Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

December 2, 2015, 1:00pm-3:00pm

DVHA Large Conference Room, 312 Hurricane Lane, Williston

Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action?
1	1:00-1:05pm	Welcome and Introductions	Steven Costantino		
2	1:05-1:10pm	Minutes Approval	Steven Costantino	Attachment 2: Draft October 28, 2015, Meeting Minutes	Approval of Minutes
3	1:10-1:20pm	Core Team Update *Public comment*	Lawrence Miller & Georgia Maheras		
4	1:20-1:40pm	Medicaid Episode of Care Update & Proposal	Alicia Cooper	Attachment 4: Medicaid EOC Proposal	
5	1:40-2:00pm	Funding Recommendation: VITL-ACO Gap Remediation and VITL-VCN Gap Remediation	Simone Rueschemeyer & Georgia Maheras	Attachment 5a: Phase II Gap Remediation (.pptx) Attachment 5b: VITL Response to HDI Work Group Questions Attachment 5c: VITL Response to Follow-Up Questions Attachment 5d: Steering Committee Financial Proposal – VITL Gap Remediation	Vote
6	2:00-2:20pm	Funding Recommendation: DLTSS Technology Assessment and Next Steps	Simone Rueschemeyer & Georgia Maheras	Attachment 6a: DLTSS Data Gap Remediation Project Next Steps Attachment 6b: Steering Committee Financial Proposal – DLTSS Gap Remediation The final DLTSS Technology Assessment Report is available on the VHCIP website: http://healthcareinnovation.vermont.gov/node/863	Vote
7	2:20-2:35pm	SCÜP Update	Simone Rueschemeyer & Georgia Maheras	Attachment 7: SCÜP Presentation	
8	2:35-2:55pm	Vermont ACO Integrated Informatics Proposal Presentation	Leah Fullem	Attachment 8a: Vermont ACO Integrated Informatics Proposal Presentation (.pptx) Attachment 8b: Vermont ACO Integrated Informatics Proposal (.docx) Attachment 8c: Public Comment (through 11/30)	
9	2:55-3:00pm	Public Comment, Next Steps, Wrap-Up and Future Meeting Schedule	Steven Costantino	Next Meeting: Wednesday, December 30, 2015, 1:00-3:00pm, Montpelier	

Attachment 2: Draft October 28, 2015, Meeting Minutes

Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, October 28, 2015, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Al Gobeille called the meeting to order at 1:01pm. A quorum was present.	
2. Minutes Approval	Bob Bick moved to approve the minutes by exception and Dale Hackett seconded. The motion passed with one abstentions.	
3. Core Team Update ***Public comment***	Georgia Maheras provided a Core Team update. • *Year 3 Activities and Budget:* The Core Team approved our Year 3 milestones and budget (Attachment 3) at their October 13th meeting. Georgia noted that a significant amount of our budget has been allocated, with a small amount still unallocated – this portion will be discussed at the Core Team's December meeting. This budget includes both our Year 3 budget and Year 2 Carryover budget, which will both be spent in CY2016. • *Year 3 Operational Plan:* Due to CMMI on Monday. This focuses heavily on our contractors, staffing model, governance, and anticipated activities for next year. The Operational Plan is built around just our Year 3 budget activities, and does not include activities funded by our Year 2 Carryover budget (to be submitted in January). • *Year 2 Approvals:* Our Year 2 contracts and budget were approved last week, after many months of effort. Georgia thanked the group for their patience, and our Finance Team for their efforts. • *Project-Wide Updates:* We have fully transitioned to our new governance structure at this point. We are rolling out our new meeting schedule in November, and will also begin to schedule 2016 meetings (many of which will now be moved to Waterbury). There was no additional comment.	

Agenda Item	Discussion	Next Steps
4. Shared Savings Program (SSP) Updates	Richard Slusky and Alicia Cooper presented results from the Year 1 ACO Shared Savings Program (Attachment 4). <u>Year 1 ACO SSP Update</u>: *Financial Summary*: Richard noted that this is the first year we've had performance information for Vermont's ACOs for their attributed lives for the Medicaid and commercial ACO programs. This is a significant milestone, but we have a lot to learn in Years 2 and 3 of the programs. Financial summary is calculated by a contractor (Lewin). The number of attributed lives for both ACOs represents the number of patients receiving services predominantly through each ACO's network of primary care providers. • Medicaid SSP: o Rick Barnett asked whether there is a margin of error or confidence interval for expected aggregated total. Richard responded that the Medicaid SSP has a minimum savings rate (similar to the Medicare SSP) that ACOs must achieve to be eligible to share in savings. o Jay Batra asked what percentage of Medicaid enrollees are attributed to an ACO. Alicia responded that in Year 1, about 65% of the eligible Medicaid population (approximately a third of the total Medicaid population). o Bob Bick asked whether savings are a decrease in spending, or a reduction based on trend. Richard responded that based on actuarial calculations, there is an estimated amount of money that will be spent on a defined set of services for a particular population. We believe that by reducing unnecessary utilization and improving coordination, we are saving dollars from what would otherwise have been spent. The contract between the ACO and the payer is an agreement to share those savings between the ACOs and payers. Al Gobeille added that spending actually went up between the baseline year and Year 1 of the program, but it increased less than projected. o Dale Hackett asked whether this shows improvement in patient outcomes and quality of care. Al responded that quality measurement isn't perfect, but that we've made great strides in building our capacity to measure. Catherine Fulton added that the current measure set is our starting point, and will continue to grow and evolve. Measures selected were not low-hanging fruit for providers, they were areas that needed work, and that will continue to evolve as well. Al added that seeing OneCare's Medicare quality measures for Years 1 and 2 of the MSSP has shown significant improvement. Richard noted that this process began in 2013 as a collaborative process of payers, consumers, providers, and advocates working together to select measures and develop standards and rules around the SSPs. This was a consensus agreement around the measures we would start with. o Steven Costantino commented that Medicaid enrollment has changed significantly since this program was designed, which has made predicting trends challenging. Year 2 may show	

Agenda Item	Discussion	Next Steps
	significantly different results as new enrollees use services in different ways. Al noted that 2014 was a reordering year in health care across the country. In Vermont, VHAP and Catamount went away, the individual market changed, the small group insurance market changed. GMCB and DFR did their best to develop rates in good faith, but set rates too low. Alan Ramsay added that he works with the uninsured in his practice, and finds that patients coming into the system for the first time have significant chronic disease burdens. o Jay Batra asked whether there were savings found for unattributed Medicaid populations. Cecelia Wu responded that DVHA is looking at this, but noted that this is a challenging comparison to make. o Al noted that PMPM payments vary across ACOs. These numbers are risk adjusted. o Richard suggested we don't draw conclusions based on these numbers, but suggested we should use these to ask questions. • Commercial SSP: Expected total based on medical expense portion of premium (amount payer expects to spend on medical services) because this was a new population – as previously mentioned, premiums were set low for this population, so savings went back to consumers and came out of Blue Cross reserves. Al noted that this is different than Medical Loss Ratio, which includes some services that are excluded from the SSP total cost of care calculation. Richard noted that savings calculation for the commercial SSP also includes a minimum savings rate, but that calculations are different than for the Medicaid program. o Dale Hackett suggested that in some cases, overspending may not be bad, if it supports appropriate utilization needs that were previously unmet. Richard noted that these numbers are risk adjusted, and commented that there are many reasons that ACOs might not have hit savings targets for the commercial SSP. o Mike Hall asked whether in determining expected spend, these numbers were trended forward. Richard noted that there was no trend since this was a new market. Al commented that during rate setting, GMCB looked at potential exchange populations and predicted 2013 and 2014 spending based on this, but it was a challenging prediction to make. Mike asked what percent of the attributed population was newly insured and what percent was previously insured by Blue Cross. Al noted that another factor was whether MVP or Blue Cross would receive healthier populations for their exchange plans – and in fact, MVP did receive a healthier population. Richard commented that Blue Cross was not able to identify the specific individuals that might be signing up – there wasn't a history of people who had been in the program, as was the case in Medicaid. Al and Steven noted that variables within Exchange plan design impacts enrollment and makes this a harder area to predict without years on which to base trends – precision will increase in future years, as volatility decreases. Al commented that rate review is hard, dealing with large populations and a lot of money, and commented that increased discussion and	

Agenda Item	Discussion	Next Steps
	understanding of this process is a step forward. o Richard noted that MVP did not have sufficient Exchange enrollment to participate in the commercial SSP, though they were willing to. • Medicare SSP: Richard noted that CHAC achieved savings, but not in excess of the minimum savings rate, so none of Vermont's ACOs received shared savings payments from the Medicare SSP in 2014. o Richard clarified that minimum savings rates are in place to ensure savings aren't attributable to chance. • Lewin and the DVHA team are working on sub-analyses to try to identify the causes behind the financial results we're seeing. • Results and lessons learned will inform future development of capitation/global budgets through the all-payer model/Next Gen ACO model. • Joyce Gallimore commented that the CHAC board is very committed to distributing savings back to the community and to providers to support ongoing work and improvement. *Quality Measurement Overview:* Alicia presented on quality measurement results for the Medicaid and commercial programs. She noted that the lack of historical data for the commercial SSP was a challenge for quality measurement as well as rate setting/financial trending. She also commented that measure collection and analysis was challenging, especially for clinical data collection, and commended the ACOs for the collaboration and work they did to make this possible. • Susan Aranoff noted that there are different quality scores across the three SSPs, and asked if the DVHA team has an idea of why that might be, or if they will be looking at this. Alicia responded that there are a number of variables here, for example, national benchmarks for Medicaid and commercial populations might be quite different. She also suggested that we should not compare overall scores between the Medicaid and commercial programs since the number of measures was different across programs. She noted that things may also change from Year 1 to Year 2. • Tracy Dolan noted that ACOs are incentivized to improve quality because it impacts their payments, but that individual providers' payments have not changed, creating a differing incentive – but clearly we're still seeing results. Richard commented that though savings are paid to ACOs, much of the savings is distributed to those providers. How this impacts provider salaries differs by organizations. Alan Ramsay commented that provider reporting fatigue is significant, and there is resistance to quick change. He suggested that it will be critical to ensure that providers trust that measurement improves care and outcomes for patients, rather than getting in the way of actually providing care to patients. Joyce Gallimore noted that measurement fatigue is real, but that the collaborative quality improvement environment is a significant motivation for providers – it's not solely about the financial investment. Catherine Fulton added that continued movement from process to outcome measures is part of our work to make measurement meaningful and useful.	

Agenda Item	Discussion	Next Steps
	• Dale Hackett asked how much data on attributed lives was available. Alicia responded that claims-based measures include results for all attributed individuals; clinical measures come from a sample of patients. • Rick Barnett asked whether VCP would continue in the SSPs in future years. Richard responded yes, only for the commercial program though. • Debbie Ingram commented that this is very encouraging, and asked whether there are ways to share this information more broadly with consumers and others. Georgia noted that we've had some press coverage on this, and plan to do some webinars to offer broader educational activities. She also invited members to suggest venues or audiences to hear more about this, and noted that this could align with the Blueprint for Health results expected to come out later this year. <u>Year 3 Commercial SSP Downside Risk Decision</u>: Richard announced that by mutual agreement, BCBS and the ACOs participating in the commercial SSP, we will forego downside risk in 2016 in favor of a more robust two-sided model in 2017. The Medicaid program does not have downside risk in 2016. • Dale Hackett suggested that not having downside risk in 2016 should help providers make investments to improve outcomes in 2016. Richard Slusky commented that downside risk is critical and will occur, but potentially in a new form. There was no additional public comment.	
Public comment		
5. Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Wednesday, December 2, 2015 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Bick 1°
Dale Hackett 2°
approved by exception
1 abstention

VHCIP Steering Committee Member List

Roll Call: 10/28/2015

Member		Member Alternate		Minutes	
First Name	Last Name	First Name	Last Name		Organization
	2		1		
Susan	Aranoff ✓				AHS - DAIL
Rick	Barnett ✓				Vermont Psychological Association
Bob	Bick ✓				DA - HowardCenter for Mental Health
Peter	Cobb				VNAs of Vermont
Steven	Costantino ✓				AHS - DVHA, Commissioner
Elizabeth	Cote				Area Health Education Centers Program
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
Susan	Donegan	David	Martini ✓		AOA - DFR
John	Evans	Kristina	Choquette ✓		Vermont Information Technology Leaders
Kim	Fitzgerald ✓				Cathedral Square and SASH Program
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Joyce	Gallimore ✓				Bi-State Primary Care/CHAC
Don	George				Blue Cross Blue Shield of Vermont
Al	Gobeille ✓				GMCB
Bea	Grause				Vermont Association of Hospital and Health Systems
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett ✓				None
Mike	Hall ✓ after vote	Angela	Smith-Dieng		Champlain Valley Area Agency on Aging / COVE
Paul	Harrington				Vermont Medical Society
Debbie	Ingram ✓				Vermont Interfaith Action
Craig	Jones				AHS - DVHA - Blueprint
Trinka	Kerr ✓			A	VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
Jackie	Majoros ✓				VLA/LTC Ombudsman Project
Todd	Moore ✓	Vicki	Loner		OneCare Vermont

Mary Val	Palumbo				University of Vermont
Ed	Paquin				Disability Rights Vermont
Laura	Pelosi				Vermont Health Care Association
Allan	Ramsay ✓				GMCB
Frank	Reed	Jaskanwar	Batra ✓		AHS - DMH
Paul	Reiss				Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓	Joined after vote			Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Shawn	Skafelstad	Selina	Hickman ✓	after vote	AHS - Central Office
Julie	Tessler ✓				DA - Vermont Council of Developmental and MH Services
Sharon	Winn ✓				Bi-State Primary Care
	36				

15 Q ✓

VHCIP Steering Committee Participant List

Attendance: 10/28/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Steering Committee
Susan	Aranoff	here	AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey	here	Vermont Care Network	X
Heidi	Banks		Vermont Information Technology Leaders	X
Rick	Barnett	here	Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Jaskanwar	Batra	here	AHS - DMH	MA
Bob	Bick	here	DA - HowardCenter for Mental Health	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Amanda	Ciecior		AHS - DVHA	S
Sarah	Clark		AHS - CO	X
Peter	Cobb		VNAs of Vermont	M
Lori	Collins		AHS - DVHA	X
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper	here	AHS - DVHA	S
Steven	Costantino	here	AHS - DVHA, Commissioner	C

Elizabeth	Cote		Area Health Education Centers Program	M
Diane	Cummings	here	AHS - Central Office	S
Susan	Devoid		OneCare Vermont	A
Tracy	Dolan	here	AHS - VDH	M
Richard	Donahey		AHS - Central Office	X
Susan	Donegan		AOA - DFR	M
Gabe	Epstein	here	AHS - DAIL	S
John	Evans		Vermont Information Technology Leaders	M
Jaime	Fisher		GMCB	A
Kim	Fitzgerald	here	Cathedral Square / SASH	M
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn		AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Catherine	Fulton	here	Vermont Program for Quality in Health Care	M
Joyce	Gallimore	phone	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	M
Al	Gobeille	here	GMCB	C
Bea	Grause		Vermont Association of Hospital and Health Systems	M
Sarah	Gregorek		AHS - DVHA	A
Lynn	Guillett		Dartmouth Hitchcock	M
Dale	Hackett	here	None	M
Mike	Hall	here	Champlain Valley Area Agency on Aging / COVE	M
Janie	Hall		OneCare Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Paul	Harrington		Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Diane	Hawkins		AHS - DVHA	X
Karen	Hein			X
Selina	Hickman	phone	AHS - Central Office	X
Debbie	Ingram	here	Vermont Interfaith Action	M
Craig	Jones		AHS - DVHA - Blueprint	M

Kate	Jones		AHS - DVHA	S
Pat	Jones		GMCB	S
Joelle	Judge	here	UMASS	S
Trinka	Kerr	phone	VLA/Health Care Advocate Project	M
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein		AHS - VDH	S/MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Deborah	Lisi-Baker		SOV - Consultant	M
Sam	Liss		Statewide Independent Living Council	X
Vicki	Loner		OneCare Vermont	MA
Robin	Lunge		AOA	X
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Jackie	Majoros	phone	VLA/LTC Ombudsman Project	M
Carol	Maloney		AHS	X
David	Martini	here	DFR	MA
Mike	Maslack			X
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Darcy	McPherson		AHS - DVHA	X
Marisa	Melamed		AOA	S
Jessica	Mendizabal		AHS - DVHA	S
Madeleine	Mongan		Vermont Medical Society	X
Todd	Moore	phone	OneCare Vermont	M
Brian	Otley		Green Mountain Power	X
Dawn	O'Toole		AHS - DCF	X
Mary Val	Palumbo		University of Vermont	M
Ed	Paquin		Disability Rights Vermont	M
Annie	Paumgarten		GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Judy	Peterson		Visiting Nurse Association of Chittenden and Grand Isle Counties	M
Luann	Poirer		AHS - DVHA	S
Allan	Ramsay	here	GMCB	M
Frank	Reed		AHS - DMH	M
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M

Simone	Rueschemeyer	Here	Vermont Care Network	M
Jenney	Samuelson		AHS - DVHA - Blueprint	X
Larry	Sandage		AHS - DVHA	S
Suzanne	Santarcangelo		PHPG	X
Howard	Schapiro		University of Vermont Medical Group Practice	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Shawn	Skaflestad	(Interim)	AHS - Central Office	M
Mary	Skovira		AHS - VDH	A
Richard	Slusky	here	GMCB	S
Angela	Smith-Dieng		Area Agency on Aging	MA
Kara	Suter		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	here	DA - Vermont Council of Developmental and Mental Health Serv	M
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Julie	Wasserman	here	AHS - Central Office	S
Spenser	Weppler	here	GMCB	S
Kendall	West		Bi-State Primary Care Association	X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn	Here	Bi-State Primary Care	M
Cecelia	Wu	here	AHS - DVHA	S
				106

