

HIE Work Group Meeting Agenda 6-04-2014

***VT Health Care Innovation Project
HIE Work Group Meeting Agenda***

**Wednesday, June 4, 2014; 9:00-11:30am
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call-In Number: 1-877-273-4202; Passcode 2252454**

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	9:00-9:05	Welcome and Introductions	Simone Rueschemeyer & Brian Otley	
2	9:05-9:10	Review and Acceptance of May 7 th Meeting Minutes	Simone Rueschemeyer & Brian Otley	Attachment 2: HIE Work Group Minutes 5.07.2014
3	9:10-9:20	Update on two approved proposals (ACO & ACTT)	Simone Rueschemeyer & Brian Otley	
4	9:20-9:55	Grant Program: recommendations to the Steering Committee: <ul style="list-style-type: none"> • Sub-grant Program 101 • Share Core Team's request • Review summaries of proposals • Brainstorming Exercise 	Georgia Maheras	Attachment 4: VHCIP Grant Program Round Two Link to VHCIP Round One Grant Application: http://healthcareinnovation.vermont.gov/sites/hcinovation/files/VHCIP.GP_Application.1.16.14.Final.pdf
5	9:55-10:25	Overview of the Vermont Health Information Strategic Plan (VHISP)	Steve Maier	Attachment 5a - VHISP Proposal Attachment 5b - Vermont Health Information Strategic Plan Acronyms
6	10:25-10:45	HIE/HIT Work Group Preview: June-November 2014	Georgia Maheras	Attachment 6a: HIE/HIT Work Group Preview for June-November 2014 Attachment 6b: Six month progress report and preview presented to the Core Team on May 19 th (background document)

7	10:45-10:55	Public Comment	Simone Rueschemeyer & Brian Otley	
8	10:55-11:00	Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	

Attachment 2 - HIE Work
Group Minutes 5-07-14



***VT Health Care Innovation Project
Health Information Exchange Work Group Meeting Minutes***

Date of meeting: Wednesday, May 7, 2014; 9:00-11:30am DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Attendees: Brian Otley, Co-Chair; Judy Audette, VA; Lou McLaren, MVP; Larry Sandage, Jennifer Egelhof, Alicia Cooper, Steve Maier, DVHA; Joel Benware, NMC; Peter Cobb, VNAs of VT; Brendan Hogan, Bailit Health Purchasing; Becky-Jo Cyr, Nancy Marinelli, AHS; Heather Skeels, Bi-State; Richard Slusky, Spenser Weppeler, Anna Bassford, GMCB; Jennifer Woodard, Tela Torrey, DAIL; Sandy Rouse, CVHHH; David Martini, DFR; Sean Uiteerwyk, WRFP; Mike Gagnon, VITL; Arsi Namdar, VNA of Chittenden County; Leah Fullem, One Care; Jim Harrison, Onpoint; Kaili Kuiper, VT Legal Aid; Amy Putnam, NCSS; Stuart Graves, WCMHS; Johnathan Bowley, Community Health Ctr. Burlington; Bob West, BCBS; Jessica Mendizabal, George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome, roll call and agenda review	Brian Otley called the meeting to order at 9:04 am.	
2. Approval of April 9th minutes	Heather Skeels moved to approve the minutes and Nancy Marinelli seconded. There was no discussion and the motion passed unanimously.	
3. Telemedicine/ Telehealth/ Telemonitoring Intro	<p><u>Telehealth (attachment 3)- Judy Audette, Vermont Veterans Association (VA)</u></p> <ul style="list-style-type: none"> • Data collected is monitored by an RN in real time. The computer can alert the RN to cases they need to pay attention to. • When nurses reach the patient they can assess what needs to be done to remedy the situation. • VA costs are \$1600 per year per person- but it's uncertain as to whether this includes the RN's time to evaluate data. • In-home technical requirements: currently POTS (Plain Old Telephone System) so internet access is not required. 	The group will need to develop criteria around telehealth proposals.

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • The technology provides the ability to catch something before it becomes crisis. Information is looked at each day and they can start to see trends more quickly, whereas it may not occur to the patient that they are getting into trouble. • Data is getting measured through the machine (weight, blood pressure, shortness of breath). • Steve Maier asked the group to think about possible reasons why telemedicine is still not widely used: payment barriers and cultural/clinical, where the technology is not trusted to yield the right kind of care remotely. • Patients could be discharged earlier because you know the patient will be able to be monitored at home, which could yield cost savings in hospitalizations. • “Store and Forward”- data is gathered and sent to a specialist for analysis. An example is Retinal Imaging for diabetes patients. For the VA, a clinician and technician are at every clinic and they find that the more stable patients are seeking care earlier, trying to supplement the annual eye exam. Technicians, LPNs or Medics run the equipment but they can’t make the assessment. VA retinal exams are being read in North Carolina. • With teledermatology they use a high tech camera and images are sent to dermatologist. About 50% of the patients don’t need to come to the office for a follow up. • Clinical Video occurs in real time and most of the time the transmission is uninterrupted. They can hold two visits at the same time and there is no delay. Sometimes there are other technical difficulties for which they have policies and procedures in place to minimize disruption. Computer staff is not used to having their work interfere with patient care but it’s rare to have a system go down and not get it back up. • High definition cameras and monitors are given to care providers. Currently 30 providers have this equipment. <ul style="list-style-type: none"> ○ This equipment is not custom- but the data needs to be compressed and sent securely in a codec (coder/decoder). The VA has a VLAN for clinical applications. If there are technical difficulties, the first system to go down is the administrative software, not provider/patient equipment. • The clinician needs a space to perform visits and be comfortable with the equipment. In some cases they could start medication early and then ask for a follow up appointment in person later. • VT VA is providing remote teaching for Wound and Ostomy to other VAs. • Jabber is a computer program being used in the homes. Its labor intensive on the patient side, so techs are sent to the home to set up the computer and have a video consult. They just started 	<p>The group may also want to form a telehealth subcommittee.</p>

Agenda Item	Discussion	Next Steps
	<p>this type of visit. They use a portable exam station with the same functions as larger cart and try to connect to patient's home using internet or use a cellular signal.</p> <ul style="list-style-type: none"> ○ New technology is coming with smaller devices that are more phone and tablet-like. The VA has a lot of regulations before they can make that change. ○ The VA often pays for travel for the patient so sometimes it's more cost effective and they get to see the patient's environment to see if that is affecting their health. <ul style="list-style-type: none"> ● Scheduling is the most complicated piece. Providers have a calendar that techs can schedule into using Microsoft SharePoint or Outlook. Staff may hold blocks of time specifically to schedule telehealth appointments. ● Patients can go to a different clinic when travelling (such as out of state) and still get care from their same provider. ● Recruitment and retention is higher because it allows providers to work from home. ● For those with cognitive issues or the older population, it is still easy to interact with the machines which are designed to be user friendly. ● Groups and peer support will connect with other veterans as people get a better of self-management. ● The VA has an EHR, but they will make appointments in VISTA and Outlook and then they have to marry the appointments. ● VA has licensed independent practitioners to practice telehealth but they can have their licensure in any state and work with the VA. ● Cell phone apps may do a similar job in the future at a lower cost. The VA is working on mobile apps but the most important aspect is that a clinician is assessing the data on the other end. <p><u>Home Care Telemonitoring- presentation by Peter Cobb, VNAs of Vermont</u></p> <ul style="list-style-type: none"> ● Insurance companies pay a fee for use. The Senate recently passed bill S.234 where Medicaid will pay for telemedicine services related to Congestive Heart Failure starting in July, 2014. ● Most agencies use satellites to transmit data. Devices are voice activated and smaller (like iPads). ● Telemonitoring is currently working well for the majority of patients that have it. ● For some patients it may mean more home care visits and for some they may go to the hospital quicker than they would otherwise, but they can be treated more quickly and problems resolved earlier. 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • Congestive Heart Failure: smaller studies have demonstrated that telemonitoring works well but larger studies (such as the New England Journal of Medicine) show that it doesn't work as well and improved outcomes are more related to care coordination. Is health improved because of telemonitoring or because patients are getting more direct care? This will vary by patient. Some patients can be taught to learn what their symptoms are and that is where the success can be: for them to do self-monitoring. • All VNAs have the telemonitoring equipment. • Payment from Medicaid is \$350/month/person and does not replace payment for nurse visits. The total cost would include equipment, maintenance, and nurse's time. <p>Tara McMahon, from VNA of Chittenden and Grand Isle Counties, gave an equipment demonstration of a portable device patients can use in the home by themselves. The equipment can test vital signs and asks health questions.</p> <ul style="list-style-type: none"> • As long as the visually impaired can hear, they only have to press one button and can still use the equipment. • If patients don't check in at a certain time, the nurse calls within the hour. Patients can check more often, but they know a nurse may not see it. • Nurses do look out for unusual activity (such as other people in the household using the equipment). • Telemonitoring is being used for Diabetes but Medicaid is not going to pay for it yet. Because most patients don't have just one diagnosis, Diabetes is not the primary reason for care. Patients can still punch in blood sugar numbers and be monitored. • Central VT HHH is piloting telemonitoring with Diabetes. The entire care management team is receiving the data and having monthly meetings as well. <p>Regarding future funding:</p> <ul style="list-style-type: none"> • The new legislation allows DVHA and HHH to seek grant funding for expense reimbursements. The VNAs may apply for a provider grant. Medicaid reimbursable costs are not eligible to be grant funded but they can apply to fund other aspects. • Arsi Namdar noted challenges around data that exists within the HHH. The data is not shared with other agencies or the HIE. Each vendor has requirements and costs. The data is also transferred manually from one program to the other- there is no import function. 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • Richard talked with John Evans about connectivity criteria: if organizations are purchasing an EHR in VT, there needs to be capabilities to send it to VEHI and if the data can't be transmitted, should there be consequences? Arsi responded that the VNA of Chittenden County has had their system for 20 years and it could take up to three years to implement a new system. Their current system can be upgraded but they need to find funding to pay for it to connect to other programs. • Other companies are working on features including motion detectors such as AT&T, Verizon etc. Machines will continue to improve and that kind of technology is likely. Working with these companies might not be feasible since the VNAs need to follow certain standards such as EHR compatibility. • Judy noted it's important that the nurses monitoring the data don't become complacent. As a manager she can see what the patient reported and how the nurse intervened, so she can manage the staff better. • A common question that arose in the legislature was "will telemonitoring make health care less personable?" Stuart Graves noted its making health care more personable because it's bringing groups together for care coordination. • Richard stated that there is funding assigned to the HIE work group for telehealth. He referenced the ACTT proposal where different organizations came together to develop a proposal and the VNAs could do the same for telehealth needs. • Eric Topol gave a Ted Talk entitled "The Wireless Future of Medicine" related to cell phone technology and health care to which the group may be interested in listening. Creative Destruction of Medicine is a related book by the same speaker. 	
<p>4. Grant Program 'referrals' discussion</p>	<p>Some provider grant applications that were not awarded have been referred to work groups by the Core Team. They are looking for qualitative feedback on the applications, and further guidance will be provided soon. The HIE work group wants to have a general conversation about criteria before looking at each application individually. The group is not meant to score the applications necessarily, but look at the applications to see if there are ideas that align with the group's work plan, and/or whether the applicant should re-apply in round two.</p> <p>Richard reminded the group that the two proposals already funded with HIE work group funds will most likely come back to the group for more funding, and there is funding allocated for telehealth proposals as well- so there may be less funding available for those referred applications.</p>	<p>Georgia, Co-Chairs and work group staff will provide more information and guidance and a timeline for to the group.</p>

