

Vermont Health Care Innovation Project
HIE Work Group Meeting Agenda
February 5, 2014
9:00-11:30am
AHS Training Room, 208 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments:
1	9:00-9:05	Welcome and Introductions	Brian Otley and Simone Rueschemeyer	
2	9:05-9:10	Review and Acceptance of January 10 th Meeting Minutes	Brian Otley and Simone Rueschemeyer	Attachment 2: HIE Work Group Minutes 1.10.2014
3	9:10-9:15	Staff Housekeeping: - Conflict of Interest Policy Reminder	Richard Slusky and Steve Maier	
4	9:15-10:00	Presentation: FSP Proposal	FSP representatives	Attachment 4: This is will provided closer to the meeting to the Work Group
5	10:00-10:45	Discussion of ACO Proposal	Brian Otley and Simone Rueschemeyer	Attachment 5a: ACO Presentation from January 10, 2014 meeting Attachment 5b: Population-Based Collaborative HIE Project Proposal
6	10:45-11:00	Public Comment	Brian Otley and Simone Rueschemeyer	
7	11:00-11:15	Next Steps, Wrap-Up and Future Meeting Schedule	Brian Otley and Simone Rueschemeyer	Next meeting Feb 26, 2014 9am – 11:30, Montpelier Pavilion Building



***VT Health Care Innovation Project
HIE/HIT Work Group Meeting Minutes***

**Date of meeting: Jan 10, 2014 1pm to 9am to 11:30am; Pavilion 4th Floor Conference Room, Montpelier.
Call in 877-273-4202 Passcode 2252454**

Attendees: Simone Rueschemeyer and Brian Otley, Co-Chairs; Mike Del Trecco, VT Assn of Hospitals; Todd Moore and Leah Fullem, One Care; Amy Cooper; Joel Benware, NW Medical Center; Nick Emlen, VT Council on Devel't and MH Services; Paul Harrington, VT Medial Society; Arsi Namdar, Visiting Nurse Assn of Chittenden and Grande Isle; Sandy Rouse, Central VT Home Health & Hospice; Amy Putnam, NW Counseling and Support Ctr; Heather Skeels, Bi-State Primary Care; Michael Gagnon and Sandy McDowell, VITL; Steven Maier, Marybeth McCaffrey, Alicia Cooper, Larry Sandage, Eileen Underwood, and Jennifer Egelhoff, AHS; Richard Slusky, Spenser Weppler, GMCB; Georgia Maheras, AOA; Nelson LaMothe and George Sales, Project Team.

Agenda Item	Discussion	Next Steps
1 Welcome and Introductions	Simone Rueschemeyer called the meeting to order at 9:01.	
2 Review and Acceptance of Nov 20 Minutes	Marybeth McCaffrey moved to accept the Nov 20 Minutes. Heather Skeels seconded the motion. The motion passed unanimously.	
3 Review of HIE Work Plan	Larry Sandage presented an overview of the draft Work Plan to the Work Group. This draft is the product of many planning meetings over the past couple months. The Goals of VHCIP have been incorporated into the HIE goals. Objectives for State of Vermont (2 nd column) are VHCIP specific. Today's process is to begin discussion about the Work Plan. In column #1: In summary, the 1 st goal focuses on source system optimization. The 2 nd goal is focused on data quality across Health Information Exchange and includes the necessary	

Agenda Item	Discussion	Next Steps
	<p>outreach to providers to assist in data clean up.</p> <p>The 3rd goal focuses on connectivity for all health care professionals orgs.</p> <p>The 4th goal focuses on integration with state systems to build a more complete “personal health record”</p> <p>The 5th goal facilitates consumer engagement on their own health care through the use of technology, The 6th goal is to development of policies, data rules and procedures that support HIE, e.g. consent policy and CFR Part 2.</p> <p>Column #2 is focused on VHCIP objectives. Column #3, Supporting Activities, has a significant amount of content. The overall design of the Work Plan template is intended to get more specific as one moves from left to right.</p> <p>Larry asked that any specific feedback and input to the Work Plan be forwarded to him. Larry will compile all contributions and work it into draft for review by Co-Chairs & Team. Please edit your comments into the .pdf and forward to George Sales of the Project Management Team.</p> <p>Larry mentioned that there are more columns intended to the right of Supporting Activities, e.g. “Measurements of Success” which need more development at this time.</p> <p>Brian Otley asked if the framework looked reasonable and works for Members?</p> <p>Mike Gagnon commented that nothing missing, but perhaps adding /broadening the infrastructure to include other data types would be helpful.</p> <p>Todd Moore commented that the Work Plan is an expanded HIE strategy, and while it is intended to support SIM payment reform, it is not just VHCIP/SIM oriented.</p>	
<p>4 Group Breakout Sessions</p>	<p>Simone Rueschemeyer segued to the next agenda item: the breakout sessions are intended to look closely at Suggested Supporting Activities, begin to develop a cross section of Measurements of Success, and then define some next steps. The larger group split in to three to discuss 1) Source Systems 2) Data Quality, and 3) Connectivity</p>	
<p>5 Breakout Groups Report on Discussion</p>	<p>Source Systems report out: A comprehensive inventory of systems and where they reside is needed. VITL is conducting an inventory, and to be successful, it needs to be broadened to include post-acute care and home health agencies. The inventory would serve as a benchmark to know where to invest. Technical capabilities available like a single sign on approach. How will providers link with Blueprint, etc... How best to integrate systems at functional level? What clinical and payment measures are necessary (Can the QPM Work Group assist?)? And what do the ACO’s need to do their job? How will information be extracted from non-ACO’s?</p> <p>Data Quality: HIE goals and objectives are appropriate as written. Suggest #4 (Align and Integrate Vermont’s electronic health information) to offer advanced analytics to providers. Important to add</p>	

Agenda Item	Discussion	Next Steps
	<p>documentation of the existing data systems to assess overlaps and redundancies.</p> <p>Connectivity: Recognized need to address breadth of health continuum beyond acute care. It is unlikely that EHR's will be adopted by home based providers, leaving patients with Traumatic Brain Injury, substance abuse issues, and other disabilities out. It is important to have a bi-directional exchange of health information. It is helpful to develop a standard menu of tools and processes to access data across multiple provider types. There should be standardized transitions of care documents and a single sign-on. VITL is likely the best funnel for information. We need to develop Chronic Disease feeds to providers that would be useful to improve outcomes. One important Measure of success is the number # of providers with access, and the number of times they access the system.</p> <p>An analysis of provider types with technology that is cloud based so that others would have access is also needed. How can we maximize impact in a 2-3 year window?</p> <p>Paul Harrington suggested that the preamble of the work plan to discuss what is necessary to support payment model reforms.</p>	
<p>6 ACO Presentation</p>	<p>Richard Slusky provided background for the next agenda item and then Todd Moore presented:</p> <p>The three ACO's (One Care Vermont, Community Health Accountable Care, and Accountable Care Coalition of the Green Mountains) are providers coming together to achieve collective objectives. The ACOs' presentation is about information technology infrastructure and is a request that the HIE/HIT Work Group recommend funding some or all of the proposed activities using SIM/VHCIP funds. The proposal, discussed in the presentation, recommends that VITL be selected as the contractor for the work described. The 3 ACOs, in collaboration with VITL, developed a plan to maximize existing infrastructure and then expand on it to support providers' reporting and information sharing needs.</p> <p>The Statistics reflected on page 6 reflect the providers that interact with the three ACOs.</p> <p>The ACO's goal is to have all providers enabled with seamless access and contribution, with a full range of health information. The proposal includes components that could be expanded to include providers beyond those participating in one of the ACOs.</p> <p>A feature in this proposal is to enable gateway architecture to facilitate third party analytics vendors.</p> <p>The proposal also includes a discussion of the need to identify gaps in the system. Gap remediation appears to be the largest piece of the work ahead, e.g. which providers have EHR's vs. which do not, and what will it take to implement for providers without EHR's?</p> <p>Richard Slusky suggested that EHR's may not be solution for everybody. Sandy McDowell responded that there are no preconceived notions until the gap analysis is completed. The DVHA grant with VITL is already funding a review of all types of providers including home health, and nursing home organizations.</p> <p>Arsi Namdar asked in the event that a provider is non-compliant (e.g. archaic EHR's, etc.) – what is the</p>	

Agenda Item	Discussion	Next Steps
	<p>appropriate remediation? Sandy responded that VITL's programs are expanded to all provider types. When providers join the ACO, they are cognizant that they must buy into systems and protocol to facilitate information sharing. VITL is also required to produce a set of standards for inter-operability to the GMCB.</p> <p>The Budget schedule, as presented, does not include a cost for gap remediation for ACO providers and there was some speculation that this could be a significant cost. Richard Slusky responded that once the gap analysis has been completed, the decisions to allocate dollars spent on gap remediation will focus on the cost requirements and the related ROI produced.</p> <p>Todd Moore discussed next steps in the ACO proposal: First step is to figure out with HIE Work Group how to propose the budget and implement with VHCIP collaboration. Timing is critical, and the ACOs are ready to go.</p> <p>Paul Harrington moved to approve recommending use of SIM/VHCIP funds for the purposes outlined in the ACO proposal.</p> <p>Brian Otley suggested the motion was premature. The motion is tabled.</p> <p>Simone and Brian will inquire about the process to recommend spending to the Steering Committee and whether meetings can be adjusted to limit the time between approvals.</p> <p>The Work Group participants will have the opportunity to submit questions to the ACOs regarding their proposal. These questions should be submitted to Larry Sandage by January 17th.</p>	
7 Conflict of Interest Policy	<p>Georgia Maheras reported that the Core Team approved a Conflict of Interest policy in December. Members and Interested parties must read, sign the Acknowledgement page and forward to George Sales. Please contact Georgia with any questions. Georgia encourages all to please come forward with any concerns about conflicts during Work Group meetings.</p>	
8 Public Comment	<p>Public Comment: None offered.</p>	
9 Next Steps, Wrap up, and Future Meeting Schedule	<p>Next meeting Wednesday, February 5, 2014; 9am to 11:30am - AHS Training Room, 208 Hurricane Lane, Williston</p>	

Pan ACO

SIM Funding Proposal to the VCHIP HIE Workgroup
January 10, 2014



OneCareVermont



- Introduction – What and Why
- Benefits
- Problems and Vision
- Plan
- Timeframe and Costs
- Summary
- Next Steps

Agenda

- There are **three Accountable Care Organizations** in Vermont, whose members comprise a large and growing majority of the healthcare delivery system in the state:
 - OneCare Vermont (OCV)
 - Community Health Accountable Care (CHAC)
 - Accountable Care Coalition of the Green Mountains (ACCGM)
- **Collaborating** to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients.
 - **Key Message: Heavily aligns with the state HIE Plan and Priorities**

What Are We Doing?

