Vermont Health Care Innovation Project
Health Data Infrastructure Meeting Agenda
February 17, 2016, 9:00-11:00am
Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex
Call-In Number: 1-877-273-4202; Passcode: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	9:00-9:10am	Welcome and Introductions; Minutes Approval	Simone Rueschemeyer & Brian Otley	Attachment 1: Draft January 20, 2016, Meeting Minutes	Approval of Minutes
2	9:10-9:30am	Update: Blueprint Clinical Registry	Mary Kate Mohlman and Hans Kastensmith	Attachment 2: Update: Blueprint Clinical Registry	
3	9:30-9:50am	VHCIP Project Updates: • Core Team Update – DLTSS Gap Remediation, DA/SSA Data Quality Improvement • ACO Integrated Informatics Proposal and ACO Gap Remediation Proposals • Telehealth Pilots	Georgia Maheras		
4	9:50-10:15am	DLTSS Gap Remediation Project	Susan Aranoff	Attachment 4: DLTSS Gap Remediation Proposal	
5	10:15-10:55am	Discussion and Next Steps: Shared Care Plan/Universal Transfer Protocol Projects	Georgia Maheras	Attachment 5: SCÜP Project Update: Shared Care Plans and Universal Transfer Protocol	
6	10:55-11:00am	Public Comment Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	Next Meeting: Wednesday, March 16, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex	

Additional Materials: January 2016 Status Reports – VHCIP Health Data Infrastructure Projects, available at
http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/HIE/VHCIP%20Status%20Reports%20for%20January%202016%20-%20HDI%20Focus%20Area.pdf.

Attachment 1: Draft January 20, 2016, Meeting Minutes

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

Pending Work Group Approval

Date of meeting: Wednesday, January 20, 2016, 9:00am-11:00am, Ash Conference Room, Waterbury State Office Complex, 280 State Drive, Waterbury.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Simone Rueschemeyer called the meeting to order at 9:08am. A roll call attendance was taken and a quorum was present. Eileen Underwood moved to approve the December minutes by exception. Stefani Hartsfield seconded. The minutes were approved, with two abstentions (Kaili Kuiper and Brian Isham). Simone noted two major accomplishments at the end of 2015: • CHAC Gateway completed. • ACO Gap Remediation	
2. 2015 Year in Review and Workplan Review	Georgia Maheras presented on the project's work and accomplishments in 2015 (Attachment 2a). Sarah Kinsler presented the group's 2016 workplan (Attachment 2b), emphasizing that the workplan objectives are based on our project milestones, and focus on the HDI Work Group's tasks over the next year (rather than staff or contractors). • Mike Gagnon asked for more information about row 8, on building a cohesive strategy for data warehousing. Georgia noted that she and Craig Jones are leading this work, but have not yet developed a process or made significant progress. Georgia and Craig expect to bring this topic back to the group in late winter or early spring.	
3. Updates	*DocSite Clinical Registry:* Georgia Maheras announced that the acquisition and migration of the DocSite clinical registry is complete; more information to come from Craig and the Blueprint in future months. *VCN Data Repository:* Simone Rueschemeyer provided an update. VCN has contracted with NORC to complete this work, with kick-off meetings occurring this week.	

Agenda Item	Discussion	Next Steps
	ACO Gap Remediation: Mike Gagnon announced that VITL has completed 64% as of the end of December. Recent accomplishments include collecting inpatient CCDs from UVMMC. Mike clarified 64% represents the percentage of beneficiaries of OneCare treated by organizations which VITL is connected to. Georgia noted that non-ACO providers can utilize this information if they have proper permissions in place. *ACO Integrated Informatics Proposal:* Georgia Maheras provided an update, and noted that this was also discussed at the 12/2 Steering Committee and 1/15 Core Team meeting. In December, the Steering voted to send this proposal, along with the VITL ACO Gap Remediation Proposal, back to the HDI Work Group for further review and prioritization. The ACO Integrated Informatics proposal is being reconsidered by the ACOs and a revised proposal will likely be brought back to this group in the coming months. The Steering Committee motion on this proposal will be clarified at their 1/27 meeting. • Dale Hackett commented that the Steering Committee motion clarification is mostly about wording. Susan Aranoff noted that the Steering Committee motion asked this group to prioritize projects in the event there is limited funding. • Dale Hackett reminded the group that data and data analytics need to be supporting improved care and outcomes for individuals. *Telehealth Pilots:* The bid review team has selected two apparent awardees at this point; the State is in contract negotiations with the apparent awardees. *New GMCB Staff Member:* Roger Tubby is the new GMCB Director of Data and Analytics. He will be a voting member for GMCB going forward.	
4. Data Utility/Data Governance	Georgia Maheras introduced this agenda item (Attachment 4). Lawrence Miller has requested this group discuss a statewide data utility and HIE governance structure, and provide comments and recommendations to him. Georgia provided some framing questions. • Brian Otley clarified that the utility is around health information, not data generally. Other areas of state government are off the table. Brian noted that he works for a regulated utility (Green Mountain Power), where regulation simulates a competitive market to avoid duplicative infrastructure. o VITL has been in the process of building out a data transport function across the state, and a lot of work has been done to get to a solution. A utility could mitigate some challenges VITL has been faced with so far (gaps in funding, varied focus, contracting challenges), but it would also constrain VITL in other areas. The group discussed the following: • Mike Gagnon noted that VITL identifies a significant portion of its work as "public good" – VITL wants anything they create or collect to be valuable to as much of the population as possible, but has had to	