Agenda Item	Discussion	Next Steps
	<p>The Core Team is looking for feedback by June 30th. There will be an in-depth discussion on this topic at the next meeting.</p>	
<p>5. Public Comment</p>	<p>Jen Egelhof noted having the status reports from other work groups was helpful.</p> <p>Richard Slusky stated that the ACO proposal has been approved by CMMI and the ACTT proposal is going through the approval process.</p>	
<p>6. Next Steps, Wrap-Up and Future Meeting Schedule</p>	<p>Next Meeting: Wednesday, June 4th 9:00 – 11:30 am, AHS - DVHA Large Conference Room, 312 Hurricane Lane, Williston.</p> <p>Next Steps: Larry Sandage reminded the group that at the next meeting they will review the work plan to identify any clear gaps in what has not been accomplished to date and identify any high priority projects that would help not only their organization, but also the greater goals of HIE.</p>	

Attachment 4 - VHCIP Grant Program Round Two

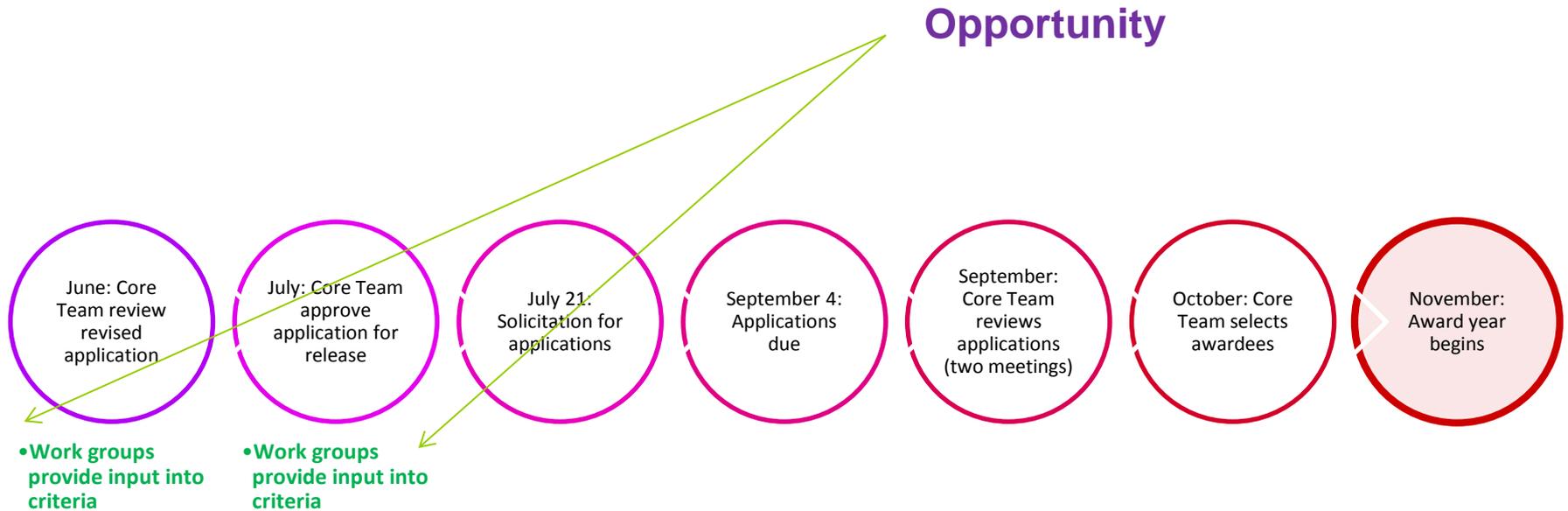
VHCIP Round Two Grant Award Background

June 5, 2014

Georgia Maheras, JD

Project Director

Timeline



Request:

- The Core Team requested that the work groups provide feedback that would inform the criteria used in a subsequent round of grant funding.

Grant Program Goals

- Grant Program is intended to foster health care innovation throughout Vermont.
- To maximize the impact of non-governmental entity involvement in this health care reform effort.

Grant Program Criteria

- Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application.
- Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
 - **Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;**
 - Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
 - Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference for:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots.

Awardee Summaries:

Grantee
Rutland Area Visiting Nurse Association & Hospice in Collaboration with Rutland Regional Medical Center, Community Health Centers of the Rutland Region and the Rutland Community Health Team
Project Description
This project will support design and implementation of a supportive care program for seriously ill patients with congestive heart failure and /or chronic lung disease. The program will improve communication between the multiple providers and organizations involved in the care of these patients and advance a patient-centered model for care planning and shared decision-making. The project is expected to reduce use of hospital and emergency department care, improve patient quality of life and save money.

Grantee
Northeastern Vermont Regional Hospital in Collaboration with Northern Counties Health Care, Rural Edge Affordable Housing, the Support and Services at Home (SASH) Program, the Northeastern Vermont Area Agency on Aging and Northeast Kingdom Community Services
Project Description
This project will provide flexible funding for goods and services not normally covered by insurance, enabling an integrated multi-disciplinary community care team to better care for clients who are at risk for poor outcomes and high costs of medical care.

Awardee Summaries:

Grantee
White River Family Practice in Collaboration with the Geisel School of Medicine at Dartmouth College
Project Description
This project will continue work at one of the most innovative primary care practices in the state to manage patient care using data systems, team-based care protocols and tools shown to improve patient self-management of their health. The focus will be on patients with chronic conditions who often have high emergency room use and high rates of hospital readmission.

Grantee
InvestEAP in Collaboration with the Burlington Community Health Center and Northern Counties Health Care
Project Description
InvestEAP, Vermont's public/private employee assistance program, and two federally-qualified health centers, will partner to demonstrate the impact of integrating an innovative stress prevention and early intervention program with traditional primary care delivery. The project embodies the core belief that early intervention aimed at the social determinants of health and the root causes of stress will improve health outcomes and reduce medical expenditures.

Awardee Summaries:

Grantee

The Vermont Medical Society Education and Research Foundation in Collaboration with Vermont’s “Hospitalist” Physicians and the Fletcher Allen Health Care Department of Pathology and Laboratory Medicine

Project Description

This project will support an effort to decrease waste and potential harm in the hospital setting based on evidence behind the national “Choosing Wisely” campaign that estimates 30 percent of U.S. health care spending is avoidable and potentially harmful. Physicians from Vermont hospitals and Dartmouth-Hitchcock Medical Center will work together to reduce unnecessary lab testing, and in doing so will create a statewide provider network to lead additional waste reduction and care improvement efforts.

