***Vermont Health Care Innovation Project***
***Health Data Infrastructure Meeting Agenda***

**December 16, 2015, 9:00-11:00am**

*4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier*

**Call-In Number: 1-877-273-4202; Passcode: 2252454**

| Item # | Time Frame | Topic | Presenter | Relevant Attachments | Action Needed? |
|---|---|---|---|---|---|
| 1 | 9:00-9:05am | Welcome and Introductions; Minutes Approval | Simone Rueschemeyer & Brian Otley | Attachment 1: Draft November 18, 2015, Meeting Minutes | Approval of Minutes |
| 2 | 9:05-9:25am | Updates:<br>• CMMI/No-Cost Extension<br>• Steering Committee Discussion: VITL-ACO Gap Remediation and ACO Integrated Informatics Proposals | Georgia Maheras | | |
| 3 | 9:25-9:55am | Health Data Inventory Findings and Recommendations | David Healy | Attachment 3: Inventory and Analysis of Existing Vermont Health Data: Recommendations<br>The draft Health Data Inventory Report is available on the VHCIP website:<br>http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/HIE/12-16-15%20HDI%20-%20DRAFT%20Health%20Data%20Inventory%20Report.pdf | |
| 4 | 9:55-10:25am | Vermont HIT Plan Update | Steve Maier & Laura Kolkman | Attachment 4: Vermont HIT Plan Update Presentation | |
| 5 | 10:25-10:55am | Data Utility/Data Governance | Georgia Maheras | Attachment 5a: Data Utility and Governance Slides<br>An article on public utility models:<br>http://www.preservearticles.com/2012022823834/what-are-public-utilitiesand-state-its-characteristics.html<br>Attachment 5b: Compiled Public Comments | |
| 6 | 10:55-11:00am | Public Comment Next Steps, Wrap-Up and Future Meeting Schedule | Simone Rueschemeyer & Brian Otley | Next Meeting: Wednesday, January 20, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex | |

Additional Materials: Attachment 6: November 2015 Status Reports – VHCIP Health Data Infrastructure Projects

# Attachment 1: Draft November 18, 2015, Meeting Minutes

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

## *Pending Work Group Approval*

**Date of meeting:** Friday, November 18, 2015, 9:00am-11:00am, Calvin Coolidge Conference Room, National Life Building, Montpelier.

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome and Introductions** | Brian Otley called the meeting to order at 9:05am. A roll call attendance was taken and a quorum was present. | |
| **2. Review and Acceptance of October 21st Meeting Minutes** | Brian Otley entertained a motion to approve the October 21st meeting minutes. Leah Fullem moved to approve the minutes by exception. Heather Skeels seconded. The minutes were approved, with Trinka Kerr and Mary Alice Bisbee abstaining. | |
| **3. VITL – ACO Gap Remediation Presentation** | Brian Otley introduced the Gap Remediation items. VITL responded to questions from Work Group leadership and members after the October 21st meeting. Georgia Maheras invited additional questions, follow-up, or discussion.<br><br>The group discussed the following:<br>• Richard Slusky requested clarification on what has been achieved to date on Round 1 of Gap Remediation. He noted that VITL is already on track to meet some deliverables (or has achieved/surpassed them) but is not on track for others, and that VITL's goals have changed for some areas. Kristina Choquette spoke to VITL's process for goal setting, noting that balancing organizational size and readiness are key factors for focusing efforts. As VITL works to meet these goals, they're working with a large universe of possible connections and working to prioritize strategically to meet goals. Brian commented that the original goals were not absolute numbers and may have been optimistic – they depended on significant provider readiness that may not have borne out in the provider community. Kristina characterized the likelihood of connecting to UVMMC and CVMC as medium to high, with discussions in process to make these connections happen. John Evans agreed, and noted that the technical connection is possible, but it's a matter of prioritizing connection at the provider organization and the EHR vendor level. Kristina also noted that VITL will be utilizing ONC's vendor complaint process if necessary, and added that this complaint process has been a great tool to get vendors to the table. | |

| Agenda Item | Discussion | Next Steps |
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| | • Brian Isham asked for more information on vendor blocking, and noted that exorbitant provider-side costs are a significant issue. Kristina clarified that high pricing can qualify on data blocking. John commented that VITL is funded to do this work, decreasing cost to providers. In addition, VITL has a small amount of money every year that goes to small practices to reimburse for connection costs.<br>• Dale Hackett asked whether in Year 3, we'll have useful data, or whether this may not come until 2017 or 2018. John responded that this project's timeline focuses on getting to 80% in 2016, though the work won't be totally done at that point.<br><br>Paul Harrington moved to provide support for Phase 2 of the Gap Remediation Extension Project as outlined in Page 2 of Attachment 3a of today's materials, with a vote by exception. Leah Fullem seconded. The motion carried with Ken Gingras, Mike Gagnon, and Leah Fullem abstaining. | |
| **4. VITL – VCN Gap Remediation Presentation** | Brian invited comments or questions about the VCN Gap Remediation proposal (also discussed in Attachments 3a and 3b). There were no additional comments or questions.<br><br>Dale Hackett moved to approve this proposal by exception. Leah Fullem seconded. The motion carried with Ken Gingras abstaining. | |
| **5. SCÜP Update** | Larry Sandage provided an update on the SCÜP Project (Attachment 5).<br>• Technical proposal nearly finalized, currently undergoing review and will be released soon.<br>• At their October meeting, the Core Team approved a budget of $1.15 million for the SCÜP and Event Notification System projects. This will likely result in ~$400,000 available for SCÜP, but ENS is still being negotiated so this amount is not final.<br>• Mike Gagnon asked if we've thought about how the Universal Transfer Protocol form will come back into the patient's record. Larry responded that this will be further discussed in the recommendation, but that the project did not fully explore whether or how this information would be integrated back into the patient record.<br>• Brian Isham asked how this is different from current work with Medicity and VITL. Georgia and Larry will have an offline conversation with Brian and AHS. Richard Slusky asked that Georgia's response to AHS be brought back to the group in the interest of transparency.<br>• Dale Hackett noted that this is an important first exploratory step, but that it's hard to be prescriptive about how providers communicate with one another. Erin Flynn responded that this isn't intended to be prescriptive, it's trying to create a tool to support this communication in a way that providers want. Dale agreed that this project is unique and fills a gap.<br>• Leah Fullem clarified that OneCare doesn't yet have a scope for the ACO Care Management Solution and hasn't executed a contract with a vendor – it's impossible to say that the scope will accommodate the SCP requirements at this point. Larry noted that all of the possible solutions are still in pre-implementation stages – OneCare has been a helpful and open partner in these conversations, and the SCÜP team will continue to talk with other solution providers. | |

| Agenda Item | Discussion | Next Steps |
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| | • Mary Alice Bisbee asked for a quick description of MMIS Care and PatientPing. Larry responded that MMIS Care is the Medicaid care management system being developed by the Department of Vermont Health Access. PatientPing is an Event Notification System vendor already working with VITL and the state.<br>• Julie Wasserman asked how the ACO Care Management system would work for people not attributed to an ACO; Larry responded yes. Julie noted that the ACO total cost of care is focused on hospital and physician services, and asked whether the Care Management solution would have a broader view; Larry responded that it would. Leah added that the intent is to provide a care management solution to all organizations involved in a patient's care, including community agencies and other affiliated participants.<br>• Dale Hackett asked whether DVHA has planned changes in reimbursement rates that will affect this. Georgia responded that this is not applicable to this conversation – Georgia is not sure whether FY 2016 budget issues will impact MMIS Care.<br>• Stefani Hartsfield commented that this needs to be closely aligned with the Integrated Communities Care Management Learning Collaborative or communities will create their own tools. Erin noted that St. Johnsbury and Rutland were two of the communities from which the SCÜP team gathered information.<br>• Mike Gagnon expressed concern about the size of this project, which was supposed to start as a pilot. He commented that this group needs to see the architecture of a solution before we can move ahead. Mike moved to table this for now, pending additional information on architecture and pilot scope.<br>• Georgia responded that the use of the word recommendations was perhaps the wrong term and that was intended to meet a deadline of having recommendations at this meeting. The information is more of an update about the project. The information provided shows that more discovery is needed and that they are consistent with Mike's suggestion for further information gathering. There is no funding requested from this group today. She suggested that Work Group members review the Technical Proposal when it is released and provide comment. Susan Aranoff noted that this is still a pilot, and that this is a great petri dish to learn from.<br>• Georgia clarified that the funds allocated to this project are not specifically allocated to discovery or a solution.<br><br>Brian commented that he does not think we need a vote on this today. We need additional information on architecture and cost on this project before a vote, and in the meantime, we can continue a limited staff investment in further information gathering.<br>• Richard noted that there are some pieces of the total amount ($1.15 million) that are allocated – ENS, specifically – and asked whether slowing SCÜP would slow ENS. Georgia replied that ~$400,000 of the total is held for SCÜP, but we are not waiting for SCÜP to move forward on ENS.<br>• Brian suggested we split ENS, UTP, and SCP for the future. Larry agreed, and noted that we'll be proposing solutions for these as three separate projects, and will be reporting on this as three separate projects in the future.<br>• Mike revoked his motion. | |