Attachment 4: Medicaid EOC Proposal

Medicaid Episodes of Care

December 2, 2015

VHCIP Steering Committee

VHCIP & Episodes of Care

- **2012**: SIM Application
  - Propose bundled payment models based on EOC
- **2013**: Year 1 Operational Plan
  - Pursuing bundled payment models based on EOC
  - Propose developing EOC analytics tools to drive delivery system transformation
- **2014**: Year 2 Operational Plan
  - Bundled payment models not a high priority for stakeholders
- **2015**: Year 3 Operational Plan
  - Convene EOC Sub-Group to discuss Episode analytics
  - Developing 3 Medicaid EOCs

Episodes of Care

- Conceptually, an episode of care consists of all related services for one patient for a specific diagnostic condition from the onset of symptoms until treatment is complete.
- Episodes constitute clinically and economically meaningful units of service, such as all services and total costs associated with treating a particular condition, or providing a particular type of service.
- Episode testing being done in three other SIM States: Arkansas (round 1), Ohio and Tennessee (round 2)

Key Selection Criteria for Medicaid Episodes

- Annual episode volume and number of unique beneficiaries impacted
- Number of providers impacted
- Total annual Medicaid spend on episode
- Pre-existing episode specifications and/or potential for alignment with other payer Episode of Care programs

Episodes Approved for Development

- Perinatal
- Neonatal
- Repeat ED Visits

Illustration - Episode Exclusion Criteria

- Perinatal Episode
  - includes all prenatal, delivery, and postpartum health care services (for the mother) beginning 9 months prior to delivery and concluding two months after delivery
- 2,682 total Medicaid births in 2014
  - 119 excluded for Out of State (not including DHMC)
  - 134 excluded for third party coverage
  - 404 excluded for not having continuous coverage 6 months prior to birth
  - 224 excluded as overall episode cost exceeds outlier threshold (2 standard deviations from mean)
  - 155 excluded because CPT procedures indicating both a vaginal and Cesarean delivery
  - 4 excluded because of conflicting service date
  - 459 excluded for patients with 1 of 29 co-morbidities

Perinatal Illustration cont'd

- Remaining Perinatal Episodes = 1,581

- Total Unique Service Providers (for 1,581 qualifying deliveries)= 159
- Exclusions applied:
  - Provider must have performed delivery
  - Provider must have delivered services to patient 60 days prior to delivery
  - Must have >5 qualifying episodes in the measurement year

- Principally Accountable Providers = **53**
- Final beneficiary count = **582**

Items to be Finalized

- Payment model construction
  - Gain/loss sharing thresholds
- Whether provider participation will be voluntary or mandatory
- Episode report design and information sharing strategy

Timeline

- December 2015
  - Present proposed episodes to VHCIP Steering Committee and Core Team
  - Finalize payment model construct
  - Determine provider participation requirements
  - Convene provider/stakeholder workgroup to provide input on clinical episode specifications
- Jan-March 2016
  - Finalize key design elements
  - Seek stakeholder input on report design and dissemination
- April-June 2016
  - Share reports with participating providers for baseline period (2015)
  - Host introductory report learning sessions and/or webinars for participating providers

Next Steps

- Feedback from Payment Model Design and Implementation Work Group due by November 30th. Please send comments to amanda.ciecior@vermont.gov
- Presentation and feedback to Steering Committee on December 2, 2015
- Presentation and feedback to Core Team on December 9, 2015

Attachment 5a: Phase II Gap Remediation

Gap Remediation Phase 2 Proposal

Proposal to the Health Data Infrastructure Work Group

October 21, 2015

HEALTH FIRST

OneCareVermont

Community Health Accountable Care LLC
Transitioning Our Communities for Better Health

VITL

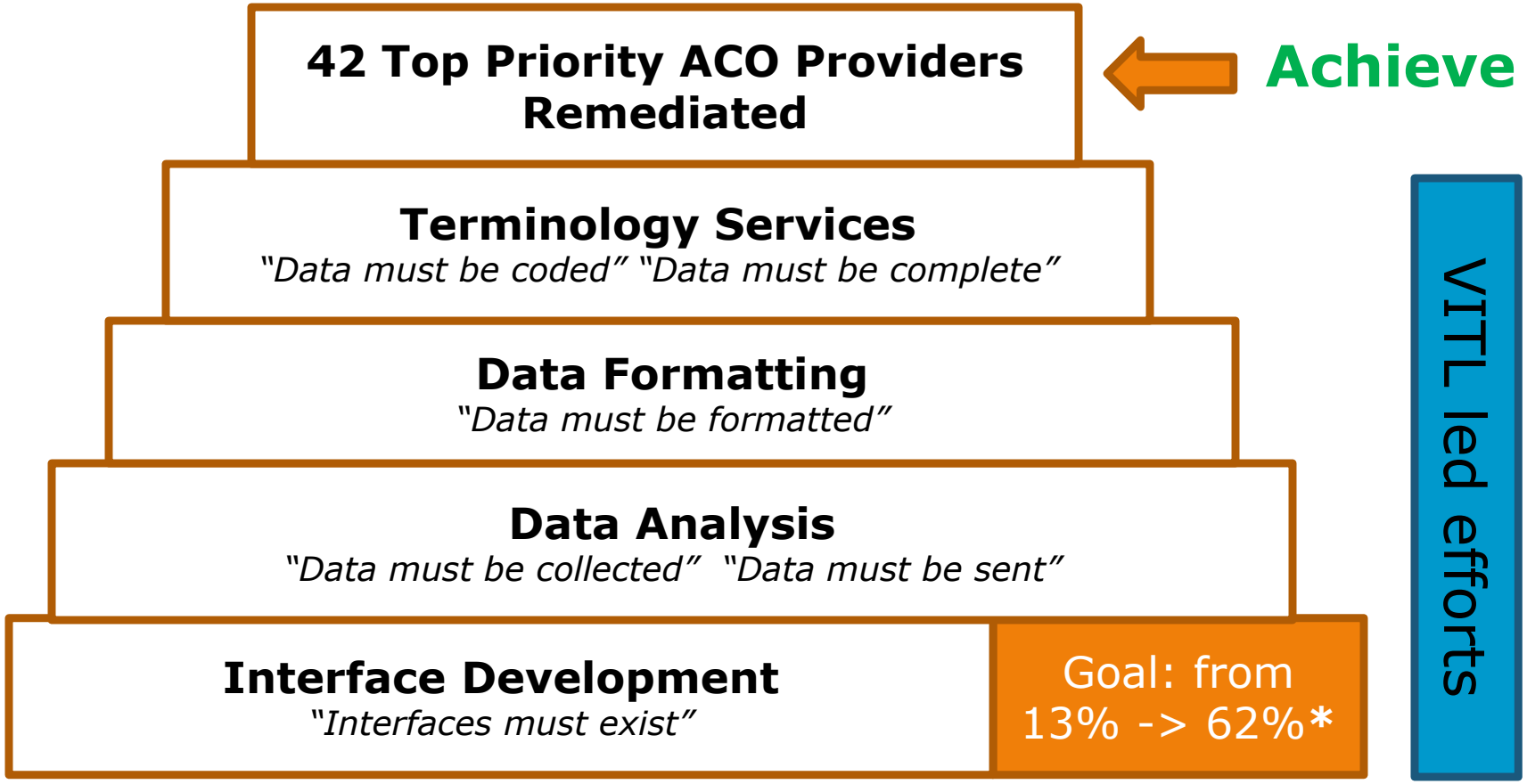
Vermont Health Care Innovation Project

Interfaces must **exist**

- Data must be **collected**
  - Data must be **sent**
    - Data must be **formatted** correctly
      - Data must be **coded** or normalized
        - Data must be **complete**, accurate and consistent

Successful Remediation

State of Remediation for ACO Providers Based on Beneficiary Population Size



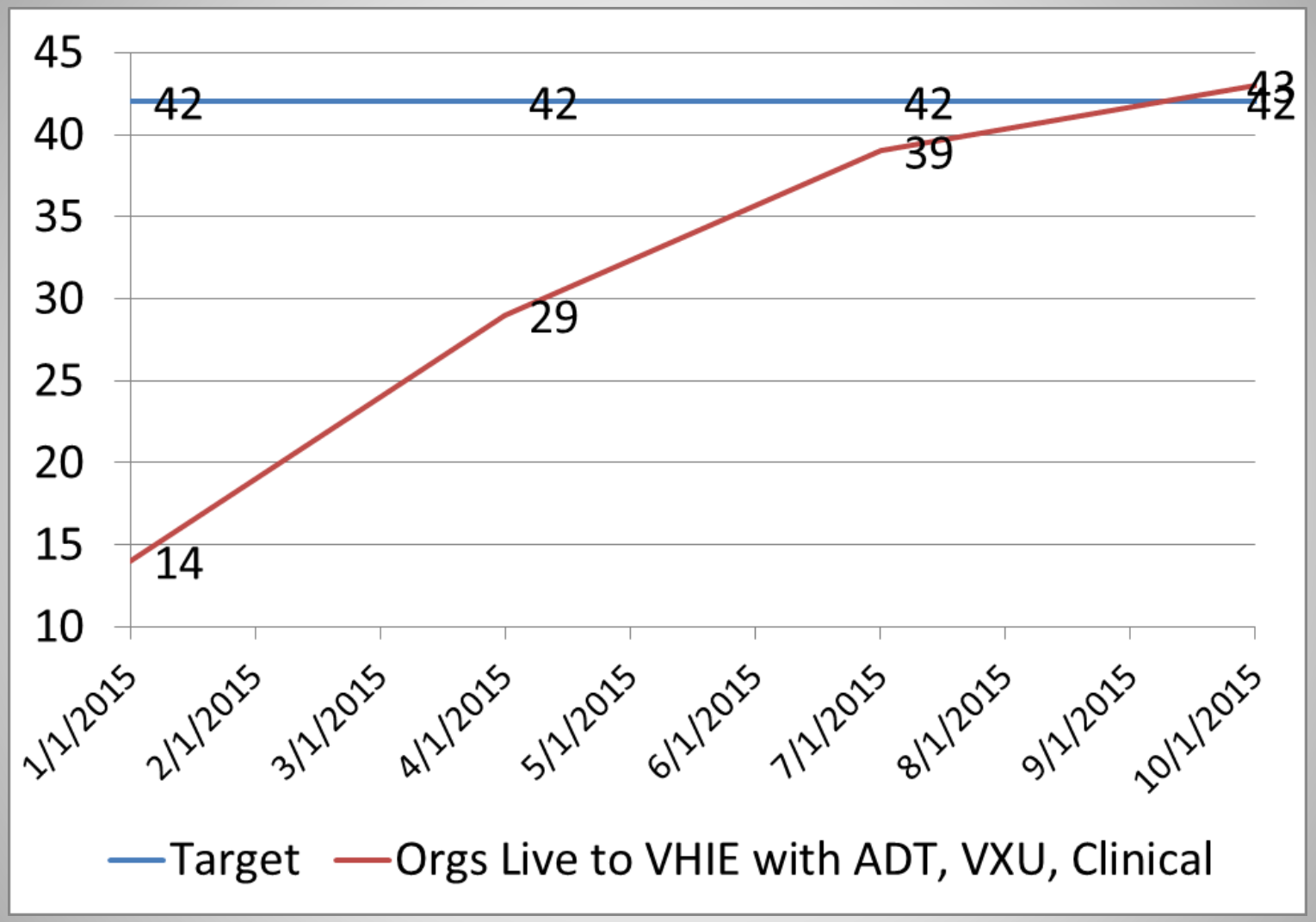
*All ACOs have identified interface priorities. Expectation is to achieve 62% of beneficiary data for ACCGM and OCV top priority practices.
CHAC beneficiary totals TBD.

- SIM Funds used to contract a dedicated interface development team (SET team) resulted in:
  - 42 CCD interfaces (versus 8 in FY14)
  - 50 VXU interfaces (versus 39 in FY14)

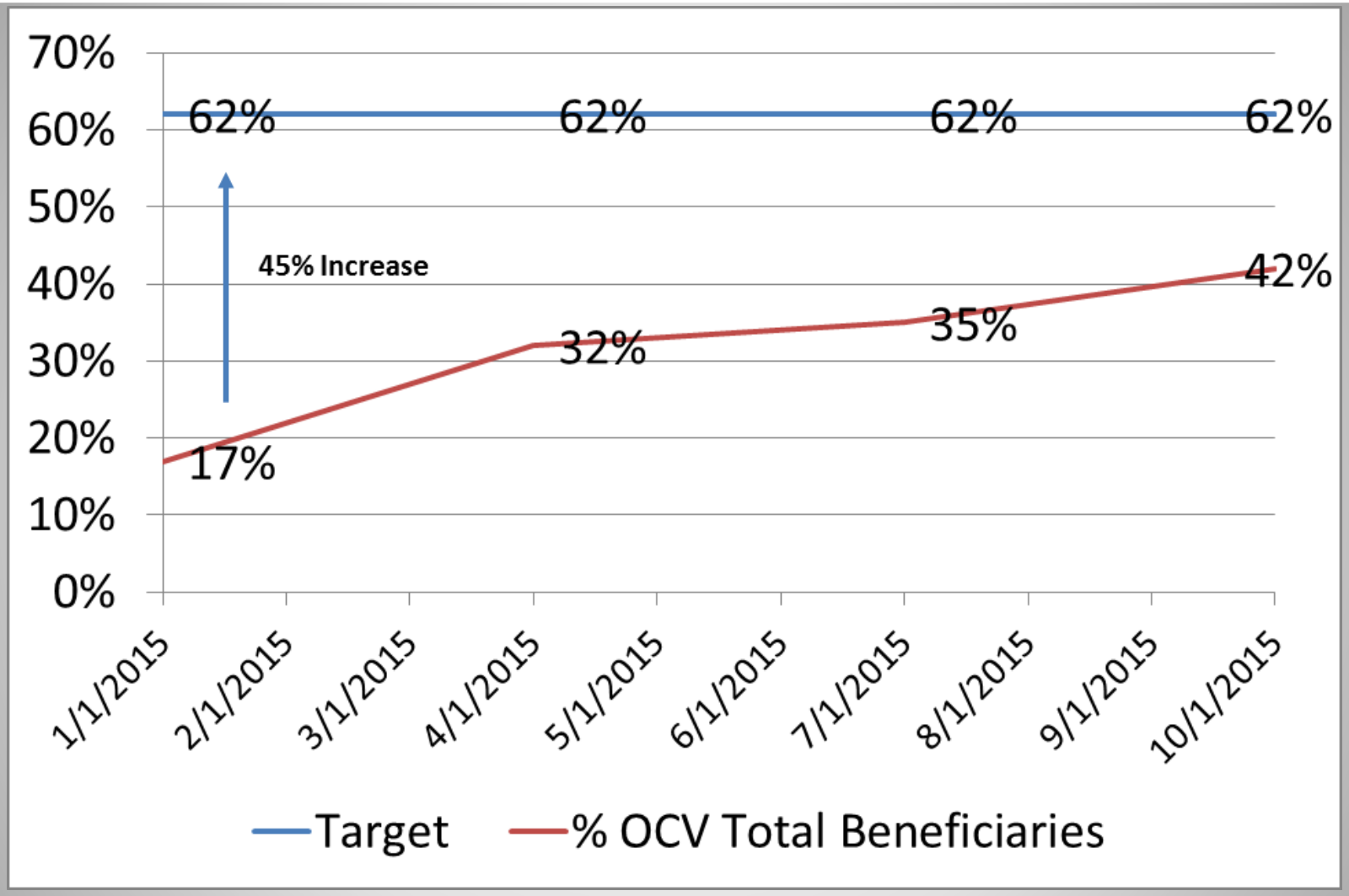
- Led to improved vendor collaboration and organization prioritization on connectivity and data remediation

CVMC/eCW	UVMMC/Epic
MFH/Medent	NCHC/GE

Celebrate Phase 1 Success!