Grantee

Bi-State Primary Care in Collaboration with all Participating Providers and Affiliates of Community Health Accountable Care

Project Description

Seven Federally Qualified Health Centers and Bi-State have formed a primary care centric Accountable Care Organization, Community Health Accountable Care (CHAC), to participate in Shared Savings Programs with all payers. This capacity grant will allow CHAC to further develop their ACO infrastructure to manage patient care. Their specific focus will be to integrate with other community providers, including Behavioral Health Network of VT, the VT Assembly of Home Health and Hospice, Area Agencies on Aging and the Support and Services at Home program.

Awardee Summaries:

Grantee

HealthFirst in Collaboration with all Participating Providers and Affiliates of their ACOs: Accountable Care Coalition of the Green Mountains and Vermont Collaborative Physicians

Project Description

HealthFirst is an Independent Practice Association that includes 120 physicians in 58 independent practices in Vermont. HealthFirst has formed ACOs to participate in both the Medicare and commercial shared savings programs. This capacity grant will allow HealthFirst to further develop their ACO infrastructure to manage patient care. Their specific focus will be increasing coordination between physical and mental health providers and increasing communication between primary care and specialty physicians.

Grantee

The Vermont Program for Quality in Health Care in Collaboration with the Vermont Association of Hospitals and Health Systems, all Vermont hospitals and the Vermont chapter of the American College of Surgeons

Project Description

This grant will provide partial funding for a statewide surgical quality improvement program. The program will gather clinical data to feed into a national database maintained by the American College of Surgeons, allowing Vermont surgeons to benchmark their practices and outcomes against peers nationally and target improvement efforts. The program is expected to improve surgical outcomes, enhance patient safety and reduce costs from surgical complications.

Attachment 5a - VHISP Proposal

Overview of the Vermont Health Information Strategic Plan (VHISP)

Steve Maier

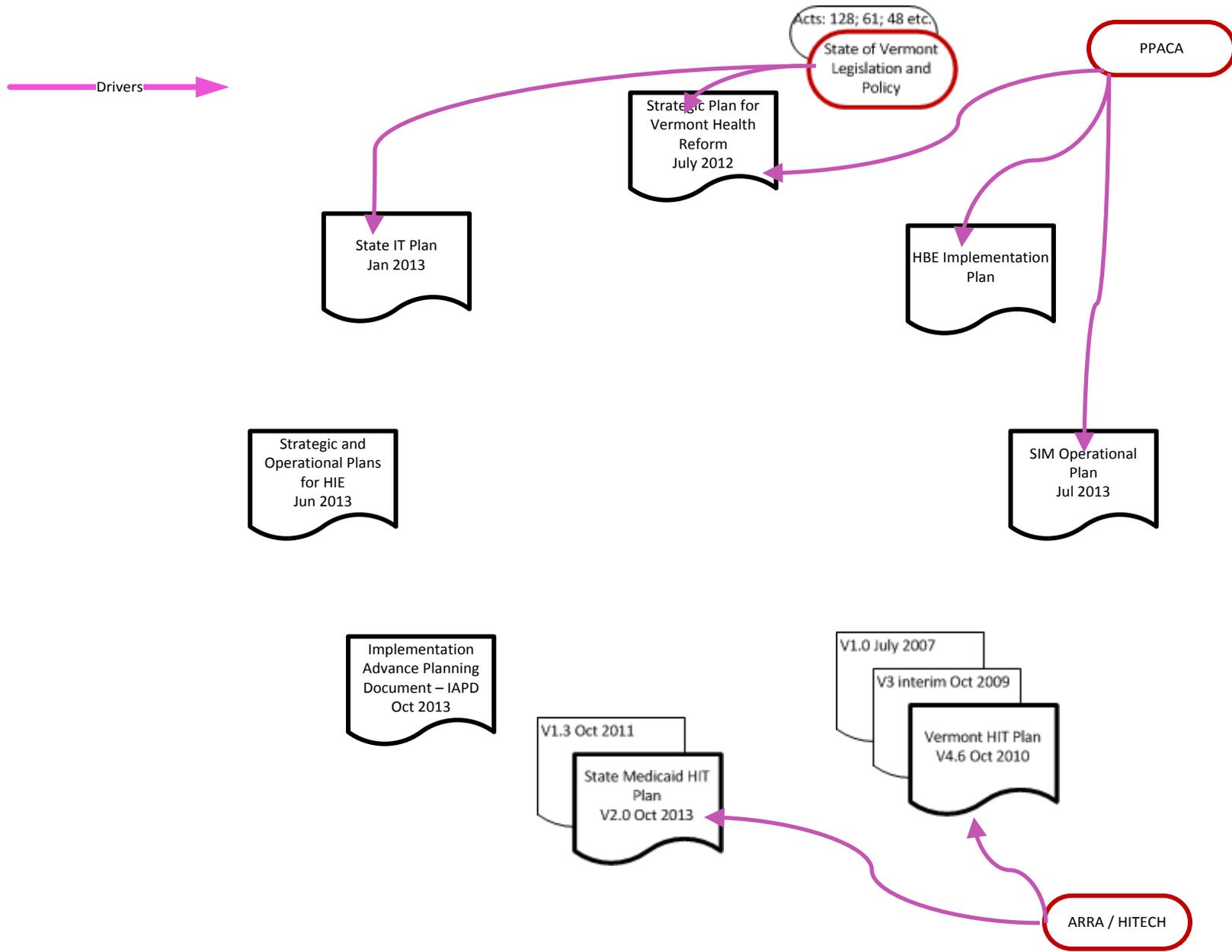
Health Care Reform Manager, DVHA

June 4, 2014

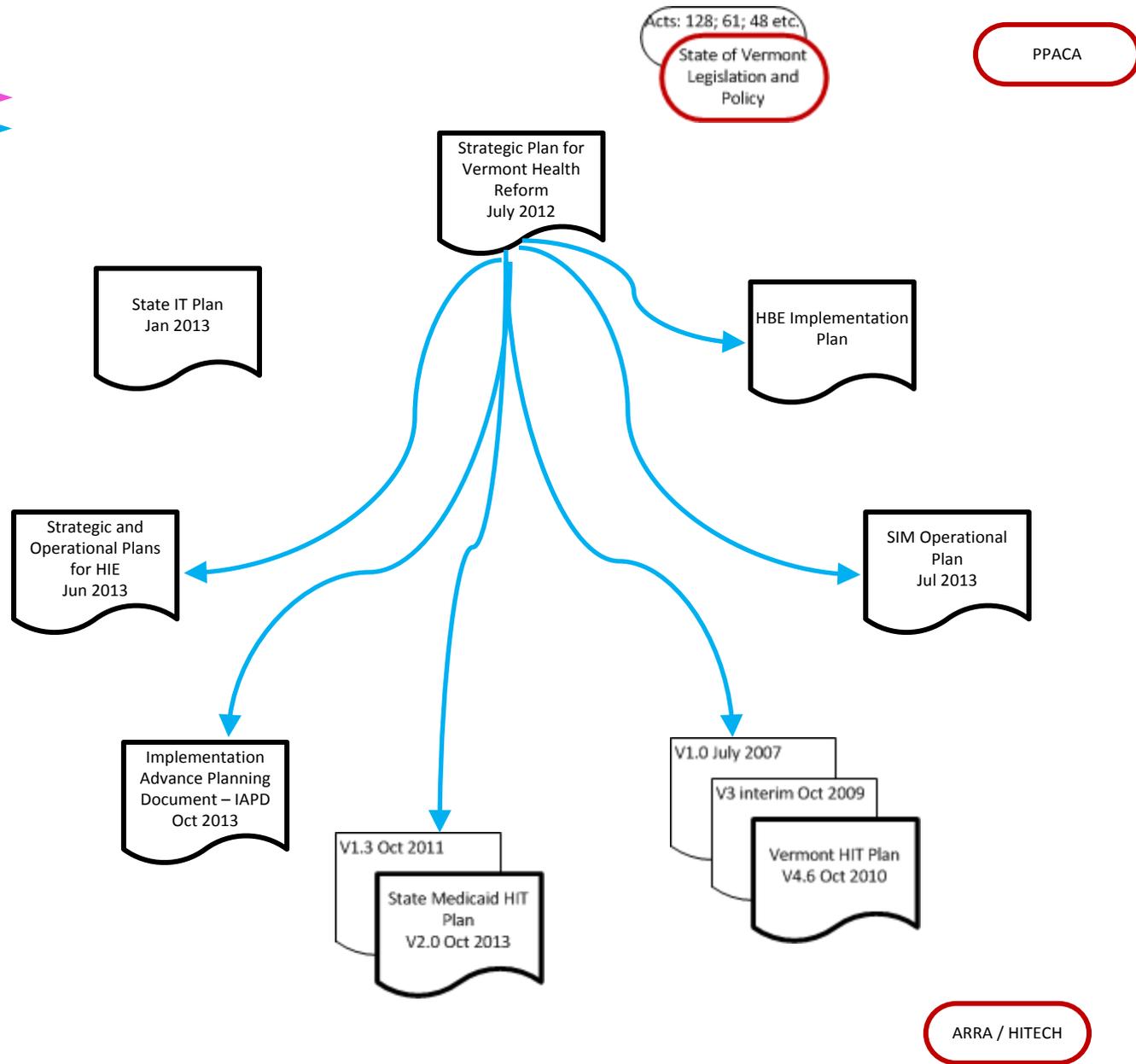
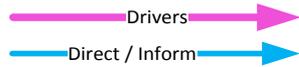
VHISP Proposal

