

Attachment 1 - VHCIP Steering Committee 3.5.14 Meeting Agenda

**VT Health Care Innovation Project
Steering Committee Meeting Agenda**

March 5, 2014 1:00 pm- 3:00 pm
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:05	Welcome and Introductions	Al Gobeille and Mark Larson	Attachment 1: Agenda
2	1:15-1:25	Public Comment	Al Gobeille and Mark Larson	
3	1:25-1:30	Minutes Approval	Al Gobeille and Mark Larson	Attachment 3: February Minutes
4	1:30-1:35	Core Team Update	Anya Rader Wallack	
5	1:35-2:00	Policy Request: <ol style="list-style-type: none"> 1. QPM WG: Proposed Standard Relating to Shared Savings Program/ACO measure review and modification 	Pat Jones and Alicia Cooper	Attachment 5: Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs dated 2/10/14
6	2:00-2:50	Financial Requests: <ol style="list-style-type: none"> 1. Population Health Work Group Spending Proposal 2. HIE/HIT Work Group Spending 	Georgia Maheras	Attachment 6a: Population Health Work Group Spending Proposal Memo Attachment 6b: Advancing Care Through Technology Proposal

		Proposal		
8	2:50-3:00	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille and Mark Larson	Next Meeting: April 16 th 10:00am-12:00pm in Williston

Attachment 3 - Steering Committee Minutes 02.12.2014



VT Health Care Innovation Project Steering Committee Meeting Minutes

**Date of meeting: February 12, 2014 at DVHA Lg Conference Rm - 312 Hurricane Lane - Lg Conf Rm - Williston
Call in: 877-273-4202 Passcode 8155970**

Attendees: Mark Larson, and Al Gobeille, Co-Chairs; Robin Lunge, AoA; Anya Wallack, Core Team Chair; Georgia Maheras, AoA; Bob Bick, Howard Center; Peter Cobb, VT Assembly of Home Health and Hospice Agencies; Elizabeth Cote, AHEC; Tracy Dolan, AHS; Nancy Eldridge, Cathedral Square & SASH; John Evans, VITL; Catherine Fulton, VT Program for Quality in Health Care; Bea Grause, VT Assn of Hospitals and Health Systems; Paul Harrington, Vermont Medical Society; Trinka Kerr, and Jackie Marjoros, VT Legal Aid; Todd Moore, One Care; Mary Val Palumbo, UVM; Ed Paquin, Disability Rights Vermont; Judy Peterson, Visiting Nurse Assn of Chittenden and Grande Isle; Simone Rueschemeyer, Behavioral Health Network of VT; Julie Tessler, VT Council of Developmental and Mental Health Services; Sharon Winn, Blue Cross, Blue Shield; Annie Paumgarten, Harry Chen, VDH; Julie Wasserman, AHS; Alicia Cooper and Erin Flynn, DVHA; Diane Cummings, AHS; David Martini, DFR; Marybeth McCaffrey, DAIL; Dale Hackett, Consumer Advocate; Stephanie Beck, AHS; Allan Ramsay, Christine Geiler, Richard Slusky, GMCB; Nelson LaMothe and George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome & Introductions	Mark brought the meeting to order at 1:33pm	
2 Public Comment	None offered.	
3 Financial Request:	<p>Mark introduced the Population-Based Collaborative Health Information Exchange funding proposal. This proposal was recommended by the HIE/HIT Work Group to the Steering Committee. The proposal would entail a contract with VITL.</p> <p>Al Gobeille referenced the VHCIP conflict of interest policy and stated that he is an uncompensated member of VITL’s Board. Robin Lunge also declared that she is also an</p>	