of ACO Organizations Capable



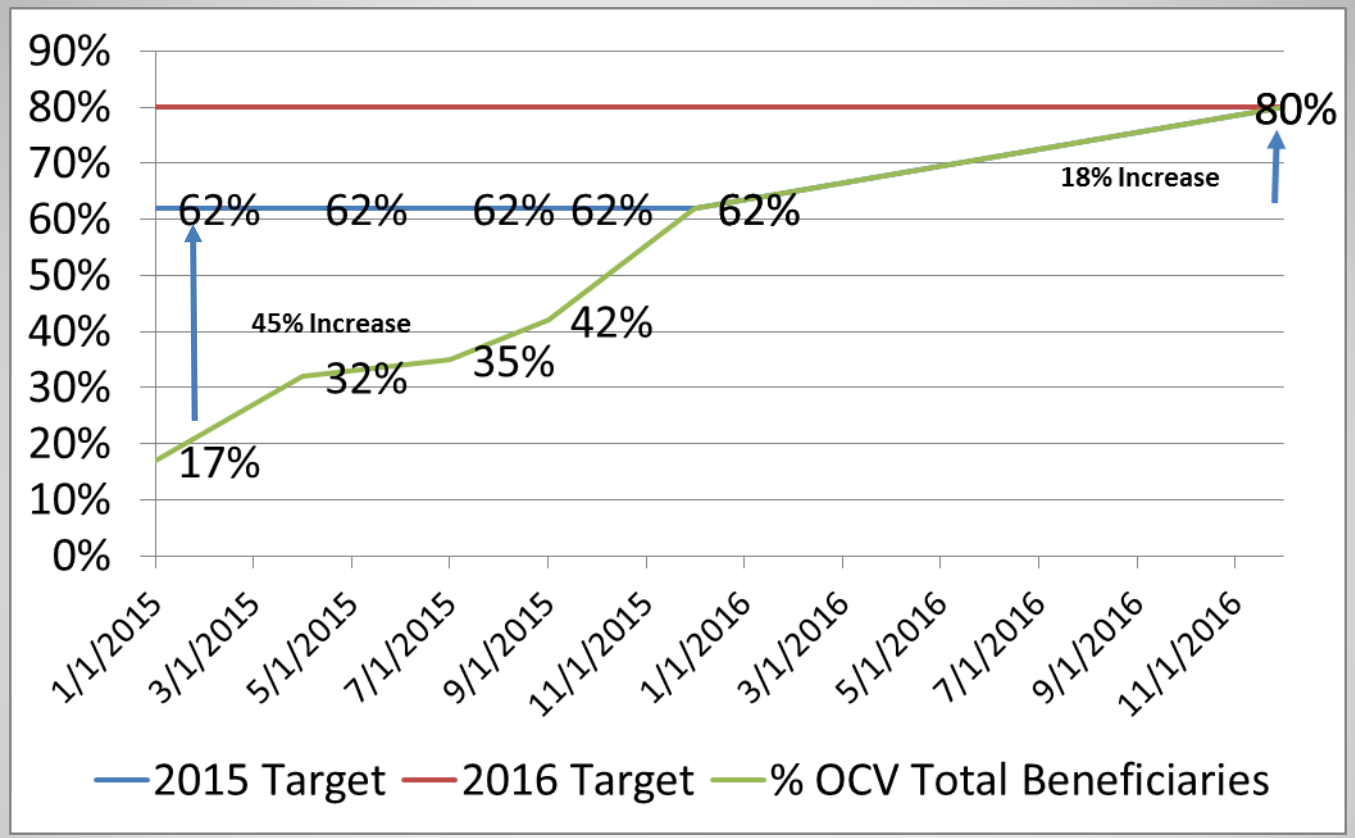
% Beneficiaries representing the HCOs Remediated to Date

Interfaces are becoming more complex

- Building interfaces to vendor EHRs varies greatly in complexity
- VITL has built most of the interfaces for organizations whose vendors are cooperative
- As we continue to add data to the VHIE the interfaces are getting harder
- Example: Epic (UVMMC and Dartmouth) and eClinical Works (11 practices) do not send care summaries to the VHIE

- UVMMC (22%)
- CVMC (12%)
- CHCRR & SMCS (5.4%)
- GCH & GCFP (1.7%)
- NCHC
- NMC hospital
- Northern Tier Center for Health

Interfaces (% Beneficiaries) in Queue



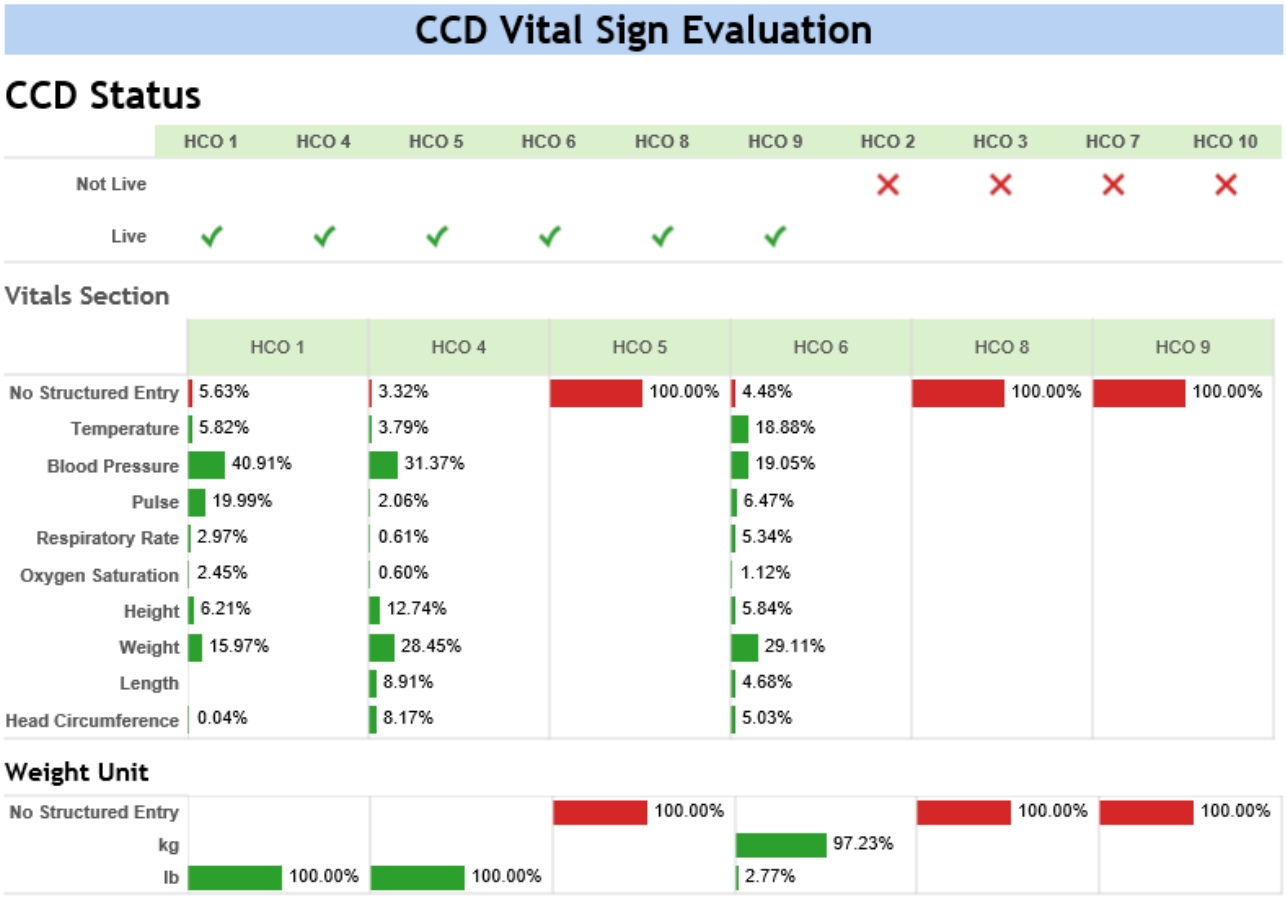
Target of % Beneficiaries Remediated

- Reduce ACO dependency on full chart manual extraction
- Understand and improve the health of highest risk patients
- Assess and improve performance prior to reporting to CMS
- Useful in comparing patient populations, providers, clinical groupings, etc.
- Identify patients of interest based on risk score, clinical conditions, etc.
- Complements the next phase of ACO analytics

ACO success relies upon this work!

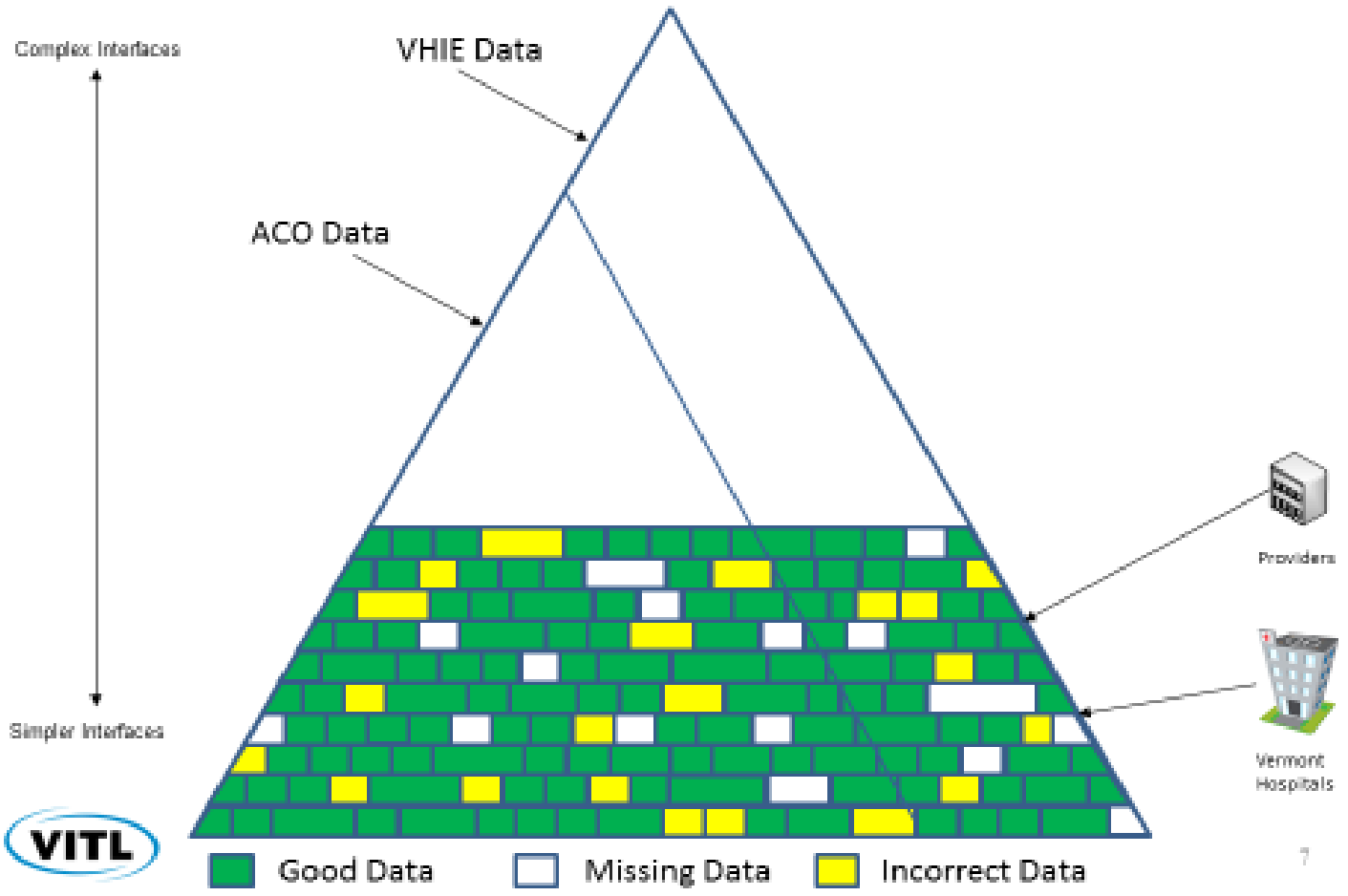
- Clinically rich data in the VHIE provides:
  - up-to-date patient information in VITLAccess from multiple sources for viewing at the point of care
    - Supports clinical decision-making
    - Reduces redundancy in patient testing
    - Supports care management and coordination
- Leverages the ENS system since clinicians will be compelled to view clinical event information in the VHIE

Vermont clinicians rely upon this work!



Data Quality Remediation Reports

3 Steps of Data Remediation: ACO Data Remediation



Accelerate Interface Development

- ☑ Continue to accelerate interface development. This is a Prerequisite for full data remediation.

Data Analysis and Formatting

- ☑ Increases the percentage of data that can meet the ACO quality measures in an electronic reportable way and reduce the need for chart abstracts (aka chart "pulls").

Terminology Services

- ☑ Utilize the Infrastructure Technology investment (funded)
- ☑ Enhances clinical data quality

Funding approval is needed so that we can help the ACOs meet their goals!

Summary

ACO and VITL Recommendation

Type of Cost	*Cost*
Interface Development and Gap Remediation (missing data) 1 year ***Prerequisite***	$600,000
Data Quality Reporting and Terminology Services Implementation 1 Year	$400,000
Remediation Proposal – Phase 2 Total	**$1M**

Proposal

Questions?

VCN/VITL ACTT Data Quality Project with DAs & SSAs

Health Data Infrastructure

Workgroup Meeting

October 21st, 2015

Simone Rueschemeyer, Executive Director, VCN
Judith A. Franz, VP Client Services, VITL

Background

- Goal was to implement the VCN data quality project with the 16 DAs & SSAs to enable them to have structured, reliable data (quality data)
- Three phases of the data quality project -
  - Phase One – 'Current state' assessment
  - Phase Two - Gap Analysis
    - Current state assessment
    - Desired state/data dictionary
    - Perform analysis & report findings
  - Phase Three - Remediation
    - Develop custom remediation & training plan

VITL

Current Status

- 'Current state' assessments & report of assessment findings for the original 11 agencies:
  - For 8 agencies -
    - All 'current state' assessments have been completed
    - Two 'current state' assessment reports have been completed and six reports are in process
  - For 2 agencies –
    - 'Current state' assessments are just beginning
    - 'Current state' assessment reports for these two need to be written
  - For 1 agency -
    - Agency has not yet engaged in phase one; the 'current state' assessment process
- Introductory Meeting for the 5 ARIS SSAs will be held Oct 29th

VITL

Scope Complexity

- Increased amount of work – driven by number of sites at each agency and complexity of data collection at each site – requires additional funds
  - ‘Current State’ assessments increased to a total of approximately 100 assessments for the first 11 agencies’ sites (all agencies except for the 5 SSAs).
    - Conduct ‘current state’ assessment
    - Write report of ‘current state’ assessment findings

VITL

Go-forward Plan

- Finish ‘current state’ reports for agencies that have completed the assessment (workflows and narratives)
- Finish assessments with remaining agencies followed by the current state reports (workflows and narratives)
- Complete gap analyses for all agencies
- Develop report with best practice recommendations
- Collaborate with VCP leadership on best practice recommendations

VITL

Go-forward Plan

- Facilitate discussion for custom remediation plan development with each agency at follow-up meetings
- Fine tune the best practice recommendations to develop a custom remediation plan
- Develop additional data quality remediation and training tools
  - Generic tools for use with all agencies
  - Custom tools specific to each agency's needs
- Conduct 1 training per agency

VITL

Need for additional funding

- Remaining work for phases one and two
  - Estimate we'll need November through January to complete Current State and Gap Analyses based on agreed upon 'Desired State' definition
  - Required resources – 2 FTEs - same VITL team –
- Additional funding needed for phase three
  - Remediation phase to begin Feb 1, 2016
  - 2 FTEs for 6 months
  - Total funding required – $150K

VITL

Questions

- Questions?

VITL

Attachment 5b: VITL Response to HDI Work Group Questions

Section A – Gap Remediation phase 1 and 2 scope, activities, and cost tables

Phase 1 – Gap Remediation Original Project 1/1/15 to 12/31/15

Project Scope:

- Accelerate interface development
- Improve the quality of data transmitted via the interfaces

Activities:

- Secure Medicity SET team of dedicated resources for 6 months to rapidly deploy interfaces prioritized by the ACOs and the State
- Increase the percentage of data that can meet the ACO quality measures:
    - Identify data elements contained in the messages
    - Recommend EHR enhancements to remediate gaps
    - Facilitate practice workflow improvements
- Select and purchase terminology services to develop a clinical data management infrastructure

Gap Remediation Task	**Cost**	**Expenses to date**	**Deliverable**	**Status as of 10/31/15**
Dedicated Medicity SET Team	$610,000	$610,000		
VITL Gap Remediation	$407,500	$394,500		
Total	*$1,017,500*	*$1,004,500**	• *Implement interfaces capable of transmitting clinical data for **42** ACO organizations* • *ACO member organizations capable of transmitting clinical data to cover **62%** of the beneficiary population*	• ***Exceeded target** – **43** provider organizations transmitting* • ***On track to meet deliverable** – **42%** of the beneficiary population covered*
Gap Remediation Task	**Cost**	**Expenses to date**	**Deliverable**	**Status**
Terminology Services (2 years)	$284,000	$0		
Total	*$284,000*	*$0*	• *Standing up the infrastructure, deploying solution and 2 years subscription* • *Secure Terminology Services vendor for use in VHIE by any contributing HCO in VT*	• ***Contract negotiation in progress** - RFP completed and vendor selected*
Total Gap Remediation	***$1,301,500***	***Funds committed****	• ***Phase 1 complete***	• ***90% complete***

* SIM Agreement between SOV and VITL contains detail regarding scope, timeframes, cost, approvals. Payment schedule

Phase 2 –Gap Remediation Extension Project 1/1/16 to 12/31/16

Project Scope:

- Capitalize on the investments in resources and technology made in Phase 1:
  - Accelerate interface development for organizations beyond the phase 1
  - Begin to improve the quality of all clinical data collected in phase 1 and phase 2

Activities:

- Contract additional staff to rapidly deploy interfaces prioritized by the ACOs and the State
- Increase the percentage of data that can meet the ACO quality measures:
  - Identify data elements contained in the messages
  - Recommend EHR enhancements to remediate gaps
  - Facilitate practice workflow improvements
- Utilize data management infrastructure purchased under phase 1 (terminology services) to translate clinical data elements from source code to machine readable standard clinical classifications and code sets (LOINC, SNOMED, etc.)