- Background: the Planning Landscape for Vermont Health Care Reform
- VHISP Value Proposition
- VHISP Major Components
 - Update; Expand; Develop
- High Level Plan for the VHISP Development
 - Possible Sequence
- Status Update and VITL Role
- Clarifications Required Before Proceeding
- Discussion and Direction

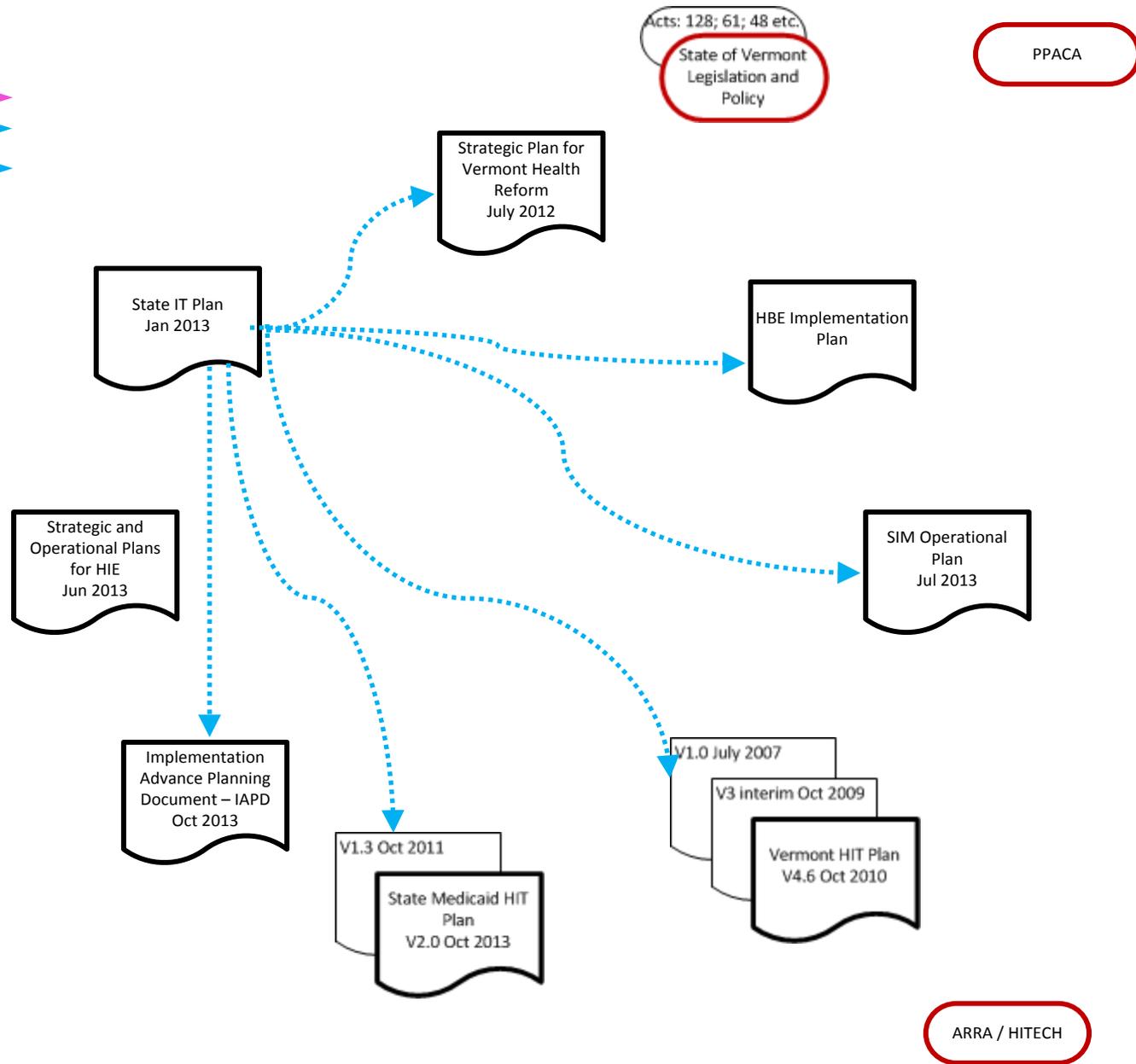
Planning Landscape for Health Care Reform



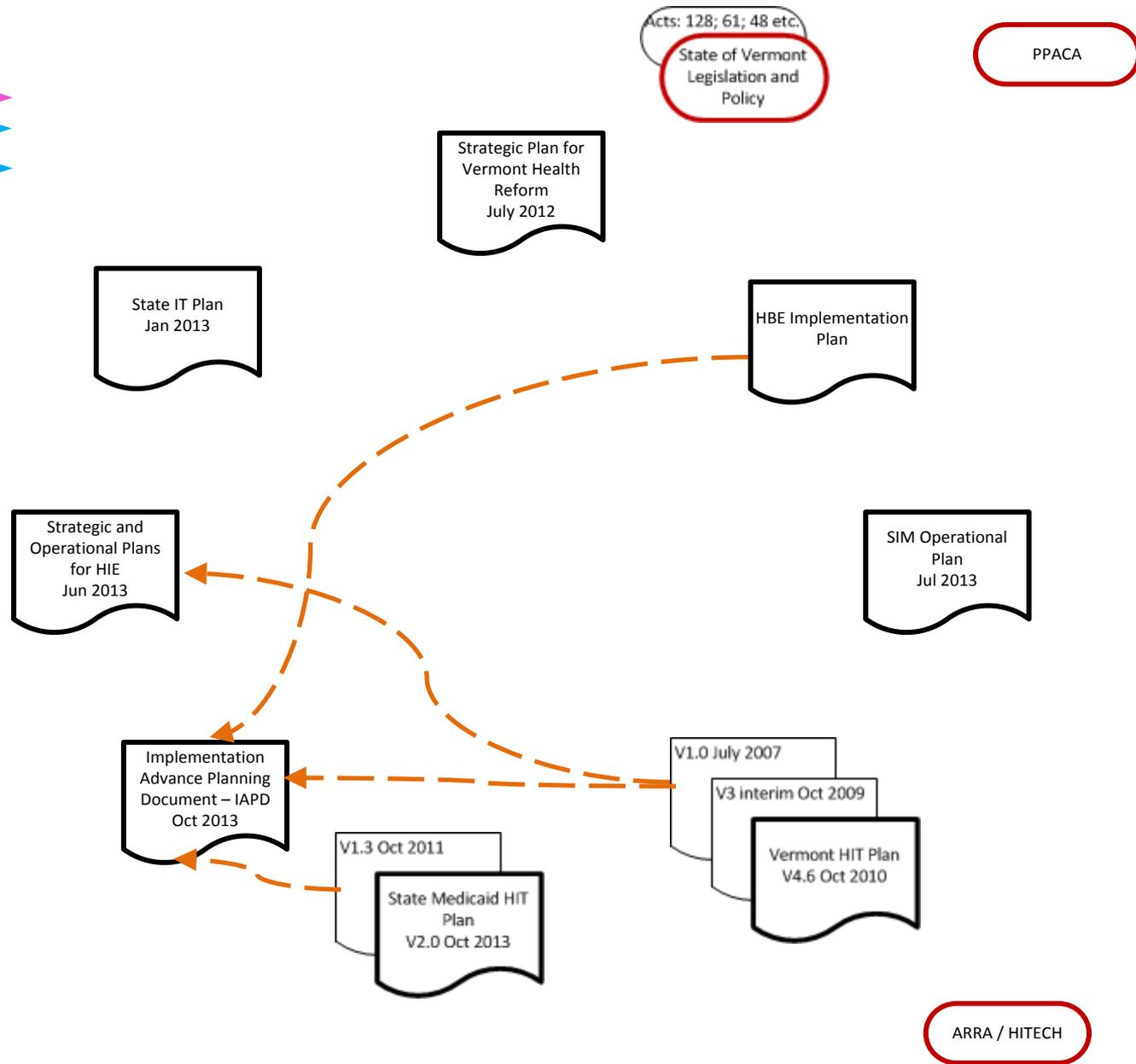
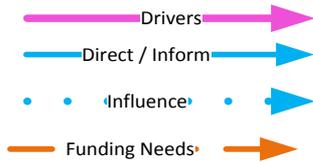
Planning Landscape for Health Care Reform