- The Pan ACO collaboration is to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017.
- The **3 ACOs are collaborating** on aligned processes and infrastructure where it makes sense including **with VITL to build technology infrastructure** that is consistent with a state-wide **high performing healthcare system**.

Why Are We Collaborating?

- Make **rapid progress against state HIE plan**
 - Faster than other approaches
- Provide **path for 2014 patient care benefits** of healthcare information exchange across providers and through ACO population approaches
 - Clinically more impactful, earlier than other approaches
- **Exploit the efficiencies of a collaborative project effort** involving all three Vermont ACOs, their providers, VITL, and the VHCIP work group
 - Less expensive than other approaches
- Provide a mechanism for the VHCIP work group to **measure and demonstrate tangible progress**
 - More concrete to show progress to CMS/CMMI, VHCIP Steering Committee, Core Team, GMCB

Benefits

	Hospitals	FQHC	PCPs - Blueprint PCMH	PCP - Non- Blueprint Practices	Specialty Physician	SNF	HH	MH & SA
OCV	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices	2 Independent Practices	All Hospital Employed (1800 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Providers
CHAC	Expected Local Collaborations	7 FQHCs	Participating FQHC Practice Sites(35 Practice sites) 100+ PCP FTEs	None	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
ACCGM	Expected Local Collaborations	None	10 Independent Practices	2 Independent Practices	6 Independent Practices	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Sub-Total in ACOs	100%	91%	70%	40%	85%	80%	80%	100%
Remaining Providers	None	None	30%	60%	15%	20%	20%	None

ACO Participants

- All providers **seamlessly contributing a full range of accurate clinical information** electronically to VITL
- **Well designed tools and interfaces** to access that information subject to data use agreements and patient consent models
- **Designed to serve a range of customers** including providers, ACOs, GMCB, other regulators, DVHA/payers, others where appropriate

Vision of the Future

- We **don't know the current baseline status** of provider ability to capture and electronically transmit the clinical information needed for ACO/VCHIP Quality Measure data elements
- We need a way for **electronic data to be routed to ACOs** for Care Management and Analytic processes to support patient care
- We don't have the ability to **notify our Providers and Care Managers real time** when our patients have an important clinical event
- We still need to **fill some basic gaps** in HIE interfaces and data element exchange from hospitals and other providers

Problems to be Addressed

- **Gap Analysis**

- Identify the gap among state-wide ACO data requirements and data capacity

- **Pan ACO Gateway Build**

- Build the technical architecture to support movement of data from source systems to analytics destinations (*next slide*)

- **Event Notification**

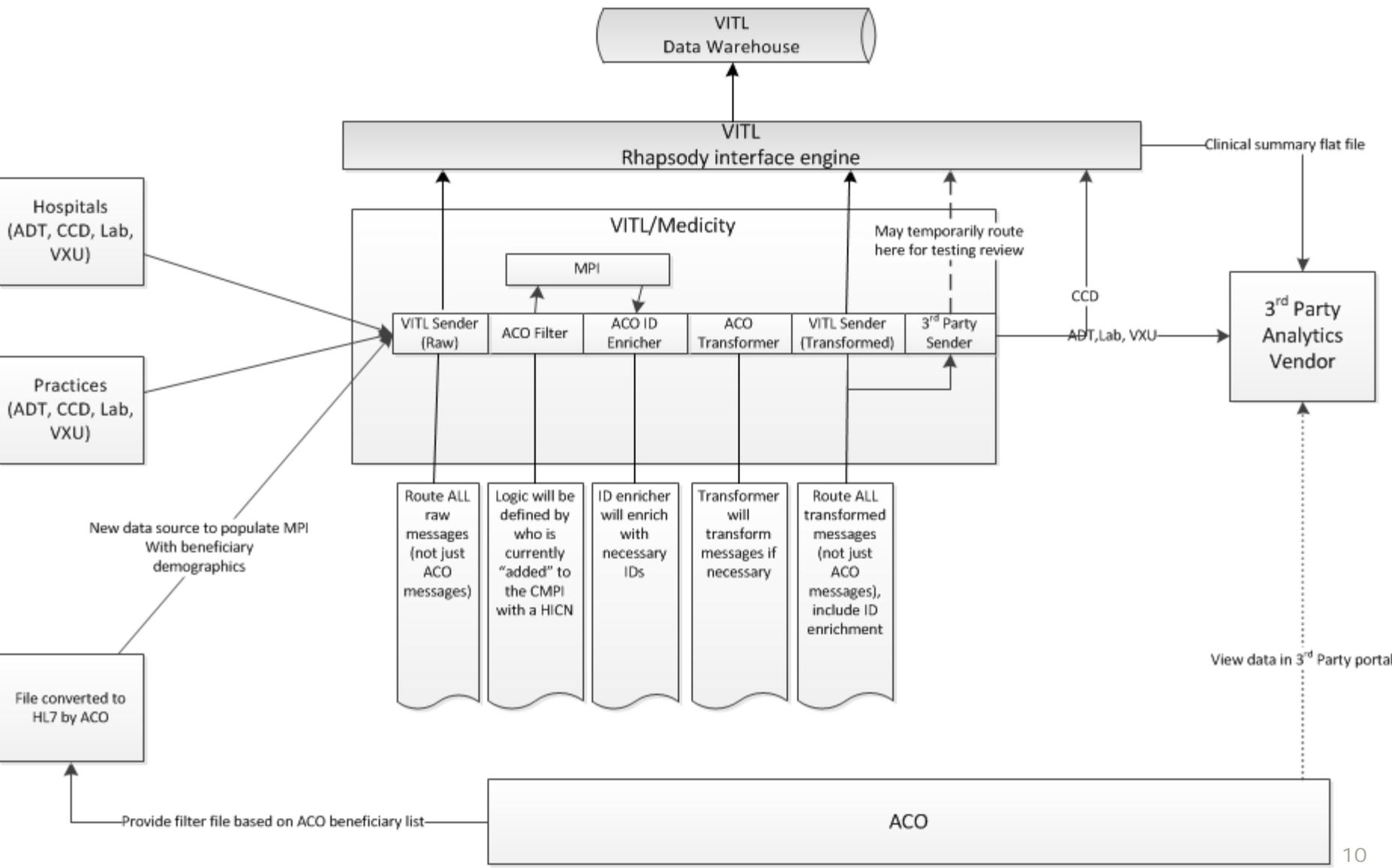
- Install a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters

- **Gap Remediation**

- Expand data capacity of the State for improved population management

Scope of Work

ACO Gateway Architecture



Initiative Timeframe¹

Gap Analysis	<ul style="list-style-type: none">• Estimated Start – Q1 2014• Estimated complete Q3 2014
Pan ACO Gateway Build	<ul style="list-style-type: none">• Estimated Start - Q1 2014• Estimated complete –Q2 2015
Event Notification	<ul style="list-style-type: none">• Estimated Start – Q1 2014• Estimated complete – Q4 2014
Gap Remediation	<ul style="list-style-type: none">• Estimated Start – Q1 2015• Estimated complete – Q3 2016

¹ Start dates dependent on release of SIM funds

Timeframe

Initiative	Low Estimate ¹	High Estimate
Gap Analysis	\$50,000	\$75,000
Pan ACO Gateway Build	\$1,115,000	\$1,545,000
Event Notification	\$375,000	\$625,000
Gap Remediation (full)	TBD	TBD
Support	\$570,000	\$800,000
Total	\$2,110,000	\$3,045,000

¹ Based on preliminary pricing

Implementation Costs & 1st Year Support

Initiative	Annual Support ¹ (2015 and ongoing)	
Gap Analysis	\$0	
Pan ACO	50,000 Beneficiaries:	\$438,000
Gateway (annual)	100,000 Beneficiaries:	\$876,000
	200,000 Beneficiaries:	\$1,752,000
Event Notification	Range of \$82,100 - \$136,800	
Gap Remediation (full)	TBD	

¹ Based on preliminary pricing

Support Costs (multiple sources of funding)

- **Collaboration** of 3 ACOs
- Providing **care to majority of Vermont residents**
- Collaborating with VITL to build single common patient data infrastructure to:
 - Better **manage patient care** (Improve Care)
 - Report on **quality of care** (Improve Care)
 - Notify and **manage care transitions** (Improve Care)
 - **Exchange relevant clinical information** among caregivers (Improve Care)
 - **Reduce healthcare costs**

Summary

- **Support from the VCHIP HIE Workgroup** for the vision and collaborative effort
- **Approve for release of SIM funds** for committed initiatives
 - **Implementation: \$2,110,000 - \$3,045,000**
 - **Support: Ongoing funding of support requires additional discussion of funding sources**
- **Support for refinement of costs** and well-defined funding requirements
 - **Pan ACO to refine Implementation and Support Costs: June 2014**
- **Timing is critical**

Next Steps

Questions?