Agenda Item	Discussion	Next Steps
	<p>uncompensated VITL Board member, appointed by the Governor. Bea Grause also declared she is on the VITL Board representing Vermont hospitals. Paul Harrington declared he is Chair of VITL’s Board. Simone Rueschemeyer declared she is an active member of VITL’s Finance Committee. There was a brief discussion of the role of the VITL Board member.</p> <p>Mark summarized the discussion reminding Steering Committee Members that disclosing the appearance of a conflict of interest does not necessarily require recusing participation in discussion and voting.</p> <p>Georgia Maheras advised that John Evans may participate in preliminary discussion, but will need to recuse himself later when the Committee considers a motion and engages in further discussion.</p> <p>Mark asked if anyone objects to all Steering Committee members participating in discussion of the proposal. Anya noted that VITL is unique in that it was created by statute and chartered as the state’s health information exchange entity.</p> <p>Before proceeding with the next Agenda item dealing with financial proposals, Mark asked a second time for any objections related to potential conflicts within the Steering Committee; none were offered.</p> <p>Simone Rueschemeyer provided background on the Population-Based Collaborative Health Information Exchange proposal and the process at the HIE/HIT Work Group. The proposal is consistent with the Work Group goals and VHCIP’s goals. Goals incorporated in the proposal include 1) improving interoperability 2) improving data quality 3) improving the ability to exchange information. The Work Group voted to recommend this proposal with one no vote from DAIL. DAIL submitted a memo to the HIE WG citing several concerns. The Work Group’s motion and DAIL’s memo were all distributed to the Steering Committee ahead of their February 12th meeting.</p> <p>John Evans provided an overview of the proposal. Affected providers include: 100% of Vermont Hospitals, 91% of FQHC’s, and the vast majority of Primary Care Physicians, Specialty Care Physicians, Skilled Nursing Facilities, Home Health and Designated Agencies.</p> <p>The goal of this proposal is to</p>	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> - provide timely information and support better care; e.g. reporting timely and accurate information contributes to patient safety, and addresses the existing challenges to obtaining medical records. - provide the analytical requirements for Population Health management. - improve quality, reduce the cost of care, and manage transitions in care. <p>The challenges include</p> <ul style="list-style-type: none"> - performing a gap analysis of the technical readiness of providers' engaged w/ ACO's, - address the need to route info to ACO's analytics provider (NEACC) - report event notification to providers <p>The proposal Timeline reflects the following :</p> <ul style="list-style-type: none"> - Gap Analysis completed by end of Q1 2014 - Create the ACO gateway completed by end of Q4 2014 - Event notification completed by Q4 2014 <p>The proposed Budget request at \$3,023,798 for VITL includes developing the structure including ongoing maintenance and support to keep that investment current. Support for Event notification will not begin until Q1 2015.</p> <p>Discussion of the proposal ensued with several questions posed:</p> <p>Bob Bick asked if gap remediation is not part of the project, the implication is there will be a second proposal. John confirmed that is correct.</p> <p>There were a series of questions about patient consent to allow providers to use the information in the HIE. The Steering Committee determined that it would be beneficial to have a separate meeting about this consent policy especially the mental health and substance abuse data.</p> <p>Nancy Eldridge asked which patients are not included or affected by this proposal. The Shared Savings ACO Program is focused on Physician and Hospital spending, and the proposal reaches the vast majority of Vermonters. However, the population pipeline being built can assist any provider, not just ACO affiliated providers</p> <p>Allan Ramsay expressed that because of high expectations around HIE technology we need a way</p>	

Agenda Item	Discussion	Next Steps
	<p>to ensure performance. Georgia Maheras responded that in addition to DVHA’s oversight as the contracting agent, the HIE Work Group has recommended a sub-committee to oversee this work.</p> <p>Jackie Majoros expressed concern that patients with disabilities requiring long term support services (LTSS) are not included in this proposal. Simone responded that a second proposal focused on LTSS providers will be discussed in the HIE/HIT Work Group in the near term to address linkage of important data for this sector.</p> <p>Al Gobeille expressed concern about creating another sub-committee to oversee the VITL deliverables and progress. Simone clarified that formal oversight could be folded into a sub-set of the existing HIE Work Group to monitor VITL’s performance.</p> <p>Dale Hackett expressed concern about deliverables and longer term costs to sustain the project.</p> <p>John Evans left the room for the remainder of this discussion.</p> <p>Peter Cobb moved to accept the proposal, Paul Harrington seconded the motion. Motion passed with one opposed, Nancy Eldridge and three abstentions: Trinkia Kerr, Ed Paquin, and Jackie Marjoros.</p>	
4 January Minutes Approval	Bea motioned to approve minutes, Robin seconded and this motion passed unanimously.	
5 Reminder: COI	Georgia Maheras reminded participants to read the Conflict of Interest Policy, sign the Acknowledgement and forward to Sales, George George.Sales@partner.state.vt.us .	
6 Shared Savings ACO Program Update:	<p>Richard Slusky provided an update on the Commercial Shared Savings ACO Program: Agreements between ACOs and Payers were sent to ACOs yesterday. Next step is for ACOs to contract with providers.</p> <p>Mark Larson provided an update on the Medicaid Shared Savings ACO Program: Two of the three ACOs have brought the proposal to their Boards. A formal announcement is expected soon.</p>	
7 Core Team Update	Anya Rader Wallack provided a Core Team update to the Steering Committee: The Core Team spent time deliberating the rules and scoring of applications for the sub-recipient grant program. Proposals are due on Friday February 14 th . The Core Team also approved technical support to the same Grant Program awardees. The Core Team believes that technical support will leverage the	