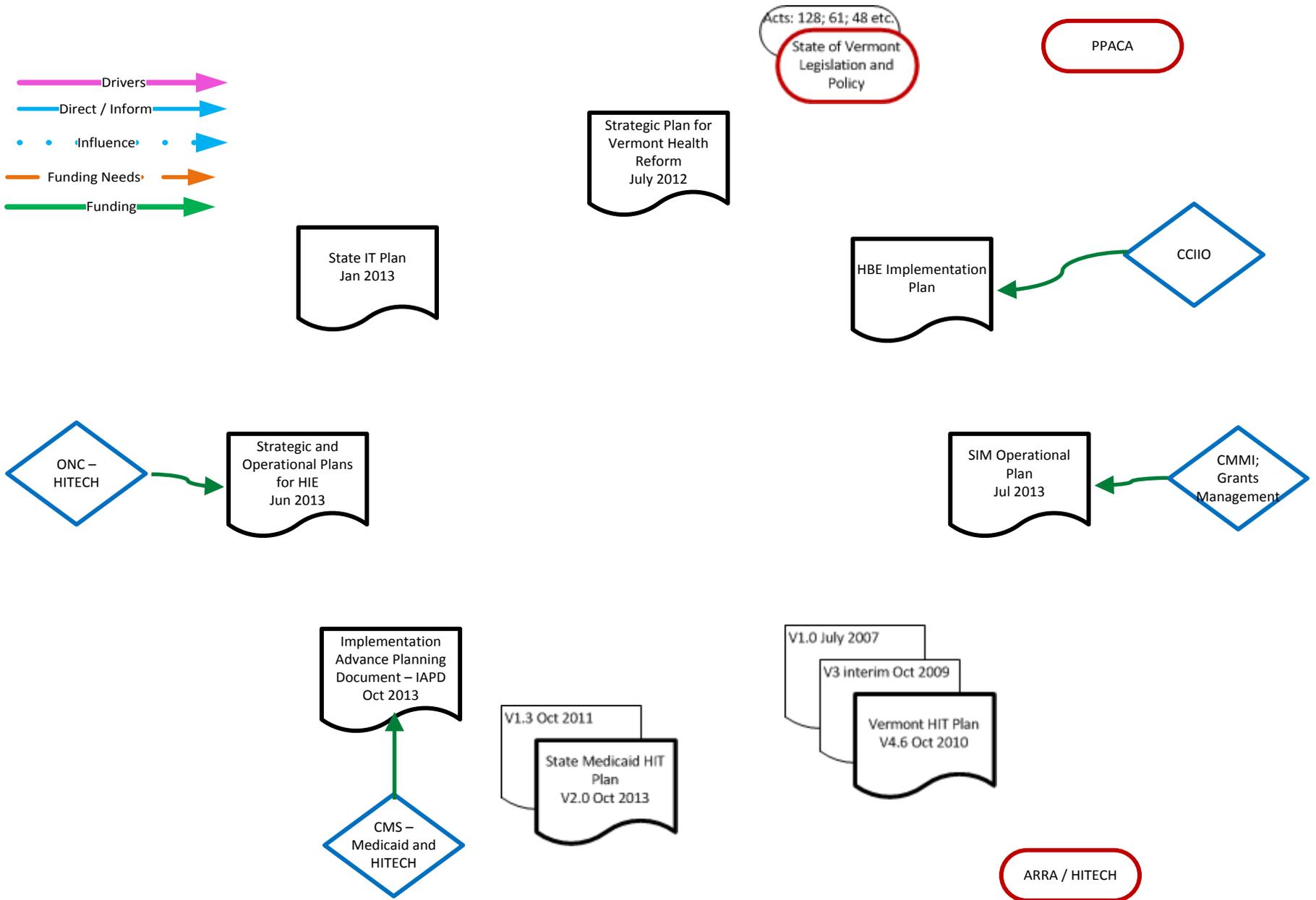
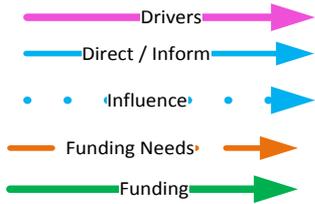
Planning Landscape for Health Care Reform