Agenda Item	Discussion	Next Steps

	focus on clinical data first. Working on population health data and sending data to the Blueprint has not been the primary focus thus far. Funding is an ongoing challenge, and SIM has helped to fill in the gaps, but eventually we will need to figure out a funding model that makes sense and is sustainable. GMCB has approved interoperability criteria, but they aren't mandated or enforced yet. This could be an opportunity to institute some requirements for providers that would make data sharing easier and more useful.
	• Chris Smith provided written comment. He commented that the crux of the matter is how to fund this going forward. He is reluctant to embrace creating a utility because he believes this is too small at the moment, but this needs to last for the next few decades and we need to pay for the overhead for it. Georgia clarified that this is not just about funding, but is more about the concept, scope, and structure of a utility.
	• Susan Aranoff asked whether Lawrence has put time parameters around this. She noted that we'd asked Stone Environmental to look at what other states have done in this area, and whether any have utility models. Can Stone do a national review with pros and cons of different models? It would be good to learn from earlier adopters.
	    ◦ Mike Gagnon doesn't believe there is a lot to learn from other states – we're ahead of most, and trying something that is unique, and all states are still learning. VITL is trying to learn from other industries rather than other states, since other industries are closer to achieving what we're trying to do for health data.
	    ◦ Larry Sandage commented that the HDI leadership team is in touch with other states as well (through ONC technical assistance), and we can learn from them. Some other states have set up robust governance structures, including Colorado, and we do want to learn from their experience. There are comparable models in other states.
	• Georgia suggested talking about data utility and governance separately, and refocused the discussion on data utility. She noted that there are few states pursuing data utility in the way Vermont might, but we have a lot to learn from others on governance. Lawrence would have loved this feedback in late 2015, but there is no firm deadline – this will support ongoing state planning.
	• Dale Hackett commented that there is overlap between utility and public good –
	• Brian Otley suggested defining the scope of the utility. A utility will have a scope of work that is noncompetitive monopoly because it supports the public good and requires significant infrastructure; the state simulates a competitive market through tight regulation. We want the functions of the utility to be as tightly defined as they can be to encourage the competitive market outside of the utility scope. What are the functions of the utility?
	    ◦ Brian: Data transport, from provider organization to any other entity as appropriate.
	    ◦ Steve Maier: We want good data, so need a quality component to be part of scope. The utility would have the authority to identify the mechanisms they will use to clean data and to specify for data-producing organizations what they need to do to provide quality/clean data.
	    ◦ Mike Gagnon: Standards around collection, transport, and quality. Includes semantic capabilities of	

Agenda Item	Discussion	Next Steps
	data. Might also consider creating something that would allow users to open up data ("service bus") with proper permissions and confidentiality protections to allow others to create applications to work with the data. "We should be developing the App Store without developing the apps." This would bring in the free market and make money to help fund the utility. Brian added that this describes a data platform that would be responsible for having high penetration, high quality, and high accessibility, and would allow others to use this platform to create other things. Having competing platforms for this would be really hard, and expensive. o Roger Tubby: Privacy and security. Entities that would use this utility would have different needs and would need data not available publically. Mike Gagnon agreed, and noted that we need to have a path for organizations to appropriately use identifiable data. o Steve Maier: Upstream work to develop the use cases that drive our need for data will be key. When we started work on the VHIE a decade ago, we were working to improve and support the clinical setting, and only later started talking about panel management and population health. Does this just include clinical data, or also VHCURES, VDH, Labor, Corrections? We need to clarify what we're trying to do and why we're trying to do it. We might want a single place where people can get all of that data in aggregate as we need it. The utility might not need to be the custodian of all of those datasets, but they would need the authority within their scope to receive datasets from other places to address the variety of use cases. Brian Otley commented that there is a difference between transport of data and warehousing/archiving of data. There are arguments for leaving those separate, or keeping them together. Brian also commented that we can't predict all future use cases, and it's the ease, quality, and accessibility of data that will support innovative and creative use cases. Mike Gagnon added that it should be relatively low-cost to solve individual problems, rather than create new, massive systems. o Chris Smith: If someone wants data from a data producer, do they have to go through the utility? Brian believes the utility would at the least enforce standards about how this data is collected (so it's done in a way that's additive to what's existing, not incompatible). This could be a next priority for the utility to create. Mike Gagnon commented that VITL has a process like this for organizations that want to be part of the VHIE, which a series of steps to connect fully – there are various levels of connection and data contribution. o Susan Aranoff: The role of a strong consumer advocate can't be underestimated. Vermont has regulations about patient access to information without an appeal process, and which consumers don't know about. She also commented that home- and community-based services providers need access to data. Payment for participation (and data submission vs. data viewing) will be a key issue for many providers. These are ongoing issues that have played out throughout the SIM grant. Simone Rueschemeyer added that consent management is a key issue. o Brian Isham: A key question will be who owns the data. We have data at UVM, at VITL, managed by Medicity, and it's not clear who would own it. What happens if Medicity stops operating, for example? Brian Otley agreed that this is a key question, though it may be a governance question.	