Agenda Item	Discussion	Next Steps
	outcomes of the Provider Grants.	
8 Provider Grant Program	Georgia provided an update: Hard copy and electronic copy applications are required per Vermont law. Early submissions are allowed. Notification of awards will be public by March 25. A component of the Grant Program offers technical assistance to applicants was approved and separately funded by the Core Team. Technical assistance vendors (Wakely, Policy Integrity, Truven Analytics, VPQHC and Bailit Health Purchasing) are intended to leverage the applicant’s ability to deliver scope.	
9 Status Report	Al Gobeille requested brief work group status reports form Co-Chairs and referenced the more detailed hard copy reports attached to meeting materials.	
10 Financial Requests	<p>1. Georgia Maheras presented a recommendation by the Workforce Work Group to contract for services supporting the collection and analysis of data on the Vermont health care workforce. The Vermont Department of Health (VDH) and the Office of Professional Regulation (OPR) both collect information today, and helped to identify gaps in current data and developed a plan to remediate these gaps. The proposal focuses on identifying gaps in existing data, enhancing data collection, and data analysis.</p> <p>Elizabeth Cote suggested that the proposal as written does not address some information that could be really useful (e.g. licensed professionals are included in the analysis, but registered professionals like home health workers, dental hygienists, technicians, etc. are not), and would like to reconfirm that data can be easily extracted, analyzed, and disseminated to policy makers.</p> <p>Georgia responded that as this proposal was being developed, VDH and OPR collaborated and indicates their software is flexible enough to accommodate added data collection from registered health care professionals.</p> <p>Paul Harrington moved that proposal be approved with an amendment to the scope on page 1: “contractor shall provide data ‘consistent w/ act 79, Sec 44’”. Peter Cobb seconded and the motion passed. Tracy Dolan and Harry Chen abstain.</p> <p>2. Georgia and the Co-Chairs of the Disability and Long Term Support Services (DLTSS) Work Group recommend a spending proposal of \$90,000 each for two contractors through February 2015. In the interest of expediting this proposal, it is presented to the Steering</p>	

Agenda Item	Discussion	Next Steps
	<p>Committee prior to being formally recommended by the Work group. The request is for approval conditional upon a vote by the DLSS Work Group on 2/20/14. The contracts are identical, and complementary. The two contractors involved, Bailit Health Purchasing and Pacific Health Policy Group have a history of working as a team and bring different skills to table. The vendors focus will be to ensure that DLSS populations are included in health care reform consistent with SIM goals.</p> <p>Dale Hackett moved to approve the proposal; Judy Peterson seconded the motion and it passed unanimously.</p>	
Next steps:	Next meeting March 5, 2014. The new VHCIP website will launch on Tuesday.	

Attachment 5 - Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs.

VHCIP Quality and Performance Measures Work Group
Process for Review and Modification of Measures Used in the Commercial
and Medicaid ACO Pilot Programs

Work Group Recommendation (Approved February 10, 2014)

Standard:

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.
2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.
3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the

VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.
5. The GMCB will release the **final measure specifications for the next pilot year by no later than October 31st** of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.
6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work

Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

Attachment 6a - Population
Health Work Group
Spending Proposal Memo

To: Steering Committee
Fr: Population Health Work Group
Re: Contract for Population Health Technical Services provided by Jim Hester
Date: February 26, 2014

This request is to continue an existing contract with Jim Hester to provide support to the population health work group related to the SIM Grant/VHCIP. This contract would be funded by the SIM/VHCIP funds allocated to the Population Health Work Group for work group support.

Background

The SIM grant requires the State of Vermont to work towards improving overall population health.

The Population Health Work Group examines current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. This work group will examine these initiatives and SIM/VHCIP initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for, or enhancement of, local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

In 2013, the VHCIP determined the need for assistance with the development of the population health work group described in the SIM Operational Plan. Jim Hester is uniquely positioned to perform this work.

Vendor Qualifications

Mr. Hester has recently completed two and a half years assisting in the start-up of the Center for Medicare and Medicaid Innovation at CMS. He is familiar with both the population health work at the federal level and the work in Vermont. At the federal level, he was the Acting Director responsible for the initial work on the Pioneer ACO shared saving model, the Comprehensive Primary Care Initiative Model and the Bundled Payment models. Significantly, he served as the Acting Director of the Population Health Models Group overseeing the

development of enhanced measures and strengthening the population health component of the payment models. He has a strong set of working relationships with public and private partners, especially CMS and CDC. His Vermont experience includes serving as director of the Health Care Reform Commission for the state legislature for four years, the Blueprint Executive Committee since its inception and the VITL board for three years.

Scope of Work

The specific tasks for this contract would be:

- assist the co-chairs of the work group in developing the initial approach, work plan, and resource needs for the work group
- assist in developing agendas for the work group once it is formed.
- through ongoing work with CDC, IOM and others, identify models and resources in other states and communities that could inform the design of sustainable financing models for improving population health.
- assist in identifying the population health measures and measurement systems required to support the population health financing system.
- help formulate an approach to creating Vermont pilots of Accountable Health Communities by drawing on expertise in models being tested in other states

Recommendation:

Approve a sole source contract with Jim Hester for an amount not to exceed \$28,000 for a twelve month engagement. This price is competitive in relation to the other contracts held by the State for support for work groups and other technical areas.