| Agenda Item | Discussion | Next Steps |
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| **6. DLTSS Technology Assessment and Next Steps** | Susan Aranoff presented on high-level findings and proposed next steps from the DLTSS Technology Assessment Report. (Attachment 6 – the full report is available here on the VHCIP website.)<br>• Sue asked that participants review the report and invited readers to contact her if they discover information in the report that is now out of date.<br>• This is a proposal to allocate money, similar to the telehealth proposal last year, to support increased connection for Home Health Agencies and Area Agencies on Aging with specific projects to be defined later. Sue noted that Home Health data exchange and measurement capabilities will be increasingly important for future payment and care delivery models.<br><br>The group discussed the following:<br>• Trinka Kerr commented that she supports this proposal due to the need for better electronic access among non-acute providers.<br>• Sue added that it is late in the SIM timeline to put out additional RFPs – we could pursue this work by expanding the scope of another SIM contract with VITL. That discussion will happen if funds are approved.<br>• Paul Harrington commented that billing capacity is less important than integration and communication capacity, and that capital investment is important but implementation and uptake are necessary to ensure adoption. Sue noted that readiness varies across agencies, but that VITL provides some support for uptake. Sue suggested that new laws and rules will require providers to gain comfort with this.<br>• Mary Alice Bisbee commented that a recent experience with home health showed a lack of coordination and need for increased communication.<br>• Amy Cooper commented that Healthfirst has reached out specifically to Skilled Nursing Facilities to improve communication, but this is a challenge without capabilities on the home health side. Leah Fullem seconded this comment.<br>• Julie Wasserman noted that no SIM money has been put toward HHAs yet.<br>• John Evans noted that some HHAs are already pushing information to the VHIE – primarily admissions, discharges, and transfers, though one is sharing CCDs – and that this has been funded through VITL's core agreement with DVHA. John noted that VITLAccess onboarding is not particularly expensive and would allow organizations to access VHIE data, but that interface development is significantly more expensive. Sue responded that it would be good to flesh out the proposal if this group chooses to move a proposal along to the Steering Committee and Core Team.<br>• Dale Hackett expressed support for this proposal. He also noted that HHAs are being continually asked to do more with fewer dollars, and commented that he wants to see quality and other results for HHAs.<br>• Stefani Hartsfield expressed support for the goals of this proposal. She suggested that the UTP and SCP projects could also provide some of the necessary care coordination support, and asked the group to keep that in mind as we plan next steps.<br><br>Brian Otley entertained a motion, noting that there is clearly strong support for investment in this area, but that this | **Send feedback on DLTSS Technology Assessment Report to Susan Aranoff (susan.aranoff@vermont.gov).** |

| Agenda Item | Discussion | Next Steps |
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| | proposal does not include a clear ask. He suggested a motion recommending an investment, and proposing to set aside funds to be made available to support more specific proposals in the coming months with the requirement that proposed activities can be accomplished within the grant period.<br><br>Dale Hackett moved to recommend that HHAs and AAAs receive money to support health information exchange through VITL, dependent on resources the Core Team has to allocate. Brian suggested adding that more specific proposals will be forthcoming. Heather Skeels suggested adding language recognizing that this request is in response to a change in the landscape. Mary Alice Bisbee made a friendly amendment to include "strongly recommend or prioritize" with this request. Amy Putnam recommended adding that the DLTSS Technology Assessment Report indicates this is an area of priority.<br><br>Final motion, moved by Dale Hackett, for approval by exception: Dale Hackett moved to strongly recommend that HHAs and AAAs receive money to support health information exchange through VITL, dependent on resources the Core Team has to allocate, recognizing that this request is responsive to a change in the landscape and the results of the DLTSS Technology Assessment Report, and that more specific proposals will be forthcoming to address previously limited investment in this area. Mary Alice Bisbee seconded. The motion carried with Chris Smith abstaining.<br>• Staff will work with VITL to scope a more specific proposal, ideally before the Core Team meeting on 12/9. | |
| **7. Data Utility/Data Governance** | Brian Otley proposed tabling this item for our next meeting, and requested participants review materials and send any comments to Sarah Kinsler (sarah.kinsler@vermont.gov); they will be included in the materials for the next meeting. | **Send comments to Sarah Kinsler (sarah.kinsler@vermont.gov) by 12/1.** |
| **8. ACO Presentation** | Leah Fullem noted that representatives of all three ACOs, the Blueprint, and VITL are here to present this proposal today. This proposal is not up for a vote today; this is an opportunity for group members to provide feedback and comments.<br>• The proposed solution seeks to create a "single source of truth" for the ACOs about attributed individuals.<br>• Solution would allow each ACO to access data about their attributed populations, as well as to look at aggregate information across the three ACOs. This would provide CHAC and Healthfirst with more analytic capabilities than they currently have.<br>• Collaboration with the Blueprint: How to work with patients that use ACO providers but aren't attributed?<br>• Timeline for implementation is aggressive, but Leah believes this is realistic given that OneCare has already been able to do much of this work.<br>• Proposal will go to the Core Team with $1.8 million budget on 12/9. Most of this would go to technical integration for CHAC and Healthfirst ($1.4 million); $75,000 will go to legal work across all three ACOs; $205,000 to staff time across all three ACOs; and $150,000 to project management across all three ACOs. Amy Cooper noted that CHAC and Healthfirst haven't been able to build foundational IT infrastructure to | **Share feedback with Georgia Maheras (georgia.maheras@vermont.gov) by 12/1.** |

| Agenda Item | Discussion | Next Steps |
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| | the same extent that OneCare has, and commented that timing is ideal because it builds on historical collaboration and workflow development across ACOs.<br><br>The group discussed the following:<br>• Kelly Lange noted that BCBS has confidentiality concerns, and would want input into any part that requires changes on BCBS's end. Leah commented that each ACO has a DUA with BCBS.<br>• Sue Aranoff asked how necessary this proposal would be if the ACOs don't merge, noting there are significant legal barriers to merger. Leah responded that this architecture separates data from each ACO; if the ACOs don't merge, OCV will act like a vendor to CHAC and HF at a lower cost than a private vendor.<br>• Paul Harrington noted that he would like to hear from someone at the Governor's Administration about the Administration's overall health care reform agenda to give the group some context about how this all fits together and advances a larger vision. Paul noted that from his perspective, the All-Payer Waiver seems like the highest priority; if that's correct, this project is consistent with that vision and should be prioritized. If that is not the case, that's important to know as well as this group reviews this and similar proposals. Richard commented that the Steering Committee has criteria to guide decision-making, and that it might be worth revisiting those criteria.<br>• Georgia clarified that this proposal is not planning on going to the Steering Committee – it is a proposal that has been requested by the Core Team. Susan Aranoff asked that it be brought to the Steering Committee on 12/2. Georgia and Sarah will work together to fit this onto the agenda.<br><br>Brian requested that participants share any feedback with Georgia (georgia.maheras@vermont.gov) no later than December 1st; feedback will be shared with the Core Team prior to their 12/9 meeting. Feedback shared before Thanksgiving will also be shared with the Steering Committee. | |
| **9. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules** | **Next Meeting:** Wednesday, December 16, 2015, 9:00-11:00, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier. | |

**VHCIP Health Data Infrastructure Work Group**
**Roll Call** **11/18/2015**

Leah Fullem 1°
Heather Steele 2°
Motion carried; 1 abstention

Paul Harrington 1°
Leah Fullem 2°
motion carried; 3 abstentions

Dale Hackett 1°
Leah Fullem 2°
motion carried; 1 abstention

N/A

Dale Hackett 1°
Mary Alice Bisbee 2°
motion carried; 1 abstention

| Member | | Member Alternate | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | Minutes | ACO Gap Remediation | VCN Gap Remediation | ~~Phase II~~ | DLTSS Next Steps | Organization | Health Data Infrastructure |
| Susan | Aranoff ✓ | Gabe | Epstein | | | | | | AHS - DAIL | M |
| | | | | | | | | | | |
| Joel | Benware ✓ | Dennis | Boucher | | | | | | Northwestern Medical Center | M |
| | | Jodi | Frei | | | | | | Northwestern Medical Center | MA |
| | | Chris | Giroux | | | | | | Northwestern Medical Center | MA |
| | | | | | | | | | | |
| Peggy | Brozicevic | | | | | | | | AHS - VDH | M |
| | | | | | | | | | | |
| Amy | Cooper ✓ | | | | | | | | HealthFirst/Accountable Care Coalition of th | M |
| | | | | | | | | | | |
| Steven | Cummings ✓ | | | | | | | | Brattleboro Memorial Hopsital | M |
| | | | | | | | | | | |
| Mike | DelTrecco | | | | | | | | Vermont Association of Hospital and Health | M |
| | | | | | | | | | | |
| Chris | Dussault ✓ | Angela | Smith-Dieng | | | | | | V4A | M |
| | | | | | | | | | | |
| Leah | Fullem ✓ | Greg | Robinson ✓ | | A | | | | OneCare Vermont | M |
| | | | | | | | | | | |
| Michael | Gagnon ✓ | Kristina | Choquette ✓ | ~~✓~~ | A | | | | Vermont Information Technology Leaders | M |
| | | | | | | | | | | |
| Ken | Gingras ✓ | | | ~~✓~~ | A | A | | | Vermont Care Partners | M |
| | | | | | | | | | | |
| Eileen | Girling | | | | | | | | AHS - DVHA | M |
| | | | | | | | | | | |
| Dale | Hackett ✓ | | | | | | | | Consumer Representative | M |
| | | | | | | | | | | |
| Emma | Harrigan | Tyler | Blouin ✓ | | | | | | AHS - DMH | M |
| | | Kathleen | Hentcy | | | | | | AHS - DMH | MA |
| | | Brian | Isham ✓ | | | | | | AHS - DMH | MA |
| | | | | | | | | | | |
| Paul | Harrington ✓ | | | | | | | | Vermont Medical Society | M |
| | | | | | | | | | | |
| Stefani | Hartsfield ✓ | Molly | Dugan | | | | | | Cathedral Square | M |
| | | Kim | Fitzgerald | | | | | | Cathedral Square and SASH Program | MA |
| | | | | | | | | | | |
| Kaili | Kuiper | Trinka | Kerr ✓ | A | | | | | VLA/Health Care Advocate Project | M |
| | | | | | | | | | | |
| Nancy | Marinelli | | | | | | | | AHS - DAIL | M |