Project Task	**Cost**	**Deliverable**

VITL Interface development and Gap Remediation	$600,000	• *ACO member organizations capable of transmitting clinical data to cover 80% of the beneficiary population (18% increase from original target)*
		• *In partnership with the ACOs:*
		  ○ *Deploy an EPIC CCD solution*
		  ○ *Deploy the eCW CCD solution to capable organizations*
		  ○ *Deploy a VITL solution to collect non-42 CFR part 2 patient data from willing organizations*

VITL Data Quality reporting and Terminology Services	$400,000	• *Deployment of terminology services system for VT* • *Perform terminology mapping for at least 3 data sets* • *Provide ACO specific data quality reports*
Total	*$1,000,000*	
Total Gap Remediation	***$1,000,000***	• *Phase 2 complete*

Section B – HDI Workgroup ACO Gap Remediation Request Questions:

1. If the request for an additional one million SIM dollars is not approved - what other resources are available to improve the ACOS data transfer?

   VITL Response: No resources specific to improving ACO work will be available after 12/31/15. ACO provider orgs will be incorporated in the normal scheduling and prioritization process

2. The original project requested $1.3M and set a target of 42 providers to achieve 62% of the beneficiaries. Current state has been reported as 43 providers achieving 42% of the beneficiaries. How much of the original $1.3M funding has been spent to achieve the 43/42% level? How much of the original $1.3M funding remains unspent? If any portion of the original $1.3M is left unspent, what is the estimate of how much further can be accomplished by spending the remaining portion without needing additional funds beyond the original $1.3M?

   VITL Response: See Phase 1 and Phase 2 tables above.

3. VITL has separated question #3 to distinct statement/questions in order to respond.

   a. If $1.3M was spent to achieve the 43/42% level,

   VITL Response: $1.3M was awarded for the *entire* scope of the project for phase 1. At the time, ACO organizations were capable of sending data to the VHIE on 17% of the beneficiaries. $1M of the award was allotted to accelerate interfaces with the goal to increase the percent of covered beneficiaries to 62%, an increase of 45%.

   b. and with the addition of 2 providers - UVMMC (22%) and CVMC (12%) - another 34% would be picked up totaling 76% of beneficiaries,

   VITL Response: We are currently in discovery phase with UVMMC and CVMC.

   c. why is another $1M needed to reach the almost 80% next objective?

VITL Response: The ACOs and VITL are requesting $1M for the entire scope of phase 2. Of that amount, $600,000 is allotted to ***implement*** the identified interface solution for UVMMC, CVMC and/or any other ACO health care providers who utilize the more complex vendor products struggling to become interoperable. The goal for phase 2 is to increase the percentage of covered beneficiaries transmitted through the VHIE from 62% to 80%. This is an increase of 18%.

4. VITL says vendor relationship breakthroughs have been made with both Epic and eCW recently to gain access to the needed data. With cooperative vendors, is the effort/cost to connect these 2 important providers really $1M?

   VITL Response: Of the $1M requested for phase 2, $600,000 is allotted to accelerate interfaces and increase the beneficiary count to 80%. These vendors are cooperating and are willing to discuss potential solutions with VITL to test, reconfigure and rebuild their product. Once connectivity is achieved, each organization requires an interface to be configured. Thorough testing of the data structure, data integrity, and patient matching rules within the organization vault and across the VHIE needs to occur. This funding request is based on VITL's experience with vendors, the types of data transmitted, the type of organization (hospital, individual vs. multi-location primary care practice, etc.) collecting the data, and the level of effort needed to contract resources in order to accelerate this effort.

   $400,000 has been allotted to utilize the clinical data management infrastructure purchased under phase 1 (terminology services):
   - Costs related to infrastructure and software licensing are $122,000.
   - Costs related to configuring the software and to perform additional mapping to translate clinical data elements from source code to machine readable standard clinical classifications and code sets (LOINC, SNOMED, etc.) are $175,000.
   - Costs related to creating data quality reports are $103,000.

5. It feels like the additional funding request is muddying the waters between the work originally proposed and approved and additional work that all parties would like to begin or keep going. Can you provide a breakdown of what has been spent to-date from the original $1.3M funding on:
   a. Interface development?
   b. Data analysis & formatting?
   c. Terminology services?

   VITL Response: See Phase 1 table above.

6. Can you provide a breakdown of how the additional $1M funding will be spent on:
   a. Interface development?
   b. Data analysis & formatting?
   c. Terminology services?

VITL Response: See Phase 2 table above.

7. What percentage of the work (as defined in the original project plan) has been accomplished to date?

   VITL Response: See Phase 1 table above.

8. How much of the original funding request has been spent to date?

   VITL Response: See Phase 1 table above.

9. What was the planned duration of the original funding request?

   VITL Response: 1 year. It ends on 12/31/15.

10. Does the funding request represent additional work not previously identified in the project plan?

    VITL Response: Yes. When phase 1 was approved by the workgroup, the ACOs and VITL acknowledged that a subsequent phase would be necessary.

11. If this work was not part of the original project plan, what is the justification for including it now?

    VITL Response: Not applicable

12. If this work was part of the original work plan, why is additional funding being requested now?

    VITL Response: This work was not part of the original scope of work. It supports the next phase of Gap Remediation. The scope of phase 2 is to:
    - Accelerate interface development for organizations not included in phase 1
    - Perform data quality improvement utilizing terminology services for all data collected during phase 1 and phase 2.

    Capitalizing on the investments made in phase 1 is in alignment with the SIM goals to include expanded connectivity between SOV data sources and ACO providers.

Section C – ACTT Data Quality Project scope, activity phase, and cost table

The table below is provided to assist the reader in understanding the responses to each question.

	Original Project	Original Project Changes		New Project Request	
		Group A Completion by Nov 30th	Group A Completion (with extension) by Dec 31st	Group A	Group B (1 DA, 4 SSAs & 1 DDA)
Agencies	16	10 (37*)	10 (37*)	10 (37*)	6
Work/Scope	Phases 1, 2 & 3	Phase 1 & part of Phase 2	Remainder of Phase 2	Phase 3	Phases 1, 2 & 3
Funding	$200K	($135K) spent $65K balance		$150K	
* Number of sites					

Section D - HDI Workgroup ACTT Data Quality Project Request Questions:

1. What was original funding amount? Original scope of deliverable? Original schedule?
   VITL Response:
   - $200K

- Original scope included a Current state assessment (phase 1), a gap analysis (phase 2) and a remediation plan (phase 3) for 11 DAs & 5 SSAs
- Amendment term is December, 2014 to December, 2015

2. How much of the original funding amount has been spent? How much remains to be spent? How much of the original scope can be delivered with the original budget?
   VITL Response:
   - ~$135K of the original $200K has been spent (calculated through the end of September).
   - ~$65K of the original $200K remains to be spent
   - Phase 1 and Phase 2 (current state assessment and gap analysis for the 10 agencies currently in flight, Group A) can be completed within the original budget with 2 FTEs.

3. How many "unique sites" (with unique data collection requirements) did the project turn out to be across the original 11 agencies?
   VITL Response:
   - ~42 unique sites so far across 10 agencies (97 interviews to date) with 2 remaining interviews to conduct with CSAC, 1 remaining interview to conduct for HCRS and Clara Martin respectively.
   - 1 DA and 4 SSAs/DDAs remain – (to total 16 agencies), with X 'unique sites' for the SSAs/DDAs and X unique sites for Rutland. Per Ken, the 5 SSAs/DDAs will be assessed via two meetings.

4. What is the plan to get the 1 agency that has not engaged to engage? Why have they not engaged yet?
   VITL Response:
   - VCN is managing the discussion regarding whether or not to include this agency

5. Can Phase 1 and 2 be completed with the original funding?
   VITL Response:
   - Yes, for the 10 DAs (Group A) with Rutland and the 5 SSAs/DDAs (Group B) excluded based on the VCN (and participating member agency leadership) finalizing the desired state/data dictionary definition ASAP.

6. Having learned the complexity of the DAs, how confident is the funding ask to complete Phase 3 at $150K of additional?
   VITL Response:
   - Confident given there will be a remediation plan for each agency (with a section for each site) and a presentation of the plan to the VCP and agency leadership team and a training session for each agency. Phases 1, 2, & 3 for the remaining DA and 5 SSAs/DDAs will also be completed with the additional funds (2 FTEs for six months).

7. What percentage of the work (as defined in the original project plan) has been accomplished to date?
   VITL Response:

- Phase 1 will be completed and phase 2 underway (for the 10 agencies (Group A) – excluding Rutland or the 5 SSAs/DDAs {Group B}) by Dec. 31st. Evaluation of the SSAs/DDAs is 'on hold' (given they have just selected their unified EHR)

8. How much of the original funding request has been spent to date?
   VITL Response:
   - $135K - answered in #2

9. What was the planned duration of the original funding request?
   VITL Response:
   - The original amendment's term was Dec 1, 2014 to Dec 1, 2015.

10. Does the funding request represent additional work not previously identified in the project plan?
    VITL Response:
    - Yes, while it is the same three phases of work being conducted, the client determined the work needed to be done for multiple sites at some of the larger agencies. Multiple individual sites within one DA agency have been individually assessed due to the decentralized nature of the larger agencies.

11. If this work was not part of the original project plan, what is the justification for including it now?
    VITL Response:
    - Because of the decentralized nature of the larger agencies, the data quality team discovered the individual sites needed individual assessments to arrive at the data quality value level the VCP is seeking. Simone validated this finding and directed VITL to perform the assessments at the individual site level to arrive at the 'quality of assessment' level that would be truly prove valuable and impactful to the member agencies.

12. If this work was part of the original work plan, why is additional funding being requested now?
    VITL Response:
    - N/A

Attachment 5c: VITL Response to Follow-Up Questions

Thank you so much. We do have a few more questions and you can either address in a revision to this document, which I would need by Thursday morning or alternatively, have the information as part of the discussion at the Work Group meeting. The questions are listed below:

1. Please provide the FTE for each of the categories where personnel are identified as necessary for the work.

   VITL Response:

   - Gap remediation phase 2: 2 FTE new staff, consulting, plus reallocation of existing staff for Gap Remediation Interfaces and data formatting
   - Terminology and Data Quality: 1200 hours of new staff for terminology mapping and ACO data quality reports
   - ACTT Data Quality: 2 FTE existing staff already dedicated to the ACTT data quality project

2. Please provide more information about the software license- it is currently undefined. Do you have a vendor for this selected or will you go out to bid?

   VITL Response: A portion of the $122,000 includes licensing to upgrade the data quality infrastructure including SQL enterprise, Tableau, and Rhapsody communication points. These are an expansion of existing capabilities.

3. Gap Remediation:

   a. Just want to confirm - the document seems to state that VITL will meet the 42 providers/62% beneficiary population within the initial budget which has $13K left to be spent. Is that correct? That means the % beneficiaries will raise from the current 42% to 62% with the spending of the last $13K. Is that correct?

      VITL Response: Yes.

   b. Weren't UVMMC and CVMC both included in the original 42 providers/62% beneficiaries scope?

   VITL Response: The targets were based on the 42 top priority ACO provider organization that represent 62% of the covered beneficiaries. Not all of the original targeted 42 provider organizations, which included UVMMC and CVMC, were ready to connect to the VHIE. As a result, VITL engaged with the next group of provider organizations as determined by the ACOs. We are still working with the top priority provider organizations and their vendors (to include UVMMC and CVMC) and depending on their readiness, may go-live as part of the original 42 provider organizations or within phase 2.

4. Can you please confirm that interface development work is also funded under the DVHA-VITL Core Grant and Contract and that the interfaces could include ACO members?

   VITL Response: No resources specific to accelerating ACO specific work will be available after 12/31/15. ACO provider organizations will be incorporated in the normal scheduling and prioritization process.

Additional resources are required to accelerate the ACO specific interfaces because existing VITL resources are already engaged and committed to developing interfaces with the following organization types based on the DVHA Grant Agreement:

> "Connectivity of HIE infrastructure: Subrecipient shall provide Interface development work designed to develop connectivity between the VHIE networks and hospital, ambulatory and other Health Care Organizations.
>
> 4.1.3.1 Subrecipient Interface development shall include the following, other than the work specifically funded outside the scope of this Grant as detailed in Section 3.18 above:
>
> - Connectivity to patient-centered medical homes and other primary care providers;
> - Connectivity to mental health providers;
> - Connectivity to substance abuse treatment providers;
> - Connectivity to other specialty care providers;
> - Connectivity to long term care and skilled nursing providers;
> - Connectivity to community services;
> - Connectivity to public health registries;
> - Connectivity to home health; and
> - Connectivity to other data sources."

5. Please confirm what defines a connection: is it an ADT, a Lab, multiple connections? How are these counted?

   VITL Response: A connection is defined as an interface for each data type (ADT, Immunization, etc.). One connection is defined as one interface.

6. Terminology Services was previously approved as part of the 2015 Gap Remediation work. Can you please explain why there are new Terminology Services lists in the 2016 request? How do these overlap? Are personnel included in the 2016 number?

   VITL Response: 2015 work included: standing up the infrastructure, 2 yrs subscription and securing terminology services vendor. 2016 proposed work includes: deployment of terminology services system; performing term mapping for at least 3 data sets; and providing ACO specific data quality reports.

   When phase 1 was approved by the workgroup, the ACOs and VITL acknowledged that a subsequent phase would be necessary. If this additional amount is not approved, the data quality work for the ACOs would suffer significantly. This is because the infrastructure would exist as a result of phase 1, but resources would not be available to fully utilize the system and to achieve a return on this investment.

   Phase 2 work represents $400,000 to include:

   - 1200 hours of new staff time at $125/hour
   - $128,000 consulting fees

- $122,000 in data quality infrastructure costs and licensing

7. The response to D7 does not include a percentage. Can you please provide a percentage of progress on the initial scope?

VITL Response:

	Original Project	Original Project Changes		New Project Request	
		Group A Completion by Nov 30th	Group A Completion (with extension) by Dec 31st	Group A	Group B (1 DA, 4 SSAs & 1 DDA)
Agencies	16	10 (37*)	10 (37*)	10 (37*)	6
Work/Scope	Phases 1, 2 & 3	Phase 1 & part of Phase 2	Remainder of Phase 2	Phase 3	Phases 1, 2 & 3
Funding	$200K	($135K) spent $65K balance		$150K	
* Number of sites		50	60	40	

100%

Attachment 5d: Steering Committee Financial Proposal – VITL Gap Remediation

Financial Proposal – VITL Gap Remediation

December 2, 2015

Georgia Maheras, JD

Project Director

AGENDA

1. HDI Work Group: VITL-ACO Gap Remediation and VITL-VCN Gap Remediation (Agenda Item 5)
2. HDI Work Group: DLTSS Technology Assessment and Next Steps (Agenda Item 6)

HDI Work Group: VITL-ACO Gap Remediation and VITL-VCN Gap Remediation

- Request from the Work Group: Recommend approval of next phase of VITL-ACO Gap Remediation and VITL-VCN Gap Remediation work.
  - Project timeline: 12 months for ACO gap remediation (through 2016), 6 months for VCN gap remediation (through July 2016)
  - Project estimated cost: $1.15 million total
    - $1 million for ACO Gap Remediation
    - $150,000 for VCN Gap Remediation
  - Project Summary: Continue and expand upon current gap remediation efforts at ACOs and DAs/SSAs.
  - Budget line item: *Technology and Infrastructure:* Expanded Connectivity HIE Infrastructure
  - The HDI Work Group is responsible for exploring and recommending technology solutions to achieve SIM's desired outcomes.

HDI Work Group: VITL-ACO Gap Remediation and VITL-VCN Gap Remediation

- Is the recommendation consistent with the goals and objectives of the grant?
- *Yes. VHCIP's Operational Plan outlines the following tasks:*

HDI Work Group

This group will build on the work of the work group to date and:

- Identify the desired characteristics and functions of a high-performing statewide information technology system;
- Explore and recommend technology solutions to achieve VHCIP's desired outcomes;
- Develop criteria for a telehealth pilot program and launch that program;
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
  - Support for enhancements to EHRs and other source data systems;
  - Expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers;
  - Implementation of and/or enhancements to data repositories; and
  - Development of advanced analytics and reporting systems.

HDI Work Group: VITL-ACO Gap Remediation and VITL-VCN Gap Remediation

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No. These funds would supplement a previous investment.
- Has the recommendation been reviewed by all appropriate Work Groups?
  - The HDI Work Group reviewed the proposal and voted to approve it.

Attachment 6a: DLTSS Data Gap Remediation Project Next Steps

DISABILITY AND LONG-TERM SERVICES AND SUPPORTS DATA GAP REMEDIATION PROJECT: NEXT STEPS

Susan Aranoff, Esq.

Health Integration Quality Analyst

Vermont Department of Disabilities, Aging, and Independent Living

November 18, 2015

BACKGROUND

- Since its inception, increasing the Health Information Technology capacity of Vermont's Disability and Long-Term Services and Supports (DLTSS) Providers and other "non-Meaningful Use providers" has been a stated goal of the Vermont Health Care Innovation Project. (See-application, operational plans, work plans, and milestones).

- The DLTSS Data Gap Analysis and Remediation Project began as part of the Accessing Care Through Technology (ACTT) suite of HIE/HIT projects.

DLTSS Data Gap Remediation Project-Phases

- This project is a “planning phase to build a comprehensive budget request for Phase Two that allows for IT gap remediation work to occur.”

- The gap analysis was submitted in April 2015 and finalized in November 2015.