Agenda Item	Discussion	Next Steps

	In the utility model, the utility might own the pipes through which the data flows, but not the data itself. This requires more discussion. Steve Maier commented that he thinks the answer to this question will be very dynamic over the next decade. Generally, we believe records are owned by providers, not individuals, though individuals have a right to access their records. Steve commented that he believes that in 10 years, we will see data as patient-owned, at least in part. That makes providers and others uncomfortable.
	
	   o Stefani Hartsfield: We're not going to decide today what the answer is – we need to talk about process. Warehousing is a key issue, as is aggregation and analysis. Mike is identifying apps as the key to analysis and aggregation, but many organizations at the table here are already doing this or building systems to do it, and many of us are doing our own analysis. We should consider that as a function of the utility. SASH is piloting VITLAccess for nurses, but is finding that it's not particularly useful because they have access to the data through another mechanism. It's also a challenging to get information to patients who request it, and that requires a considerable amount of consumer education. Simone commented that some of this is around ease of access.
	
	   o Eileen Underwood: Likes the idea of scoping this at data transmission. What data goes in? VDH collects an enormous amount of information from providers now (immunizations come through the VHIE). VDH needs lab reports for reportable diseases, but in a different format than what comes through the VHIE. Would scope also include identity management? VDH has had to build its own identity management system to ensure data is attached to the correct individual when it comes to VDH.
	
	   o Steve Maier: There's a lot we can learn from current utilities and how they're regulated, but would caution against assuming all of what we have set up for regulating power, for example, will be what we need for health data. He noted that the public service board has been around for a century, and has had a lot of evolution during that time. We may not want to start out with all of the regulatory infrastructure. Brian agreed and noted that some of the principles may be right, but structure might be wrong.
	
	  • Brian Otley: Every time we put a function into place, we need funding to sustain and maintain it. There are a number of ways we could approach funding (State-funded, user-funded, value-funded).
	
	   o Mike Gagnon: A hybrid model – core public good funded out of a State fund, but as the value proposition builds, that becomes user-funded. The core could be something everyone gains access to, but to build onto that, users will fund it. PatientPing is an example of how this plays out.
	
	   o Stefani Hartsfield: We know EHRs' main strength is data collection, not aggregation and analysis. A lot of community-based providers' systems are not built to support this. Instead of building this infrastructure in provider settings, put this money into building a tool for everyone – this could also work for other places where providers are looking to improve their systems. Simone commented that timing, incentives, and requirements are key factors here.
	
	   o Ben Watts: Dept. of Corrections now has VITLAccess with Centurion, its contracted health provider. DOC has nearly completed implementation of an EHR that meets 2014 MU standards. He	