Attachment 6b - ACTT Proposal

Advancing Care through Technology (ACTT)

ACTT PARTNERSHIP

**Proposal submitted to the Vermont Health
Care Innovation Project & Health Information
Exchange Work Group**

February 26, 2014

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ABSTRACT: ADVANCING CARE THROUGH TECHNOLOGY (ACTT) PARTNERSHIP & ITS CURRENT PROJECTS

The Advancing Care through Technology (ACTT) partnership is a consortium of Designated and Specialized Agencies (DA/SSA) and long term services and support (LTSS) providers and their advocacy organizations, including Area Agencies on Aging, Adult Day Providers, Home Health and Hospice Agencies, Residential Care Homes, Nursing Homes and Traumatic Brain Injury Providers. The ACTT partnership is requesting funds from the Vermont Health Care Innovation Project (VHCIP) to support three of its four projects: Project #1: DA/SSA Data Quality and Repository; Project #2: LTSS Data Planning; and Project #3: Universal Transfer Form. The largest funding request is in Project #1: DA/SSA Data Quality and Repository. As such the narrative and work plan are more detailed. The other two projects are early planning opportunities that will enable LTSS providers to determine how to best integrate into the VHIE and how to design and implement a universal transfer form. Project #4 is not seeking funding now; it is included as Appendix A because there are several important inter-relationships and inter-dependencies between this project and other ACTT projects and we expect that development and implementation of the HIE and Part 2 Project will require VHCIP funding in the future.

The purpose of the ACTT Partnership is to enable Vermont's DA/SSAs and other LTSS providers (namely providers who have not been eligible to participate in federal incentive funding for electronic health records) to collaborate with local and state partners to achieve population health goals through the use of technology. Leveraging the power of this partnership and building on previous and current work, the ACTT partnership is seeking to fund work initiatives that use integrated efforts and technology to enable: data quality, enhanced reporting, population and individual health management and improvement; and connectivity to the state-wide HIE for many of Vermont's essential community providers.

The Institute for Healthcare Improvement's triple aim calls for improving the patient experience of care, improving the health of a population, and reducing per capita costs. This can only be realized when health information technology is extended beyond physical care to reach the types of providers who address the social determinants of health, behavioral health and long term services and support services (which are inclusive of support for people who need services for mental health, substance use, developmental disabilities, aging, traumatic brain injury, and physical disabilities). The ability to link information systems will enhance care coordination through assuring that the right information is available at the right time in the right setting and that it proceeds with the individual across care settings to promote "whole person" care. Population management will be supported through data collection, reporting, and benchmarking, in turn leading to improvement in the quality of services provided and permit the more accurate projection of need and resource allocation.

Data liquidity is essential to achieving the goals of health care reform. Having the capacity to track, exchange, analyze and use both clinical and claims data will not only enable the State to control costs and more accurately predict service need, but will enable providers to work together to improve access and care delivery across the continuum of care. The ability to have complete clinical and long term services and supports information for an individual when they are seeking care reduces redundancy in services, saves limited healthcare funds, and allows providers full knowledge of the patient's history, problem list, medications, and allergies. This reduces errors in diagnosis and treatment and also allows for population management, focusing the attention of healthcare professionals on what is needed rather than on who is seeking care.

The overall goal of VHCIP/ HIE Workgroup is to ensure the availability of clinical health data or information necessary to support the care delivery and payment models being tested in the VHCIP

Project, including those associated with the Shared Savings/ ACO, Episode of Care, Pay-for-Performance, and other Care Delivery models. The ACTT Partnership projects work toward that overall goal by impacting four of the identified VHCIP HIE Work Plan goals, including:

- To improve the utilization, functionality & interoperability of the source systems providing data for the exchange of health information
- To improve data quality and accuracy for the exchange of health information
- To improve the ability of all health and human services professionals to exchange health information
- To align and integrate Vermont's electronic health information systems, both public and private, to enable the comprehensive and secure exchange of personal health and human services records

BUDGET SUMMARY FOR CURRENT ACTT PROJECTS

Below is the proposed Budget Summary for the Advancing Care through Technology proposal to the VHCIP/HIE work group. These budget numbers are intended to represent informed estimates on the scope of work proposed in these projects. There are some Phase 1 activities embedded in the proposal. With additional time and discovery, additional requests for funding will likely be proposed in the upcoming year.

ACTT Project Name	Budget	Notes
DA/SSA Data Quality and Repository	\$1,939,838	*includes \$400,000 for a DS unified EHR, development of a data dictionary, quality remediation and the development of a DA/SSA data repository
LTSS Data Planning	\$178,000	
Universal Transfer Form Planning	\$215,072	
42 CFR Part 2 Consent and Data Architecture - Phase 1		Phase 1 funded through DVHA Grant (estimated @ \$20-30,000). Not asking for resources at this time.
TOTAL:	\$ 2,492,910.00	

ACTT PROJECT #1: DA/SSA DATA QUALITY AND REPOSITORY

NARRATIVE

The potential impact of the Advancing Care through Technology: Data Quality and Repository project (ACTT: DQR) is significant. The purpose is to enable Vermont's sixteen designated and specialized service agencies (DAs/SSAs) to have structured, reliable and complete data that can be used to: strengthen communication with community partners; enhance care coordination with primary care; improve the quality of care across the network; promulgate best practices of integration; demonstrate value; and increase their ability to report to ACOs, the State and other entities to which they are in partnership or accountable. This work will have a significant impact statewide as it relates to cost control, funding mechanisms, care delivery models and population health improvement. It will also have a tremendous impact at the local level enabling individual DAs/SSAs to utilize data to improve the care provided at their agency and to work with other community-based providers such as FQHCs, home health agencies, employment agencies and housing organizations to enhance care coordination and care delivery. This is inclusive of the care provided that impacts the social determinants of health.