Minutes ACO VCN N/A DLTSS

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|---|---|---|---|---|---|---|---|---|---|---|
| MaryKate | Mohlman ✓ | | | | | | | | AHS - DVHA - Blueprint | M |
| Brian | Otley ✓ | | | | | | | | Green Mountain Power | C/M |
| Kate | Pierce | | | | | | | | North Country Hospital | M |
| Amy | Putnam | Todd | Bauman | | | | | | DA - Northwest Counseling and Support Ser | M |
| | | Kim | McClellan | | | | | | DA - Northwest Counseling and Support Ser | MA |
| Amy | Putnam | | | | | | | | VCP - Northwest Counseling and Support Se | M |
| Sandy | Rousse | | | | | | | | Central Vermont Home Health and Hospice | M |
| Simone | Rueschemeyer ✓ | | | | | | | | Vermont Care Network | C/M |
| Julia | Shaw ✓ | Lila | Richardson | | | | | | VLA/Health Care Advocate Project | M |
| Heather | Skeels ✓ | Kate | Simmons | | | | | | Bi-State Primary Care | M |
| Richard | Slusky ✓ | Kelly | Macnee ✓ | | | | | | GMCB | M |
| | | Spenser | Weppler ✓ | | | | | | GMCB | MA |
| Chris | Smith ✓ | Lou | McLaren | | | | | X | MVP Health Care | M |
| Russ | Stratton | | | | | | | | VCP - HowardCenter for Mental Health | M |
| Eileen | Underwood ✓ | | | | | | | | AHS - VDH | M? |
| ???? | ???? | Mike | Hall | | | | | | Champlain Valley Area Agency on Aging / C | MA |
| ???? | ???? | Arsi | Namdar | | | | | | VNA of Chittenden and Grand Isle Counties | MA |
| | | | | | | | | | | 39 |

Darin Prail / Diane Cummings ✓ AHS-Central Office

Mary Alice Bisbee ✓ X Consumer

30

Q ✓

## VHCIP Health Data Infrastructure Work Group
## Attendance Sheet 11/18/2015

| | First Name | Last Name | | Organization | Health Data Infrastructure |
|---|---|---|---|---|---|
| 1 | Diane | Cummings | here | AHS - Central Office | S |
| 2 | Darin | Prail | | AHS - Central Office | X |
| 3 | Julie | Wasserman | here | AHS - Central Office | S |
| 4 | Becky-Jo | Cyr | | AHS - Central Office - IFS | X |
| 1 | Susan | Aranoff | here | AHS - DAIL | M |
| 2 | Gabe | Epstein | here | AHS - DAIL | MA |
| 3 | Nancy | Marinelli | | AHS - DAIL | M |
| 4 | Tela | Torrey | | AHS - DAIL | X |
| 5 | ~~Beth~~ | ~~Rowley~~ | | AHS - DCF | X |
| 6 | Tyler | Blouin | | AHS - DMH | MA |
| 7 | Emma | Harrigan | | AHS - DMH | M |
| 8 | Kathleen | Hentcy | | AHS - DMH | MA |
| 9 | Brian | Isham | here | AHS - DMH | MA |
| 10 | Lucas | Herring | | AHS - DOC | X |
| 11 | Amy | Coonradt | | AHS - DVHA | S |
| 12 | Jennifer | Egelhof | here | AHS - DVHA | X |
| 13 | Erin | Flynn | here | AHS - DVHA | S |
| 14 | Eileen | Girling | | AHS - DVHA | M |
| 15 | Sarah | Kinsler | here | AHS - DVHA | S |
| 16 | Carole | Magoffin | | AHS - DVHA | S |
| 17 | Steven | Maier | here | AHS - DVHA | S |
| 18 | Jessica | Mendizabal | | AHS - DVHA | S |
| 19 | Larry | Sandage | here | AHS - DVHA | S |
| 20 | James | Westrich | here | AHS - DVHA | S |
| 21 | Bradley | Wilhelm | | AHS - DVHA | S |
| 22 | Cecelia | Wu | | AHS - DVHA | S |
| 23 | Craig | Jones | | AHS - DVHA - Blueprint | X |
| 24 | MaryKate | Mohlman | here | AHS - DVHA - Blueprint | M |
| 25 | Miki | Olszewski | | AHS - DVHA - Blueprint | X |

| | | | | | |
|---|---|---|---|---|---|
| 26 | Peggy | Brozicevic | | AHS - VDH | M |
| 27 | Eileen | Underwood | here | AHS - VDH | M |
| 28 | Georgia | Maheras | here | AOA | S |
| 29 | Bob | West | | BCBSVT | X |
| 30 | Charlie | Leadbetter | | BerryDunn | X |
| 31 | Heather | Skeels | here | Bi-State Primary Care | M |
| 32 | Joyce | Gallimore | | Bi-State Primary Care/CHAC | X |
| 33 | Kate | Simmons | | Bi-State Primary Care/CHAC | MA |
| 34 | Kendall | West | | Bi-State Primary Care/CHAC | X |
| 35 | Daniel | Galdenzi | | Blue Cross Blue Shield of Vermont | X |
| 36 | Kelly | Lange | | Blue Cross Blue Shield of Vermont | X |
| 37 | James | Mauro | | Blue Cross Blue Shield of Vermont | X |
| 38 | Steven | Cummings | | Brattleboro Memorial Hopsital | M |
| 39 | Stefani | Hartsfield | here | Cathedral Square | M |
| 40 | Molly | Dugan | | Cathedral Square and SASH Program | MA |
| 41 | Kim | Fitzgerald | | Cathedral Square and SASH Program | MA |
| 42 | Paul | Forlenza | | Centerboard Consultingt, LLC | X |
| 43 | Sandy | Rousse | | Central Vermont Home Health and Hospice | M |
| 44 | Mike | Hall | | Champlain Valley Area Agency on Aging / C | MA |
| 45 | Kevin | Kelley | | CHSLV | X |
| 46 | Jonathan | Bowley | | Community Health Center of Burlington | X |
| 47 | Dale | Hackett | here | Consumer Representative | M |
| 48 | Bob | Thorn | | DA - Counseling Services of Addison County | X |
| 49 | Todd | Bauman | | DA - Northwest Counseling and Support Se | MA |
| 50 | Kim | McClellan | | DA - Northwest Counseling and Support Se | MA |
| 51 | Amy | Putnam | | DA - Northwest Counseling and Support Se | M |
| 52 | Nick | Emlen | | DA - Vermont Council of Developmental an | X |
| 53 | Richard | Boes | | DII | X |
| 54 | Lucie | Garand | | Downs Rachlin Martin PLLC | X |
| 55 | Ena | Backus | | GMCB | X |
| 56 | Susan | Barrett | here | GMCB | X |
| 57 | Jamie | Fisher | | GMCB | X |
| 58 | Christine | Geiler | | GMCB | S |
| 59 | Al | Gobeille | | GMCB | X |
| 60 | Pat | Jones | | GMCB | S |
| 61 | Kelly | Macnee | here | GMCB | MA |
| 62 | Stacey | Murdock | | GMCB | X |
| 63 | Annie | Paumgarten | | GMCB | S |