Vermont Health Care Innovation Project (VHCIP)

DRAFT Project Proposal

Population-Based Collaborative Health Information Exchange (HIE) Project

Version 1.0 - Presented to VHCIP HIE Work Group

February 5, 2013

Prepared by:

Accountable Care Coalition of the Green Mountains

Community Health Accountable Care

OneCare Vermont Accountable Care Organization

Vermont Information Technology Leaders

Contents

- I. Project Purpose, Background and Summary**
- II. Scope of Work**
- III. Health Care Delivery System Impact**
- IV. Project Budget**
- V. Sustainability Plan**
- VI. Appendix A: ACO Participants**
- VII. Appendix B: ACO Gateway Architecture**
- VIII. Appendix C: Q and A from HIE Work Group Leaders/Members**
- IX. Appendix D: PowerPoint Presentation of Concept to HIE Work Group January 10, 2014**

I. Project Purpose, Background and Summary

Purpose Statement

The purpose of the project is to develop and implement a population-based infrastructure within Vermont HIE capabilities, to fully align with national health care reform through CMS and Vermont reform which emphasizes collaborative clinically integrated providers held accountable for the cost and quality of health care delivered to the populations they serve.

Background

The work plan for the VHCIP/HIE Work Group states:

“Vermont’s strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance.”

Four Vermont organizations have partnered to develop a collaborative, statewide approach designed to support this strategy. These organizations include:

- The Accountable Care Coalition of the Green Mountains (ACCGM)
- Community Health Accountable Care (CHAC)
- OneCare Vermont (OCV)
- Vermont Information Technology Leaders (VITL)

The proposal developed by the above organizations is intended to be in direct alignment with the goals of the VHCIP grant.

Over the last nine years VITL has worked closely with Vermont’s healthcare providers, many of which are members of the three ACOs, to shift from a paper to an electronic environment (see Appendix A, ACO Participants). The result is that Vermont enjoys one of the highest electronic health record (EHR) adoption rates in the United States. At the same time, VITL has worked with these providers to build the infrastructure to connect EHRs as the source systems for clinical documentation to the VHIE.

This progress can now be leveraged broadly to better inform clinical decision making at the point of care and to utilize clinical data for analytics and population health data management.

The advent of specific ACOs measures requires that the four organizations perform a Data Gap Analysis that aligns with the HIE Workgroup’s goal ‘to improve the utilization, functionality and interoperability of the source systems providing data for the exchange of health information’. A second purpose of the analysis also aligns directly with the HIE Workgroup objective to identify

gaps related to EHR usage as well as the ability of source systems to provide information such as lab results, admission/discharge/transfer (ADT) and other data needed to achieve the ACO measures.

VITL's work with healthcare provider members of the three ACOs has closed many technology gaps but a thorough analysis based on the ACO measures will identify gaps in technology that still exist and result in future recommendations also aligned with the HIE Workgroup's objective to 'invest in technologies that improve the integration of health care services'. These recommendations will be submitted as part of a second proposal for 'remediation' through investments in EHRs and the development of interfaces between the EHR and the VHIE, thereby supporting the HIE Workgroup objective to 'facilitate connectivity to the HIE for ACOs and their participating providers and affiliates'.

This proposal also includes the expansion of VITL's infrastructure to support the exchange of clinical data for analytics. VITL will build 'gateways' which allow the clinical data of ACO specific beneficiary populations to be sent to analytics sources designated by the ACOs (see Appendix B, ACO Gateway Architecture). Analytics will include a combination of clinical and payer specific claims data designed to assist ACO provider members report and perform against the ACO measures.

An additional aspect of this proposal is the development of an Event Notification System (ENS) designed to inform both ACO member organizations and any authorized healthcare provider statewide choosing to participate, that a patient involved in their care has been admitted, discharged or transferred by an acute care hospital in Vermont or by Dartmouth Hitchcock Medical Center in New Hampshire. This service achieves the HIE Workgroup's related objective that technology investments result in 'enhanced communication among providers'.

The last aspect of this proposal is designed to recognize the need to provide on-going customer and system support once the technical infrastructure and technology service investments have been made. A per member per month methodology based on the total number of ACO beneficiaries has been development to sustain these support costs.

The three ACOs and VITL believe that collaborating to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients directly supports the goals of the VHCIP.

The following table demonstrates the strong alignment of this project with the VHCIP HIE Workgroup objectives.

HIE Goals	VHCIP/HIE Work Group Objectives	Alignment with Population-Based Collaborative HIE Project
To improve the utilization, functionality & interoperability of the source systems providing data for the exchange of health information	<ul style="list-style-type: none"> • Explore and, as appropriate, invest in technologies that improve the integration of health care services and enhanced communication among providers • Identify core requirements for source systems to meet SOV HIE standards 	<ul style="list-style-type: none"> → Event Notification System → Data Gap Analysis
To improve data quality and accuracy for the exchange of health information	<ul style="list-style-type: none"> • Increase resources to facilitate improved EHR utilization at the provider practice level • Identify and resolve gaps in EHR usage, lab result, ADT, and immunization reporting, and transmission of useable CCDs. • Improve consistency in data gathering and entry • Support the Development of advanced analytics and reporting systems as needed 	<ul style="list-style-type: none"> → Data Gap Analysis → Data Gap Remediation → ACO Gateways
To improve the ability of all health and human services professionals to exchange health information	<ul style="list-style-type: none"> • Facilitate connectivity to the HIE for ACOs and their participating providers and affiliates • Standardize technical connectivity requirements to participating provider entities • Facilitate EHR adoption to current non-adopters • Facilitate connectivity to providers who are not yet connected to the HIE regardless of ACO participation 	<ul style="list-style-type: none"> → Data Gap Remediation → Data Gap Remediation → Date Gap Remediation → Data Gap Remediation

The benefits we intend to achieve as a result of funding this proposal include:

- Making rapid progress against the state HIE plan
- Providing a path for 2014 patient care benefits of healthcare information exchange across providers and through ACO population approaches
- Exploits the efficiencies of a collaborative project effort involving all three Vermont ACOs, their providers, VITL and the VHCIP work group
- Provides a mechanism for the VHCIP work group to measure and demonstrate tangible progress

We are excited with the opportunity to advance healthcare reform efforts in Vermont and believe this proposal assures that a health care system is affordable and sustainable through coordinated efforts to lower overall costs and improve health and health care for Vermonters.

II. Scope of Work

Project Activity Scope

There are two major threads to the project we are proposing:

1) Connect Providers (Information from Providers to VITL)

- a. Hospitals – Various Systems Interfaced to VITL
- b. Physician/Ambulatory EHRs Interfaced to VITL
- c. Community Providers Information Interfaced to VITL
 - i. HH, SNF, MH & SA
- d. Potential – Other Information Sources Interfaced to VITL

2) Make Information Available (Information from VITL to providers, ACOs, others)

- a. Complete development and implementation of electronic population “pipeline” to GMCB/State Analytic Vendors/ACOs/Payers
 - i. Supports analytic systems and payment reform efforts
 - ii. Enables full-functionality NNEACC Tool for OneCare Vermont ACO and its providers
 - iii. Enables full functionality tool for CHAC and ACCGM analytics vendors

Project Data Scope

CHAC, OneCare, and ACCGM have collectively identified several Health Information Exchange needs. It will prove imperative for the ACOs to receive at the ACO level real-time admission, discharge, and transfer information re: ACO beneficiaries, wherever they are in the health system. The ACOs would also find value in receiving real-time lab results, discharge summaries, radiology reports, and immunization results. The tasks to be completed, specific deliverables, and timelines are listed in the table below.

	Task	Deliverable	Target Date
Gap Analysis			
	Who has an EHR	VITL will identify for each participant for whom we have EHR data the EHR used by that participant.	Q1 2014
	Those who are unknowns	Based on the outcome of Task #1, VITL will contact each participant for whom VITL has no EHR information. VITL will update its customer base to reduce the number of OCV participants with unknown EHRs.	Q1 2014
	Hospitals sending lab results	VITL has knowledge of which hospitals are sending lab results to the VHIE. There is not a dependency on practices.	Q1 2014

	Task	Deliverable	Target Date
	Health care organizations sending ADT	VITL has knowledge of which health care organizations are sending ADT to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations <u>could</u> technically send an ADT but are not in the process of building an ADT interface.	Q1 2014
	Health care organizations sending immunization	VITL has knowledge of which health care organizations are sending VXU (immunizations) to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations <u>could</u> technically send a VXU but are not in the process of building a VXU interface.	Q1 2014
	Health care organizations sending CCDs	VITL knows which organizations are sending clinical data through the VHIE. VITL will be able to identify which organizations are sending CCDs that could be parsed and forwarded to NNEACC in a flat file for NNEACC analytics. VITL will also indicate which organizations <u>could</u> technically send a CCD but are not in the process of building a CCD interface.	Q1 2014

	Task	Deliverable	Target Date
	For those organizations ending CCDs, what quality measures are included	VITL will review data in Docsite to identify which of the quality measure data elements are included in a CCD for those organizations sending CCDs.	Q1 2014
Systems			
	OCV Medicare		
	Build Medicity functionality - Beneficiary file	A OCV master person index is created for Medicare beneficiaries	Q1 2014
	OCV Labs	OCV Medicare filtering on labs is complete, and sent to NNEACC	Q1 2014
	OCV ADT, CCD, VXU	OCV Medicare filtering on ADT, CCD and VXU is complete, and sent to NNEACC	Q2 2014
	Build NNEACC CCD Interfaces	Convert inbound CCDs to a flat file for NNEACC	Q3 2014
	OCV Medicaid		