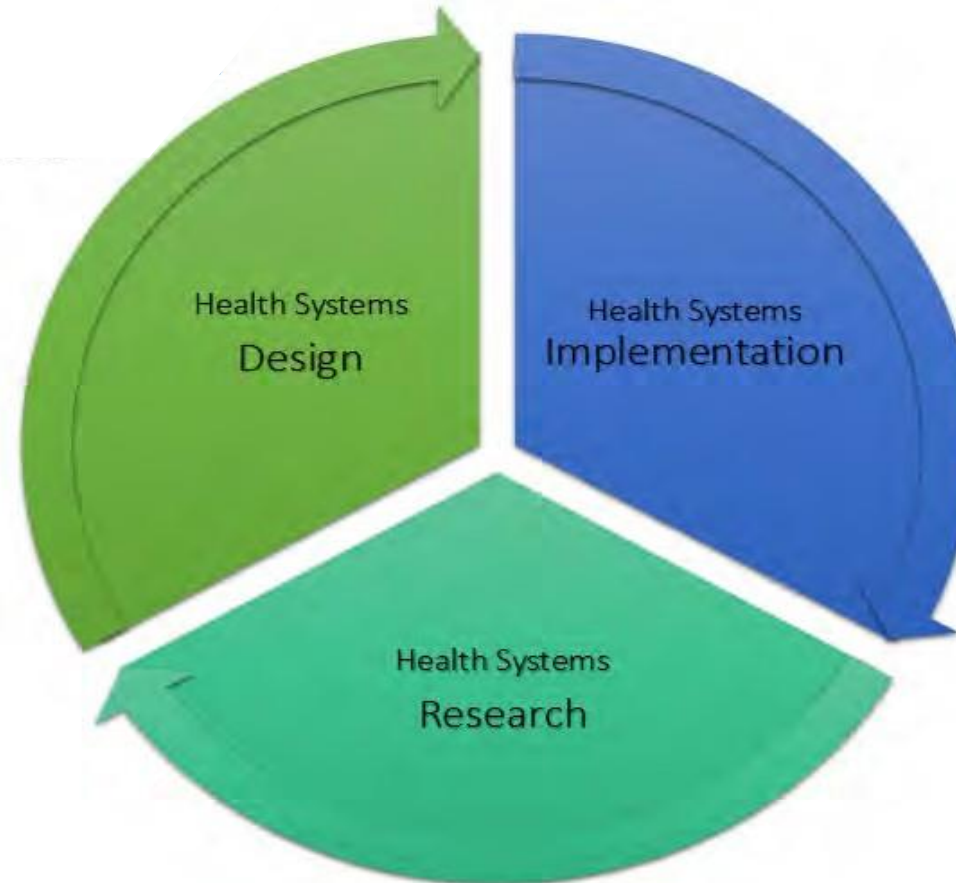| Agenda Item	Discussion	Next Steps

	suggested casting a broad net to catch DOC, HCBS, and other populations that are at-risk and complex. Simone commented that Part 2 data plays into this significantly.
	   o Mike Gagnon: Recent meeting with IBM Watson Health – this is exactly what they're trying to do, and it includes social data, genomics, and much more. They're building this infrastructure – we're not inventing this from scratch.
	   o Chris Smith: Size is a key factor, as is stability. Utilities are often highly stable and not particularly innovative – it's hard to get both. Brian noted that we need to strike a balance there, and a good regulatory structure with incentives or directives will support this.
	   o Roger Tubby: The model might be closer to the internet – it's lightly regulated, we can direct and control the flow of data, it doesn't involve as much widespread physical infrastructure (wires and poles), and it encourages people to want to use the data.
	   o Richard Terricciano: Is there opportunity for a company to exist as both operators of the utility structure and operating in the private space as well? Brian commented that there can be mandated functions and also market opportunities.
	   o Susan Aranoff: There's a public/private dynamic here that is very different from the internet. We've already put millions of dollars into creating the ACO structure and supporting this, and we have a responsibility to ensure this structure supports the public good. There are large areas of Vermont without access to the internet, and large sectors of providers that don't have access to the HIE structure.	

5. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	There was no additional public comment. **Next Meeting:** Wednesday, February 17, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury.	