| | | | | | |
|---|---|---|---|---|---|
| 64 | David | Regan | | GMCB | X |
| 65 | Richard | Slusky | here | GMCB | M |
| 66 | Spenser | Weppler | here | GMCB | MA |
| 67 | Brian | Otley | here | Green Mountain Power | C/M |
| 68 | Amy | Cooper | here | HealthFirst/Accountable Care Coalition of t | M |
| 69 | Paul | Reiss | | HealthFirst/Accountable Care Coalition of t | X |
| 70 | Jon | Brown | here | HSE Program | X |
| 71 | Richard | Terricciano | here | HSE Program | X |
| 72 | Jay | Hughes | | Medicity | X |
| 73 | Lou | McLaren | | MVP Health Care | MA |
| 74 | Chris | Smith | here | MVP Health Care | M |
| 75 | David | Wennberg | | New England Accountable Care Collaborati | X |
| 76 | Kate | Pierce | | North Country Hospital | M? |
| 77 | Matt | Tryhorne | | Northern Tier Center for Health | X |
| 78 | Joel | Benware | here | Northwestern Medical Center | M |
| 79 | Dennis | Boucher | | Northwestern Medical Center | MA |
| 80 | Jodi | Frei | | Northwestern Medical Center | MA |
| 81 | Chris | Giroux | | Northwestern Medical Center | MA |
| 82 | Leah | Fullem | here | OneCare Vermont | M |
| 83 | Todd | Moore | | OneCare Vermont | X |
| 84 | Laurie | Riley-Hayes | | OneCare Vermont | A |
| 85 | Greg | Robinson | here | OneCare Vermont | MA |
| 86 | Tawnya | Safer | | OneCare Vermont | X |
| 87 | Karl | Finison | | OnPoint | X |
| 88 | Beth | Waldman | | SOV Consultant - Bailit-Health Purchasing | X |
| 89 | Joelle | Judge | here | UMASS | S |
| 90 | Richard | Wasserman, MD, MPH | | University of Vermont - College of Medicine | X |
| 91 | Chris | Dussault | here | V4A | M |
| 92 | Angela | Smith-Dieng | | V4A | MA |
| 93 | Russ | Stratton | | VCP - HowardCenter for Mental Health | M |
| 94 | Amy | Putnam | | VCP - Northwest Counseling and Support Se | M |
| 95 | Julie | Tessler | | VCP - Vermont Council of Developmental a | X |
| 96 | Martha | Buck | | Vermont Association of Hospital and Health | A |
| 97 | Mike | DelTrecco | | Vermont Association of Hospital and Health | M |
| 98 | Gary | Zigmann | | Vermont Association of Hospital and Health | X |
| 99 | Simone | Rueschemeyer | here | Vermont Care Network | C/M |
| 100 | Ken | Gingras | here | Vermont Care Partners | M |
| 101 | Shelia | Burnham | | Vermont Health Care Association | X |

| | | | | | |
|---|---|---|---|---|---|
| 102 | Kristina | Choquete | here | Vermont Information Technology Leaders | MA |
| 103 | Michael | Gagnon | here | Vermont Information Technology Leaders | M |
| 104 | Paul | Harrington | here | Vermont Medical Society | M |
| 105 | Trinka | Kerr | phone | VLA/Health Care Advocate Project | MA |
| 106 | Kaili | Kuiper | | VLA/Health Care Advocate Project | M |
| 107 | Lila | Richardson | | VLA/Health Care Advocate Project | MA |
| 108 | Julia | Shaw | here | VLA/Health Care Advocate Project | M |
| 109 | Arsi | Namdar | | VNA of Chittenden and Grand Isle Counties | MA |
| 110 | Peter | Cobb | | VNAs of Vermont | X |
| 111 | Stuart | Graves | | WCMHS | X |
| 112 | Joanne | Arey | | White River Family Practice | A |
| 113 | Mark | Nunlist | | White River Family Practice | X |
| 114 | ~~Sean~~ | ~~Uiterwyk~~ | | White River Family Practice | X |
| 115 | Narath | Carlile | | | X |
| 116 | Mike | Maslack | | | X |
| 117 | Win | Turner | | | X |
| | | | | | **121** |

Laura Kolkman Mosaica Partners
Bob Brown Mosaica Partners

# Attachment 3: Inventory and Analysis of Existing Vermont Health Data: Recommendations

# Inventory and Analysis of Existing Vermont Health Data: Recommendations

Health Data Infrastructure Work Group Meeting

December 16, 2015

David Healy / Barbara Patterson, Stone Environmental Inc.

Steve Kappel, Policy Integrity LLC

# Project Summary

Inventoried

- 44 Organizations
- 256 Data Systems/Databases

Priority Datasets

- 5 Organizations
- Acquisition Costs: $39,110,500 (excluding VHCURES)
- Annual Operational Costs: $9,927,000 (excluding VHCURES)
- > 40 FTE

Recommendations and  Findings

Health Data Portal

# Recommendations

- Organizational
- System
- Data Quality, Documentation, and Analytics

# Organizational Recommendations

There is need for enabling legislation and policies to support health data collaboration, accessibility, and adoption of data standards.

Vermont needs a single health data organization responsible for health data, standards, and technology.

Management of new, large, overarching data systems should be managed or coordinated with adequate staffing and expertise.

There is reluctance to shift to new and unknown systems because adequate staffing and expertise is not always available. Vermont Health Data Professionals and Health Program Managers should attend national health information conferences on an annual basis.

# System Recommendations

Vermont should consider teaming with other states in the development of new large/complex health data systems.

The focus of health data systems should be to support end user needs– the public, the providers, the payers, or state staff members.

Health data and information systems need to be holistic, harmonized and comparable across and within organizations.

If Socrata is to become repository for the Health Data, DII will need to customize it to full access to health data.

The other option would be to create an independent Health Data Portal based on the open source Federal HealthData.gov.

Vermont should develop a requirement that all health organizations enter and keep up to date information of their data records and systems.

# Data Quality, Documentation, and Analytics Recommendations

Building Quality Control into all data systems is essential function to ensure that the analyses that result from the use of the data is credible.

There has to be a state mandate to maintain systems, reporting, and documentation.

Vermont should adopt coding standards for critical elements of each health database, including Health Provider ID, Patient ID, Geography, Addresses, etc.

All health data sets, both source and derived, need complete metadata defined using a common set of metadata standards and tags.

Consistent with privacy requirements, health data should be open, available, and downloadable in a single searchable data repository.

# Data Quality, Documentation, and Analytics Recommendations (continued)

Simple Universal Database Tools are needed to extract, analyze and combine critical clinical and claims datasets

Vermont should embrace GIS technology as an enabling and analytical tool for better spatial understanding of clinical, population, and financial health data.

Products that are the result of using extracts from the state's large databases, such as VHCURES, are not generally accessible. There is no clearinghouse to make this information available.

STONE ENVIRONMENTAL

## Discussion

## Thank you!

**For More Information:** dhealy@stone-env.com/bpatterson.stone-env.com

# Attachment 4: Vermont HIT Plan Update Presentation

# State of Vermont

## Vermont Health Information Technology Plan (VHITP)

## Health Data Infrastructure Meeting

**December 16, 2015**

# Agenda

- Project Schedule
- Initiatives
- Funding Plan Process
- Next Steps

# Project Schedule

# Project Schedule

Thursday, Dec 17, 2015
- Present preview of Initiatives to GMCB

Friday, Jan 8, 2016
- VHITP Final Draft sent to Steering Committee for review

Thurs, Jan 14, 2016
- Steering Committee final review of VHITP Final Draft

Friday, Jan 15, 2016
- VHITP sent to GMCB
- VHITP released for public comments

Thurs, Feb 4, 2016
- Present VHITP Final Draft to GMCB

Thurs, Feb 25, 2016
- Present VHITP Final Plan to GMCB

Thurs, March 10, 2016
- GMCB approves VHIT Plan

# Initiatives

## Stakeholder Engagement & Participation

1. Centralize efforts for stakeholder outreach, education, and dialogue relating to HIT/HIE in Vermont.
   Consolidate efforts to convene and educate health care stakeholders so that they can both obtain information on HIT/HIE efforts and engage in a dialogue that promotes ongoing participation and ownership/buy-in of these efforts.

## Statewide HIT/HIE Governance & Policy

2. Establish (and run) comprehensive statewide HIT/HIE governance.
   Create an entity that has appropriate authority, accountability, and expertise to ensure/promote the success of public and private HIT/HIE efforts in support of health care and payment reforms across the state of Vermont.

3. Strengthen statewide HIT/HIE coordination.
   Provide overall coordination and communication of the statewide HIT/HIE related projects and activities.

4. Establish and implement a statewide master data management program (data governance) for health, health care, and human services data.
   Establish a statewide master health data management program to address/manage the access, availability, quality, integrity, and security of data.

5. Develop and implement an approach for handling the identity of persons that can be used in multiple situations.
   Develop an approach that will uniquely identify a person across systems and points of care that includes both health care and human services information.

6. Provide bi-directional cross state border sharing of health care data.
   Develop and implement an approach to easily share health information electronically with other states.

## Business, Process, & Finance

7. Continue to expand provider EHR and HIE adoption and use.
   Continue to grow the numbers of providers who have access to, and use EHRs and HIE capabilities.

8. Simplify State-required quality and value health care related reporting requirements and processes
   Provide more efficient, streamlined processes for providers to report on required health metrics.

9. Establish and implement a sustainability model for health information sharing.
   Develop and implement a model that ensures that the on-going services, resources, funding, benefits, and cultural norms that foster broad health care information data sharing are achieved and maintained over time.

## Privacy & Security

10. Ensure that statewide health information sharing consent processes are understood and consistently implemented for protected health information – including information covered by 42 CFR Part 2.
    Creates a common approach that can be used statewide for complying with patient consent requirements.