Planning Landscape for Health Care Reform

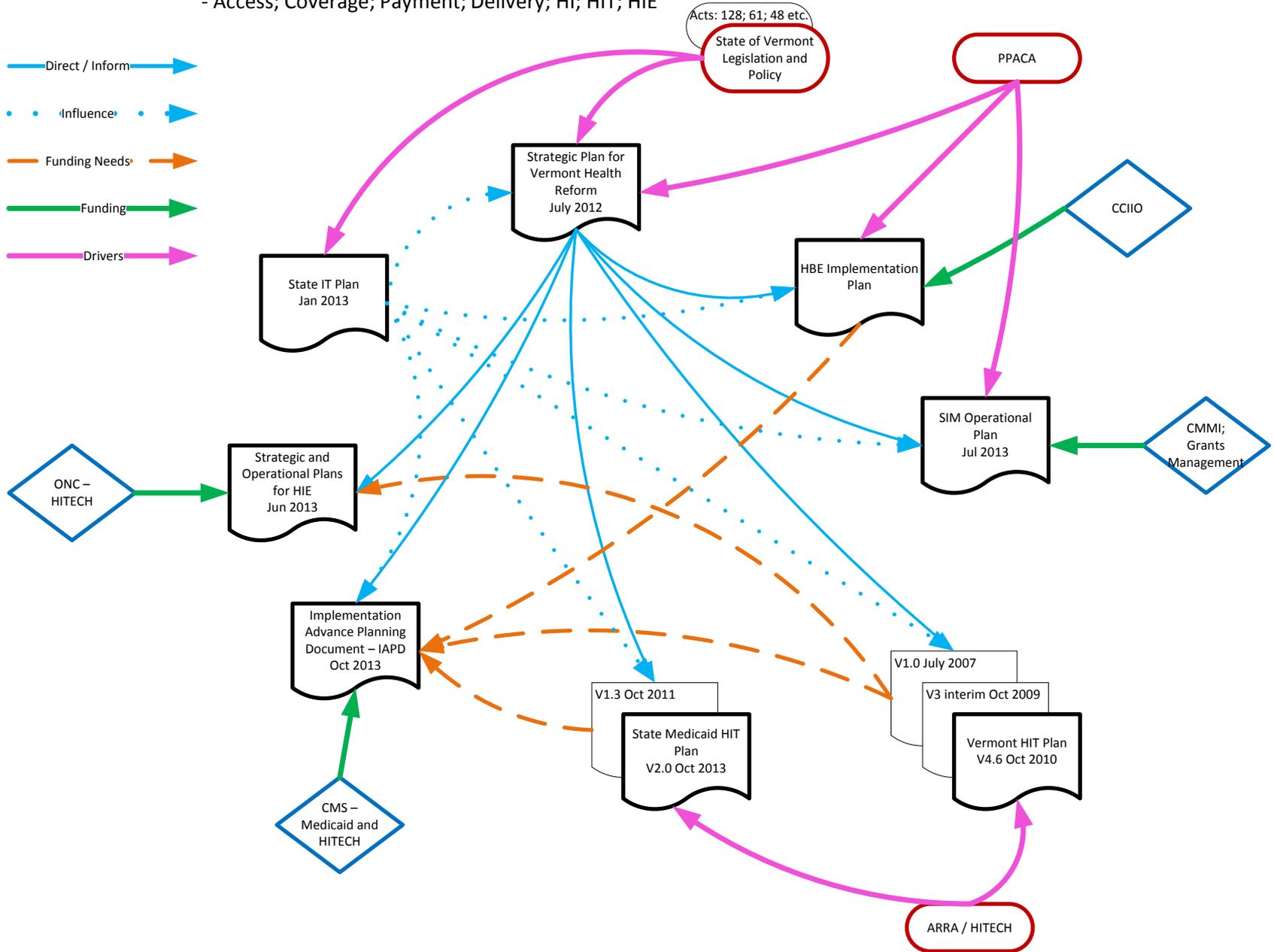


Planning Landscape for Health Care Reform



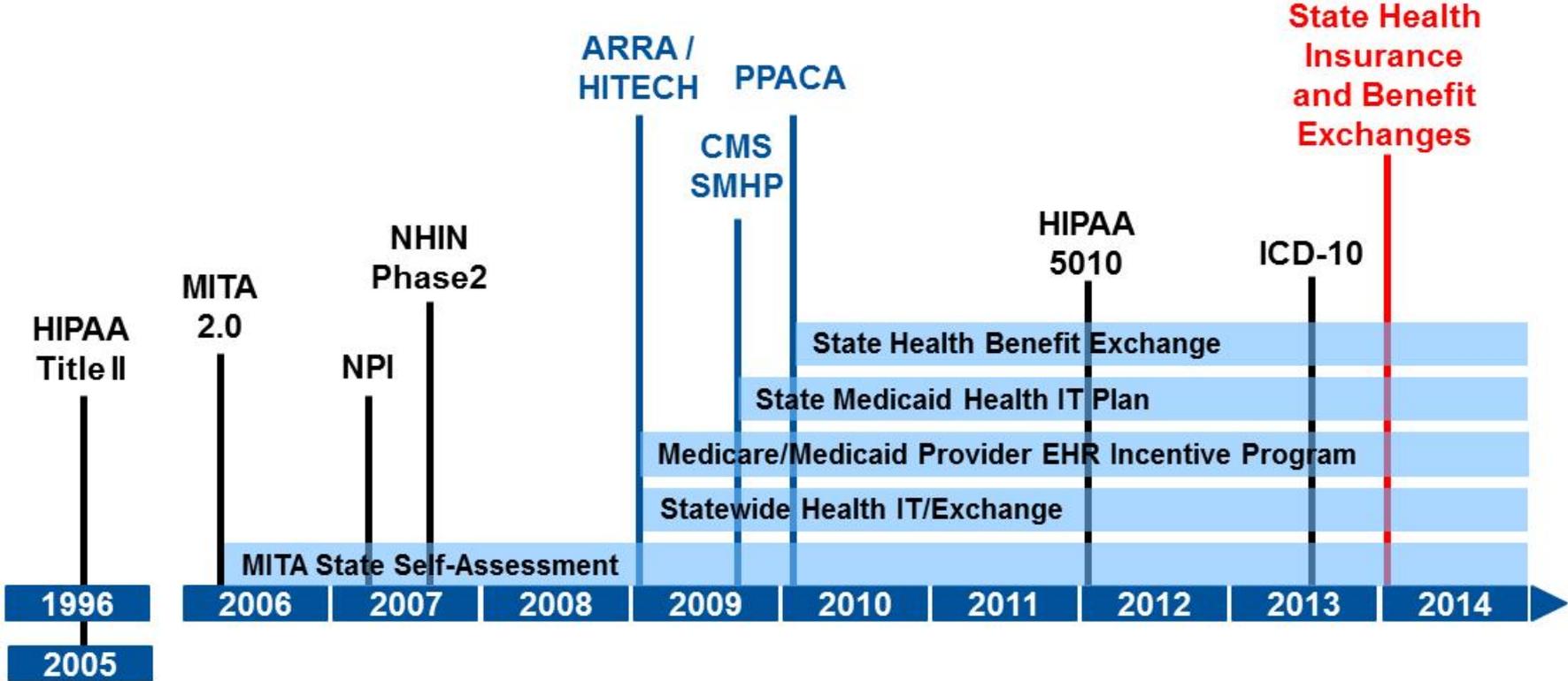
Planning Landscape for Health Care Reform

- Access; Coverage; Payment; Delivery; HI; HIT; HIE



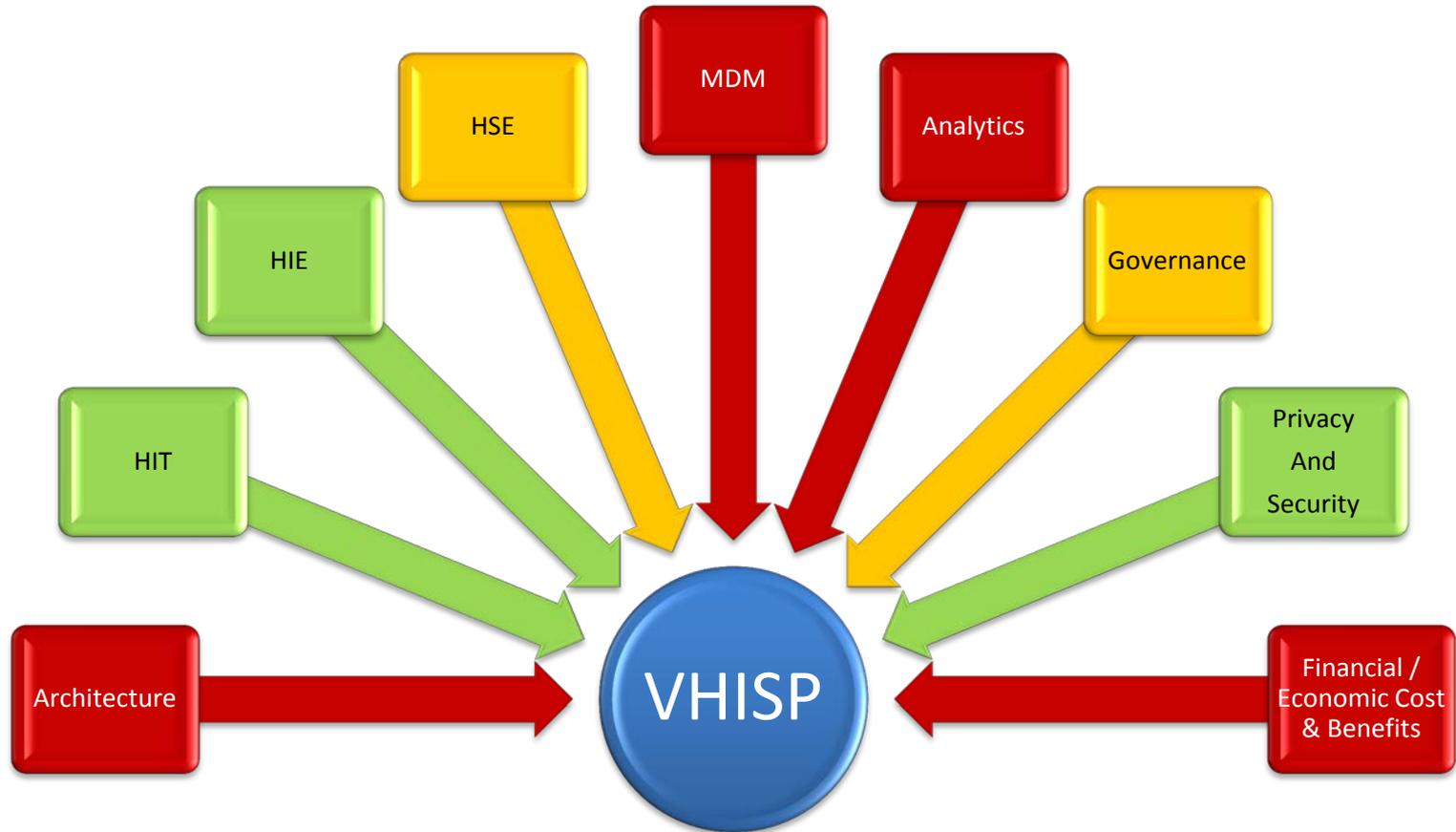
Integrating Opportunities and Mandates

Each of these distinct but complementary activities has been sequentially released to meet specific policy or program objectives but without a unifying architectural framework.