	Task	Deliverable	Target Date
	Build Medicity functionality - Beneficiary file	A OCV master person index is created for Medicaid beneficiaries	Q3 2014
	OCV Labs, ADT, CCD, VXU	OCV Medicaid filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q3 2014
	OCV Commercial		
	Build Medicity functionality - Beneficiary file	A OCV master person index is created for commercial beneficiaries	Q3 2014
	OCV Labs, ADT, CCD, VXU	OCV commercial filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q3 2014
	CHAC		
	Build Medicity functionality - Beneficiary file	A CHAC master person index is created for CHAC beneficiaries	Q4 2014
	OCV Labs, ADT, CCD, VXU	CHAC beneficiary Medicare filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q4 2014
	ACCGM		

	Task	Deliverable	Target Date
	Build Medicity functionality - Beneficiary file	An ACCGM master person index is created for ACCGM Medicare and commercial beneficiaries	Q4 2014
	OCV Labs, ADT, CCD, VXU	ACCGM beneficiary Medicare and commercial filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q4 2014
	ENS	An Event Notification System (ENS) delivers real-time ADT information about a patient’s medical services encounter, for instance at the time of hospitalization, to a permitted recipient with an existing relationship to the patient, such as a primary care provider.	
	One time software license purchase	Software license fee	Q4 2014
	One time ENS Implementation	Implementation fee	Q4 2014
	One time hosting environment setup	Build the hosting infrastructure	Q4 2014
	Onboarding per provider organization	Onboarding organization who will receive event notifications	Q4 2014

DRAFT

	Task	Deliverable	Target Date
First Year Support			
	OCV Medicare		Feb 2014
	OCV Medicaid		June 2014
	Commercial		July 2014
	CHAC		November 2014
	ACCGM		[not live 2014]

III. Health Care Delivery System Impact

There is broad agreement on the power and importance of health information exchange (HIE) in providing well-coordinated, high quality healthcare which avoids waste. Both Vermont and national reform have focused on new programs and incentives for networks of health care providers to take accountability populations of patients they serve. In Vermont, the formation of these networks and participation in available programs has been very strong, and this is now a part of the unique Vermont story growing nationally. The types of providers across the continuum of care and services represented at the table are also expanding. The table on the following page shows the three ACO organizations in Vermont and the very broad network participation they have today.

Given the strong ACO participation, we are envisioning many cross-collaborative relationships which further supports this multi-ACO approach to HIE. Although some providers have not decided to participate with any of the ACOs to date, we expect this project and approach to connect and support providers who may end up taking an independent path under reform. We believe that incentives to be a part of an ACO network should exist, but would expect some pathway will be available to those who choose independence but wish to collaborate on patient care.

ACO-based programs use a model of “attribution” of patients based on physician relationships with patients and are strongly focused on primary care relationships. As the table indicates, there are nearly 450 primary care physicians representing a strong majority of all the primary care physicians in the state of Vermont participating across the three ACO organizations. With the payer programs in place or expected to be in place for Medicare, Medicaid, and across the Vermont Health Connect plans from Blue cross Blue Shield of Vermont and MVP Healthcare, we expect over 100,000 Vermonters be attributed in 2014 and grow over time.

To proactively coordinate care and measure quality, Vermont’s ACOs envision the availability of the key information tools described earlier from VITL to support our efforts. We plan to make great use of the population-based pipeline of information to (a) feed our ACO analytic and care management systems, and (b) support collaborative processes across the continuum of care, especially as patients transition from one setting of care to another. Specific examples of tools and processes that will be enabled by the project requested in this document, with its additive HIE infrastructure developed by VITL, are anticipated to include:

- Combined cost, utilization, quality, and clinical reporting to fully capture the current performance and opportunities for improving care to a population of patients
- Generation of such population-based analysis at any level desired: compare among ACOs, ACO wide, regional, local community, or individual practice or provider

- More refined and accurate reports identifying specific “capturable” opportunities for improvement; an example would be greatly expanding analysis on metrics based on national physician associations guidelines on avoiding waste and unnecessary care based on evidenced based research (example: “Choosing Wisely” campaign)
- Real time quality metric performance monitoring for the designated population measures in ACO programs; an ACOs population “score” can be known through the year giving us an opportunity to improve
- Automated annual submissions of quality information to CMS, DVHA, Commercial Payers, and the GMCB for the selected patient samples rather than relying on retrospective (and costly) chart or EHR audits
- Movement beyond simple and incomplete registries of patients with chronic illness into a much richer and effective chronic disease management program based on complete clinical information and risk analysis
- Drive evidenced-based care “gap analysis” by patient to ensure no patient falls through the cracks who would benefit from specific approaches based on clinical outcomes research
- Drives systems to better assign patients needing care coordination to “work lists” for those most able to engage with that patients and coordinate their care, whether they be staff in the PCMH, hospital, community based provider, designated agency, other support services program, or at the ACO itself.
- Provides those assigned a “care manager” the tools and combined visit history and clinical snapshot of the patient to jump start and monitor that patient’s care
- Provide a single real time source alerting those involved in a patient’s care about a major clinical events (such as a hospital admission or Emergency Room visit); this will allow more proactive coordination and planning for that patient’s needs given the acute nature of the major events

Please note that these are all systems and processes in development, and to be deployed using the underlying capabilities from this project. Some including the Event Notification System are included in the project scope, but other are being developed by the ACOs and their providers. Not all the tools and processes above will be defined and in place by the end of the project and may vary in scope and design by each ACO. Additional VHCIP assistance for an ACO or among the ACOs in developing and deploying the systems and processes described above may be included in other projects proposals for VHCIP work groups.

Overall, the three ACOs and non-ACO estimates are given in Appendix A.

IV. Project Budget

Project Budget

A table summarizing the project budget by components is as follows:

	Item	Units	Rate	Labor	Purchased Service	Total	Justification
Salaries and Wages							
	Project Managers	#####	\$ 125	\$ 433,800		\$ 433,800	These are fully loaded rate, including salary, benefits, overhead, and contingency. There are 2-3 project managers almost full time. No costs have been included for ENS implementation and eHealth Specialists for gap
Subtotal Salaries						\$ 433,800	
Systems							
	OCV Medicare						
	Build Medicity functionality - Beneficiary	1			\$ 12,650	\$ 12,650	
	OCV Labs	1			\$ 132,250	\$ 132,250	
	OCV ADT, CCD, VXU	1			\$ 250,700	\$ 250,700	
	Build NNEACC CCD	1			\$ 34,500	\$ 34,500	
	OCV Medicaid						
	Build Medicity functionality - Beneficiary	1			\$ 12,650	\$ 12,650	
	OCV Labs, ADT, CCD, VXU	1			\$ 172,500	\$ 172,500	
	OCV Commercial						
	Build Medicity functionality - Beneficiary	1			\$ 12,650	\$ 12,650	
	OCV Labs, ADT, CCD, VXU	1			\$ 172,500	\$ 172,500	
	CHAC						
	Build Medicity functionality - Beneficiary	1			\$ 12,650	\$ 12,650	
	OCV Labs, ADT, CCD, VXU	1			\$ 172,500	\$ 172,500	
	ACCGM						
	Build Medicity functionality - Beneficiary	1			\$ 12,650	\$ 12,650	
	OCV Labs, ADT, CCD, VXU	1			\$ 172,500	\$ 172,500	

		Item	Units	Rate	Labor	Purchased Service	Total	Justification
Systems								
	ENS							
		One time software license purchase	1			\$ 125,000	\$ 125,000	
		One time ENS Implementation	1			\$ 156,250	\$ 156,250	
		One time hosting environment setup	1			\$ 31,250	\$ 31,250	
		Onboarding per provider organization	100			\$ 312,500	\$ 312,500	
Subtotal Systems							\$ 1,795,700	
First Year Support								
		OCV Medicare	1				\$ 465,740	Prorated at # of beneficiaries * number of months expected to be live * \$.73 PMPM
		OCV Medicaid	1				\$ 127,020	
		Commercial	1				\$ 118,552	
		CHAC	1				\$ 82,986	
		ACCGM	1				\$ -	
Subtotal First Year Support							\$ 794,298	
Total First Year							\$ 3,023,798	

V. Sustainability Plan

This proposal identifies specific investments in four key aspects of developing and sustaining health information exchange capabilities and services needed by Vermont's ACOs to achieve their goals as part of Vermont's healthcare reform efforts.

The gap analysis will identify the gaps that exist among state-wide ACO data requirements and data capacity. The prioritization and costs associated with the remediation of those gaps will be part of a second proposal. The building of ACO 'gateways' leverages the existing infrastructure of the VHIE by deploying the technical architecture to support movement of data from source systems to analytics destinations. Installing a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters leverages and expands the VHIE's capabilities to provide a service for all Vermont healthcare providers.

Once investments are made in technology and services, the on-going costs associated with providing customer and system support need to be sustained financially.

These costs include customer support to ACO participants and encompass: patient identify management; interface maintenance, upgrades and replacement; continuously measuring and improving data quality; and the provision of a 24x7 support center.

Sustaining costs for system infrastructure support include: interface monitoring; monitoring message routing; maintaining beneficiary matching rules; maintaining message transformers to include consent flags; resolving errors and performing testing on new interfaces; and maintaining provider profiles and other aspects of an Event Notification System (ENS).

The investments recommended in this proposal are minimal in comparison to the investments made to develop and maintain the VHIE, yet are designed to leverage current technological capabilities to directly support ACO needs as part of healthcare reform efforts. It is anticipated that accountable care approaches to the Medicare beneficiary population will be expanded over the next few years to include Medicaid and commercially insured beneficiary populations. The VHIE and the investments recommended in this proposal will continue to be leveraged to support the data exchange and measures based analytic services required to support these additional ACO beneficiary populations.

In 2014 the proposed technology investments will shift from implementation to the need to provide ongoing customer and system support. As a result, these costs will occur incrementally and can be linked to the specific capabilities and functions the investments generate.