11. Ensure continued compliance with appropriate security and privacy guidelines and regulations for electronic protected health information.
    Ensure that all systems housing or transporting protected health data in State or statewide systems comply with the Security Rule and all other applicable security and privacy regulations.

## Technology

12. Design and implement statewide consent management technology for sharing health care information.
    Develop a technical infrastructure and tools to support the common statewide patient consent approach and processes.

13. Ensure VHIE connectivity and access to health and patient information for all appropriate entities and individuals
    Complete the implementation of all appropriate providers to VHIE. This includes all appropriate provider practices, regardless of size or location, providers of physical health, mental health, substance use, and support services.

14. Oversee and Implement the State's Telehealth Strategy.
    Direct, manage, and update as needed the State's 2015 Telehealth Strategy.

15. Enhance, expand, and provide access to statewide care coordination tools.
    Provide appropriate on-line tools that are organization-independent and broadly available to those involved in providing and coordinating health and human services.

16. Enhance statewide access to tools (analytics and reports) for the support of population health, outcomes, and value of health care services.
    Develop and implement the infrastructure, tools, and processes needed for broad and timely access to analytics capabilities and reports that are needed to evaluate the effectiveness and value of health and human services.

17. Provide a central point of access to aggregated health information where consumers can view, comment on, and update their personal health information.
    Implement tools and processes for consumers to access their aggregated health information in a timely fashion, add information, and correct erroneous information

# Funding Plan Process

# Funding Plan Development Process

- Identify all relevant HIT/HIE projects.
- Map projects to initiatives.
- Identify funding requirements for mapped projects.
- Identify the contribution of projects to initiatives.
- Identify gaps between the needs of the initiatives and what the projects are intended to accomplish.
- Estimate the cost of initiatives/projects over 5 years – development and maintenance.
- Determine overall funding required for the initiatives.
- Identify current and potential sources of funding.
- Determine the gap in funding for the initiatives.

# Funding Plan Assumptions

- HIT Fund will continue beyond current sunset.
- Continue to leverage the HIT Fund with CMS and other funding opportunities.
- There may be funding resources for the initiatives that are in addition to the HIT Fund.
- HIT Fund can continue to be leveraged through Global Commitment and other CMS programs.

# Next Steps

# Summary and Next Steps

Summary

- There are many HIT/HIE initiatives needed to support Vermont's Health Reform Efforts and this will require significant resources
- HIT Fund should continue after current sunset to provide support for these initiatives
- Prioritization of current and future projects is needed

Next Steps

- Meeting on December 17, 2015 with GMCB
- Obtain feedback on initiatives
- Conduct further analysis of needs vs. funds available
- Staff and VHITP Steering Committee recommendations on project prioritization and funding plan

# Thank You!


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Health Access (DVHA)

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Laura Kolkman, President
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# Attachment 5a: Data Utility and Governance Slides

# Feedback Requested: Data Utility and Governance

Georgia Maheras, Esq.
Project Director
November 18, 2015

# BACKGROUND

- Request from Lawrence Miller to develop recommendations for:
  - Support of a state ‘data utility’
  - Statewide HIE Governance structure

# Data Utility – Brainstorm

- Scope of the utility: What functions would be under regulation and therefore positioned as non-competitive? Should the utility also be able to engage in non-regulated activities where there is competition?
- Regulatory model: Who plays the role of consumer advocate to balance utility priorities?
- Planning process: How do utility plans and budgets get set, approved, monitored, and verified?
- Funding: How do the budgets get funded? On what timeframes? What is the funding source?
- Cost: How much cost does regulation create?

# Statewide HIE Governance

- Part of HIT Strategic Plan
- Create an entity that has appropriate authority, accountability, and expertise to ensure the effective, efficient use of resources for public and private HIT/HIE efforts in support of health care and payment reform across the state of Vermont.

# Brainstorm: What would make good governance?

- Key consideration:
  - About the processes for making and implementing decisions. Not about making ‘correct’ decisions, but about the best possible process for making those decisions.

# Attachment 5b: Compiled Public Comments

**Health Data Inventory Work Group**
**December 16, 2015**
**Public Comment – Data Governance and Data Utility**

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**Comments from Chris Smith, MVP Health Care**

I love a short slide deck! I reviewed attachment 7 – Data Utility and Governance slide and the article on public utilities.

A couple of comments on the article – and this may be just out of a different point of view/concept. I'm a firm believer in keep it simple and the concept of the utility as described by the article bothered me because what we are talking about – setting the rules – can't be delegated. Implementing the rules can but if that's all we are after then we don't need a utility – we need an integrator and a funding model.

1. The article indicates that public utilities trade the benefits of competition for those of stability. For a well understood field with very large capital investments that makes sense – i.e.: laying power lines and transmission stations.
2. The utility model brakes down in the face of change and attempts to

    a. Restrict technology improvements – i.e.: only one cable company granted a right to handle cable in your area and they aren't going to drop prices or innovate – they own your area. They won't change pricing in any way to rock the boat.
    b. Artificially keeps the price of playing high as choice is never introduced. The disruption model we are seeing at play here is internet service providers supplanting cable providers as they offer choice cracking the monopoly that the cable providers had.
    c. Creates more waste as the entrenched players attempt to retain their exclusive right to "the old way" (See Taxi Drivers vs. Uber - http://www.newyorker.com/magazine/2015/08/03/revving-up )

3. If the capital investment isn't as large – in today's terms not in the many millions or billions of dollars – why would we support a single dominant player? Utilities bring with them long term overhead.
4. Creating a utility gives the utility the right to collect money and become self-sufficient. It creates a monopoly player. Do we really need one with the overhead required (politically, structurally) if the capital investment is modest?

I would propose that we only consider a utility when we require infrastructure where massive investment of long term capital is required

1. Think rails for a railway all being the same gauge. Traffic management allows the sharing of the infrastructure – the rails.
2. Roads following standards for building and maintenance. Traffic management and end user licensing creates an environment that supports general use of the utility.

3. Electrical wiring infrastructure required to be standardized and supported. Grid management becomes the key factor to keeping power flowing and ensuring we have adequate power for peaks and valleys in demand and generation.
4. Cellular towers built out in standard ways to create the best coverage and redundancy. The cellular companies can then sell services in a competitive environment – i.e.: charge for usage time and bandwidth consumption.

I would also propose that we aren't making a large capital investment.

But at the same time use capitalism for what it does best – as a servant and not a master – competition within bounds is very efficient. The bounds are provided by the utilities.

1. Trains can be run by any shipping company with locomotives from more than one source and rates set by the shippers. Use of the rails is contracted with the traffic management/rail owners.
2. Drivers can buy a car/truck from anywhere (within standards) and drive on the roads which they support through taxes, fees and tolls.
3. Consumers can buy their power from multiple utilities paying a transaction fee for line usage – enabling the infrastructure to be supported but allowing consumer choice to help change the way power is generated and sold. The introduction of consumers generating their own power has helped to force changes in this industry.
4. You can buy cellular service from dozens of companies – and they use the cellular towers built out by a handful creating competition in the cellular market so much so that in urban areas prices dropped and service increased dramatically. Usage fees are used to support rural areas infrastructure.

Enough of the academic. For this data hub/utility a better way that might work:

1. Regulate and govern – create and require standardized transaction sets. The regulator

    a. Sets the standards
    b. <u>Owns</u> the data – and contracts for someone to implement on their behalf for the

        i. Aggregation
        ii. Storage
        iii. Dissemination of the data
        iv. Portability to ensure the process and data set can be moved from one implementer to another
        v. DO NOT LET SOMEONE ELSE OWN THE DATA. It's the asset that allows you to gain value and insight.

    c. Modifies the standards
    d. Set's the utilization model

        vi. Who provides, what they provide, how they must provide it
        vii. Who can consume, what they can consume and how they must consume it.

e. Fund it at this level – as close to the top of the pyramid as possible.

2. Aggregator role – could be the regulator/governing group but could also be a hosted/outsourced solution. The role of the aggregator of the data is to implement –

    f. Collecting the data as submitted (either direct or by clearing house).
    g. Implement the rules the regulatory/governance group specifies.
    h. The aggregator is not a utility – the buildout to meet the rules in today's information technology world should be modest and scale over time.

Funding model – the real question we are dancing about here is how do we fund such a model for the short term and long term. Why create a utility that is incented in the middle to collect fees and pay for things and give it life? The overhead isn't worth it when the buildout is modest. Consider instead funding the regulatory/governing body and having it contract for the implementation.

1. We can charge the data submitters a per transaction fee – if more convenient we could call it a fee or tax as appropriate. Wait – this is insane. Why would you charge data submitters?

    a. This fee would be paid by the health care provider, practice or facility in many cases. The data goes beyond normal claims data for payment of a claim and the payers add no value in the middle of the relationship.
    b. Charging them a fee per transaction can be used as an inducement to ensure the data providers provide accurate data – each wrong transaction costs them.
    c. With no fee what model do you have to drive compliance? A modest per transaction fee will ensure that the data providers become very compliant very quickly.
    d. If charging a fee doesn't work consider paying the data submitters a fee – based on non-duplicate accurate, complete and timely transactions only and audit them for compliance where the risk they are at is higher than the reward in fee's they could gain.