The State of Vermont relies on independent, non-profit designated and specialized service agencies to provide mental health, substance use and developmental services throughout the state. State and federal sources, particularly Medicaid, fund our services at approximately \$360 million annually. The DA/SSAs enable many Vermonters to secure and maintain employment, keep their families intact, secure and maintain housing and avoid hospitalization, institutionalization and incarceration. Each year over 45,000 Vermonters use these services and over 6,000 Vermonters are employed by our agencies. The DA/SSA system provides comprehensive services, including case management to adults who have severe and persistent mental illness (CRT program), individuals with significant developmental disabilities (DS waiver program), assessment and treatment for substance abuse disorders and children with severe emotional disturbance (SED waiver program) who would otherwise be at risk of institutional placements. Additionally we provide a range of child, youth and family services, crisis services and outpatient services.

The success of the Vermont community mental health system is evident in our low utilization of psychiatric hospital care, low utilization of correctional facilities and the absence of a state school for those with developmental disabilities. The treatment for mental health conditions includes clinical, residential and other support services. Most individuals who receive developmental disability services will need care on a life-time basis. Many individuals in our developmental disability program, and CRT program for people with severe and persistent mental illness are able to successfully secure and maintain employment and contribute to the state's tax base. Our programs are geared toward recovery by encouraging individuals to learn to live active, productive and independent lives.

Some of the individuals we serve require a focus on public safety. We provide oversight and services to individuals who can't be adjudicated due to cognitive disability or mental illness or who have completed their prison sentence and need ongoing oversight and meet the criteria for our system of care. We also serve individuals coming out of prison who have severe functional impairments that don't meet program eligibility criteria, but do need our services; public safety is a key part of their programming. There are over 200 sex offenders in developmental disability services, plus others in the mental health system.

DA/SSA practices are geared toward the whole person through an array of educational, preventive, early intervention, emergent, acute and long term care, services and supports. When a person walks in the door of one of our agencies we assess, plan and support that individual, their family and their community in relation to their specific needs, strengths and goals. Our psycho-social supports take a strength-based approach that includes social integration and community outreach and education. In doing so, we often

take the lead on coordinating with other health, education and human services organizations. We focus on both physical and emotional well-being and all of our services, particularly clinical interventions, are trauma informed. Our practices promote human rights, oppose discrimination and reduce stigma related to mental health, substance use disorders and developmental disabilities. Cultural sensitivity and appreciation is a core competence of our network. People with mental health and substance use conditions are often poverty stricken and experience social isolation and trauma all of which can lead to high stress levels and can reduce access to the critically needed primary care services. Management of the social determinants of health as well as access to primary care are necessary to manage the conditions that often co-occur with mental illness and substance use such as diabetes and cardiovascular, respiratory and infectious diseases.

Nationally, approximately one in four primary care patients suffer from a mental health disorder, and over two-thirds with mental health disorders also experience medical conditions – often chronic. Treatment of co-morbid physical and mental health conditions requires close coordination among providers and is central to “whole person” care. The historical divide between behavioral/mental health and physical health services for a person has resulted in fragmented services and continues the stigma of seeking mental health treatment, with the primary care provider often not knowing that their patient is receiving services. Through the Vermont Blueprint for Health, pilots for bi-directional care and health homes are beginning the inter-system communication process yet our information systems have not kept pace.