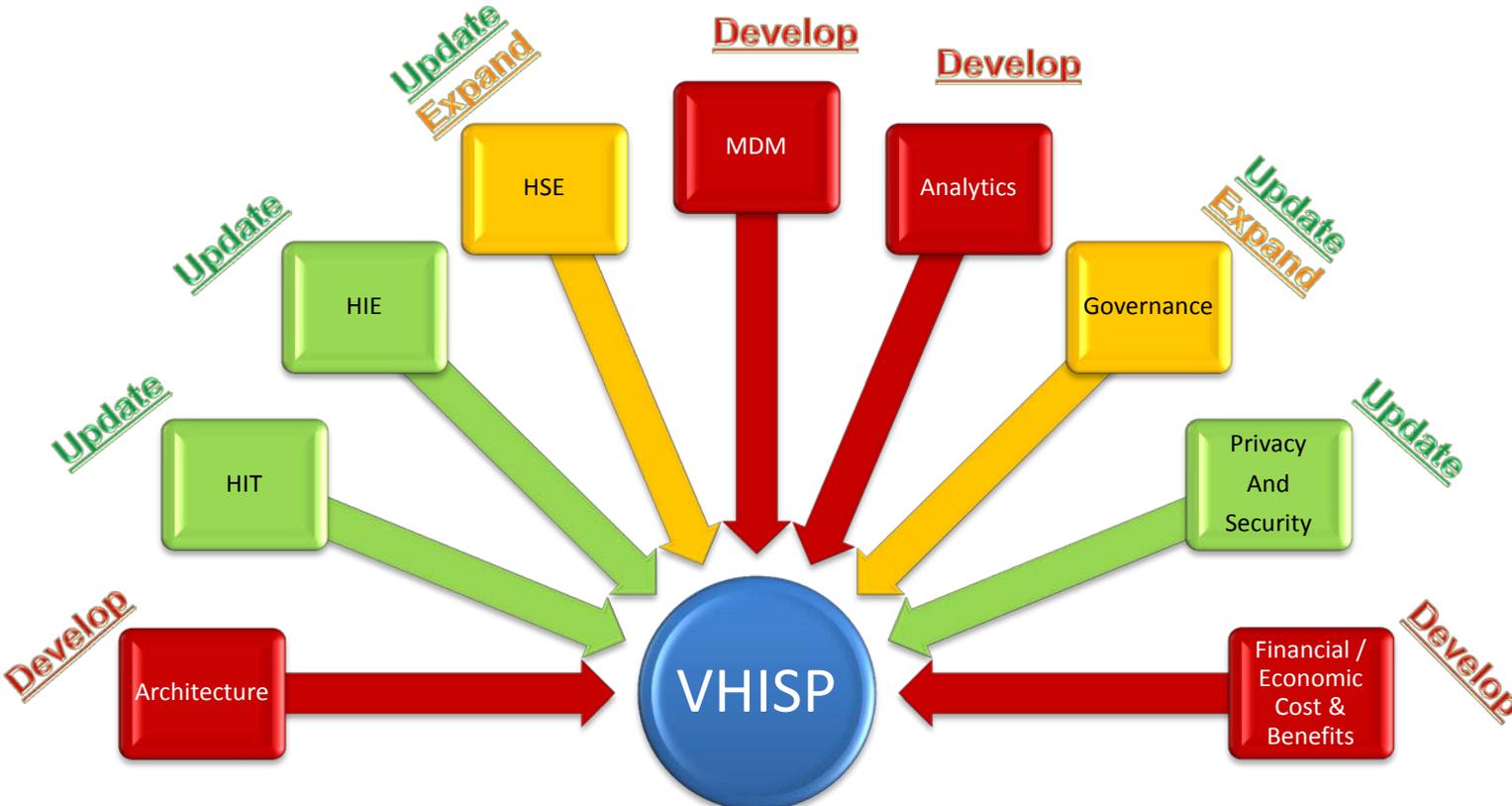


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VHISP Components



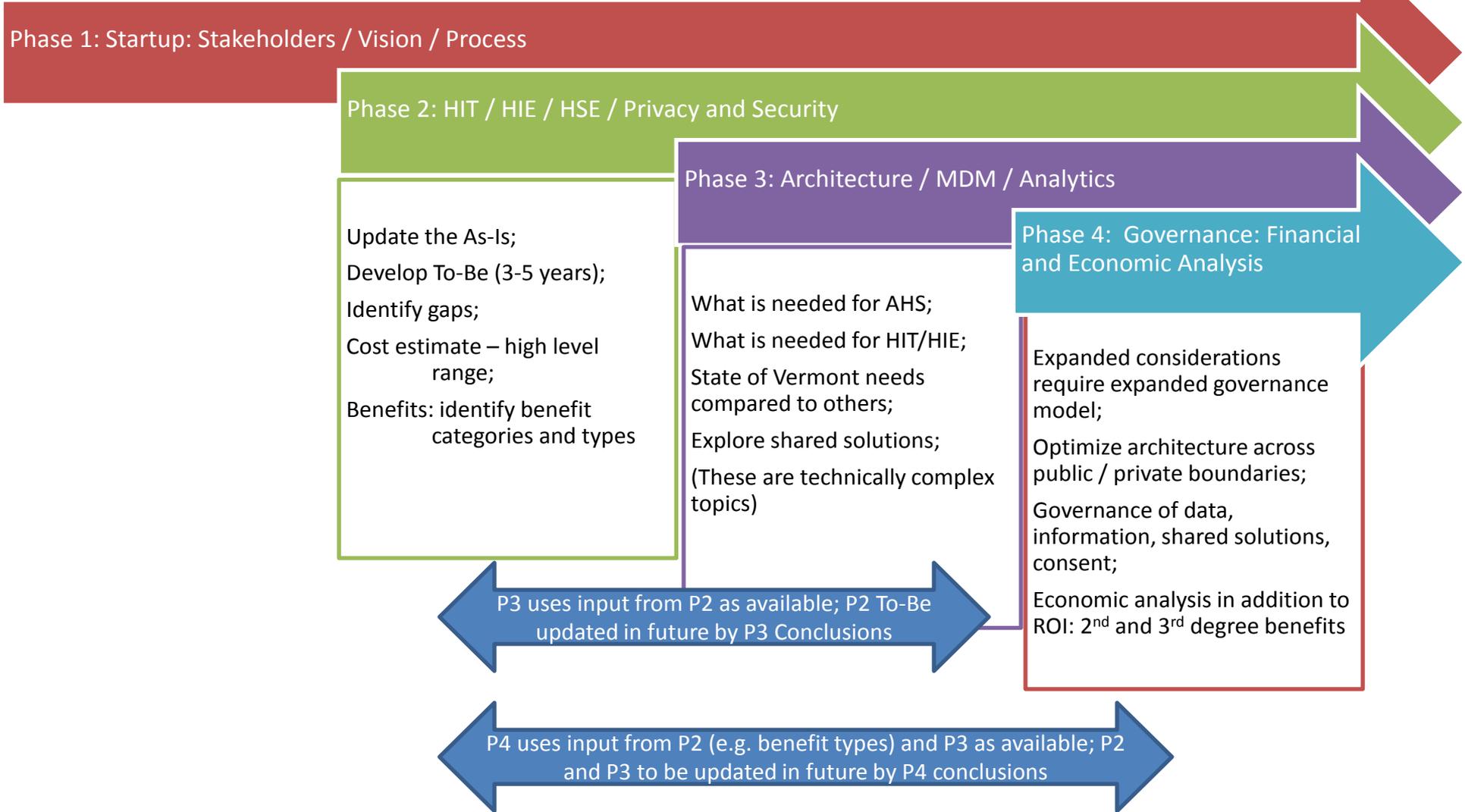
VHISP Components



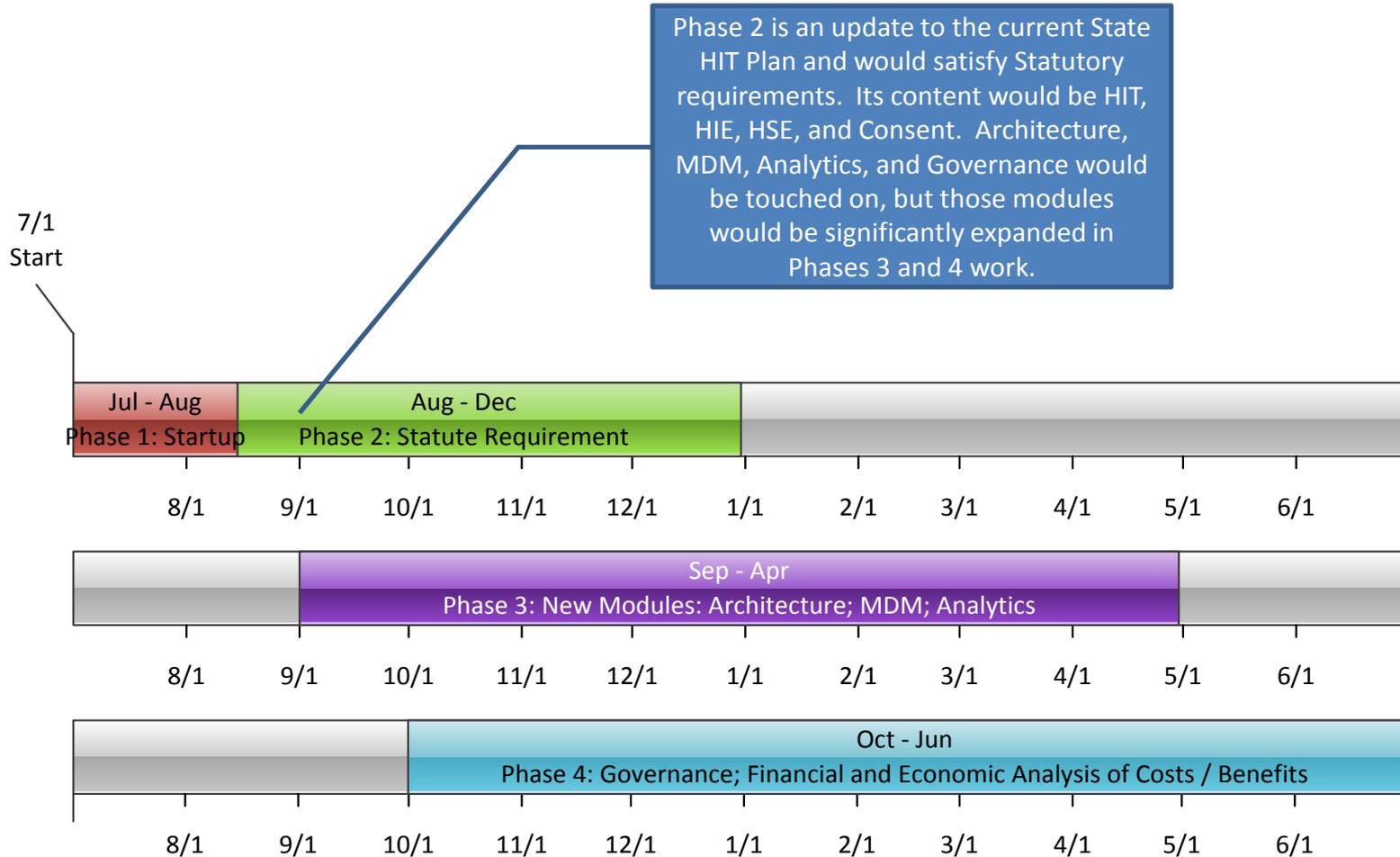
VHISP – the Value Proposition

- VHISP Scope: *Health Information (HI)*
- HI for acute and clinical care
- HI for coordination: clinical and administrative
 - Care, benefits, payment
- HI to drive the Analytics Engine
- HI requires Data Liquidity
- Data Liquidity derives from HIT
- HIT supports movement of data
- HIE combines HIT, networks, and intended actions
- Triple Aim is the necessary outcome, but Benefits must Outweigh Costs
- Major topics include: Architecture; MDM and Analytics; Governance; Financial and economic analysis
- VHISP addresses the full to-be vision, including Single-Payer