VITL is undertaking these technologies based on both the existing infrastructure of the VHIE and its internal capabilities, expertise and experience with the exchange of health information. Some of the requested services are at the forefront of HIE technology so precise costs associated with

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deployment and sustaining costs are not completely known. As a result, a range for the costs of sustaining the technology have been developed within the total not to exceed investment request.

The methodology used to develop a framework for estimating the costs of sustaining customer and system support was based on expectations of growth in the ACO beneficiary population size. VITL's costs for sustaining the VHIE, as a subset of its total expenses, was used to determine customer and system support costs. The development of a per member per month rate was developed by dividing the total potential number of ACO beneficiary population members by the costs associated with sustaining the VHIE.

This proposal's request for support cost funding encompasses a range from \$570,000 to \$800,000 based on the computed per member per month rate, estimates of timelines for technology shifting from implementation to support and estimates of increases in ACO beneficiary populations over the first year of the VHCIP.

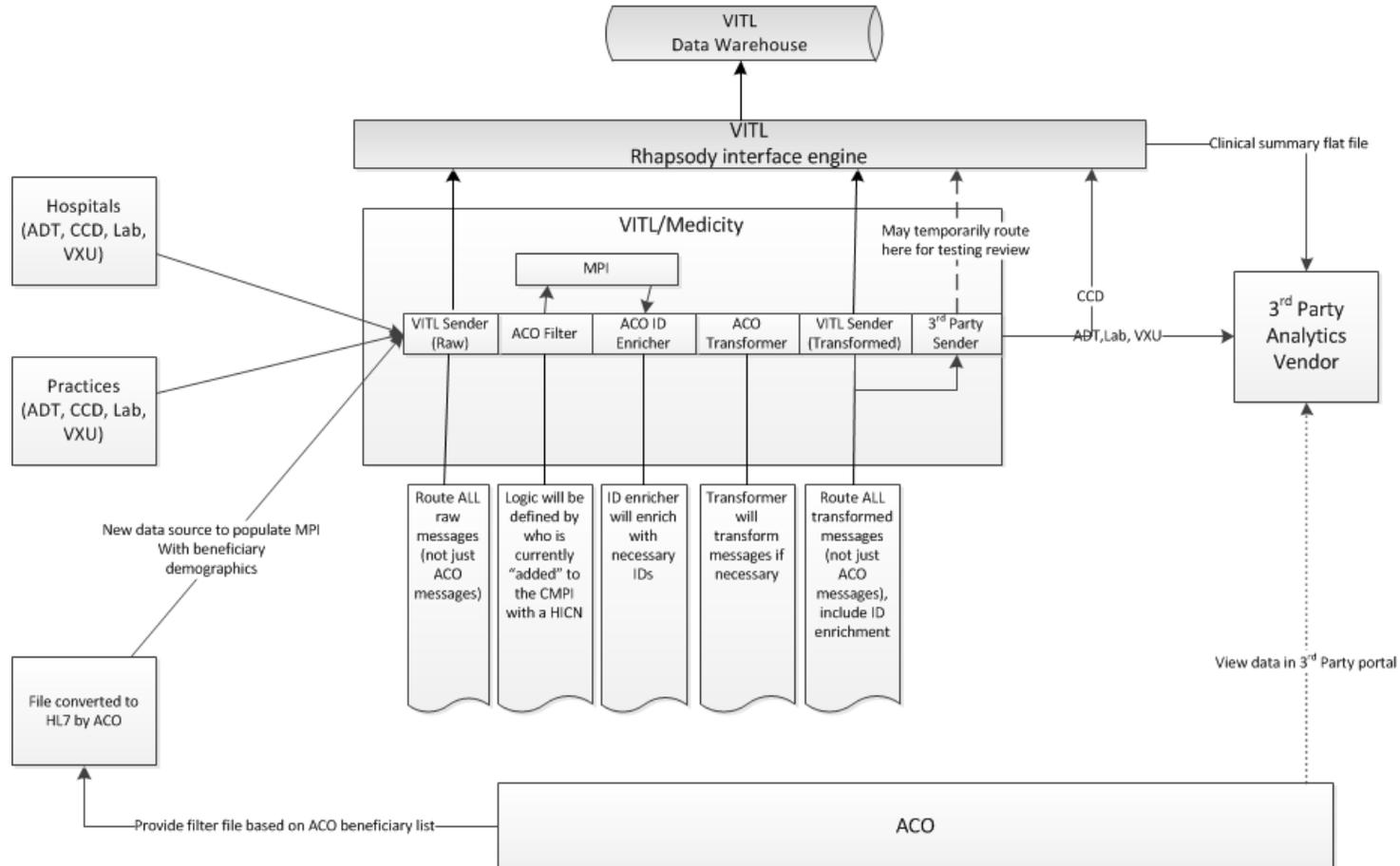
Appendix A – ACO Participants

Accountable Care Organization (ACO) Networks in Vermont

ACO/Network	Hospitals	Federally Qualified Health Centers (FQHC)	Primary Care Physicians (PCP)	Specialty Care Physicians (SCP)	Skilled Nursing Facility (SNF)	Home Health Agencies (HH)	Designated Agencies (DA) for Mental Health & Substance Abuse (MH & SA)	Other Designated Agencies (DA) and/or Long Term Supports & Services (LTSS)
OneCare Vermont (OCV)	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices TOTAL: 300+ PCP FTEs	All Hospital Employed (1800 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned SNF included Additional Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Agencies	Network Affiliate Agreements Expected
Community Health Accountable Care (CHAC)	Expected Local Collaboration	7 FQHCs	Participating FQHC Practice Sites (35 Practice Sites) TOTAL: 100+ PCP FTEs	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
Accountable Care Coalition of the Green Mountains (ACGM) for Medicare SSP Vermont Collaborative Physicians (VCP) for Commercial Exchange SSP NOTE: Both in collaboration with HealthFirst Independent Physician Network	Expected Local Collaboration	None	15 Independent Practices TOTAL: 45+ PCP FTEs	Independent Specialty Practices Collaboration through HealthFirst	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Vermont Sub-Total in ACOs	100%	100%	70% (Approx.)	85% (Approx.)	80% (Approx.)	80% (Approx.)	100%	TBD

Appendix B – ACO Gateway Architecture

ACO Gateway Architecture



Revised: 1/2/2014

File name: ACO Architecture - SM-1-2-14 with CCD.vsd

Appendix C - HIE Work Group Q & A

Questions for the Population-Based Collaborative Health Information Exchange (HIE) Project Presenters - January 17, 2014

Introduction

Several of the questions relate to the statewide impact to non-ACO providers. Briefly, this is how non-ACO providers would envision their participation in health care reform.

VITL sends and receives data from health care organizations throughout Vermont, including all hospitals, most FQHCs, a majority of primary care providers, and other specialists and long term care. The data is not specific to ACOs and beneficiary populations. The patient care goals of ACOs are to collect quality clinical data electronically. Their facilitation for their members to achieve these goals in turn expands quality clinical data in the Vermont Health Information Exchange (VHIE). The VHIE is not restrictive to ACO providers, but is accessible to any health care provider who has signed the appropriate legal agreements with VITL. Providers may access the VHIE through a provider portal. In addition, any health care provider may participate in the Event Notification System, again, not restrictive to ACO providers. In summary then, the emphasis on quality clinical electronic data by the ACO and an Event Notification System accrues to both ACO and non-ACO providers.

The questions below were submitted by the VHCIP/HIE Work Group.

Questions related to budget:

1. *[This question was submitted by the Work Group leadership team]* Your budget has a range of \$2,110,000 to \$3,045,000. In order for the HIE Work Group to consider a recommendation, you will either need to provide a specific budget number or a "not to exceed" number that can be incorporated into an Agreement/Contract and a statement of work to support the estimated budget. Please provide a more detailed statement of work and the specific amount or "not to exceed number" you would like the work group to consider.

The ACOs and VITL are in an early planning phase. Although we believe the range provided is sound based on significant experience by VITL leadership, we are working on more firm specifications from which a more detailed model of timing and use of funds by VITL, including obtaining firm quotes by third party technology partners, can be developed. The desire is to be as specific and cost

conscious as possible once the quotes have been obtained, but some patience and understanding of the pioneering nature of this work is requested. Our formal request for the system build currently outlined at this point can be considered as a not to exceed \$3M budget.

2. *[This question was submitted by the Work Group leadership team]* Is it the intention of the PAN ACO group to seek additional SIM/VHCIP funding for Gap Remediation and support costs in 2015 and 2016? In this regard, the work group is also interested in the sustainability plan for supporting the costs of this infrastructure beyond 2016. As part of the sustainability plan, please indicate which parts of the project will be on-going operational expenses as opposed to developmental expenses.

Would you please provide the group with an estimate of additional costs that you will be asking the work group to support, if any, and what other sources of funding you intend to pursue to insure the sustainability of this infrastructure beyond 2016.