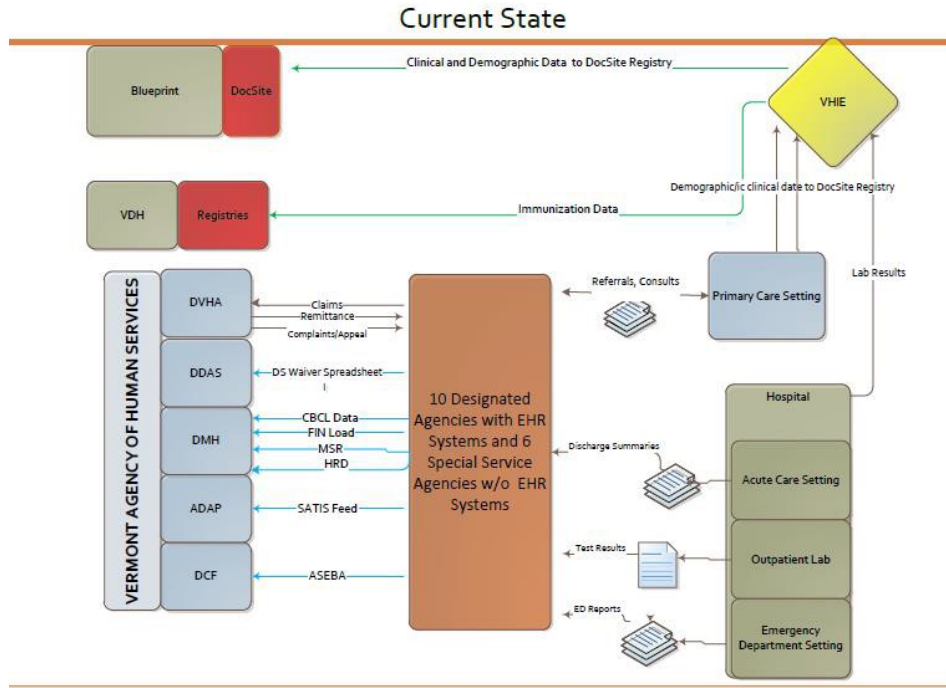
Behavioral health measures, even nationally, are not as advanced as those within the medical industry though the designated agencies are being required to report numerous measures. The National Quality Forum recently launched a new project entitled “Behavioral Health Endorsement Maintenance” seeking to endorse measures for “improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the population, especially those with mental illness and substance abuse”. While it is a good reminder that the process of developing core measures for improving the behavioral health delivery system is still a work-in progress, the State of Vermont and its efforts to reform the health care delivery system are moving full steam ahead.

There are many initiatives surrounding innovation and health care reform in Vermont that impact the designated and specialized service agency system. In many of these (Blueprint, Health Homes and Bi-Directional Care, ACOs, Act 79, Hub & Spoke etc.) the DAs/SSAs are finding redundancies and inefficiencies in data entry and data sharing. As a cohesive provider network, we fully understand the need to unify our data and develop a data dictionary and conduct the remediation necessary to build out our reporting module to meet the performance measure criteria and to build the necessary interfaces with VITL, ACOs and others. The DAs/SSAs do not have the resources to move forward with data programming or project management related to building performance measurements. The need for data is coming faster than we can produce it. This is resulting in little time for regression testing on data products, which leads to a loss in confidence of staff and data integrity.

There is a national effort to advance healthcare quality and reduce costs. Support for the installation and use of electronic health records, use of data registries for population management, and health information exchange technology to provide client specific information at various places of care has been the focus of effort for the past several years. As in other states, this is the case in Vermont for primary and specialty medical services. What is missing, however, is the full inclusion of mental health, developmental disability, and substance abuse information from the DAs/SSAs. The development of an integrated specialty data repository and inclusion in the state’s health information exchange platform will allow for the collection, reporting, and receiving of quality data that can be used to further the electronic transfer of information between care providers for the clients served and to populate registries to be used for population management and cost analyses. Linking to the ACTT 42 CFR Part 2 project will ensure

compliance with federal and state regulations.

While the DAs/SSAs provide a significant amount of data to the State as a funding requirement and some to individual partnering provider agencies, very little of this is done electronically. Additionally, even the data being provided is not interchangeable between departments. That stated the DAs/SSAs have been actively planning and installing EHRs as they strive toward meaningful use and improved care. The chart below was the current state in 2011. Now only five developmental disability agencies do not have an EHR and are working to procure a unified EHR in part through this project. In addition, the Agency of Human Services is working toward a streamlined infrastructure for data collection.



The designated agency system of care is not functioning within the same environment it was even a few years ago. Payment reform models are being piloted, care delivery models are changing and accountable care organizations are being developed. All of this is dramatically impacting the mental health, substance abuse treatment and developmental disability provider community. They are being scrutinized and mandated to report data of all types to various entities. Some required data collection relates to avoiding rate reductions by detailing if agency providers conducted a depression evaluation or suicide risk assessment (CMS). Some is used to measure care coordination between health care providers to determine if improved coordination results in improved care and lower cost. Some program specific outcomes detail whether or not the new funding is resulting in cost reductions in other systems. Meaningful Use data have multiple purposes relating to care coordination, interoperability and more. While all of the efforts around health care improvement and reform are encouraging and exciting, DAs/SSAs are facing clear challenges in addition to the lack of interfaces. This includes consolidation of measures and data integrity to ensure that their data is structured, reliable, and complete and that they have the ability to pass and receive data.