2. A fee for data consumption can be considered.
3. Central funding – i.e.: a grant or annual budget for the regulatory/governing model allows for central repository of the money and spending oversight. The central funding model allows the fees for data consumption to be kept small to encourage appropriate use.
4. The fees can be administered by the aggregators on behalf of the regulator/governing body but don't move ownership of those fees to the aggregator.

Data quality –

1. Regulators set the standard for the transaction format. This isn't the quality of the data it's the consistency of the transaction.
2. It is the responsibility of data providers to provide accurate, timely and complete data sets. For this a carrot and stick may be necessary (accuracy and complete – cost per transactions can be an incentive. For timely you may need an audit function.)
3. The aggregator can and should reject the data set of a data provider if it isn't complete, accurate and timely. This is the quality of the data. This needs to be set up front so the data providers aren't

surprised and it needs to be monitored daily so your data set is kept clean. This is essentially the adjudication of a series of business rules – is the patient accurate, is the provider accurate, are the services mentioned relevant to the patient (you can't remove an appendix twice from the same person), etc. This is probably the area of most cost – it's also a commodity service and not a utility service. No one dies if the system goes down for a day. Commerce is not negatively affected. Consumption of this data set is usually much more leisurely. If we need real time data to flow through this system to make it in-band and an alert system adding that overhead is possible and an incremental cost away to add the redundancy to keep the systems and processes available.

4. The data consumers will pull the data from the aggregator's system to consume. The data is guaranteed by the aggregator to meet the regulator's required level of accuracy and completeness.

I think that is all I have for today!

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# Attachment 6: November 2015 Status Reports – VHCIP Health Data Infrastructure Projects

# VHCIP Project Status Reports – Health Data Infrastructure Focus Area
# November 2015

# Focus Area: Health Data Infrastructure

**Focus Area: Health Data Infrastructure**
Project: Expand Connectivity to HIE – Gap Analyses

**Project Summary:** The Gap Analysis is an evaluation of the Electronic Health Record (EHR) system capability of health care organizations, interface ability of the EHR system, and the data transmitted within those interfaces. Conducting the ACO Gap Analysis created a baseline determination of the ability of health care organizations to produce Year 1 Medicare, Medicaid, and Commercial Shared Savings ACO Program quality measure data. The VCP Gap Analysis is evaluating data quality among the 16 designated and specialized service agencies. Finally, the LTSS Gap Analysis was conducted to review the technical capability of LTSS providers statewide.

**Project Timeline and Key Facts:**

- January 2014 – VITL and ACO teams launch Gap Analysis of the ACO Program quality measures.
- July 2014 – Gap Analysis of the ACO Program quality measure data completed.
- September 2014 – HIS Professionals begins LTSS Technical Assessment.
- January 2015 – Scope of Work for VCP Gap Analysis finalized.
- February 2015 – Work begins for VCP Gap Analysis with introductory meeting with Designated Agencies.
- February 2015 – HIS Professionals submits draft of LTSS Technical Assessment and recommendations.
- April 2015 – LTSS Technical Assessment work put on hold pending federal approvals of funding.
- July 2015 – A total of 67 data quality meetings held with DAs & SSAs.
- October 2015 – LTSS Technical Assessment Final Report to be completed.

**Status Update/Progress Toward Milestones and Goals:**

- Gap Analysis of ACO Program data quality measures completed in January 2014.
- VITL has conducted numerous data quality interviews with the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs). VITL has also identified that a number of DA and SSA member agencies' structures are decentralized such that they operate as multiple independent agencies. VCP has confirmed the need for full assessments to be conducted at these agencies. VITL will be pursuing additional funding to accommodate this revised scope.
- LTSS Technical Assessment Final Report completed with recommendations on next steps and distributed to stakeholders.

**Milestones:**

*Performance Period 1*: Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use (MU) providers.

*Performance Period 1 Carryover*: Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use (MU) providers:

1. Complete DLTSS technical gap analysis by 9/30/15.
2. Conduct bimonthly SSP quality measure gap analyses for ACO providers.

*Performance Period 2*: N/A

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: TBD
# Participating Providers: 400

**Key Documents:**

- ACO Gap Analysis (Fall 2014)
- LTSS Final Report (Fall 2015)

**State of Vermont Lead(s):** Larry Sandage

**Contractors Supporting:** VITL; Vermont Care Partners; HIS Professionals; Bailit.
To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:** N/A

**Focus Area: Health Data Infrastructure**

Project: Expand Connectivity to HIE – Gap Remediation

**Project Summary:** The Gap Remediation project will address gaps in connectivity and clinical data quality of health care organizations to the Health Information Exchange. The ACO Gap Remediation project improves the connectivity and data quality for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Partners (VCP) Gap Remediation will improve the data quality for the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs).

**Project Timeline and Key Facts:**

- March 2015 – ACO Gap Remediation work begun by VITL and ACO member organizations
- March 2015 – Terminology Services vendor identified by VITL
- May 2015 – SET Team work completed by VITL and Medicity
- July 2015 – Gap Remediation work continuing as 95 ADT, VXU, and CCD interfaces are in progress
- October 2015 –Phase II ACO Gap Remediation proposal
- October 2015 – VCP Gap Remediation proposal
- January 2016 – Phase I ACO Gap Remediation work to be completed and Phase II Gap Remediation to begin
- January 2016 – VCP Gap Remediation work to begin
- December 2016 – VCP Gap Remediation work to be completed
- December 2016 – Phase II ACO Gap Remediation to be completed

**Status Update/Progress Toward Milestones and Goals:**

- ACO Gap Remediation project includes five projects: Interface and Electronic Health Record Installation, Data Analysis, Data Formatting, Terminology Services, and SE Team.
- Contract with VITL executed. ACO Gap Remediation work has been in progress since March, with significant progress to date.
- VITL and VCP proposed additional gap remediation work in Quarter 4 of 2015 for Performance Period 3.
- The HIE/HIT Work Group is evaluating next steps based on the receipt of the LTSS Technology Assessment.
- The HDI Work Group approved motions to move forward with Gap Remediation for the ACO and VCP projects in the November Work Group meeting.
- The HDI Work Group approved a motion to recommend further investment into connections for the AAAs and HHAs in the November Work Group meeting.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:* N/A

*Performance Period 2:* Remediate data gaps that support payment model quality measures, as identified in gap analyses:

1. Remediate 50% of data gaps for SSP quality measures by 12/31/15.
2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted:

# Participating Providers:

**Key Documents:**

-

**State of Vermont Lead(s):** Georgia Maheras, Larry Sandage

**Contractors Supporting:** VITL; Vermont Care Partners; HIS Professionals; Pacific Health Policy Group.

To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:** N/A

**Focus Area: Health Data Infrastructure**

Project: Expand Connectivity to HIE – Data Extracts from HIE

**Project Summary:** This project provides a secure data connection from the VHIE to the ACOs analytics vendors for their attributed beneficiaries. Allows ACOs direct access to timely data feeds for population health analytics.

**Project Timeline and Key Facts:**

- March 2014 – OneCare (OCV) Gateway build started.
- February 2015 – Community Health Accountable Care (CHAC) Gateway build started.

**Status Update/Progress Toward Milestones and Goals:**

- OCV Gateway nearly completed. Estimated completion by November 2015.
- CHAC Gateway more than 50% complete. Estimated completion December 2015.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:* Completed development of ACO Gateways with OneCare Vermont (OCV) by 3/31/15 and Community Health Accountable Care (CHAC) by 12/31/15 to support transmission of data extracts from the HIE.

*Performance Period 2:* N/A

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: TBD

# Participating Providers: TBD

**Key Documents:**

-

**State of Vermont Lead(s):** Georgia Maheras

**Contractors Supporting:** Vermont Information Technology Leaders.

To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**

Project: Improve Quality of Data Flowing into HIE

**Project Summary:** The Data Quality Improvement Project is an analysis performed of ACO members' Electronic Health Record on each of sixteen data elements. Additional data quality work with Designated Agencies (DAs) to improve the quality of data and usability of data for this part of Vermont's health care system. VITL will engage providers and make workflow recommendations to change data entry to ensure the data elements are captured. In addition, VITL will perform comprehensive analyses to ensure that each data element from each Health Care Organization (HCO) is formatted identically. VITL will work with the HCOs to perform some or all of the following: (1) The HCO can change their method of data entry; (2) the HCO's vendor can change their format used to capture data; and (3) a third party could use a terminology service to transform the data.