Next Steps

- Disseminate Report
  - MMIS Implementation Team
  - HDI Work Group
  - State HIT Plan Leadership
  - HIS Implementation Team
- Gap Remediation
  - Allocate Funds
  - Identify Priorities

Context

- Vermont's Home Health Agencies and Area Agencies on Aging make it possible for aging Vermonters and Vermonters with disabilities to live independently in the community – which is not only what most people prefer – it is required by law- e.g. the Olmstead decision.
- Home Health Agencies and Area Agencies on Aging need robust connections to the VHIE in order to implement the Next Generation Medicare Shared Savings Program.
- Home Health Agencies and Area Agencies on Aging need robust connections to the VHIE in order to comply with the IMPACT Act.

Continued

- Vermont is one of the leaders in shifting the balance from people living in institutions to living in the community. At present, more than 50 % of people receiving Disability and Long Term Services and Supports live in the community.
- Vermont has the second oldest average population and the need for Disability and Long Term Services and Supports, including Home and Community Based Services, is rapidly increasing.
- Home and Community Based Services are essential for improving and maintaining the health of Vermonters- especially Vermonters living with disabilities, chronic and/or complex health conditions.

Continued

- Vermont's Home Health Agencies serve approximately 23,000 Vermonters per year. In FY 2013, Vermont's HHAs made nearly 950,000 home visits.
- Vermont's Area Agencies on Aging serve approximately 45,000 Vermonters per year.
- SIM has allocated the following for hospitals, primary care providers, specialists, ACOS, skilled nursing facilities, and SSAs/DAs:
  - Year 1 Actuals: $3,003,982.64
  - Year 2 Budget: $3,574,117.50
  - Year 3 Budget: $2,917,500

The Core Team will be considering requests for several proposals at its December meeting, including those discussed earlier today that total approximately $3 million dollars that will benefit hospitals, primary care providers, specialists, ACOS, and SSAs/DAs.

- To date, no SIM funds have been allocated to increase HIE/HIT connectivity for Vermont's Home Health Agencies and Area Agencies on Aging.

PROPOSAL

- Expand the scope of VITL's SIM-funded work to include connecting the remaining HHAs and AAAs to the VHIE if funding is approved for additional interfaces.
- Recommend that the Core Team allocate $800,000.00 of remaining funds to remediate some of the highest priority gaps identified in the DLTSS data gap analysis.
- Specifically recommend providing VITLAccess to the Home Health Agencies and Area Agencies on Aging.

Attachment 6b: Steering Committee Financial Proposal – DLTSS Gap Remediation

Financial Proposal – DLTSS Gap Remediation

December 2, 2015

Georgia Maheras, JD

Project Director

AGENDA

1. HDI Work Group: VITL-ACO Gap Remediation and VITL-VCN Gap Remediation (Agenda Item 5)
2. HDI Work Group: DLTSS Technology Assessment and Next Steps (Agenda Item 6)

HDI Work Group: DLTSS Technology Assessment and Next Steps

- Request from the Work Group: Recommend investments in improving health information exchange capabilities at Home Health Agencies (HHAs) and Area Agencies on Aging (AAAs) in response to findings from the DLTSS Technology Assessment Report. Project(s) scope and budget not yet defined.
  - Project timeline: Not yet defined
  - Project estimated cost: Not yet defined
  - Project Summary: Not yet defined
  - Budget line item: *Technology and Infrastructure:* Expanded Connectivity HIE Infrastructure
  - The HDI Work Group is responsible for exploring and recommending technology solutions to achieve SIM's desired outcomes.

HDI Work Group: DLTSS Technology Assessment and Next Steps

- Is the recommendation consistent with the goals and objectives of the grant?
- *Yes. VHCIP's Operational Plan outlines the following tasks:*

HDI Work Group

This group will build on the work of the work group to date and:

- Identify the desired characteristics and functions of a high-performing statewide information technology system;
- Explore and recommend technology solutions to achieve VHCIP's desired outcomes;
- Develop criteria for a telehealth pilot program and launch that program;
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
  - Support for enhancements to EHRs and other source data systems;
  - Expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers;
  - Implementation of and/or enhancements to data repositories; and
  - Development of advanced analytics and reporting systems.

HDI Work Group: DLTSS Technology Assessment and Next Steps

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No. This project would build on previous investments in DLTSS provider gap analysis (the DLTSS Technology Assessment Report).
- Has the recommendation been reviewed by all appropriate Work Groups?
  - The HDI Work Group reviewed the proposal and voted to recommend that the Core Team invest in this area.

Attachment 7: SCÜP Presentation

SCÜP Project Update

**(Shared Care Plans &
Universal Transfer Protocol)**

December 2, 2015

SCÜP Project Review

Overview:

This project will provide a technological recommendation that supports Vermont's providers and caregivers in successfully navigating transitions between care settings.

Project Accomplishments:

- The project team completed business requirements gathering sessions with three communities (Bennington, Rutland, & St. Johnsbury).
- Finalization and validation of business and technical requirements with the three participating communities.
- High level technical review of six potential solution providers, most of which are currently in development or scheduled for development in Vermont.
- Final report outlining:
  - Findings
  - Key Features identified
  - Overview of the technical solutions
  - Final recommendation

SCÜP Project Findings

Community interest in the solutions:

- UTP: High
- SCP: Very High

Major Barriers:

- Consent
- Access across the Care Continuum
- Integration into existing workflows or adapting workflows to tools
- Sustainable funding

Feasibility in current or to-be technical landscape:

- UTP: Currently available
- SCP: Very attainable

Other key feedback:

- Keep both solutions simple
- Reduce additional logins
- Needs to be adaptable to various workflows
- **Feedback from HDI Work Group: supports initiative, but needs more information regarding budget and scope alignment**

SCÜP Project Findings

Overall Project Findings:

- Cloud based solution
- Due to solutions available and their scheduled availability, may be best to separate the two projects once more
- Due to budget and schedule constraints, the next phase of the project(s) will need to proceed as pilots

Universal Transfer Protocol Finding:

- Most closely aligns with solution provided by PatientPing for Event Notification

Shared Care Plan Finding:

- Aligns well with multiple solutions that are in development or scheduled for development
- The ACO Care Management solution has agreed to work with the project to accommodate most requirements as well as the schedule and budget constraints
- Other solutions such as MMIS Care and PatientPing will still be considered as discovery continues more intensely with the OneCare Vermont

More information will follow in the upcoming month.

Questions?

Attachment 8a: Vermont ACO Integrated Informatics Proposal Presentation

Vermont ACO Informatics Integration Project

Proposed November 2015

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Project Objectives

- **Create a single integrated data warehouse for all ACO-attributed lives**, leveraging the existing OneCare Health Catalyst Warehouse for use by CHAC and VCP/HealthFirst
- Envision and create **analytic reports** and appropriate ad hoc analysis capacity **to support an integrated Population Health Management (PHM) approach for Vermont** supported by the three ACOs
- Create a **design of how data and informatics could work under a single, combined ACO** in 2017 assuming further evolution is possible under the All Payer Model
- Create a **plan for appropriate ACO use of the Blueprint all-payer linked claims and clinical datasets** in support of a successful statewide population health management model

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Our Combined Vision for PHM

Create a single source of truth

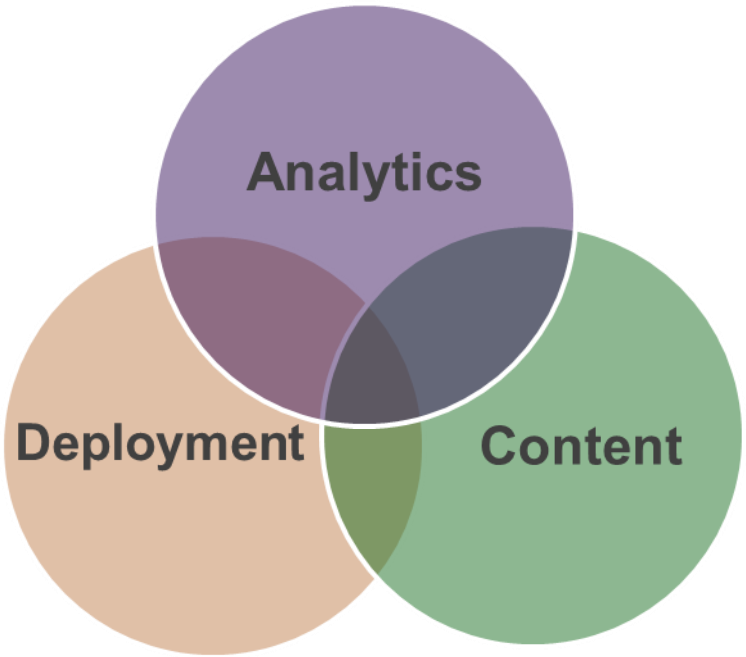
Automate the broad distribution of information

Discover patterns in data

Apply agile principles to care improvement

Workgroups focused on defining content and acting on data

Organize for scalable improvement



Define clinically driven patient populations

Use latest evidence- based medicine to identify waste

Identify high-risk and rising-risk patients

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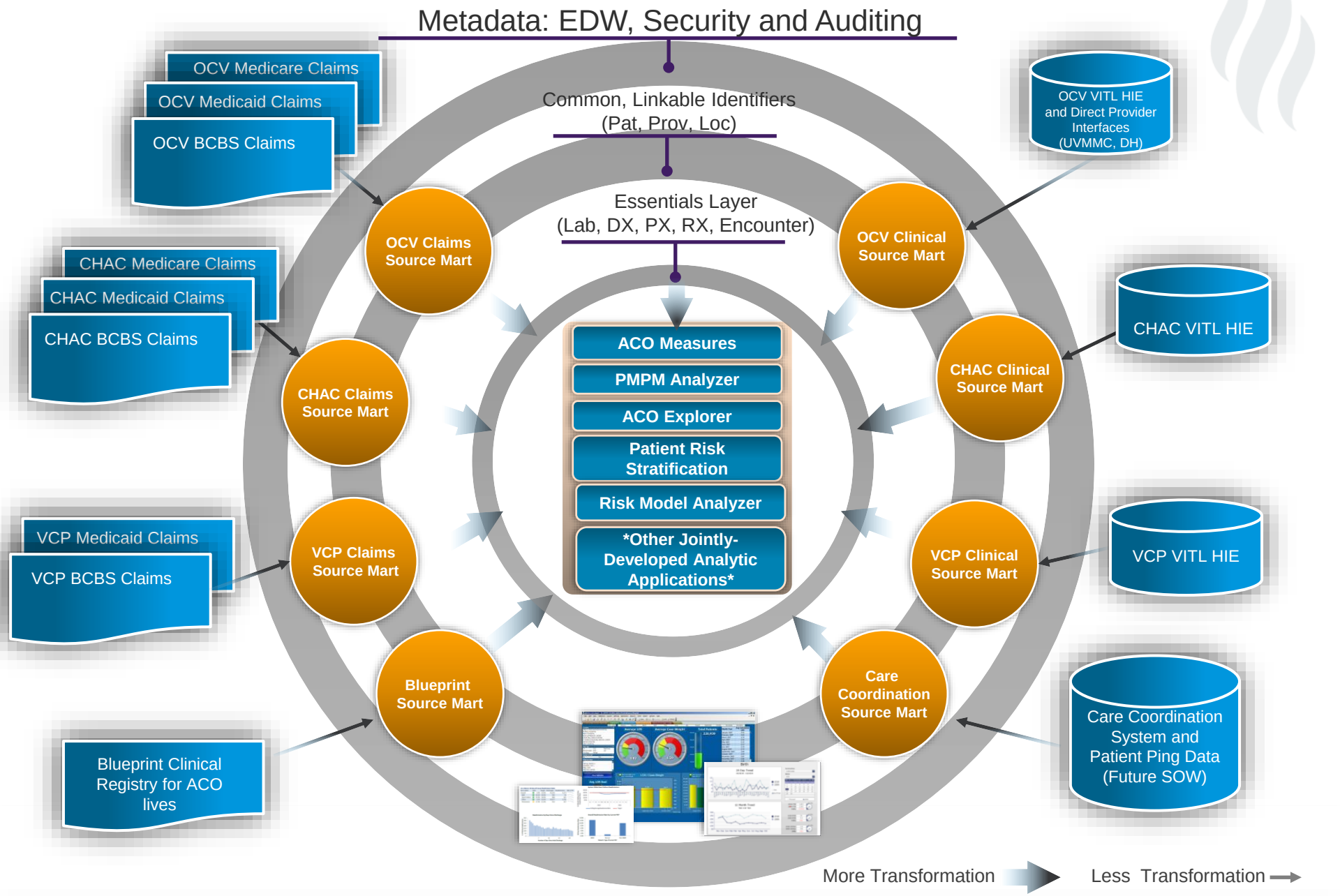
Challenges and Considerations

- Data Use Agreements and Data Sharing concerns
- Different metrics for different programs
  - HEDIS Quality Measures
  - ACO Quality Measures
  - BP Incentive Measures
  - Other available BP Measures
  - Cost/Utilization Comparisons with others
  - Patient-Level Reports
- Aligning source/data warehousing and value-added systems strategies both short term (2016) and longer term
  - VHIE
  - ACO Gateway
  - VITL Clinical Repository
  - Health Catalyst
  - Docsite
  - Current/Legacy OneCare warehouse and reporting capabilities
  - Patient Ping
  - Potential SCUP and/or OneCare Care Management/Coordination/Transitions Management Tool
  - Any current or coming DVHA tools for any of the above as part of their HCIS portfolio

Proposed Combined EDW Platform (conceptual)



Proposed EDW Platform: Why so complex?

A platform with multiple claims and clinical data source marts is what the current environment allows:

- No single source of timely patient-identifiable claims data available to all 3 ACOs and the Blueprint. VHCURES doesn't contain patient identifiers, and ACOs are not given access anyway due to VHCURES data sharing policy restrictions
- Legal work to determine if and how ACOs can share data among each other for benchmarking and care coordination purposes (De-identification will likely be required for sharing)
- Confidentiality, Privacy, and security concerns around PHI and payer sensitive data likely create the need for separate data marts.
- Common infrastructure, metadata layers, and data definitions will get us much closer to the concept of a single source of truth for unified performance analysis.

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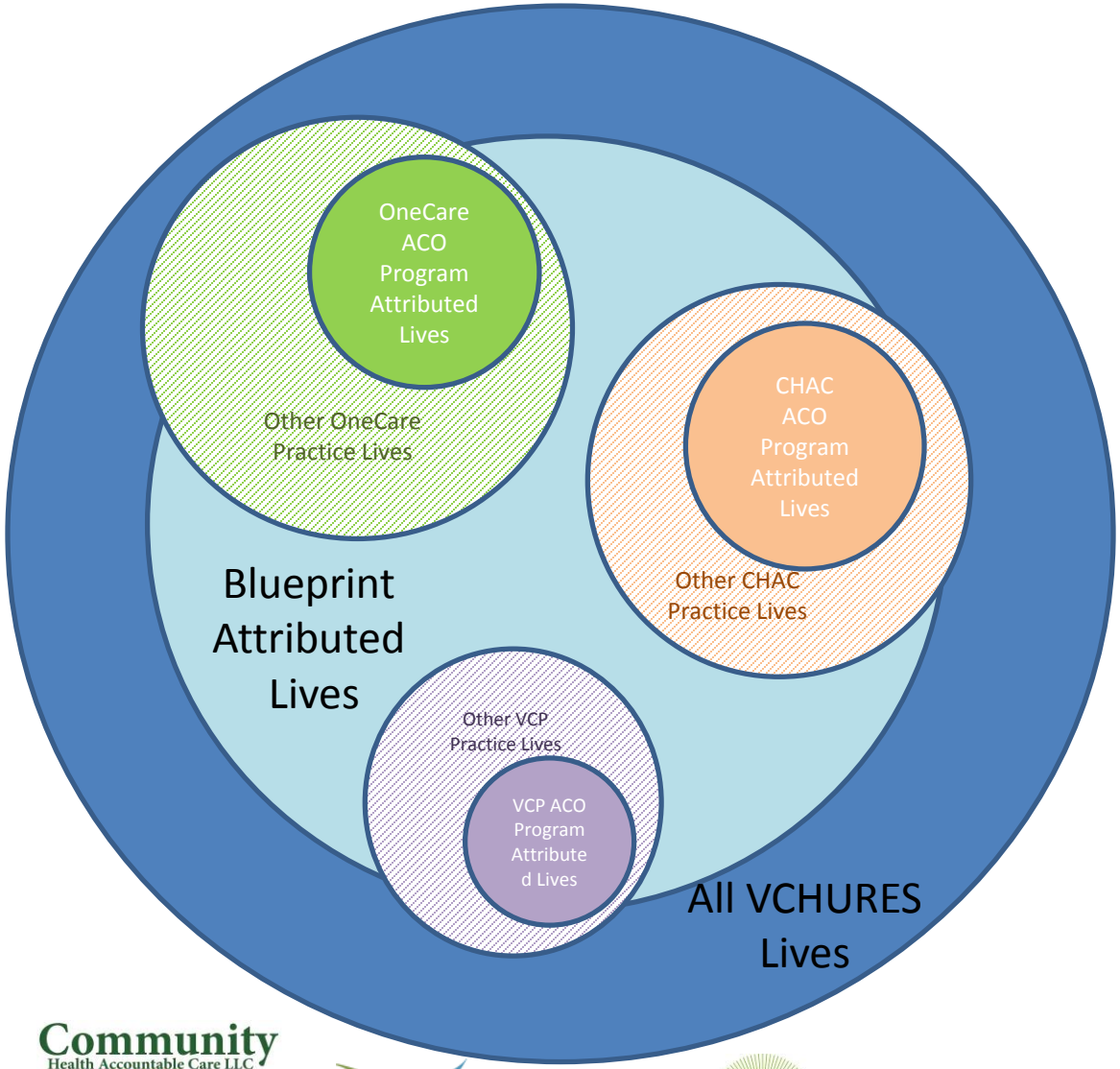
Unified Performance Reporting