Behavioral Health Network of Vermont (BHN) and The Vermont Council of Developmental and Mental Health Services (The Council), sister agencies working on behalf of the DAs/SSAs, are currently discussing with the State the gaps and opportunities in Vermont's DA/SSA health information

technology environment. The DAs/SSAs will have to do significant work to enable their EHRs to collect and report data elements in part because of EHR customization. DAs/SSAs will need time, structure, and guidance, including the development of a data workbook. This is work that is beginning to take place but it is cost and time prohibitive (nor is it feasible) for each DA/SSA to do this on their own. To use a comparable community partner, the Vermont FQHCs, who serve over 150,000 Vermonters (1 in 4) began the process of data mapping several years ago through a network grant that Bi-State Primary Care Association received. They engaged in intensive, rapid cycle improvements with each of their health centers, focusing on the quality of data and work of the IT staff. The project identified key staff at each center. Bi-State created peer-led Quality and Informatics workgroups to continue this work. The data quality work to take place in this proposal will be based on lessons learned and consultation from Bi-State.

In November 2012, the University of Colorado asked Bi-State and the FQHCs to join a provider-based research network, *SAFTINet*, which receives claims from Medicaid and matches them with clinical data feeds from the health centers. While not real time, the FQHCs would not be able to include their data in this network without a prior investment in data quality and storage. The recent ACO/VITL HIE proposal builds gateways for the ACOS to analytic platforms to support population collaborative health information exchange. The analytic platforms for the ACOs will most likely be different. OneCare will be using Northern New England Accountable Care Collaborative (NEACC). CHAC's goal is to integrate real time clinical data with claims data, coupled with the capability to produce reports that drive care management and cost initiatives. It is the goal of both ACOs to receive data from the DAs/SSAs. The work funded through this project will enable DA/SSA data to be structured, reliable and complete and thus passable from the DA/SSAs into the ACO analytic platforms and utilized to determine appropriate care coordination and treatment.

Structured, reliable and complete data that can be aggregated by Blueprint area, hospital service area, county or statewide, will benefit the Vermont Blueprint for Health work as well. We know DA/SSA services are complimenting the Blueprint due to increased referrals and some of the data demonstrated in the Blueprint's most recent annual report. From the report, one sees a visible service shift from high medical cost services to specialized services. People are beginning to get the right services from the right providers at the right time. Right now, however, DA/SSA data is not integrated into the Blueprint work. The work of this proposal would enable the DAs/SSAs to align their work, their data and their quality improvement efforts more closely with the Blueprint for Health. This is also important as the DAs/SSAs and the state continue to assess the feasibility of health homes for those with serious mental illness.

All of the health care reform activities, including the development of the ACOs, are resulting in a clear need for the designated agencies to be able to have structured reliable, complete and actionable data. It is essential that the system works to develop a process and document that cross-walks all mandated data reporting requirements. The system as a whole, through BHN, needs to clearly detail reporting requirements for: CMS – Medicare PQRS; Meaningful Use; ACOs; Agency for Human Services (both funding and outcomes); and for outcomes identified using Results Based Accountability at the program level, division level, agency level and for population management. All of this data is required for continued funding, for improvement in care delivery through best practice work and enhanced care coordination and for demonstrating value to ACOs and others. Without an infusion of resources at this time, the DAs/SSAs will fall behind in the inclusion of health care reform and will not be able to compete in a resource tight environment that already prioritizes the medical model of care delivery. Given the past, present and future investment the state makes in the DA/SSA system of care the investment in the enhancement of data accessibility is both necessary and logical. Through the work of BHN, The Council and most importantly, the agencies, the DAs/SSAs are on the cusp of being recognized for their value in a system of care delivery that ideally should care for the whole person. Information technology and the exchange of health information are essential tools in caring for the whole

person and reaching another level of parity for those with mental health conditions and developmental disabilities.

Ten of Vermont's DAs are currently using various electronic health record (EHR) platforms all at different levels of implementation and functionality. Only one SSA has an EHR in place and the others are looking to purchase through the same vendor in an efficient manner. In 2010, the Vermont Council received a State Health Information Technology Fund grant to conduct a readiness assessment of the designated agencies and the Vermont Agency for Human Services (AHS). The purpose of this assessment was to conduct a gap analysis of existing activities and to identify what the DAs/SSAs needed to do to be able to utilize the VHIE to communicate their clinical and administrative information. Some of the highlights of the report are as follows:

- Use of the VHIE for transmission of lab results is a near term opportunity.
- Privacy and compliance concerns present a significant obstacle to bi-directional exchange of clinical information. (42CFRPart2)
- The level of structured & standardized data needs improvement.
- There are opportunities for further collaboration among members around data standards and EHR best practices.
- Using the VHIE to transmit data to AHS is not yet feasible.
- The EHR vendors used by the members have little experience in standards based HIE.

The DAs/SSAs are collecting considerable and needed amounts of data. That said, it is not uniformly structured, reliable or complete and they are not able to share it easily with community partners and ACOs. They are also not able to utilize it to demonstrate system-wide value in an efficient manner or to benchmark against each other to improve the delivery of the care they provide. Without the full inclusion of the DAs/SSAs into the state's health information infrastructure, the goals to improve the health of the population at both the local level and statewide cannot be realized. The ACTT:DQR project is based on the needs identified in the readiness assessment as well as on the need to meet the goals of health care reform, inclusive of the accountable care infrastructure to reform payment and enhance care coordination and integration while improving quality and lowering costs.