**Project Timeline and Key Facts:**

- March 2015 – VITL-ACO Data Quality work begins by deploying VITL's eHealth Specialist teams to member organizations for review of Data Quality input and workflow.
- July 2015 – Significant progress has been made in data quality assessment and initial phases of gap remediation through an existing underlying contract approved in Performance Period 1; additional gap remediation progress in Performance Periods 2 & 3 pending Federal approval of contract amendment

**Status Update/Progress Toward Milestones and Goals:**

- VITL contract in place includes a Terminology Services project to provide services to translate clinical data sets submitted to the HIE into standardized code sets.
- VITL contract in place to work with providers and the ACOs to improve the quality of clinical data in the HIE for use in population health metrics within the Shared Savings Program.
- Data quantity and quality improvements have resulted so far in raising from 17% to 39% of total OCV beneficiaries the capability within the statewide HIE at VITL to produce clinical quality ACO measures. Additional work toward the project goal of 62% will occur in Performance Period 2.
- Contracts with Vermont Care Network and VITL to improve data quality and work flows at Designated Mental Health Agencies (DAs). VITL will work with DAs to implement the desired state in each agency through the development of a toolkit that will provide the necessary documentation, workflows and answers to specific questions needed.
- The HDI Work Group approved motions to move forward with data quality work for the ACO and VCP project in the November Work Group meeting.

**Milestones:**

*Performance Period 1:* Clinical Data:

1. Medication history and provider portal to query the VHIE by end of 2013.
2. State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013.

*Performance Period 1 Carryover:*

1. Data quality initiatives with the DAs/SSAs:
   Conduct data quality improvement meetings with the DAs/SSAs to focus on the analysis of the current state assessments for each agency: at least 4 meetings per month with DA/SSA leadership and 6 meetings per month with individual DAs/SSAs to review work flow.
2. Access to medication history to support care: 150 medication queries to the VHIE by Vermont providers by 12/31/15.

*Performance Period 2:*

1. Implement terminology services tool to normalize data elements within the VHIE by TBD.
2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: TBD
# Participating Providers: 977

| |
|---|
| **Key Documents:**<br>• VITL Contract SIM Amendment 2<br>• SFY 15 Year-End VITL Progress Report<br>• Gap Remediation Monthly Status Report – 8/31/15 |
| **State of Vermont Lead(s):** Larry Sandage |
| **Contractors Supporting:** Behavioral Health Network/Vermont Care Network; Bi-State Primary Care Association/Community Health Accountable Care; HIS Professionals; UVM Medical Center/OneCare Vermont; Vermont Information Technology Leaders.<br>To view executed contracts, please visit the **VHCIP Contracts** page. |
| **Additional Supporting Information:** |

**Focus Area: Health Data Infrastructure**
Project: Telehealth – Strategic Plan

**Project Summary:** Vermont contracted with JBS International to develop a Statewide Telehealth Strategy to guide future investments in this area. The Strategy, developed in collaboration between the State of Vermont and private sector stakeholders, includes four core elements: a coordinating body to support telehealth activities; alignment of state policies relevant to telehealth; telehealth technology investments that are secure, accessible, interoperable, cloud-based, and aligned with Vermont's HIT infrastructure; and clinician engagement. The Strategy also includes a Roadmap based on Vermont's transition from volume-based to value-based reimbursement methodologies to guide prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves.

**Project Timeline and Key Facts:**

- February 2015 – Contractor presents project plan to the HIE/HIT Work Group.
- March-July 2015 – Vermont Telehealth Steering Committee convenes in March 2015 to guide Telehealth Strategy development; the Steering Committee continues to meet through July.
- June 2015 – Telehealth Strategy draft submitted to DVHA contract manager.
- June 2015 – Contractor presents draft strategy elements to the HIE/HIT Work Group for comments.
- August 2015 – Final Strategy elements approved.
- June-September 2015 – Strategy review and editing.
- September 2015 – Final Strategy document approved by State of Vermont; final Strategy released.

**Status Update/Progress Toward Milestones and Goals:**

- JBS International convened the Vermont Telehealth Steering Committee in March 2015 to guide Telehealth Strategy development. Steering Committee members met biweekly via phone between March and July to come to consensus on a telehealth definition, identify guiding principles for the strategy, review key features on telehealth programs across the country, and develop strategy elements.
- A draft Statewide Telehealth Strategy was submitted to DVHA in June 2015; JBS worked with SOV staff to refine the Strategy between June and September 2015.
- The final strategy elements were approved by the HIE/HIT Work Group, Steering Committee, and Core Team in August 2015.
- The State of Vermont finalized the Strategy in September 2015 and released the final Strategy in mid-September.

**Milestones:**
*Performance Period 1:* N/A
*Performance Period 1 Carryover:* N/A
*Performance Period 2:* Develop Telehealth Strategic Plan by 9/15/15.

**Metrics:**
CORE_Health Info Exchange_[VT]

**Additional Goals:**
# Lives Impacted: N/A
# Participating Providers: N/A

**Key Documents:**

- A Statewide Telehealth Strategy for the State of Vermont
- Vermont Telehealth Pilots RFP

**Lead(s):** Sarah Kinsler

**Contractors Supporting:** JBS International.
To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**
Project: Telehealth – Implementation

**Project Summary:** Vermont is seeking pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations over a 12-month time period. This RFP's primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the state of Vermont. Successful proposals must demonstrate how they align with the health reform efforts currently being implemented as part of the SIM Grant process.

**Project Timeline and Key Facts:**

- August 2015 – Approval of draft RFP scope.
- September 2015 – Edits to draft RFP scope in response to comments; bid review team assembly.
- September 2015 – RFP released.
- November 2015 – Pilot projects to be selected.
- December 2015 – Pilot launch.
- December 2015-November 2016 – Pilot period.
- November 2016-December 2016 – Pilot project wrap-up, evaluation, and reporting.

**Status Update/Progress Toward Milestones and Goals:**

- A draft RFP scope was developed by the State and JBS International, drawing on the telehealth definition, guiding principles, and key Telehealth Strategy elements.
- The draft RFP scope was approved by the HIE/HIT Work Group, Steering Committee, and Core Team in August 2015.
- The RFP was released on September 18, 2015; the bid period closed on October 23, 2015.
- Bid selection committee has met three times to review bids.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:* N/A

*Performance Period 2:*

1. Release telehealth program RFP by 9/30/15.
2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: N/A – Program not yet launched.
# Participating Providers: N/A – Program not yet launched.

**Key Documents:**

- A Statewide Telehealth Strategy for the State of Vermont
- Vermont Telehealth Pilots RFP

**Lead(s):** Sarah Kinsler

**Contractors Supporting:** TBD – to be selected in October 2015.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**
Project: EMR Expansion

**Project Summary:** EMR Expansion focuses on assisting in the procurement of EMR systems for non-Meaningful Use (MU) providers. This would include technical assistance to identify appropriate solutions and exploration of alternative solutions.

**Project Timeline and Key Facts:**

- January 2015 – EMR acquisition project begun with VITL, VCP, and ARIS for five Specialized Service Agencies (SSAs).
- January-June 2015 – VITL assists Vermont DMH in procuring new EMR solution for State Psychiatric Hospital.
- February 2015 – Draft LTSS Technical Assessment submitted by HIS Professionals to assist in establishing understanding of technical gaps among LTSS providers.
- July 2015 – Vendor selected for SSA EMR acquisition and contract negotiations completed.
- August 2015 – Contract executed for SSA EMR acquisition.
- October 2015 – LTSS Technical Assessment and recommendations to be completed.

**Status Update/Progress Toward Milestones and Goals:**

- EMR acquisition for five Specialized Service Agencies complete.
- LTSS Technical Assessment to be completed in October 2015 with recommendations for 2016 for further actions.
- VITL contract with the Department of Mental Health to support procurement of the EMR system for the State's new hospital.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:* N/A

*Performance Period 2:*

1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16).
2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: TBD
# Participating Providers: TBD

**Key Documents:**

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**State of Vermont Lead(s):** Larry Sandage

**Contractors Supporting:** VITL, Vermont Care Partners, ARIS.
To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:** N/A

**Focus Area: Health Data Infrastructure**
Project: Data Warehousing

**Project Summary:** The VCN Data Repository will allow the Designated Mental Health Agencies (DA) and Specialized Service Agencies (SSA) to send specific data to a centralized data repository. Long-term goals of the data repository include accommodating connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State Agencies, other stake holders and interested parties. In addition to connectivity, it is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services, and support the Triple Aim of health care reform. This project will also allow the network to show the incredible value it provides to the people of Vermont and participate more fully in health care delivery reform. Additionally it will support the agencies as we transition from a fee for service reimbursement structure, to an outcome based payment methodology.

**Project Timeline and Key Facts:**

- March 2015 – RFP released for this project.
- May 2015 – Selection Committee selects preferred vendor and begins contract negotiations.
- September 2015 – Vendor contract executed.
- September 2016 – Phase One as defined in contract to be completed.

**Status Update/Progress Toward Milestones and Goals:**

- Vermont Care Network (VCN/BHN) is working on behalf of Designated Mental Health Agencies (DAs) and Specialized Service Agencies (SSAs) to develop a behavioral health-specific data repository, which will to aggregate, analyze, and improve the quality of the data stored within the repository and to share extracts with appropriate entities.
- VCN/BHN contract has been approved by DVHA.
- VCN/BHN is working on finalizing the contract now that DVHA has approved the contract.
- Data quality work, data dictionary development, training of analytic software, and other supporting tasks are all in progress to support the project once the team is ready for implementation.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:* Prepare to develop infrastructure to support the transmission, aggregation, and data capability of the DAs and SSAs data into a mental health and substance abuse compliant Data Warehouse:

1. Develop data dictionary by 3/31/15.
2. Release RFP by 4/1/15.
3. Execute contract for Data Warehouse by 10/15/15.
4. Design data warehousing solution so that the solution begins implementation by 12/31/15.