- **We envision this system becoming the back bone data system for much of the health reform effort during the next number of years. Once built, many participants, the state and commercial insurers included, in addition to the ACOs, are likely to derive benefits through more information and better coordination of care and cost management. Consequently, the ACOs envision full funding of system maintenance support through VHCIP until at least 2016 or at least until shared savings begin to occur. This would come from either (or a combination of) additional SIM/VHCIP funds in 2015/2016 or through a separate sustainable ACO operational funding model (with VITL support fees included) as developed through other mechanisms and implemented for 2015 or 2016. VITL is looking for confirmation that support costs will continue after development and implementation of the infrastructure.**
 - **Funding of maintenance and system enhancements beyond 2016 will, in all likelihood, need to be funded by all of the participants and beneficiaries of an improved care coordination model. We envision this sustainable model of ACO funding (again, with VITL support fees included) must be fully developed (negotiated) and implemented before the end of 2016 to ensure sustainability of the system. These discussions should begin in the second half of 2014.**
 - **To specify the funds needed in the 2015/2016, and beyond, the ACOs will need to provide attributed lives for 3 years to VITL**
 - **We will also provide targeted funds needed for Gap Remediation (currently TBD) by June 2014**
3. As with the FQHCs, the IT resources at DA/SSAs and other full spectrum provider agencies are limited. The Pan ACO proposal will require quite a bit of agency IT staff time. Will the Pan ACO proposal provide incentive payments/stipends/subsidies for these agencies?
No incentive payments/stipends/subsidies were included in the initial proposal for either the current or prospective ACO members. We envisioned that these sorts of

additional resources, if needed, would be identified in the Gap Remediation plan. Separate funding can then be requested either as part of an expanded ACO request or by the organizations themselves.

4. Does the \$0 figure for gap analysis in the “Support Costs” section assume that all gaps/challenges will be identified initially and that no others will be discovered in subsequent project years? What happens when there are changes in ACO-provider affiliations after the gap analysis is complete?

Gap analysis will be used to determine plans for gap remediation. Gaps will continue to be generated, e.g., EHR replacement in the future. This funding request is for ACO gaps that currently exist. A reasonable level of change in ACO programs and subsequent HIE needs are part of the ongoing support payments model, but any major changes in approach, number of measures, or other ACO requirements may require additional one-time projects and new gap analysis and remediation.

5. It seems there are still questions about the feasibility of funding Gap Remediation activities. In the event that VHCIP funding is not available (or not sufficient to cover all remediation activity), how will remediation be funded? If only *limited* funding is available for remediation, how will providers/practices be prioritized for EHR upgrades & related activities? This is particularly relevant for provider types known to have large gaps at present. In the absence of a plan for addressing the costs of subsequent phases, the initial investment of \$2-3M is concerning. [The major investment is in the gateway build, but the utility of a gateway seems limited if there are still problems with capturing and transmitting data accurately.]

Most likely, the ACO proposal will as we’ve indicated create the backbone for a system which will be expanded to other users over some number of years, and through a variety of funding sources in addition to those we have now. We envision handling this problem as it arises and with the clarity of the results of the gap analysis. In general, if needs are beyond resources and such limits are placed, priority will be set based on attributed lives and the providers holding the source data elements for the required quality measures of ACO programs. Subsequent funding sources will likely need to be found and employed for further rounds of gap remediation.

Questions related to vendor selection:

6. *[This question was submitted by the Work Group leadership team]* We assume that you are recommending that this contract, if approved, would be with VITL as the provider of the services you have described. Please confirm, and please also confirm that VITL agrees with this arrangement.

We agree and third party contracts required would be sub-contractors to VITL.

Questions related to scope of work and/or existing contracts:

7. *[This question was submitted by the Work Group leadership team]* We are aware that VITL has an existing contract with DVHA to fund specific work that is related to what the PAN ACO Group is proposing. Please describe the specific work that is being funded under the current DVHA contract, what the status of that work is, and specifically how the PAN ACO proposal would supplement, not duplicate the work that is already under contract. The Work Group wants to be very clear that it does not intend to recommend funding for work that is already under contract.

The grant agreement between DVHA and VITL covers, in general:

- **New interfaces to hospitals, designated agencies, home health, and specialists**
- **Provide “REC-like” services to organizations other than primary care**
- **Expand the VITL in-house infrastructure**
- **Conduct several exploratory projects that would facilitate faster interface implementation**

None of these services would be funded through SIM. The Pan ACO work is focused on filtering data based on a beneficiary population against membership of an entity (ACO), which had not been envisioned when the DVHA-VITL agreement was developed in the spring of 2013. This new work will primarily include both a general clinical data feed (ACO Gateway) for a beneficiary population and an event notification system (ENS). The budget for the Event Notification System is for license and implementation which does not overlap labor estimates in the DVHA grant, which is focused on proof of concept and will include RFP development, and vendor evaluation and selection. Additional focus is also being added for the ACO program-specific data elements for the new Vermont Shared Savings programs which were approved by the VHCIP and not known previously. To emphasize, the SIM funding will not fund any work defined previously in the DVHA grant.

8. *[This question was submitted by the Work Group leadership team]* The State requires specific statements of deliverables and timelines in all contracts that it executes. In order to develop a contract with you, we will need you to provide a written estimate of the deliverables related to your Scope of Work, and the timelines associated with each of those deliverables.

Yes, we understand and agree.

9. Broadly, it would be helpful to see significantly more detail about how the project will proceed, and how the work group /VHCIP governance will be kept apprised of progress and challenges on a regular basis.

The Pan ACOs and VITL recommend summary updates at each HIE workgroup and more detailed and substantial updates quarterly. We anticipate HIE work group chairs will provide SIM Steering Committee updates on the project and sponsor (if desired) our quarterly updates onto the Steering Committee agenda. In addition, a more detailed project plan and budget are being prepared to help all committees involved in the recommendation and approval process to be clearer on proposed deliverables, timelines, and cost estimates.

10. How will provider types be prioritized for assessment during the gap analysis? Has a schedule been developed for this component, and what activities will the gap analysis include?

No prioritization is necessary and all ACO provider participants including affiliate participants are included. A schedule exists and the analysis is underway. Scope:

Task	Description
1. Who has an EHR	VITL maintains customer information on all ACO participants. VITL will identify for each participant for whom we have EHR data the EHR used by that participant.
2. Those who are unknowns	Based on the outcome of Task #1, VITL will contact each participant for whom VITL has no EHR information. VITL will update its customer base to reduce the number of ACO participants with unknown EHRs.
3. Hospitals sending lab results	VITL has knowledge of which hospitals are sending lab results to the VHIE. There is not a dependency on practices.
4. Health care organizations sending ADT	VITL has knowledge of which health care organizations are sending ADT to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations <u>could</u> technically send an ADT but are not in the process of building an ADT interface.
5. Health care organizations sending VXU	VITL has knowledge of which health care organizations are sending VXU (immunizations) to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations <u>could</u> technically send a VXU but are not in the process of building a VXU interface.
6. Organizations sending CCDs (clinical summaries) through the VHIE (does not specify what they are sending)	VITL knows which organizations are sending clinical data through the VHIE. VITL will be able to identify which organizations are sending CCDs that could be parsed and forwarded to NNEACC in a flat file for NNEACC analytics. VITL will also indicate which organizations <u>could</u> technically send a CCD but are not in the process of building a CCD interface.

Task	Description
<p>7. The GMCB approved quality measure data elements include measures that may be included in a Blueprint CCD. For those organizations sending CCDs VITL will identify which of the ACO-Blueprint measures are actually being sent.</p>	<p>VITL will review data in Docsite to identify which of the quality measure data elements are included in a CCD for those organizations sending CCDs.</p>

11. I'm somewhat concerned about the scope of the gap analysis with respect to measures. Though the list of measures to be considered is substantial, it is by no means comprehensive. This investment may well improve providers' abilities to capture quality information for a finite set of (largely primary care) measures, but achieving near-perfect electronic collection of these measures—as currently specified—after several years won't necessarily be sufficient in an ever-evolving measure environment, nor will it aid other provider types in collection of measures relevant to their services.

We are working on the existing scope of work for the gap analysis based on the VHCIP Data Subgroup measures. We believe that building the documentation methods and HIE connections focused on this important and varied set of measures will pave the way for additional measures (i.e. let's prove we can do it for these measures and not get bogged down with too many competing information elements).

12. Could you provide a description of the longer-term impacts of the proposed work in a post-ACO context? Given that the ACO model is designed to be a transitional model, and considering the size of the investment and the projected duration of this effort, it would be helpful to know how the products and benefits will translate to subsequent models or systems.

Although "Shared Savings Programs" with quality and satisfaction measures are generally considered to be transitional models, we anticipate that clinically integrated networks of providers (whether called ACOs or not) taking accountability for the total cost and quality of populations will be a long term model of healthcare delivery. Data sharing will remain a key and will continue post SIM funding. As indicated previously, we believe we are building the foundation data engine for the State of Vermont, and this model will be useful for any population of attributed lives. We think subsequent rounds of funding will very readily provide expansion for other stakeholders.

13. On slide 7, “Well designed tools and interfaces to access that information subject to data use agreements and patient consent model.” What I see as potentially missing is a view to the aggregate state data. I think the outlined efforts assist in getting a more complete data set by increasing the network effect, but I don’t see in the proposal a plan to create and analyze the data at a state aggregate level. It serves a mutual purpose to all ACOs to build the platform so they can take their own data out for use by their analytic tools for their patient population, but from a payment and quality perspective there may be a need for a tool to look at it from a more global perspective. Is that one of things considered in the “3rd Party Analytics Vendors?” Medicity isn’t positioned to provide analytics at a population level. That said, the project underway as mentioned before, may be a catalyst that is beneficial to the State if it is done well. There is a benefit to the ACOs to ensure quality (they don’t want garbage out).

The scope of the request does not include designing or providing, or allocating funds for ACOs to obtain and deploy analytics systems. The scope provides a foundation for improvements of data quality, to feed into the analytics vendors. We do believe a separate dialogue on this is a worthwhile discussion however, and in all probability, this project will provide the pathway for statewide analytics.

14. Event notification is missing in the current HIE system, and needed. An overlay with the Care Models group should be a discussion of what should happen for patients who have a triggering event, but aren’t engaged in the current care system. That won’t be a question the ACOs are primarily focused on. For them, it’s a person, but not one of their members for whom they are responsible. It may come down to the State who is looking out to the common good to pursue that question.

The Event Notification System is important to the success of the ACOs and better patient management, so it is being requested by the ACOs as part of the scope of the project. However, ENS is global, not specific to ACOs. We expect this to be used by providers regardless of their participation in an ACO.