Initial Vision: Unified Performance Reports

- Statewide
- Practice
- ACO
- HSA

Deeper Vision: Unified PHM support solutions with aligned processes and more defined roles across single "O"/3-ACOs, Blueprint, DVHA, and Community Collaboratives

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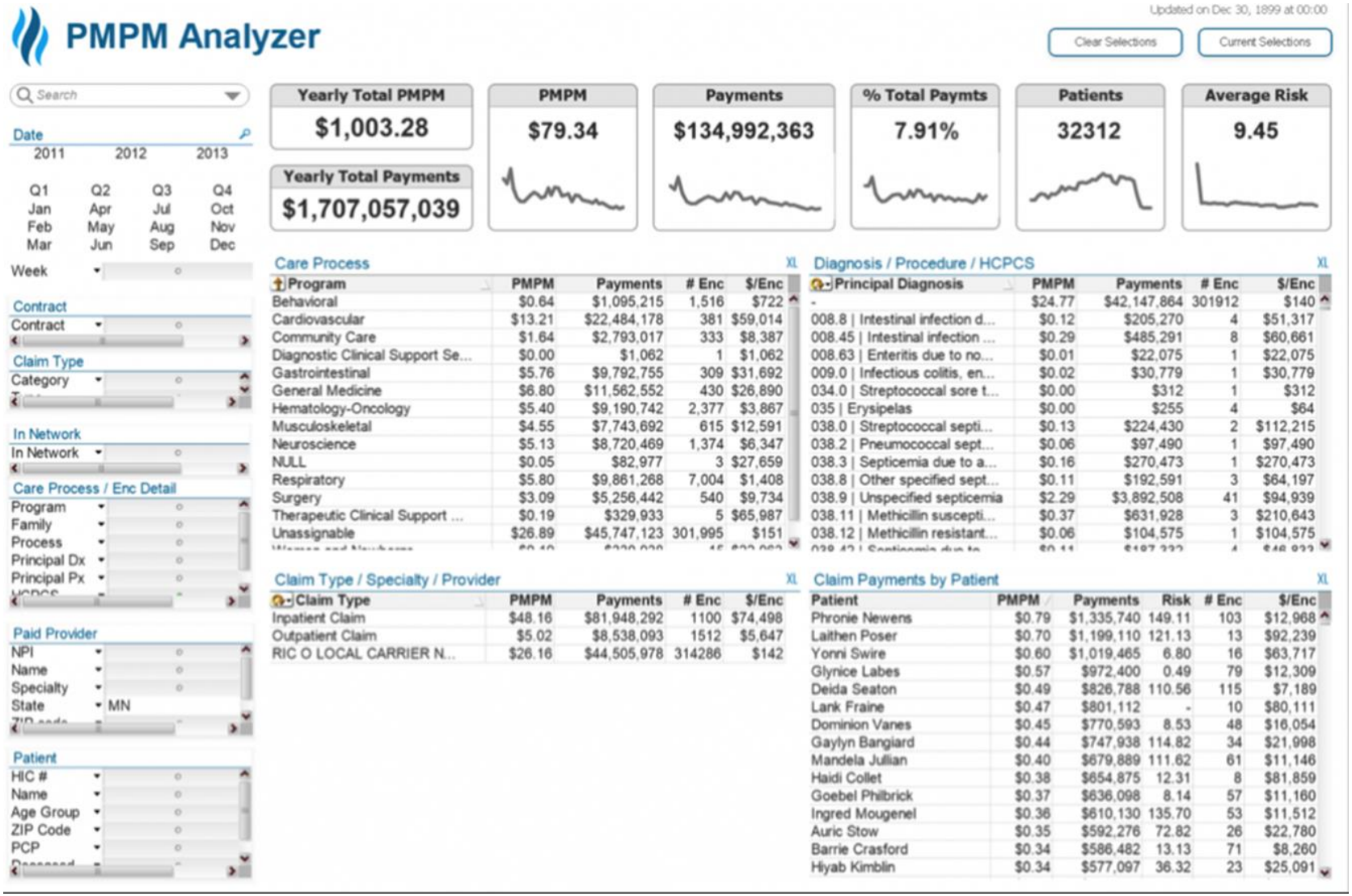
Health Catalyst PMPM Analyzer Application



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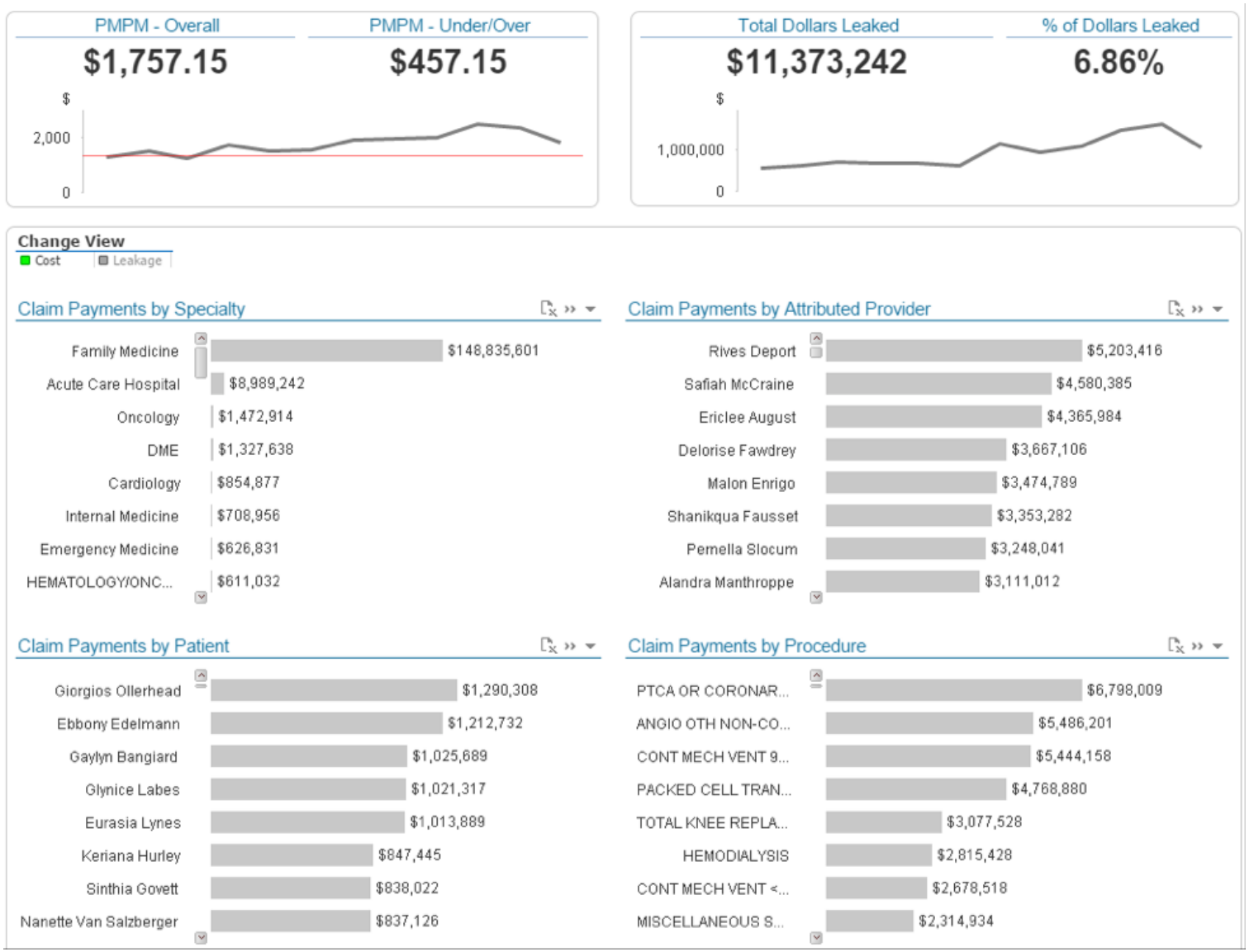
Health Catalyst ACO Explorer Application



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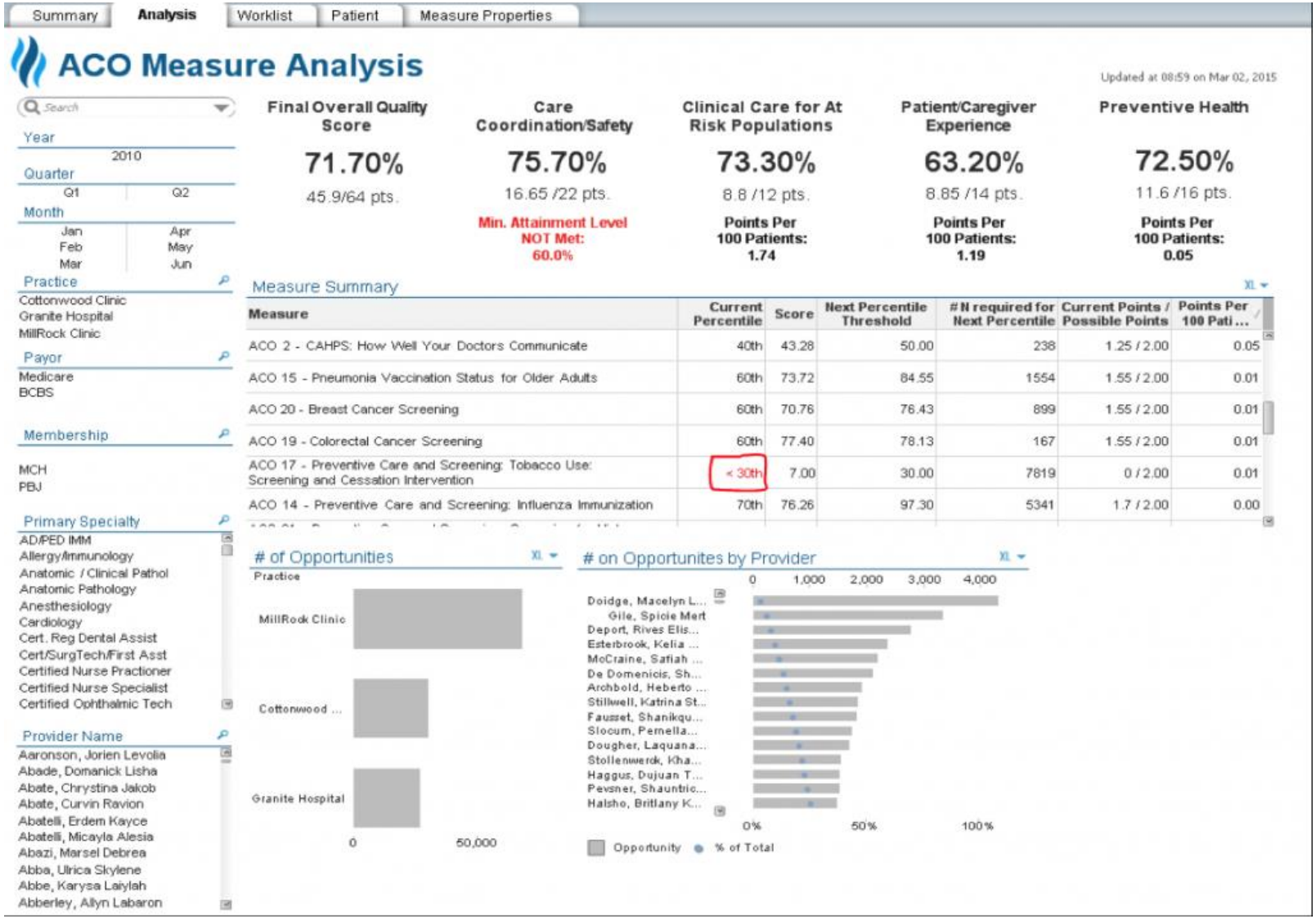
Health Catalyst ACO Measures Application



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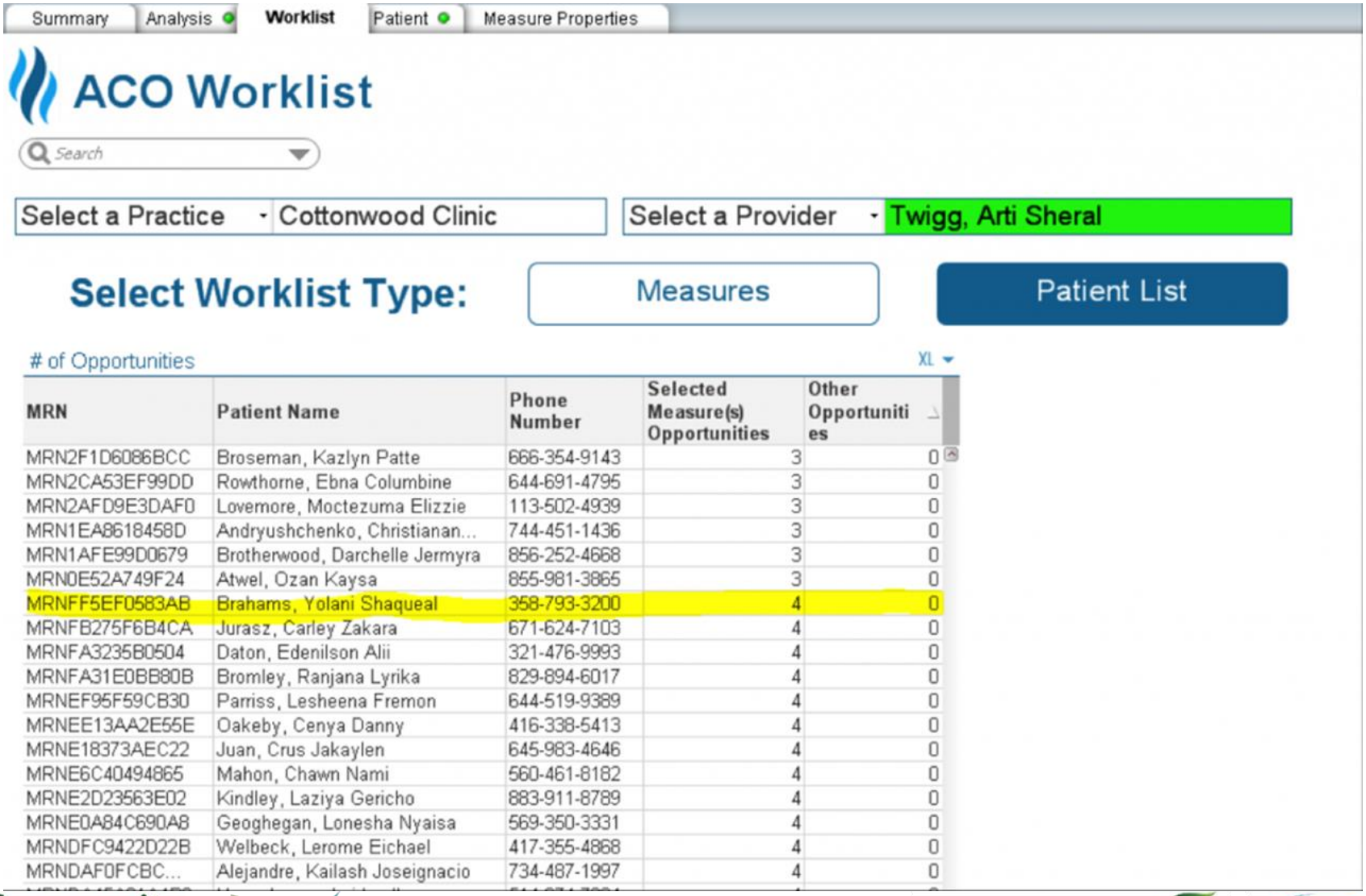
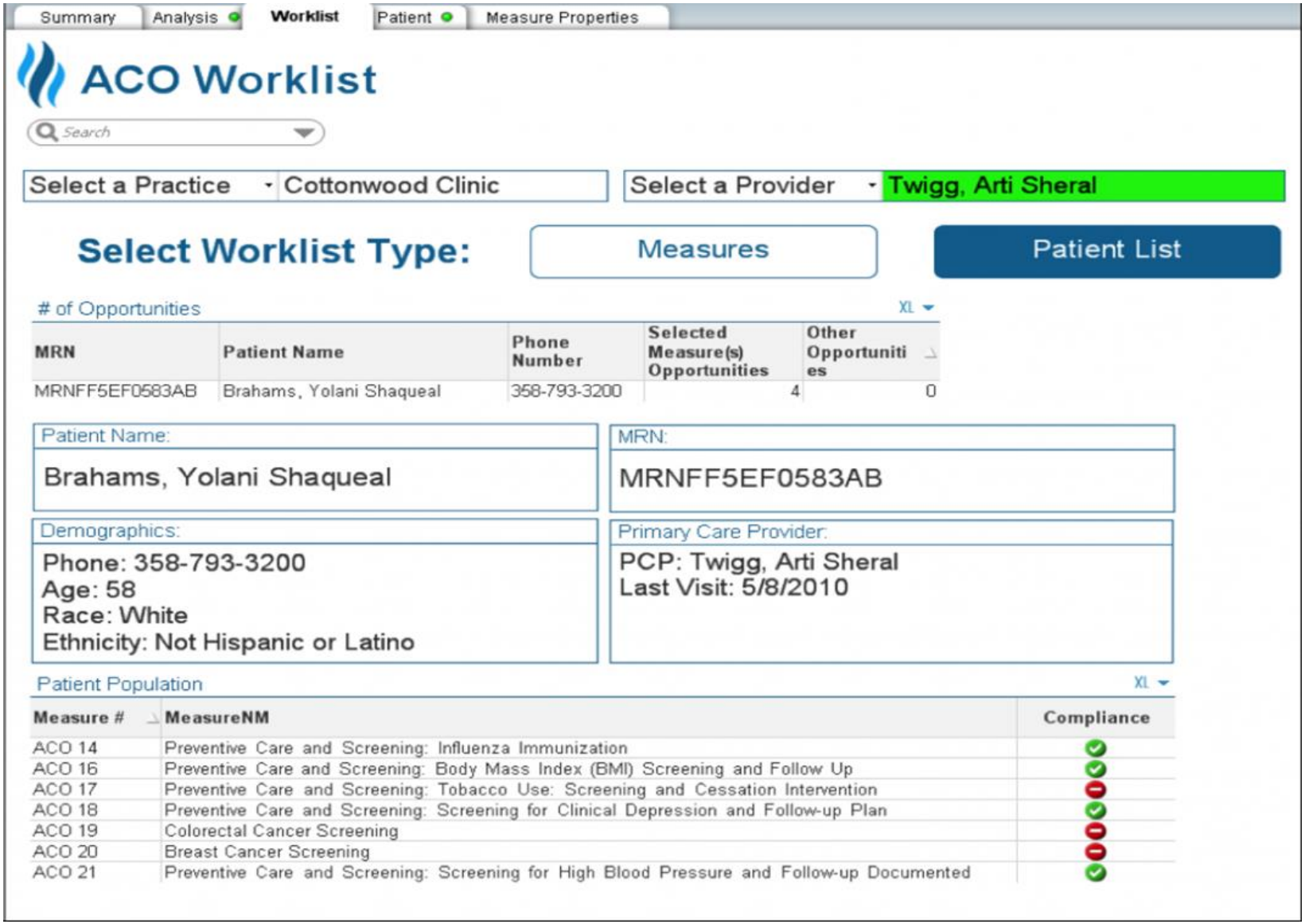
Health Catalyst ACO Measures- Worklist