Attachment 2: Update: Blueprint Clinical Registry
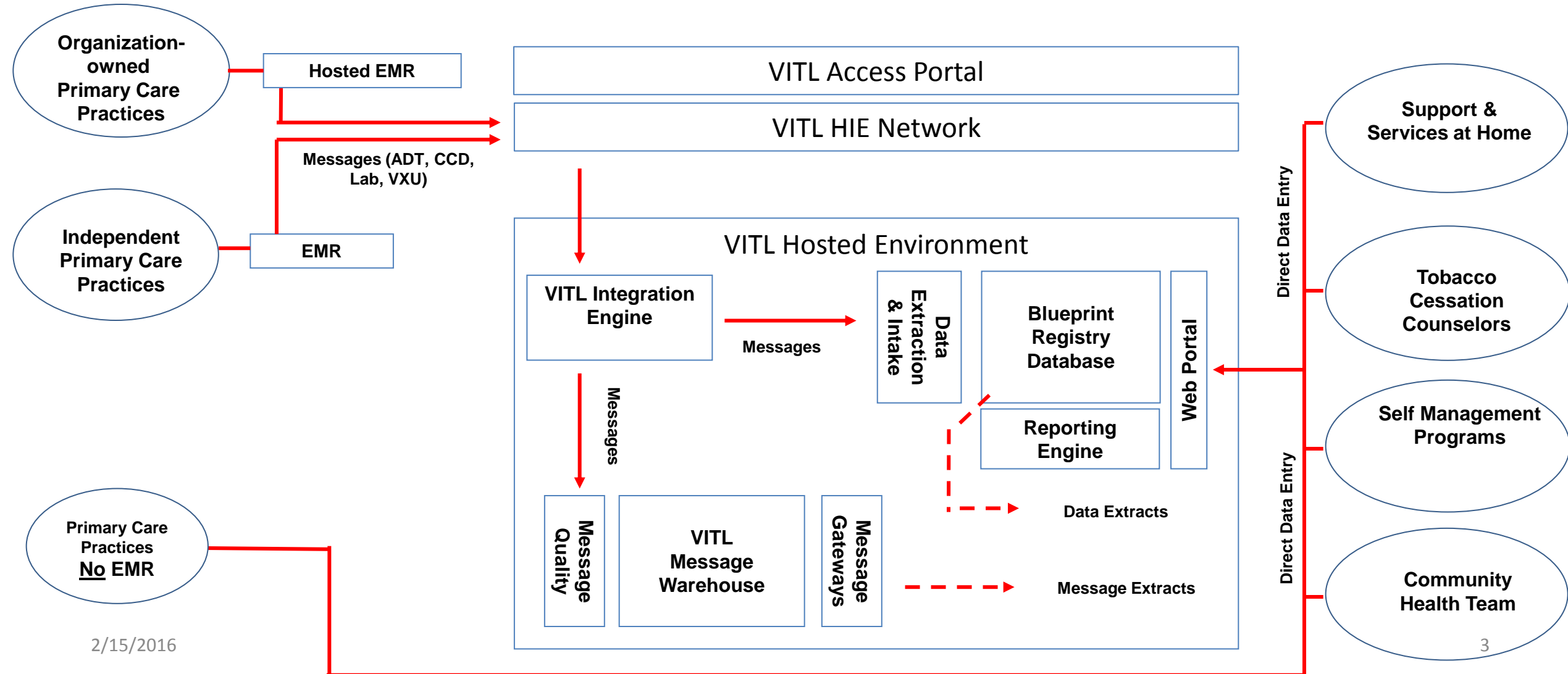
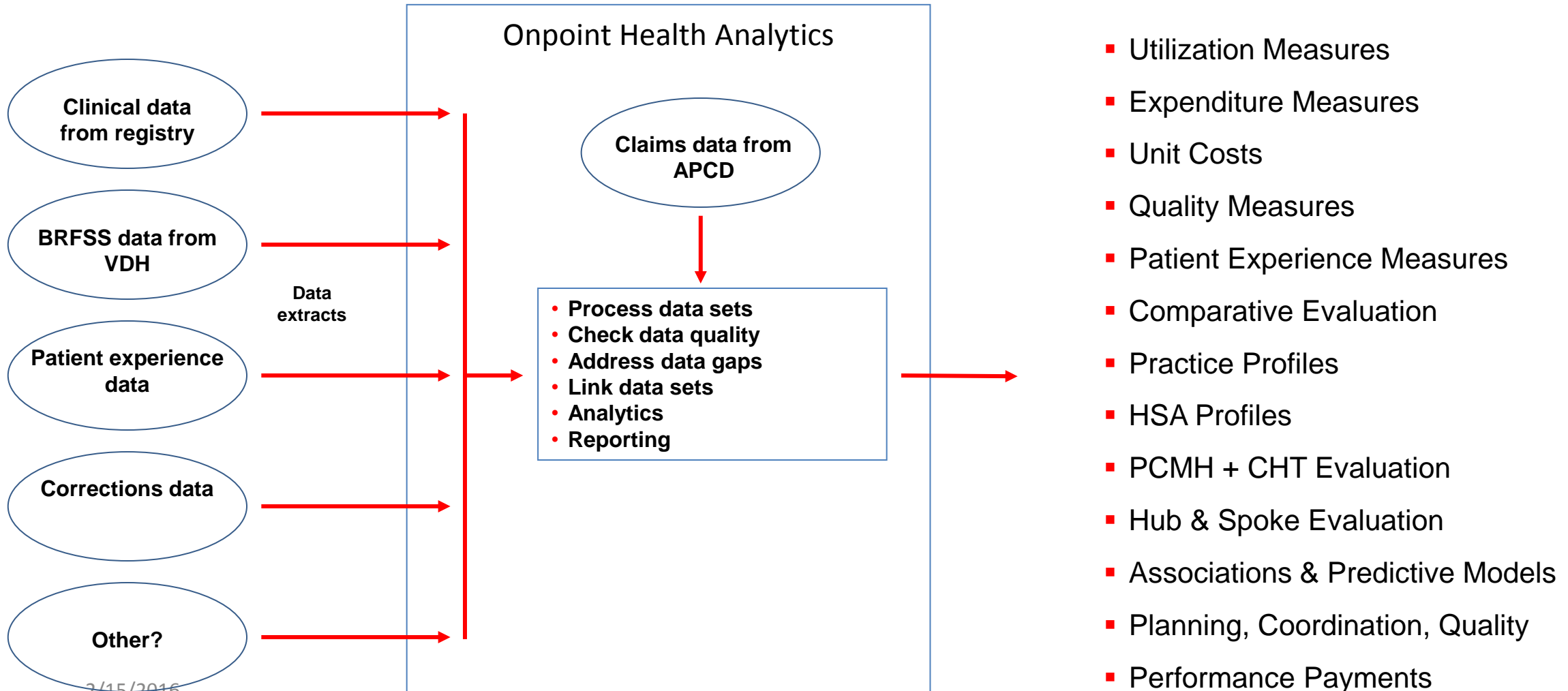# Blueprint Clinical Registry