VHISP – Example Possible Sequence



Proposed VHISP Timeline



Status Update

- Early stakeholder meetings – internal (e.g., AHS and PMO), VITL, VHCIP (HIE Work Group on 6/4)
- Simplified RFP for project assistance – proposals due 6/13
- Project Management resource requested (± 0.5 FTE)
- Interviewing candidates for Terry Bequette replacement
- Project has been slow to formally kick off (other priorities, staff turnover, support resources)
- Much more focused efforts and executive attention will be required to meet proposed timeline

Working with VITL

- VITL has history with previous versions of the plan:
 - Charged with writing the first plan
 - VHIE significantly featured in all versions of the plan
 - VHIE is core component of connectivity and Health Information Exchange in VT
- EHR expansion and adoption is in the work domain of VITL and DVHA
 - VITL operates the REC program to sign up providers and help with adoption and MU
 - DVHA operates the Blueprint for Health Program to facilitate connection and use of EHR technology
- There are overlapping activities that occur in VITL, DVHA, and other AHS
 - Master Person Identity management
 - Registries for similar and different health information
- VITL is responsible for implementing parts of the consent policy
- **So it makes sense for VITL and DVHA to partner in some fashion in updating the HIT, HIE, and consent portions of the plan**

Clarification Discussion

- Change of scope – Concur? Modify?
- Satisfy Act 48 HIT Plan requirements?
- Interaction with SIM-HIE working group
 - A different scope plan, major stakeholder overlap
- Responsibility for VHISP
 - Delegation; Responsibility; Authority
- Governance of Plan development
 - Sponsor; Steering Committee; Reporting
- Consulting/contracted Resources
 - Overall plan development; administrative support; financial and economic analysis

Questions / Discussion / Direction

- ?

Attachment 5b - Vermont Health
Information Strategic Plan
Acronyms

Vermont Health Information Strategic Plan (VHISP) Acronyms

AHS	Agency of Human Services
ARRA	American Recovery and Reinvestment Act of 2009
CMS	Centers for Medicare & Medicaid Services
DVHA	Department of Vermont Health Access
EHR	Electronic Health Record
HBE	Health Benefits Exchange (a.k.a., Health Insurance Exchange or in VT: “Vermont Health Connect”)
HIE	Health Information Exchange
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act (part of ARRA)
HSE	Health Services Enterprise
ICD-10	International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO), 10 th revision
MDM	Master Data Management
MITA	Medicaid Information Technology Architecture
MU	Meaningful Use
NHIN	Nationwide Health Information Network, now known as eHealth Exchange
NPI	National Provider Identifier
PMO	Program Management Office
PPACA	Patient Protection and Affordable Care Act (or “ACA” for short)
REC	Regional Extension Center
RFP	Request for Proposals
SIM	State Innovation Model (or in VT: Vermont Health Care Innovation Project)
SMHP	State Medicaid HIT Plan
VHIE	Vermont Health Information Exchange – the HIE operated in VT by VITL
VHISP	Vermont Health Information Strategic Plan
VITL	Vermont Health Information Technology Leaders

Attachment 6a - HIE/HIT Work
Group Preview for June-November
2014

VHCIP Six-Month Outlook for HIE/HIT Work Group

June 4, 2014

Georgia Maheras, JD

Project Director

July 2014

- Update on work group approved proposals
- Risk Mitigation Plan review
- Telehealth criteria development
- Continued VHISP Plan Discussion
- Possible QPM referral

August 2014

- Continued VHISP Plan Discussion
- Possible QPM referral
- Year Two Milestones and Measures Discussion
- Self-Evaluation Plan Discussion

September 2014

- Telehealth criteria development and solicitation of applications
- Finish Year two milestones
- Continued VHISP Plan Discussion

November 2014

- QPM referrals
- Finish VHISP Plan recommendations

Attachment 6b - Six month
progress report and preview
presented to the Core Team on
May 19th

VHCIP Progress Report and Six-Month Outlook

May 19, 2014

Georgia Maheras, JD

Project Director

PROGRESS REPORT: OCT-APR

Personnel

24 funded positions

- 14.5 are filled and 9.5 are vacant
- Recruitment efforts continue with several offers in process

Budget (contracts through 5/1/14)

Contract Title	Amount	Duration
ACTT Proposal: all contracts together	2,662,118	7/1/14-6/30/16
Baker	15,000	1/1/14-12/31/14
Bailit Health Purchasing*	1,180,000	3/31/14-1/31/17
Burns and Associates	125,000	2/24/14-12/31/14
Grant Program Awards	5,295,102	6/1/14-9/30/16
Hester	28,000	3/1/14-2/28/15
Evaluation	1,500,000	7/1/14-7/31/17
PHPG-Value Based Purchasing	57,820	6/1/14-5/31/15
PHPG-DLTSS	90,000	3/1/14-2/28/15
Policy Integrity (TA)	100,000	4/1/14-3/31/14

Budget (contracts through 5/1/14)

Contract Title	Amount	Duration
Patient Experience Survey	300,000	7/1/14-6/30/15
Population Health WG RFP*	70,000	7/1/14-2/28/15
Shared Savings ACO Analytics	2,200,000	7/1/14-7/31/15
Team Building*	15,000	7/1/14-12/31/14
UMass	500,000	9/1/13-12/31/14
Workforce WG RFP- data analysis	150,000	7/1/14-6/30/15
VITL-Population Collaborative	3,023,79	1/1/14-4/30/15
VITL- interfaces and REC	1,170,000	11/4/13-6/30/14
VPQHC(TA)	100,000	7/1/14-6/30/14
TOTAL	15,858,040	

Work Groups

- Payment Models:
 - Shared Savings ACO Programs launched 1/1/14
 - Episodes of Care: criteria development and data analyses
- Care Models:
 - Care model inventory
 - Shared Savings ACO Program Care Management Criteria
 - Learning Collaboratives
- HIE/HIT:
 - Two proposals funded:
 - Connecting LTSS and MH providers
 - Connections for SSP data
 - Telehealth/telemonitoring criteria

Work Groups

- DLTSS:
 - Quality measure recommendations
 - Model of care review
- Workforce:
 - Data analyses
 - Workforce Strategic Plan review
- Population Health:
 - Quality measure recommendations
 - Landscape review of population health activities
- Quality and Performance Measures:
 - Shared Savings ACO Program year one and year two measures

Work Groups

- Quality and Performance Measures:
 - Shared Savings ACO Program year one and year two measures
 - EOC Program year one measures
 - P4P Program year one measures

Evaluation and Monitoring

- Patient Experience Survey (fielded in Summer and Fall)
- Self-Evaluation Plan
 - Vendor #2: work to commence July 1
- RTI:
 - Getting data
 - Interviews
 - Focus groups

SIX-MONTH PREVIEW

Personnel and Budget

- Year One: re-budgeting
- Overall project re-budgeting
 - Includes Year two budget
- Continued recruitment and retention efforts including:
 - Retreat on June 17th
 - Team building

June 2014

- CMMI Site Visit: June 18 or 19
- Grant Program: discuss changes to program
- Risk Mitigation Plan review
- Finance:
 - Update

July 2014

- Grant Program: finalize application-CT approval needed
- Evaluation:
 - Update
- Work Groups:
 - HIE/HIT: update on VITL and ACTT activities
 - Care Models: Learning Coll. recommendations-CT approval needed
- Finance:
 - Submit year one reallocation to CMMI- CT approval needed
 - Submit full project (and year two) proposed budget to CMMI-CT approval needed
- Misc. follow up:
 - Health care system costs (Al and Robin)

August 2014

- Quarterly Progress Report and Six-Month Preview
- Work Groups:
 - Care Models: Care Management Standards recommendations-CT approval needed
 - QPM: Year 2 SSP measures recommendations-CT approval needed
- Finance:
 - Contracts: review RFP list for year two contracts-CT approval needed

September 2014 (two meetings)

- Evaluation:
 - Self-Evaluation Plan discussion
- Grant Program: review applications
- Work Groups:
 - HIE/HIT: Telemedicine/Telemonitoring recommendations-
CT approval needed
- Finance:
 - Update

October 2014 (two meetings)

- Grant Program: review applications and announce awards
- Work Groups:
 - Workforce: Strategic Plan Update
 - HIE/HIT: Strategic Plan Update
- Finance:
 - Update
- ***Annual Report Due to the feds on October 30th!***

November 2014

- Year One Progress Report and Six-Month Update
- Grant Program: Round one grantee update
- Work Groups
 - DLTSS: recommendations around barriers in current payment and coverage structures-CT approval needed
 - Payment Models: EOC and P4P Program Recommendations
CT approval needed

- Finance:
 - Update