15. On Slide 9, in order to understand how care transitions will be impacted by event notification, please provide descriptions (e.g. use case examples) describing how “Event notification” will benefit people receiving services from providers working in the following settings:

- private homes –case manager or family member managing person’s services
- residential care home manager
- adult day center director
- designated agency case managers
- nursing facility discharge planners

Providers in each of the aforementioned settings will have access to the Event Notification System once they have signed a data use agreement with VITL. This type of design and use of case process will be a part of the ACO work with its network and with the VHCIP Care Models and Care Management subgroup where common

approaches across ACOs is warranted. We expect the ENS system once created to expand as needed within the entire health care delivery system.

16. Can you provide specific clinical examples of how this grant will improve the delivery of care in Vermont? And for care delivered by practices not in the ACO?

- **This will provide data to analytics vendors to enable ACOs to do central analysis and identification of population-level improvement opportunities, as well as deploy patient-level systems to providers identifying specific gaps in care and evidence-based suggestions for clinical interventions to reduce more costly services and improve quality.**
- **This will allow more progress more rapidly than other approaches for providers to see aggregated data on their patients across the Vermont network in support of patient management and site of service care delivery**
- **The emphasis on data quality for ACOs to achieve their cost savings benefits patients regardless of their insurance coverage. Practices not in an ACO may have access to that data.**
- **Practices not in an ACO will be able to fully utilize the Event Notification System.**

17. Will this proposal provide resources to individual practices to develop interfaces with the HIE or the ACO or others?

Additional resources may be identified in gap remediation. This is specific to the defined scope of the Pan ACOs, including Participating Providers and Affiliates. Some work on HIE interfaces is already within the scope of VITLs contracts with DVHA, other work required outside the scope of this project will most likely require other VHCIP or other funding.

18. How does this proposal implement efficient, cost-effective bi-directional solutions for sharing key information across provider types, since many LTSS providers lack EHR.

- a. On Slide 8, is bi-directional communication between all types of providers participating in an ACO implied in the phrase “electronic data to be routed to ACOs”? Please explain and give examples.

We will include assessment of data elements needed from these providers and they will be able to participate in an ENS and can access data in VITL Access. We expect the gap analysis to identify where gaps exist and the extent of remediation work and funding required.

19. Could this work be expanded to include processes to share information across provider types through web portals that support common tools (e.g. uniform transition of care form)?

Yes, it could be expanded through VITL Access or ACO-based analytic and care management systems. We fully expect this work to lead directly to increased ability to share information. It is not however in the current scope of this proposal.

20. On Slide 3 what is meant by “relevant clinical information”
At a minimum the data elements required to support CMS-defined and VHCIP-developed and GMCB approved quality measures and events.
21. On Slide 6, Please describe the benefits of “the Gateway Build” for people receiving services from providers working in community based settings (e.g. private homes, Area Agencies on Aging, residential care homes, adult day centers).
- a. On Slide 9, how will the “Gateway Build” be used to connect long-term services and support providers with primary care and hospital providers? Please provide descriptions (e.g. use case examples) describing which “source systems” will be connected (e.g. OASIS? MDS? DA/EHR? etc.)
 - b. On Slide 10, can a more detailed explanation of the ACO Gateway Architecture be shared?

VITL is glad to provide more detail on what functionality is provided by a gateway, as a data disseminator. Again, this proposed system and project form the foundation upon which we think much of the statewide data sharing will ultimately occur. Gap remediation is intended to identify where further work will be needed and to frame some discussions as to priorities and resources needed. Ultimately, the success of the system and the benefits which accrue to patients will be dependent on the universality of coverage, so the long term goal is to connect all providers.

Questions related to data, including potential data collection restrictions:

22. *[This question was submitted by the Work Group leadership team]* Specific concerns have been raised by members of the work group regarding the ability of the Designated Mental Health Agencies to share information with VITL and other providers given the privacy restrictions related to the exchange of sensitive health information, including especially from federally regulated substance abuse treatment programs (42 CFR Part 2). How do you intend to address those restrictions in your proposal?

The scope of work for the ACOs does not include addressing 42 CFR Part 2. VITL is pursuing some options with DVHA that are parallel and independent of the Pan ACO work. A formal plan for addressing the issue is being developed jointly among VITL, DVHA, FQHCs, and the Designated Agencies.

23. What about Specialized Service Agencies? How does their client data fit in? (NFI, small Developmental Disability stand-alone agencies)

The proposed scope is ACO membership and affiliates at this time but we hope to involve all who touch ACO-attributed patients in the discussion

24. What kind of access will affiliate providers have to the data analytics for their clients? There are a number of platforms so that may differ from one ACO to the other.

This is the outcome of ACO specific decisions. ACOs intend to deploy analytics to providers across the continuum of care community.

25. What will be the impact on existing infrastructure? I see the work with the VHIE allowing for a more robust clinical data set that can enhance the current claims data set. I'm not sure alone whether either, VHIE or claims, paints a full picture, so the statement "build a single common infrastructure to electronically report on quality measures" stands out to me.

It will expand and improve the existing infrastructure by matching claims and clinical data to enable the exchange of clinical data for analytics and event notification system. This approach mitigates the need for multiple identical infrastructures, by building a single cost effective infrastructure.

Questions related to the ACO structure and/or VITL relationships:

26. How many of the DA/SSA clients will be attributed to the ACOs?

Patients are attributed to the ACOs by the patient attribution methodology. The ACOs at this time do not know the number of attributed patients for the new programs

27. How many full spectrum clients will be attributed?

Same as previous answer.

28. How are SASH teams working with VITL and the ACOs?

The providers are working with SASH directly, through Blueprint initiatives, and through the VHCIP Care Model and Care Management workgroup. This is an area that is likely to get more attention either in the gap analysis or in the next generation of the project.

29. How will the individual practices that are not part of the ACO be represented in this process?

The scope of work includes ACO providers and affiliates for the ACO gateway routing of data. It also includes an event notification system encompassing all providers in Vermont. It will also form the foundation for future expansion. We support a similar effort by VITL for all providers to have the richest data set available for ACO-attributed patients, and in a next generation system, for all providers to have access.

30. How will project be administered among the ACOs given they are very different in their size, scale, governance, and makeup?

This is in process among the ACOs and VITL. So far, we have managed to move the collaboration along through a common goal for a unified system, discussion, and facilitation by state representatives and VITL staff. If we find the need to create a more formal decision making process, then we'll have to draft one. Discussions and work sharing has been extremely collegial to this point.

31. Is (or would) the PAN ACO group be willing to include staff familiar with the technology systems supporting the following LTSS providers:

- Home Health
- Area Agencies on Aging
- Nursing Facilities
- Developmental Disabilities services

VITL has and will continue to work with any and all providers in Vermont. The ACOs and VITL want to be open and collaborative with these LTSS providers as this project works with them. The ACOs are actively working on participation agreements with a number of providers and agencies and that activity in combination with the gap analysis will quite naturally bring LTSS providers to the table either on this round or the next.

32. On Slide 6, are the ACO participants in the Designated Agencies limited to Mental Health (\$199M) and Substance Abuse (\$20M)?

The ACOs are interested in discussions related to any organizations involved with attributed members. The Medicaid Shared Savings Program (and Medicare and Commercial as well) as developed and approved by the VHCIP Payment Models work group contains information on which patient populations are attributed and which specific spending items are included in the cost targets and when.

33. On Slide 6, are developmental disabilities services (\$160M) and Traumatic Brain Injury providers included within the ACO participant network?

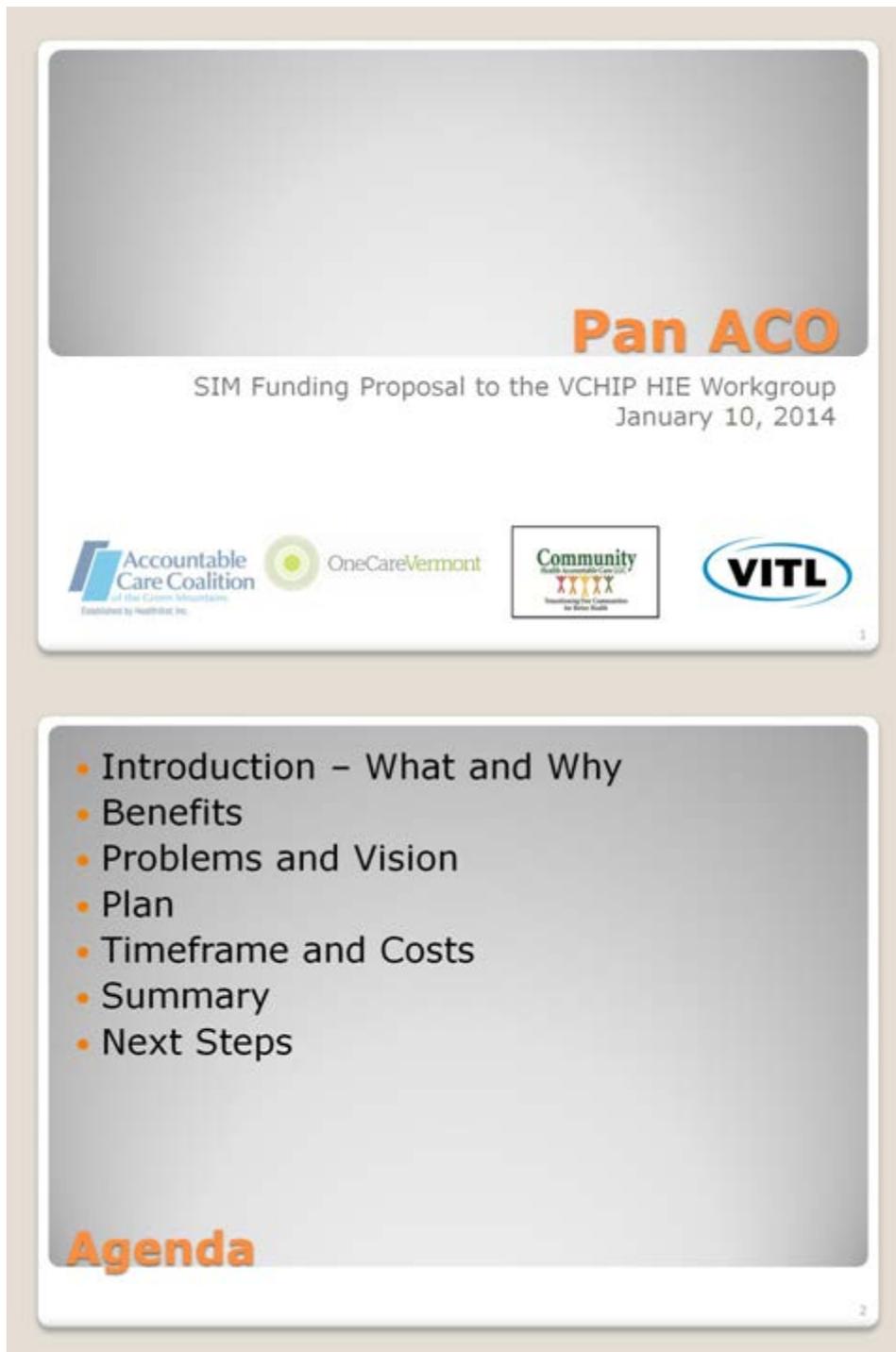
Same as previous answer.