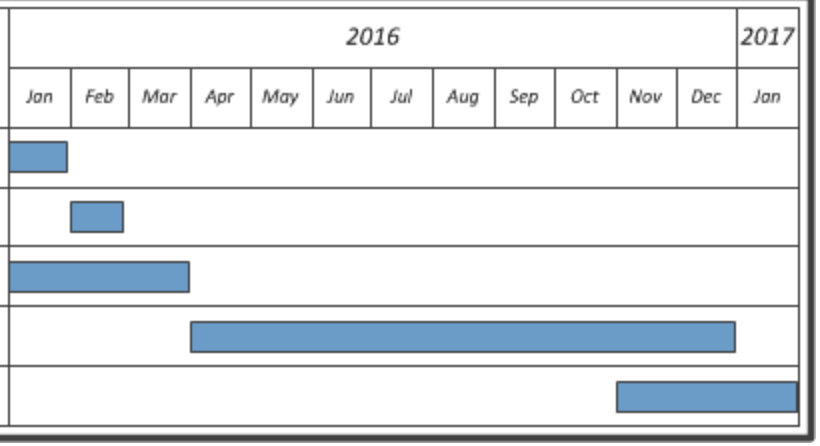
MRN	Patient Name	Phone Number	Selected Measure(s) Opportunities	Other Opportunities
MRN2F1D6086BCC	Broseman, Kazlyn Patte	666-354-9143	3	0
MRN2CA53EF99DD	Rowthorne, Ebna Columbine	644-691-4795	3	0
MRN2AFD9E3DAF0	Lovemore, Moctezuma Elizzie	113-502-4939	3	0
MRN1EA8618458D	Andryushchenko, Christianan...	744-451-1436	3	0
MRN1AFE99D0679	Brotherwood, Darchelle Jermyra	856-252-4668	3	0
MRN0E52A749F24	Atwel, Ozan Kaysa	855-981-3865	3	0
MRNFF5EF0583AB	Brahams, Yolani Shaqueal	358-793-3200	4	0
MRNFB275F6B4CA	Jurasz, Carley Zakara	671-624-7103	4	0
MRNFA3235B0504	Daton, Edenilson Alii	321-476-9993	4	0
MRNFA31E0BB80B	Bromley, Ranjana Lyrika	829-894-6017	4	0
MRNEF95F59CB30	Parriss, Lesheena Fremon	644-519-9389	4	0
MRNEE13AA2E55E	Oakeby, Cenya Danny	416-338-5413	4	0
MRNE18373AEC22	Juan, Crus Jakaylen	645-983-4646	4	0
MRNE6C40494865	Mahon, Chawn Nami	560-461-8182	4	0
MRNE2D23563E02	Kindley, Laziya Gericho	883-911-8789	4	0
MRNE0A84C690A8	Geoghegan, Lonesha Nyaisa	569-350-3331	4	0
MRNDFC9422D22B	Welbeck, Lerome Eichael	417-355-4868	4	0
MRNDAF0FCBC...	Alejandre, Kailash Joseignacio	734-487-1997	4	0

Health Catalyst ACO Measures- Patient Detail

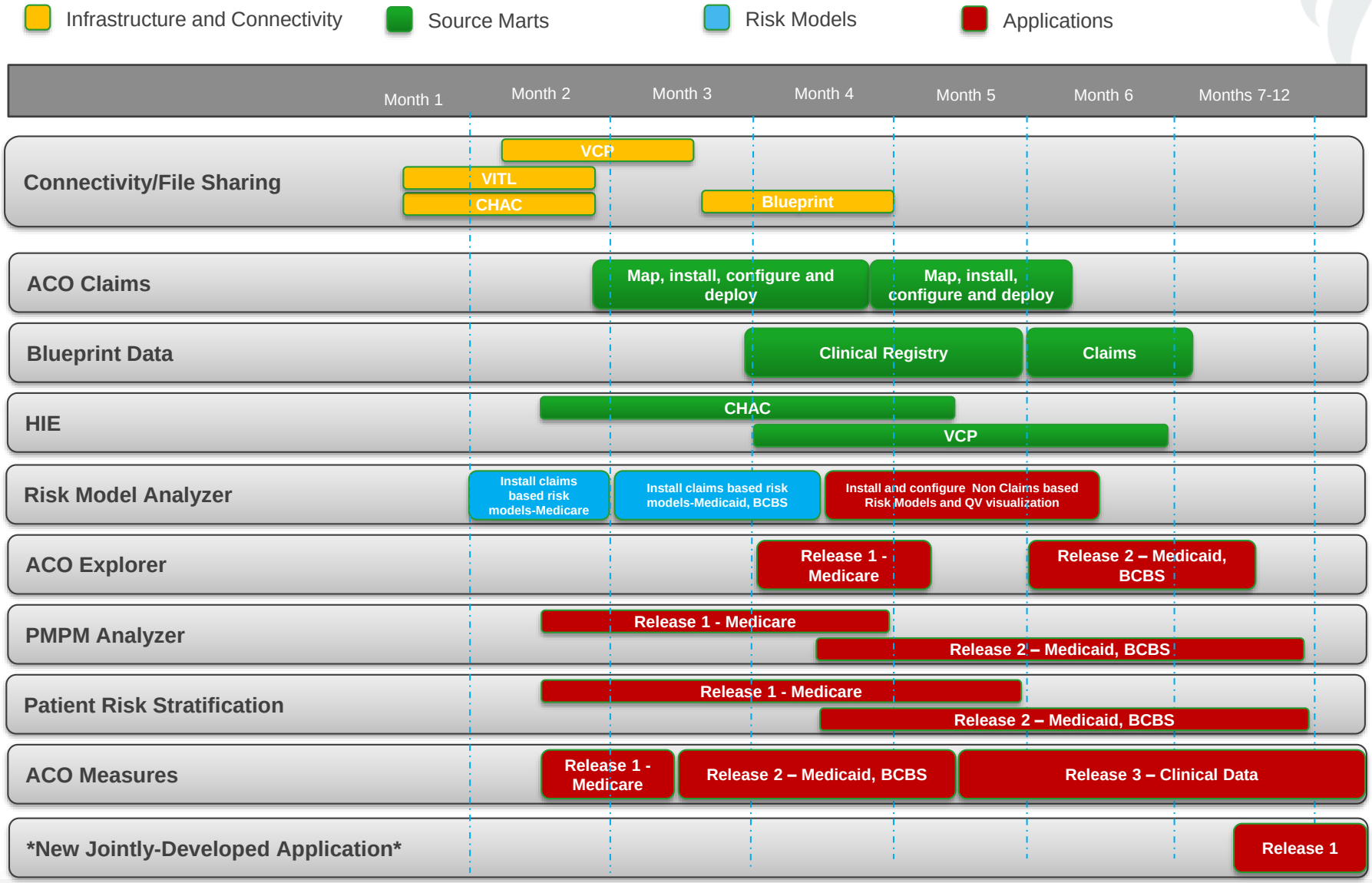


Project Timelines

ID	Task Name	Start	Finish
1	Visioning and Discovery	1/1/2016	1/29/2016
2	Project Design Planning	2/1/2016	2/26/2016
3	Legal/Contracting Work	1/1/2016	3/30/2016
4	Technical Implementation	4/1/2016	12/30/2016
5	Education and Dissemination	11/1/2016	1/30/2017



Health Catalyst Technical Implementation Sample Roadmap (*subject to design and scope*)



Proposal Budget

Project Goal	Requirement	Amount
Technical Integration of CHAC and VCP/Healthfirst Data into Health Catalyst	Health Catalyst One-Time Perpetual License Fees	$ 555,000.00
	One Time Health Catalyst Professional Services Fee for Implementation work	$ 266,000.00
	Hosting Fees- 2016	$ 184,200.00
	Connectivity	$ 240,000.00
	Qlikview Licenses	$ 13,500.00
	VITL Implementation Fees for CHAC and VCP Clinical Datamarts	$ 98,000.00
	VITL hosting fees for CHAC and VCP datamart- 2016	$ 48,000.00
	Subtotal Technical Integration	**$ 1,404,700.00**
Legal Work to support multi-ACO and Blueprint Data Sharing and Collaboration	CHAC Legal Fee Support	$ 25,000.00
	VCP Legal Fee Support	$ 25,000.00
	OCV Legal Fee Support	$ 25,000.00
	Subtotal Legal	**$ 75,000.00**
Staff Time for Planning and Design for PHM Analytic outputs	CHAC Staff for Planning and Implementation	$ 65,000.00
	VCP Staff for Planning and Implementation	$ 65,000.00
	OCV Staff for Planning and Implementation	$ 65,000.00
	Onpoint Consulting Services for work related to Blueprint data integration	$ 10,000.00
	Subtotal Staff Time	**$ 205,000.00**
Project Management	Project Management Contractor	$ 150,000.00
	Subtotal Project Management	**$ 150,000.00**
	Grand Total	**$1,834,700.00**

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Summary

- **CHAC, Healthfirst and OCV have a strong history of collaboration**
- Together we believe that statewide, multi-ACO **collaboration is significantly better than duplicating scarce resources** and allows for the 3 ACOs and Blueprint to **work together to promote evidence-based medicine, improve beneficiary engagement, meet quality and cost metrics and coordinate care in a more efficient manner**
- To this end, we intend in 2016 to **design and deploy an integrated data, analytic and Population Health Management (PHM) infrastructure** based on a combination of existing and planned OneCare, Blueprint, and VITL capabilities in order to increase use of advanced analytics for all three ACOs

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Attachment 8b: Vermont ACO Integrated Informatics Proposal

General Information:

Lead Organization Applying: University of Vermont Medical Center, Inc.
Collaborating Organizations: OneCare Vermont, LLC

Key Contact for Applicant: Todd Moore
Relationship to Applicant: employed
Key Contact Email: todd.moore@onecarevt.org
Key Contact Phone Number: 802-847-1844
Key Contact Mailing Address: 356 Mountain View Drive, Suite 301

Fiscal Officer (must be different from Key Contact): Abraham Berman
Relationship to Applicant: employed
Fiscal Officer Email: abraham.berman@onecarevt.org
Fiscal Officer Phone Number: 802-847-0887
Fiscal Officer Mailing Address (if different from Key Contact): N/A

Project Title and Brief Summary

Vermont ACO Informatics Integration Project

In 2016, CHAC, VCP/Healthfirst, and OneCare Vermont will design and deploy an integrated data, analytic and Population Health Management (PHM) toolset infrastructure in support of ACOs and HSA Community Collaboratives, in collaboration with the Blueprint for Health, working toward a highly integrated model under APM for 2017. The approach would be based on a combination of existing and planned OneCare, Blueprint, and VITL capabilities to generate support tools and increase use of advanced analytics for all three ACOs under a coordinated infrastructure.

The output of this project will include: (1) a single integrated data warehouse for all ACO-attributed lives, leveraging the existing OneCare Health Catalyst Warehouse for use by CHAC and VCP/HealthFirst, and including the ability to have both ACO-specific and combined 3-ACO instances for reporting and analytics, (2) new and re-envisioned practice, HSA, Statewide, and ACO-level analytic reports and appropriate ad hoc analysis capacity that can coherently include and report on ACO program-attributed, Blueprint-attributed, and other available population data, (3) a design of how data and informatics could work under a single "O" in 2017 assuming further evolution is possible under the APM, and 4) a plan for appropriate ACO use of the Blueprint all-payer linked claims and clinical datasets in support of a successful statewide population health management model.

The parties agree to work together to solve technical and DUA issues to facilitate timely and accurate data, and apply the ACO Gateway models to enable matched clinical information for enhanced, automated quality measurement and PHM support efforts. The parties would also work together to jointly support PHM process design for more substantial use of the VITL Access provider portal, the Event Notification System (ENS), and Care Coordination tools from both previously-funded SIM projects and ACO software portfolio capabilities, as well as develop a plan for the appropriate integration of data from the Blueprint Clinical Registry system

Budget Request Summary

Project Goal	Amount
Technical Integration of CHAC and VCP/Healthfirst Data into Health Catalyst	$ 1,404,700.00
Legal Work to support multi-ACO and Blueprint Data Sharing and Collaboration	$ 75,000.00
Staff Time for Planning and Design for PHM Analytic outputs	$ 205,000.00
Project Management	$ 150,000.00
Total	**$1,834,700.00**

Activities for which the applicant is requesting funding

Community Health Accountable Care (CHAC), Vermont Collaborative Physicians (VCP) and OneCare Vermont (OCV) are requesting support to fund a common data analytics infrastructure needed to combine clinical and claims data in support of strong population health management tools for ACO-attributed lives. We are also seeking funds in partnership with the Blueprint for Health in order to design and deliver new and re-envisioned practice, HSA, Statewide, and ACO-level analytic reports and appropriate ad hoc analysis capacity that can coherently include and report on ACO program-attributed, Blueprint-attributed, and other available population data.

Specifically we are requesting:

1. Funds to support the technical integration of CHAC and VCP claims and clinical data from VITL onto the Health Catalyst data warehouse platform currently utilized by OCV, in the amount of $1,404,700.
2. Funds to offset legal fees required to resolve issues related to Data Use Agreements, Informatics System Collaboration and Data Sharing, in the amount of $75,000.
3. Funds to support staff time from OCV, CHAC, VCP, to manage the technical and legal aspects of integrating ACO claims data and clinical data and Onpoint resources for

planning and design work related to the delivery of new and re-envisioned practice, HSA, Statewide, and ACO-level analytic reports and appropriate ad hoc analysis capacity, in the amount of $205,000.

4. Funds to support a contracted Project Management resource to oversee the work streams described in this proposal, in the amount of $150,000.

CHAC, VCP and OCV have a successful and positive history of collaboration, and aspire together to implement a vision of service-area focus on population health management by the full continuum of care and services, with all providers regardless of ACO affiliation. We operate with a high degree of collaboration with Vermont Blueprint for Health programs. Our track record of impact, collaboration, and community-based focus is clear and has been demonstrated in our efforts in statewide Learning Collaboratives, jointly-facilitated Regional Clinical Performance Committees, ACO Quality Measure training and collection initiatives, and other jointly-attended forums. We believe a common and integrated approach to informatics and technology will allow us to collaborate even further, to prevent redundancy, to reduce provider confusion with overlapping or conflicting reports, and to identify opportunities to improve care delivery across the continuum of care through advanced analytics. We view this project as the mechanism by which the three ACOs and the Blueprint for Health will agree to the principles and design of unified performance reporting for Vermont providers, and to provide the necessary analytics to prepare for taking downside risk in 2017 under the All Payer Model.

Number of Providers and Patients Impacted

The networks for the three multi-payer ACO Shared Savings programs in CHAC, VCP/HealthFirst and OCV include: UVMMC and its 1,000 plus providers; D-HH and its 800 plus providers; all community PPS and Critical Access Hospitals in VT and their employed physicians; VT's one behavioral health specialty hospital and its employed physicians; FQHCs; RHCs; community/private physician practices; 10 home health care and hospice organizations in VT;

28 skilled nursing facilities in VT; and all 10 designated community mental health centers in VT. Combined, the 3 ACOs account for over 4500 Vermont providers across the continuum of care.

This combination of large geographical reach and full continuum of care under a collaborative model has provided a powerful foundation for population health management (PHM) for our combined attributed population of over 160,000 Vermonters.

Relationship to VHCIP goals

Starting in December of 2013, OCV received a one (1) year funding opportunity under SIM to support medical leadership, quality improvement, analytics and data, and clinical facilitation to collectively support Vermont's Accountable Care Organizations' capacity to meet the Three Part Aim.