*Performance Period 2:*

1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan).
2. Procure clinical registry software by 3/31/16.
3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: 35,000
# Participating Providers: 5,000

**Key Documents:**

- Data Repository RFP

**State of Vermont Lead(s):** Larry Sandage

**Contractors Supporting:** Behavioral Health Network/Vermont Care Network; HIS Professionals; Stone Environmental; Vermont Information Technology Leaders; TBD.

To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**

Project: Care Management Tools (Shared Care Plan/Universal Transfer Protocol Project)

**Project Summary:** The Shared Care Plans/Universal Transfer Protocol (SCÜP) project will provide solutions to specific use cases, such as Shared Care Plans (SCP) and Universal Transfer Protocols (UTP), to Vermont's provider organizations. These projects will ensure that the core components of both a universal transfer protocol and a shared care plan will be captured in a technical solution that allows providers to electronically exchange critical data and information as they work together in a team based, coordinated model of care; particularly when people transition from one care setting to another.

**Project Timeline and Key Facts:**

- September 2014 – Contractor im21 beings UTP discovery.
- February 2015 – Draft UTP charter and final UTP report submitted.
- April 2015 – Through Learning Collaboratives, the need for a technical solution for Shared Care Plans is identified; UTP and SCP projects are aligned under a single project named SCÜP.
- June 2015 – Discovery on aligned SCP/UTP project begins.
- July 2015 – Requirements gathering sessions with multiple communities are performed and initial technical and business requirements are drafted.
- August 2015 – Requirements are validated with target communities.
- October 2015 – Technical Assessments of existing or proposed solutions meeting SCÜP use cases are reviewed for alignment.
- November 2015 – Final technical proposal to be submitted to HDI by SCÜP team.

**Status Update/Progress Toward Milestones and Goals:**

- Contractor performed discovery and drafted a Universal Transfer Protocol charter in 2014 and early 2015.
- Integrated Care Management Learning Collaborative Cohort 1 communities requested shared care planning tools.
- Universal Transfer Protocol and Shared Care Plan projects have merged. New project, SCÜP, currently in discovery and design phase.
- Final findings reviewed with HDI Work Group. Work Group recommended that more discovery is necessary on budget and alignment on scope.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:*

1. Discovery project to support long- term care, mental health, home care and specialist providers through a Universal Transfer Protocol solution:
   Report due 4/15/15.
2. Engage in research and discovery to support selection of a vendor for event notification system in Vermont by 10/1/15.

*Performance Period 2:* Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development:

1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out.
2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: TBD

# Participating Providers: TBD

**Key Documents:**

**State of Vermont Lead(s):** Larry Sandage

**Contractors Supporting:** Bailit Health Purchasing; im21; Vermont Information Technology Leaders.

To view executed contracts, please visit the **VHCIP Contracts** page.

**Focus Area: Health Data Infrastructure**

Project: Care Management Tools (Event Notification System)

**Project Summary:** The Event Notification System (ENS) project will implement a system to proactively alert participating providers regarding their patient's medical service encounters. VITL and the Vermont ACOs are performing discovery, design, and piloting of proposed ENS solutions.

**Project Timeline and Key Facts:**

- July 2014 – VITL begins ENS project.
- August 2014 – Proof of concept begins with 2 selected vendors.
- January 2015 – Research and discovery related to vendor selection.
- September 2015 – Vendor selected.
- October 2015 – VITL, State, and vendor are in contract negotiations.

**Status Update/Progress Toward Milestones and Goals:**

- State of Vermont is working with VITL to procure Event Notification System. Contractor selected. Anticipated start date of 11/1/15.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:*

1. Discovery project to support long- term care, mental health, home care and specialist providers through a Universal Transfer Protocol solution:
   Report due 4/15/15.
2. Engage in research and discovery to support selection of a vendor for event notification system in Vermont by 10/1/15.

*Performance Period 2:* Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development:

1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out.
2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted:
# Participating Providers:

**Key Documents:**

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**Lead(s):** Georgia Maheras, Larry Sandage

**Contractors Supporting:** Vermont Information Technology Leaders.
To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**
Project: General Health Data – Data Inventory

**Project Summary:** Vermont has engaged a contractor, Stone Environmental, to complete a statewide health data inventory that will support future health data infrastructure planning. This project will build a comprehensive list of health data sources in Vermont, gather key information about each, and catalogue them in a web-accessible format. The resulting data inventory will be a web-based tool that allows users (both within the State and external stakeholders) to find and review comprehensive information relating to the inventoried datasets.

**Project Timeline and Key Facts:**

- November 2014: Contract executed.
- December 2014: Project launch.
- January 2015: Project convenes Steering Committee to guide work.
- January-May 2015: Dataset discovery and initial information collection.
- February-May 2015: One-on-one meetings with steering committee members and other key stakeholders.
- April-May 2015: Dataset prioritization.
- May 2015-August 2015: Contract on hold pending CMMI approval of Performance Period 2 budget.
- August 2015: Project re-launched.
- September-November 2015: Data collection on prioritized datasets, recommendations development.
- November 2015: Final web-accessible inventory launched; draft report and recommendations submitted and shared with project leadership and HDI Work Group co-chairs for feedback.
- December 2015: Final recommendations presented to Health Data Infrastructure Work Group.

**Status Update/Progress Toward Milestones and Goals:**

- Contractor selected and contract executed; work was on hold May-August 2015 pending federal budget approval.
- Work on data inventory is nearly complete. Initial dataset discovery began in January. Datasets are logged in an online system (linked below).
- Contractor, working with SOV staff and key stakeholders, has identified ~20 high priority datasets for deeper data collection; additional data collection on these prioritized datasets began in May 2015 and relaunched in September.
- Contractor has engaged in research on possible portal framework options, and has tentatively selected a solution.
- Draft report submitted to contract manager and shared with project leadership and HDI Work Group co-chairs in November 2015.

**Milestones:**

*Performance Period 1:* Conduct data inventory.

*Performance Period 1 Carryover:* Complete data inventory:

1. Draft analysis of health care data sources that support payment and delivery system reforms by 4/15/15.
2. Final data inventory due by 10/31/15.

*Performance Period 2:* N/A

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: N/A
# Participating Providers: N/A

**Key Documents:**

- Stone Environmental Health Data Inventory Contract
- Preliminary Inventory (password required)

**State of Vermont Lead(s):**

**Contractors Supporting:** Stone Environmental.
To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**
Project: General Health Data – HIE Planning

**Project Summary:** The HIE Planning project resulted from a perceived gap in high-level planning and research in local and nationwide best practices for providing a robust, interoperable ability to transmit accurate and current health information throughout the Vermont health care landscape. This project will conduct further research in best practices around improving clinical health data quality and connectivity resulting in recommendations to the HIE/HIT Work Group. Additionally, the HIE/HIT Work Group has participated on multiple occasions in the 2015 revision of Vermont Health Information Technology Plan, which is scheduled for release in January 2016.

**Project Timeline and Key Facts:**

- December 2014 – Contractor selected for HIE Planning project.
- April 2015-September 2015 – HIE Planning project contracting process put on hold pending Federal approval.
- October 2015 – HIE Planning work to begin.

**Status Update/Progress Toward Milestones and Goals:**

- Contractor selected and kickoff meeting with outlined roles and responsibilities conducted.

**Milestones:**

*Performance Period 1:* Provide input to update of state HIT plan.

*Performance Period 1 Carryover:* N/A

*Performance Period 2:*

1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015.
2. HDI Work Group will identify connectivity targets for 2016-2019 by 6/30/16.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: N/A
# Participating Providers: N/A

**Key Documents:**

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**State of Vermont Lead(s):** Georgia Maheras

**Contractors Supporting:** Stone Environmental.
To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**

**Focus Area: Health Data Infrastructure**
Project: General Health Data – Expert Support

**Project Summary:** This is a companion project to all of the projects within the Health Data Infrastructure focus area. Due to the nature of those projects, we need specific skills to support the State and stakeholders in decision-making and implementation. The specific skills needed are IT Enterprise Architects, Business Analysts, and Subject-Matter Experts.

**Project Timeline and Key Facts:**

- Accessed as necessary to support various Health Data Infrastructure projects.

**Status Update/Progress Toward Milestones and Goals:**

- IT-specific support to be engaged as needed.
- Enterprise Architect, Business Analyst and Subject Matter Experts identified to support the design phase of SCÜP.

**Milestones:**

*Performance Period 1:* N/A

*Performance Period 1 Carryover:* N/A

*Performance Period 2:* Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.

**Metrics:**

CORE_Health Info Exchange_[VT]

**Additional Goals:**

# Lives Impacted: N/A

# Participating Providers: N/A

**Key Documents:**

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**State of Vermont Lead(s):**

**Contractors Supporting:** Stone Environmental; TBD.

To view executed contracts, please visit the **VHCIP Contracts** page.

**Additional Supporting Information:**