34. On Slide 8, which “care managers” are within the scope of those being notified of important clinical events?

A primary goal of this project is sharing clinical data in support of care management.

This type of design and use case process will be a part of ACO work with its network and with the VHCP Care Models and Care Management subgroup where common approaches across ACOs is warranted. While this effort is starting among the three ACOs, the goal is that each ACO “network” will encompass a very broad scope of care managers. Any health care provider in Vermont who has a data use agreement with VITL may participate in the Event Notification System.

V. Appendix D – PowerPoint to HIE Work Group



- There are **three Accountable Care Organizations** in Vermont, whose members comprise a large and growing majority of the healthcare delivery system in the state:
 - OneCare Vermont (OCV)
 - Community Health Accountable Care (CHAC)
 - Accountable Care Coalition of the Green Mountains (ACCGM)
- **Collaborating** to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients.
Key Message: Heavily aligns with the state HIE Plan and Priorities

What Are We Doing?

3

- The Pan ACO collaboration is to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017.
- The **3 ACOs are collaborating** on aligned processes and infrastructure where it makes sense including **with VITL to build technology infrastructure** that is consistent with a state-wide **high performing healthcare system**.

Why Are We Collaborating?

4

- Make **rapid progress against state HIE plan**
 - Faster than other approaches
- Provide **path for 2014 patient care benefits** of healthcare information exchange across providers and through ACO population approaches
 - Clinically more impactful, earlier than other approaches
- **Exploit the efficiencies of a collaborative project effort** involving all three Vermont ACOs, their providers, VITL, and the VHCIP work group
 - Less expensive than other approaches
- Provide a mechanism for the VHCIP work group to **measure and demonstrate tangible progress**
 - More concrete to show progress to CMS/CMMI, VHCIP Steering Committee, Core Team, GMCB

Benefits

5

	Hospitals	FQHC	PCPs - Blueprint PCMH	PCP - Non-Blueprint Practices	Specialty Physician	SNF	MH	MH & SA
OCV	2 ANCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices	2 Independent Practices	All Hospital Employed (1800 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Providers
CHAC	Expected Local Collaborations	7 FQHCs	Participating FQHC Practice Sites (35 Practice sites) 100+ PCP FTEs	None	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
ACCGM	Expected Local Collaborations	None	10 Independent Practices	2 Independent Practices	6 Independent Practices	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Sub-Total in ACOs	100%	91%	70%	40%	85%	80%	80%	100%
Remaining Providers	None	None	30%	60%	15%	20%	20%	None

ACO Participants

6

- All providers **seamlessly contributing a full range of accurate clinical information** electronically to VITL
- **Well designed tools and interfaces** to access that information subject to data use agreements and patient consent models
- **Designed to serve a range of customers** including providers, ACOs, GACB, other regulators, DVHA/payers, others where appropriate

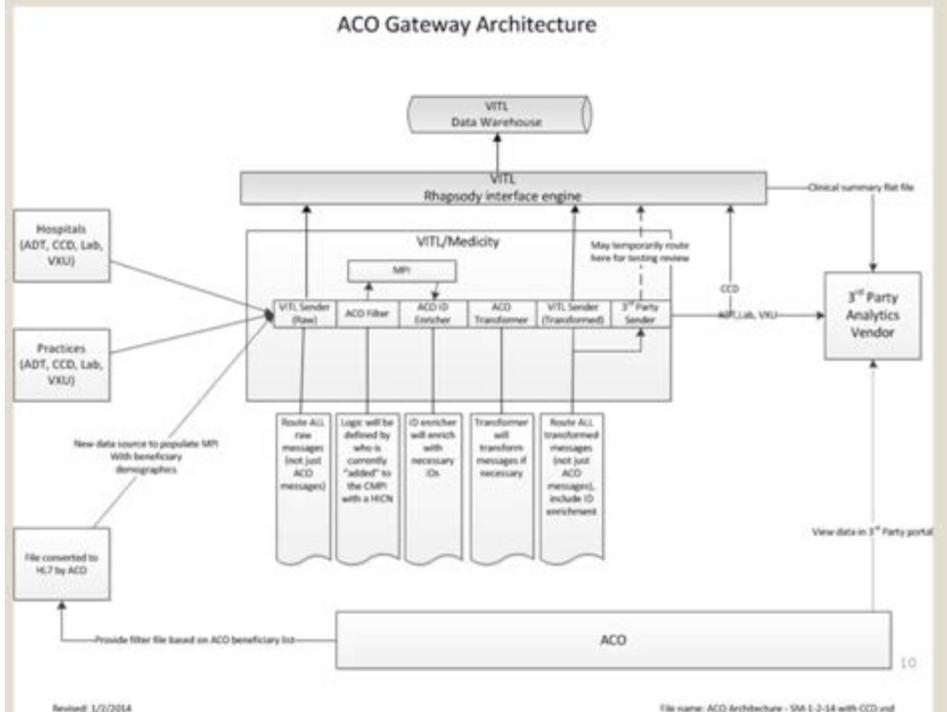
Vision of the Future

- We **don't know the current baseline status** of provider ability to capture and electronically transmit the clinical information needed for ACO/VCHIP Quality Measure data elements
- We need a way for **electronic data to be routed to ACOs** for Care Management and Analytic processes to support patient care
- We don't have the ability to **notify our Providers and Care Managers real time** when our patients have an important clinical event
- We still need to **fill some basic gaps** in HIE interfaces and data element exchange from hospitals and other providers

Problems to be Addressed

- **Gap Analysis**
 - Identify the gap among state-wide ACO data requirements and data capacity
- **Pan ACO Gateway Build**
 - Build the technical architecture to support movement of data from source systems to analytics destinations (*next slide*)
- **Event Notification**
 - Install a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters
- **Gap Remediation**
 - Expand data capacity of the State for improved population management

Scope of Work



Initiative	Timeframe ¹
Gap Analysis	<ul style="list-style-type: none"> • Estimated Start – Q1 2014 • Estimated complete Q3 2014
Pan ACO Gateway Build	<ul style="list-style-type: none"> • Estimated Start - Q1 2014 • Estimated complete –Q2 2015
Event Notification	<ul style="list-style-type: none"> • Estimated Start – Q1 2014 • Estimated complete – Q4 2014
Gap Remediation	<ul style="list-style-type: none"> • Estimated Start – Q1 2015 • Estimated complete – Q3 2016

¹ Start dates dependent on release of SIM funds

Timeframe

11

Initiative	Low Estimate ¹	High Estimate
Gap Analysis	\$50,000	\$75,000
Pan ACO Gateway Build	\$1,115,000	\$1,545,000
Event Notification	\$375,000	\$625,000
Gap Remediation (full)	TBD	TBD
Support	\$570,000	\$800,000
Total	\$2,110,000	\$3,045,000

¹ Based on preliminary pricing

Implementation Costs & 1st Year Support

12

Initiative	Annual Support ¹ (2015 and ongoing)
Gap Analysis	\$0
Pan ACO	50,000 Beneficiaries: \$438,000
Gateway	100,000 Beneficiaries: \$876,000
(annual)	200,000 Beneficiaries: \$1,752,000
Event Notification	Range of \$82,100 - \$136,800
Gap Remediation (full)	TBD

¹ Based on preliminary pricing

Support Costs (multiple sources of funding)

13

- **Collaboration** of 3 ACOs
- Providing **care to majority of Vermont residents**
- Collaborating with VITL to build single common patient data infrastructure to:
 - Better **manage patient care** (Improve Care)
 - Report on **quality of care** (Improve Care)
 - Notify and **manage care transitions** (Improve Care)
 - **Exchange relevant clinical information** among caregivers (Improve Care)
 - **Reduce healthcare costs**

Summary

14

- **Support from the VCHIP HIE Workgroup** for the vision and collaborative effort
- **Approve for release of SIM funds** for committed initiatives
 - **Implementation: \$2,110,000 - \$3,045,000**
 - **Support: Ongoing funding of support requires additional discussion of funding sources**
- **Support for refinement of costs** and well-defined funding requirements
 - Pan ACO to refine Implementation and Support Costs: **June 2014**
- **Timing is critical**

Next Steps

15