Migration and DQ

Capitol Health Associates, LLC

Learning Health System

Linking Claims & Clinical Data – 2014*

Enhancing Blueprint Reporting: Clinical Outcomes

VHCURES Members with Primary Care Visit (475,921)

Attributed to Blueprint Practices (361,316) | Non-Blueprint (114,605)

Linked to DocSite ID (305,051) | Unlinked (56,265)

Measures (162,118) | No Measures (142,933)

*CY 2014 represents dates of services on and between 01/01/2014 and 12/30/2014.
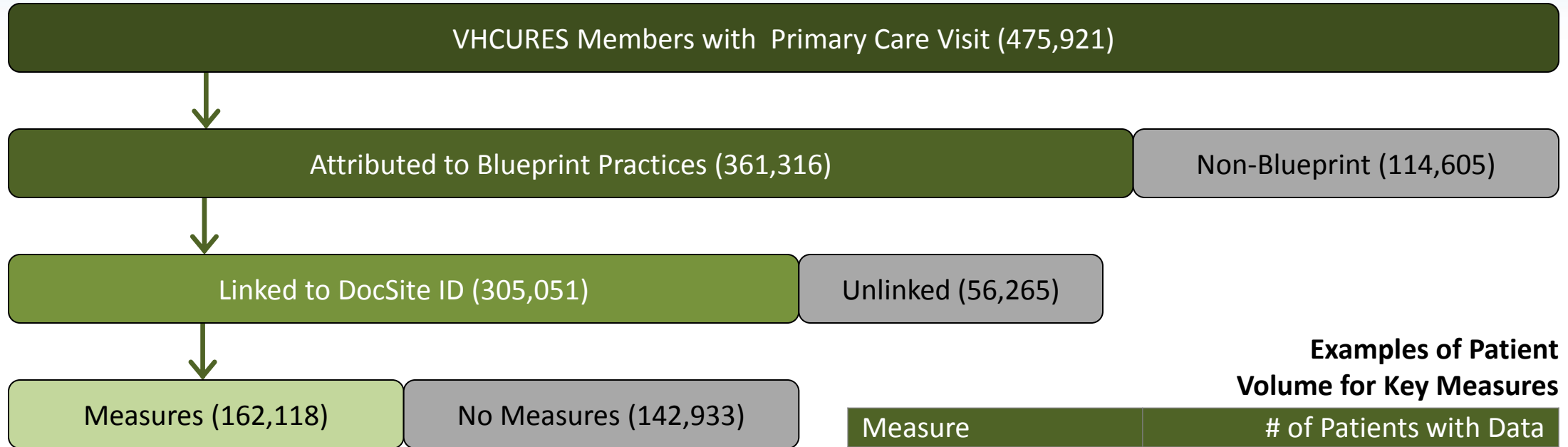
Examples of Patient Volume for Key Measures

Measure	# of Patients with Data
Weight	142,600
Blood pressure	140,286
BMI	122,428
Triglycerides	44,639
LDL-C	43,652
Tobacco use	28,779
HbA1c	21,418