OCV's work has complemented Vermont Blueprint for Health's successful commitment to primary care by bringing together Vermont's full provider continuum to execute on innovative, highly reliable, evidenced based population health management strategies that improve the lives of Vermonters.

To date, the deliverables under the grant have been met by:

- Selecting clinical priorities that align with and complement other statewide reform initiatives
- Supporting (financial, data and human resources) the development/transformation of 14 RCPCs/UCCs in every Health Service Area (HSA) in collaboration with the medical community, the continuum of care providers, the Blueprint for Health, and the other ACOs throughout the state (See Attachment B: Example Bennington RCPC Charter)
- Contracting with physician and advanced practice providers in all 14 HSAs to be clinical champions and support the clinical priorities of the RCPCs/UCCs

- Launching a statewide Learning Collaborative forum, with over 120 participants in attendance, to support performance improvement work on OCV emergency room and readmission/admission clinical priorities approved by the OCV CAB
- Developing and disseminating, at the Learning Collaborative, Readmission Change Packets which identify best practice based interventions and ideas for implementing small tests of change tools for addressing risk; Best Practice Risk Assessment Tools; Needs Assessments with a step by step guide, including some sample teach back tools; PDSA Tool; and Force Field Analysis
- Completing the quality measurement training and collection process for three (3) Shared Savings Programs with OCV, CHAC and VCP.

In addition to the VHCIP funding granted to OCV for the above initiatives, all three ACOs worked together with VITL on developing a proposal for, implementing, and now monitoring the ACO Gateway and Gap Remediation projects.

Impact on similar projects (ongoing or anticipated)

The work described in this proposal is directly related to and advances the value of the following SIM-grant funded projects already proposed or underway in the state:

1) ACO Gateway Project
   - The filtering and message routing mechanism created by VITL and Medicity to create the "ACO Gateways" for OCV and CHAC are foundational to being able to capture clinical data from the VHIE in the Health Catalyst platform.
2) VCP Gateway Project (proposed)
   - Creating a gateway for VCP will be required foundational work to capture clinical data for VCP beneficiaries in the Health Catalyst platform.
3) VITL Gap Remediation Project

- Analytic systems can only provide value when the quality and quantity of source data is sufficient. The gap remediation work performed by VITL is critical to ensuring that the ACOs have high-quality clinical data from our participants to support quality and outcomes measurement, and is a pre-requisite to this project along with the VITL Data Quality project mentioned below.

4) VITL Data Quality Project (under way)
   - As mentioned above, data quality is critical to the success of any analytics initiative. VITL's efforts to improve the quality of data coming from clinical source systems are foundational work for this project.
5) Blueprint Clinical Registry Migration Project
   - The DocSite clinical registry is a rich repository of clinical data for Blueprint and ACO attributed lives, with history preceding what is available through currently VITL. Developing a plan for use of this important asset will be essential to developing a collaborative PHM approach.
6) Expanding Population Health Strategies Project (multi-ACO Learning Collaboratives)
   - RCPC/UCC efforts and statewide learning collaboratives are informed by and rely on population health data that is presented in a digestible and relevant manner.

Applying project learning on a state-wide basis

As previously described, the combination of statewide reach, full continuum of care providers, 3 ACOs, and the Blueprint for Health under a collaborative informatics model has the potential to form a strong population health management platform able to meet the Three Part Aim for a population of over 160,000 lives. The output of the integrated informatics platform will provide direct benefit to statewide providers through the following forums:

- Joint meetings between clinical and administrative leadership of CHAC, HealthFirst, OCV and Blueprint.

- RCPCs/UCCs - represent local multidisciplinary teams that carry out the clinical priorities and engage in data driven process improvement activities. The established RCPCs/UCCs in each HSA have invited participation from the following entities:

    - Leaders from the 3 ACOs
    - Vermont Blueprint for Health
    - OCV contracted Regional Clinician Representatives and Clinical Consultants
    - Clinical and Quality Improvement experts from local or referring hospital systems
    - Representation from the primary care community, including FQHCs, RHCs and independent providers
    - Representation from care coordination entities (e.g., Blueprint Community Health Team extenders, commercial payers, SASH)
    - Continuum of care providers (home health, skilled nursing, hospice, designated agencies etc.)
    - Content experts (pediatric mental health, palliative care, chronic care etc.)
    - State agencies that serve the populations (e.g., VDH, VCCI and IFS)

Members of the RCPC/UCC team foster involvement and ownership at the local level, leading the way on care and delivery transformation.

- Statewide Learning Collaboratives: In 2014, Clinical staff from all 3 ACOs and the Blueprint for Health worked with staff from the Green Mountain Care Board to develop and implement a statewide Learning Collaborative focused on improving care management for Vermonters. The goal of the Integrated Communities Care Management Learning Collaborative is to learn about and implement promising interventions to better integrate cross-organization care management; increase knowledge of data sources, and use data to identify at-risk people and understand their needs; improve communication between organizations; reduce fragmentation, duplication, and gaps in care; and determine if interventions improve coordination of care. Agnostic of ACO affiliation, this Collaborative included teams from 3 pilot

communities and included representation from both the healthcare community, and community agencies. Response to the initial Collaborative was so positive that in 2015 two additional cohorts of Learning Collaboratives began. These cohorts are reaching out to an additional eight (8) health service areas from across the state.

Integrated analytics designed and deployed by the 3 ACOs and the Blueprint will help advance Vermont's clinical improvement efforts across the regions of the state by delivering valuable and actionable information from a single source of truth, and with an integrated approach to measurement.

Data Sharing and Connection with Existing Health Information

The ability to provide comprehensive and real-time clinical information to every health care provider is an essential requirement as part of a Population Health Management infrastructure designed to reduce costs and provide better care.

OCV delivers population-level cost, quality, and utilization analytics to compare data at an HSA-level on a number of key metrics. Additionally, custom analyses and patient-level detail reports are developed from the OCV informatics platform to support RCPC/UCC quality improvement projects.

Reporting is generated by a team of highly-skilled technical and business analysts at OCV who employ state-of-the-art approaches to covered population demographic profiles, disease state and episode registries, risk assessment, utilization analysis, cost performance, and population clinical measurement. Internal and external benchmarking, opportunity analysis, predictive modeling, and decision support are appropriately embedded in all approaches.
Specific examples of analyses performed by the OCV Analytics team to date include:

- Episode cost variation analysis by facility for Medicare beneficiaries receiving total joint replacements

- Inpatient cost and utilization comparisons between HSAs
- Readmission analysis
- Ambulatory sensitive condition admission rates by HSA
- Potentially avoidable emergency department use rates by HSA
- Home Health utilization and variation analysis by HSA
- Skilled Nursing Facility utilization and variation analysis by HSA
- Enhanced medication reconciliation reporting for a patient-centered medical home practice, combining claims and EMR data
- Beneficiary-level detail of patient risk factors for distribution to primary care providers

We envision that these types of analyses will be made available to CHAC and VCP and incorporated into an integrated analytic approach aimed at improving care for the Vermont population, regardless of ACO affiliation.

OCV, CHAC and VCP have collaborated with the Vermont Blueprint for Health to design co-branded provider and practice level reporting using the VHCURES all-payer claims database, the DocSite clinical registry, along with clinical data from the VHIE in order to meaningfully support care delivery transformation. These reports provide a comprehensive, multi-payer view of practice patient panels (including non-ACO beneficiaries) and will be designed to meet the measurement needs of the ACO while providing meaningful and actionable performance data for practices. Part of the objectives of this project are to continue design and planning work to ensure that reporting from the combined ACO analytics platform, in conjunction with valuable analytics from the Blueprint, will support the work of the RCPCs/UCCs.

Much effort has been focused in the last 2 years to increase the quantity and quality of data available for sharing between providers and ACOs for quality improvement and care coordination efforts. VITL's gap remediation projects have contributed to this effort. Practices have put significant resources into increasing the utility and interoperability of their EMR systems as well. For example, nearly all HealthFirst/VCP practices use EHRs, with 95% achieving Meaningful Use status through Medicare. Nearly all practices are also well-integrated with

VITL/HIE, with many large primary care practices already sending and receiving clinical data to and from the VHIE. HealthFirst/VCP has used previous SIM funds to enable and support community practices in collecting and documenting important population health measures in their EHRs over the past two years. The care being delivered by community practices according to population health measures is of very high quality according to all ACO quality reporting score cards, however VCP/HealthFirst does not currently have the capability to parse and manipulate claims data in an effective way, such that it can be paired with clinical data to give a "360 view" of the patient population. HealthFirst/VCP would like to march down the path of achieving this goal in alignment with OCV and CHAC, so that all provider networks in the state are able to review population health data with the same lens.

Successful Population Health Management requires the combination of claims from disparate payers and clinical data from the HIE to facilitate advanced analysis and reporting to participants, ACO leaders, and regulators. Additionally, the combination of data from the 3 ACOs and the Blueprint will allow for the analysis required to assess the feasibility and mechanism of creating a single "O" with full downside risk for a combined population in 2017.

Alternative funding sources sought

The annual operating budget for OCV is approximately $9M and is at scale with required capabilities. In 2015, the University of Vermont Medical Center (UVMMC) and Dartmouth-Hitchcock Health (D-HH) provided combined annualized funding of $4.7M. Additional funding in the amount of $2M came from network participants through participant fees and the remaining funds came from a VHCIP SIM grant. OneCare's informatics platform and personnel are funded through its operating budget.

CHAC's operations to date have been supported by a combination of member investment, VHCIP grants, and leveraged federal grants. In July 2015, the VHCIP Core Team approved additional funding to support CHAC's work, including $144,000 to support the selection and

implementation of an analytics solution for CHAC's claims data in 2016 (VHCIP grant amendment pending). If this proposal is approved, CHAC is committed to utilizing those funds in alignment with this joint analytics solution (e.g., to accelerate a provider portal implementation, etc.)

HealthFirst/VCP currently relies on SIM Grant funding to support its ACO infrastructure. SIM funds support an annual budget of approximately $300,000 per year. Previously, to support engagement in the Medicare Shared Savings program, HealthFirst partnered with Universal American. UA funded more robust analytics and care coordination ACO infrastructure at the level of $750,000 annually, but that funding stream ended on Dec 31, 2014. HealthFirst/VCP plans to continue support ACO infrastructure through shared savings or population-health payments that reward high-quality, low-cost ("high-value") care.

Technical Assistance Sought

At this time, we are not seeking technical support from State.

Return on Investment (cost and quality)

The integrated informatics approach we propose will provide CHAC and VCP/Healthfirst with an analytics platform that is significantly more affordable than what would be achievable if implementing independently. Quotes from vendors for a single implementation range from $144,000 to $1,250,000, however the products vary greatly and a lower-cost product would necessarily not have the capabilities of the solution envisioned in this proposal. Each organization would also need to fund labor for programmers, project managers, staff time for validation, create separate projects with VITL, etc. Each ACO could independently require an informatics budget of over $1 million annually to maintain separate and redundant systems.

Additionally, having multiple analytics systems with overlapping or conflicting information does nothing to advance us into a truly integrated Population Health Management Model with common definitions and approaches.

Synergy with other activities underway (avoiding duplication)

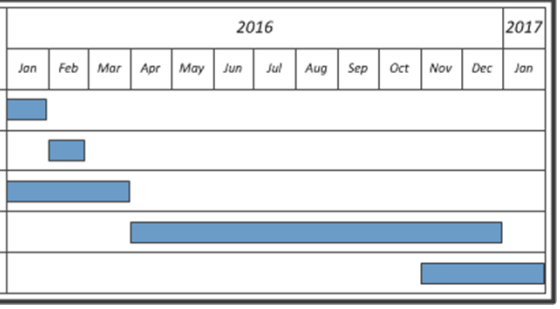
OCV, CHAC, VCP and Blueprint have a strong history of collaborating together with the goal of improving health care for the Vermont population. OCV, CHAC and VCP have participated in the following collaborative efforts:

- Aligned with the Vermont Blueprint for Health on quality measures linked to medical home payments
- Collaborated with the Vermont Blueprint for Health to provide co-branded practice level reporting using VHCURES, DocSite, and clinical data from the VHIE in order to meaningfully support care delivery transformation. These reports will be designed to directly support the work of the RCPCs/UCCs
- Partnered with the Vermont Blueprint for Health and VITL on an ACO data exchange initiative to serve our common goal for high quality, meaningful and actionable data that would bring efficiency to our care coordination and quality collection efforts.
- Partnered with the Vermont Health Care Innovation Project, the Vermont Blueprint for Health and its providers to develop and implement learning collaboratives aimed at building high-performing, multidisciplinary care coordination systems that include patients and families as partners. The learning collaboratives will explore whether integrated and collaborative care coordination services can improve quality of care, patient and family experience, and health and wellness while reducing the overall burden of cost to the health care system.

We believe that statewide, multi-ACO collaboration is significantly better than duplicating scarce resources and allows for the 3 ACOs and Blueprint to work together to promote evidence-based medicine, improve beneficiary engagement, meet quality and cost metrics and coordinate care in a more efficient manner.

Project Implementation Plan and Timeline

ID	Task Name	Start	Finish
1	Visioning and Discovery	1/1/2016	1/29/2016
2	Project Design Planning	2/1/2016	2/26/2016
3	Legal/Contracting Work	1/1/2016	3/30/2016
4	Technical Implementation	4/1/2016	12/30/2016
5	Education and Dissemination	11/1/2016	1/30/2017



A more detailed project plan will be developed as part of the “Project Design Planning” task listed above.

Budget Narrative

Project Goal	Requirement	Amount	Notes
Technical Integration of CHAC and VCP/Healthfirst Data into Health Catalyst	Health Catalyst One-Time Perpetual License Fees	$ 555,000.00	
	One Time Health Catalyst Professional Services Fee for Implementation work	$ 266,000.00	Maximum amount, subject to specific project scope and design
	Hosting Fees- 2016	$ 184,200.00	Annual fee
	Connectivity	$ 240,000.00	10K per IP per month
	Qlikview Licenses	$ 13,500.00	Data visualization tool required for Health Catalyst users. $1350 per named user, 5 for CHAC, 5 for VCP
	VITL Implementation Fees for CHAC and VCP Clinical Datamarts	$ 98,000.00	
	VITL hosting fees for CHAC and VCP datamart- 2016	$ 48,000.00	
	Subtotal Technical Integration	**$ 1,404,700.00**	
Legal Work to support multi-ACO and Blueprint Data Sharing and Collaboration	CHAC Legal Fee Support	$ 25,000.00	
	VCP Legal Fee Support	$ 25,000.00	
	OCV Legal Fee Support	$ 25,000.00	
	Subtotal Legal	**$ 75,000.00**	
Staff Time for Planning and Design for PHM Analytic outputs	CHAC Staff for Planning and Implementation	$ 65,000.00	
	VCP Staff for Planning and Implementation	$ 65,000.00	
	OCV Staff for Planning and Implementation	$ 65,000.00	
	Onpoint Consulting Services for work related to Blueprint data integration	$ 10,000.00	
	Subtotal Staff Time	**$ 205,000.00**	
Project Management	Project Management Contractor	$ 150,000.00	Maximum amount, subject to specific project scope and design
	Subtotal Project Management	**$ 150,000.00**	
	Grand Total	**$1,834,700.00**	

Summary

CHAC, HealthFirst/VCP and OCV have a strong history of collaboration. Together we believe that statewide, multi-ACO collaboration is significantly better than duplicating scarce resources and allows for the 3 ACOs and Blueprint to work together to promote evidence-based medicine, improve beneficiary engagement, meet quality and cost metrics and coordinate care in a more efficient manner. To this end, in 2016 we intend to design and deploy an integrated data, analytic and Population Health Management (PHM) toolset infrastructure based on a combination of existing and planned OneCare, Blueprint and VITL capabilities in order to increase use of advanced analytics for all three ACOs under a coordinated infrastructure.

Attachments

Attachment A: Vermont ACO Integrated Informatics Proposal.ppt

Attachment B: Budget detail

Attachment 8c: Public Comment (through 11/30)

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November 24, 2015

Georgia Maheras
Director, Vermont Health Care Innovation Project
109 State Street
Montpelier, VT 05620

Re: ACO Proposal, November 18 Health Data Infrastructure Work Group Meeting

Dear Georgia,

I am writing to comment on the Accountable Care Organization (ACO) Proposal presented by Leah Fullem at the November 18 Health Data Infrastructure (HDI) Work Group meeting, and on the prioritization of remaining State Innovation Model (SIM) grant funds. Due to the SIM budgetary constraints described at the HDI Work Group meeting, it is our view that the $1.8 million ACO Proposal should not be funded at this time. Remaining SIM funds should be examined comprehensively in concert with all current and expected proposals. Proposals should be prioritized for funding based on the greatest need and on the potential availability of other funding sources for each project. The Core Team should take into account the distribution of SIM funds to date and prioritize areas that have not yet received funding.

Our office advocates for prioritization of funding for the Disability and Long Term Services and Supports (DLTSS) gap remediation project also presented at the November 18 HDI Work Group meeting. As described at the meeting, this project would connect Home Health Agencies and Area Agencies on Aging to the Vermont Health Information Exchange and address other technology gaps for DLTSS providers. DLTSS providers are largely under-resourced and to date, no SIM funds have been allocated to increase health information technology connectivity for Vermont's Home Health Agencies and Area Agencies on Aging.

Thank you for your consideration of our comments.

Sincerely,

/s/ Julia Shaw, Health Care Policy Analyst