, 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

		Name	
Health IT Advisory Council			
	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	Kimberly Martone 3/30/2020	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 Sen.	Robert Rioux 9/20/2016	Representative of a federally qualified health center
20.	President Pro Tempore of Sen.	Jeannette DeJesus 7/31/2015	Provider of Behavioral Health Services

21.	President Pro Tempore of Sen.	Vacant	Representative of the Connecticut State Medical Society
22.	Speaker of the House of Rep.	Lisa Stump 11/22/2016	Technology expert who represents a hospital system
23.	Speaker of the House of Rep.	Vacant	Provider of home healthcare services
24.	Speaker of the House of Rep.	Vacant	Healthcare consumer or a healthcare consumer advocate
25.	Majority Leader of the Sen.	Patrick Charmel 11/30/2015	Representative of an independent community hospital
26.	Majority Leader of the House of Rep.	Vacant	Physician who provides services in a multispecialty group and who is not employed by a hospital
27.	Minority Leader of the Senate	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 Rep.	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 Rep.	Vacant	Speaker of the House of Representatives or designee
31.	Minority Leader of the Sen.	Dr. Susan Israel (designee) 1/06/2021	Minority Leader of the Senate or designee
32.	Minority Leader of the House of Rep.	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

	Medication Reconciliation and Polypharmacy Committee		
	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	**LDS**	Limited Data Set
ARRA	American Recovery and Reinvestment Act	**MES**	Medicaid Enterprise System
CCIP	Community and Clinical Integration Program	**OHS**	Office of Health Strategy
CDAS	Core Data Analytics Solution	**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	**PCMH**	Patient Centered Medical Home
DPH	Department of Public Health	**PDMP**	Prescription Drug Monitoring Program
DSS	Department of Social Services	**PSI**	Prevention Service Initiative
eCMS	Electronic Consent Management System	**R & D**	Research and Development
eCQM	Electronic Clinical Quality Measure	**RFA**	Request for Applications
EHR	Electronic Health Record	**SDLC**	Systems Development Life Cycle
FFY	Federal Fiscal Year	**SIM**	State Innovation Model
FQHC	Federally Qualified Health Center	**SIM PMO**	State Innovation Model Program Management Office
Health IT	Health Information Technology	**SMHP**	State Medicaid Health IT Plan
HEC	Health Enhancement Communities	**SMMS**	Statewide Medication Management Services
HIE	Health Information Exchange	**TA**	Technical Assistance
HIPAA	Health Insurance Portability and Accountability Act of 1996	**TEFCA**	Trusted Exchange Framework and Common Agreement
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: Structure of the DSS/OHS Joint Steering Committee

Membership Structure of 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 the minimum, the following roles: **Department of Social Services** CT METS Program Director Chief Innovation Officer Medicaid Director Chief Financial Officer **Office of Health Strategy** Fiscal Lead Health Information Technology Officer Health IT Program Manager General Counsel