ONPOINT Health Data

BPCR Migration and Data Quality Project

Task	Description	Status	Comment
1	Program Management	🟢	Ongoing
2	Project Mgmt. of Statewide BP Date Quality Initiatives	🟢	Ongoing
3	Project Mgmt. for Onboarding of new BP Data Quality Initiatives	🟢	Review of data quality from last extract. Engage Work with Vital Stats on Death Registry to claims effort
4	Involvement in Project Supports Data Quality Work	🟢	Engaged with multiple sites on data quality Continue working with Medent and VITL to discuss missing data in Medent CCDs.
5	Migration Project	🟢	Onsite visit
6	Completion of Build for Pre-Production Operational Instance of DocSite	🟢	Complete
7	DocSite Pre-Production Operational Instance Validation and Functional Testing	🟢	Complete
8	Message Processing for Pre-Production Instance of DocSite	🟢	See Weekly BPCR Status Report for details
9	Reporting of Pre-Production Instance of DocSite	🟡	Work continues on this but the timeline has been moved due to the prioritization of Rhapsody.
10	Initial Security Assessment, Penetration test, and Remediation	🟡	Delayed due to resource diverted to Rhapsody effort. Security team will reengage next week.
11	Verification of Source Code Delivery from Covisint	🟢	Complete
12	Ongoing Hosting of BPCR	🟢	See Weekly BPCR Migration Status Report for details

Capitol Health Associates, LLC

Project Timeline

Rhapsody Test Plan Complete
Mon 2/29/16

Go Live!
Mon 4/4/16

Qtrly Vulnerability Test
Wed 6/1/16

Rhapsody Spec Delivered
Mon 2/1/16

mber October November December January **Today** March April May June July

Create Mon

Initial Mon

S
M

Finish
Fri 7/1/16

DocSite Source Code Accepted
Fri 12/18/15

Rackspace Instance Complete
Wed 7/1/15

Acceptance of Source Code
Mon 2/1/16

3rd Party Software Licenses
Thu 2/25/16

Go-Live Pen Test
Tue 3/1/16

Key Performance Indicators

	GREEN Compliant	YELLOW Non-Compliant	RED Requires Immediate Review
Scope	X **In Scope** (no outstanding changes that have not been formally approved and logged)	☐ **Scope at risk** (additions/deletions being acted on without formal Sponsor approval)	☐ **Not Within Scope** (out of scope and unfunded work being done, remaining work ignored, previous warning not being acted on)
	Scope Comments: *Scope is limited to IT Communications to providers. Scope is understood.*		
Schedule	**On Schedule** Tasks are starting and ending on time and **90%** are on track to meet dates.	X **Schedule at risk** **75%+** of tasks are starting and ending on time and 90% are on track to meet dates.	☐ **Not On Schedule** **Less than 75%** of tasks are starting and ending on time and are on track to meet dates.
	Schedule Comments: *Yellow – Rhapsody discovery and develop continue. Limited documentation from Covisint has delayed efforts.*		
Budget	X **Within Budget** Costs for tasks and phases are less than **110%** of baseline costs for same.	☐ **Budget At Risk** Costs for tasks and phases are less than **125%** of baseline costs for same.	☐ **Not Within Budget** Costs for tasks and phases are **greater than 125%** of baseline costs for same.
	Budget Comments: *Reallocation of funds was done to support Static Code test remediation. This was not budgeted.*		
Deliverables	X **Deliverables** **90%+** of deliverables are on track to meet dates.	☐ **Deliverables Not Current** **75%+** of deliverables are on track to meet dates.	☐ **Impacting project** **Less than 75%** of deliverables are on track to meet dates.
	Deliverables Comments: *Deliverable is Source Code Purchase from Covisint*		
Risks	X **Risks All Mitigated** (no outstanding changes that have not been formally approved and logged)	☐ **Some Risks** (additions/deletions being acted on without formal Sponsor approval)	☐ **Issues** (out of scope and unfunded work being done, remaining work ignored, previous warning not being acted on)
	Risk Comments: *High volume of deliverables in a short timeline*		

1/4/16

Attachment 4: DLTSS Gap Remediation Proposal

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

Susan Aranoff, Esq.

Judith A. Franz

Kristina S. Choquette

February 17, 2016

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.

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

- This project was 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.

- Prior to January 29, 2016, no SIM funds had been allocated to increase HIE/HIT connectivity for Vermont's Home Health Agencies or Area Agencies on Aging.

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.

- 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.

Context (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.

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 the Core Team allocate up to $785,000 of remaining funds to remediate some of the highest priority gaps identified in the DLTSS data gap analysis.
  - Year 2: $167,000
  - Year 3: $618,000

- This will be over the time period 2/15/16-12/31/16.

Proposed Solution

- Implement <u>VITLAccess</u> for Home Health Agencies including Bayada.

- Develop <u>Interfaces</u> from Home Health Agencies' EHRs to the VHIE .

- Both VITLAccess Implementation and Interface development will be accomplished utilizing a phased approach.

- Area Agencies on Aging (AAA) Issues:
  - Are not health care organizations under HIPAA.
  - Further legal and regulatory due diligence required.
  - Will provide a proposal in at a later date.

Phased Approach

- For VITLAccess, Home Health agencies will be implemented in groups (last slide).

- For Interfaces:
  - Initial Discovery phase to determine vendor capability:
    - Total of 12 agencies using 5 different EHRs.
    - Current state:
      - Four agencies are partially connected (sending ADTs).
      - One agency is connected sending both an ADT and CCD.
    - Remediation needed:
      - 18 interfaces in total need to be remediated:
        » 7 agencies need ADTs.
        » 11 agencies need CCDs.
  - Development by organization (based on Discovery):
    - Goal is to remediate a minimum of 50% of the number of needed Interfaces.

VITLAccess Implementation Model

Implementation model consists of three phases:

- Profile: Introductory meeting and role definition.

- Enroll: User designation and technical set up of users.

- Customized Launch will include:
  - Consent and end user training (standard approach)
  - In-person onsite training sessions at agency location (standard approach)
  - Invitational regional training sessions
  - WebEx (live online) trainings
  - Train-the-trainer method

Phase 1: February 15, 2016 - June 30, 2016

- VITLAccess Rollout $122,000

  (4 agencies, ~ 305 users)

  - ❖ **Deliverable**: Stemming from a thorough profiling of the agency, a Profile document will be created outlining key drivers of the custom approach needed for enrollment and launch components of the implementation model.

- Interface Technical Discovery $45,000

  (Required)

  - ❖ **Deliverable**: IT Gap Remediation document outlining vendor capability and cost, including a recommended implementation plan to connect Home Health agencies to the VHIE in a cost effective manner.

  - ❖ Estimate based on past experience: ~60 to 70 hours/vendor

                              Total $167,000

Phase 2: July 1, 2016 – December 31, 2016

- VITLAccess Rollout $68,000

  (3 agencies, ~170 users)

  - ❖ **Deliverable**: Stemming from a thorough profiling of the agency, a Profile document will be created outlining key drivers of the custom approach needed for enrollment and launch components of the implementation model.

- Interface Development $275,000

  (5 agencies; 6 interfaces)

  - ❖ $150,000 for VITL interface implementation. Estimate based on recent home health specific implementations for two vendor systems (McKesson Homecare and Hospice; Allscripts Homecare).
  - ❖ $125,000 to cover home health agency costs charged by the EHR vendors

                                    Total $343,000

Phase 3: July 1, 2016 - December 31, 2016

- VITLAccess Rollout $50,000

  (5 agencies, ~125 users)

  - ❖ **Deliverable**: Stemming from a thorough profiling of the agency, a Profile document will be created outlining key drivers of the custom approach needed for enrollment and launch components of the implementation model.

- Interface Development $225,000

  (4 Agencies; 4 interfaces)

  - ❖ $100,000 for VITL interface implementation. Estimate based on recent home health specific implementations for two vendor systems (McKesson Homecare and Hospice; Allscripts Homecare).
  - ❖ $125,000 to cover home health agency costs charged by the EHR vendors

  Total $275,000

VITLAccess Implementation Phases

Phases	Agencies	Est. Users	Cost
1	Visiting Nurse Association of Chittenden & Grand Isle Counties (including the VT Respite House)	100	40,000
	Addison County Home Health & Hospice	40	16,000
	Bayada Home Health Care	140	56,000
	Lamoille Home Health & Hospice	25	10,000
	Total Users	**305**	**$122,000**
2	Central Vermont Home Health & Hospice	50	20,000
	Visiting Nurse and Hospice for Vermont & New Hampshire	60	24,000
	Rutland Area Visiting Nurse Association & Hospice	60	24,000
	Total Users	**170**	**$68,000**
3	Bennington Area Visiting Nurse Association & Hospice	25	10,000
	Caledonia Home Health Care & Hospice	30	12,000
	Franklin County Home Health Agency	40	16,000
	Manchester Health Services	10	4,000
	Orleans, Essex VNA & Hospice	20	8,000
	Total Users	**125**	**$50,000**
	Total users all 3 phases	***600***	***$240,000***

Vermont Health Care Innovation Project.

Attachment 5: SCÜP Project Update: Shared Care Plans and Universal Transfer Protocol

SCÜP Project Update: Shared Care Plans and Universal Transfer Protocol

Georgia Maheras

February 17, 2016

BACKGROUND

- Shared Care Plans: technical solution to share care plans among a care team.
  - Consent (non-HCOs; person-directed)
  - Business requirements

- Universal Transfer Protocol: process to improve workflows; sharing of transfer information.
  - Business requirements

Feedback

- Access across the continuum of care.
- Integrate into existing workflows/technology.
- Minimize logins.
- Adaptability.

Next Steps

- Shared Care Plans: update on two potential solutions.

- Universal Transfer Protocol: update next month.