PROJECT OBJECTIVES

The ACTT:DQR project will enable DAs/SSAs to have structured, reliable and complete data that can be transmitted electronically and used to: strengthen communication with community partners; enhance care coordination with primary care and other care continuum providers; improve the quality of care across the network to improve health outcomes; demonstrate the value of the network; promulgate best practices of integration; increase the ability of DAs/SSAs to report to, and work with ACOs, the State and other entities to which they are in partnership or accountable; expand the comprehensive relevance of the data the state uses to determine policy and practice; and utilize the network to work with ACOs and community partners to improve health outcomes and decrease cost.

Deliverables:

- 1) Move system-wide clinical workflows "above the line" in structured data fields within EMRs to build accurate measurements with the correct numerators and denominators.
- 2) Build the tools (based on lessons learned from Bi-State's data quality work) to document data development decisions and provide a roadmap to gain control of data integrity for the long-term. Develop toolkit for use statewide and for use by other community-based providers.

- 3) Design and build the data warehouse to support system-wide data as it continues to be developed.
- 4) Build out reporting module to meet the performance measurement criteria.
- 5) Build interfaces with VITL, ACOs, State HIT etc.
- 6) Assist in the procurement of a unified EHR for five developmental disability agencies.

HIGH LEVEL WORK PLANS

High Level Work Plan for Data Quality

All agencies need to build internal infrastructures that have system-wide uniformity. In order to do that, a data dictionary needs to be developed as well as a toolkit (common measurement grid, common element grid, workflow, staffing structure etc.) that can be utilized statewide. The process for development is based on the best practice quality work implemented by the federally qualified health centers.

1. Needs Assessment: Identify data and reporting needs

- Convene stakeholders
- Engage Data Quality Consultant, NCSS Program Analyst and BHN Quality Staff
- Identify most essential data elements and required data structure based on information needed for reporting, analytics, participation in ACOs, benchmarking, and for participating in standards-based HIE.
- Utilize NCSS pilot and consultation to develop and pilot tools including common measurement grid, common element grid, workflow, staffing structure etc. and to assist in developing training process and schedule for statewide use
- Create Data Dictionary to identify data to be fed into a data repository that can consume uniform data across all payer sources: Medicaid (Monthly Service Report), third party, Medicare etc.
- Confirm final scope/plan and toolkit education and implementation for other providers

2. Current State Analysis:

- Conduct agency specific review and identify gaps based on data
- Document and report to stakeholders

3. Data Quality Remediation

- Work with each agency on improving data quality (structured, complete, semantic standards compliant)
- Develop policies and procedures as needed for data quality
- Re-evaluate agency- specific data quality

4. Project Closing

- Project evaluation and final reporting
- Develop Sustainability Plan

High-Level Work Plan for Data Repository

In parallel with the data quality work, the designated and specialized service agencies will design and build, in consultation with VITL and Bi-State Primary Care Association, a data repository that will consume uniform data across all payer sources: Medicaid (Monthly Service Report), third party, Medicare etc. to be fed to funders (inclusive of CMS, AHS etc.), analytic platforms, ACOs, the VHIE, systems for quality improvement and enhanced care management and more. This will be done in conjunction with the work being proposed around 42 CFR Part 2.

1. Needs Assessment: Identify characteristics of desired solution

- Convene stakeholders (Project Steering Committee: DA/SSAs, VITL, DMH, BSPCA)
- Confirm, finalize and document data analytics and reporting needs
- Confirm, approve and document scope, timeline and participants

2. Project Planning

- Contract with VITL for architectural design build
- Hire Informatics Director
- Sign needed BAA and Data Sharing agreements with agencies and vendors
- DR architectural design build
- DR Selection and Procurement
- Define data sets and data transfer methods
- Obtain estimates from agencies' EHR vendors for data feeds to DR
- Finalize and approve DR technology work plan
- Finalize and approve project budget
- Approve project plan

3. Project Execution

a. Extract data from EHR's and send to Data Repository

- EHR vendor contracting (volume discounts) with agencies' vendors for data feed feeds to DR
- Design, develop and test data feeds to DR according to rollout schedule
- Design, develop and document data upload procedures

b. Develop Queries and Reporting from Data Repository

- Develop policies and procedures for data management and privacy (link with Part 2 Initiative)
- Install and configure database product
- Populate historical data and verify accuracy
- Program and test queries, reports, data transmissions
- Program/acquire and install end user components
- Conduct end user acceptance testing
- Train users
- Begin end user provisioning (user account management)
- Begin running reports in live environment

4. Project Closing

- Conduct project evaluation and final reporting
- Develop Sustainability Plan

DETAILED INITIAL WORKPLAN FOR DA/SSA DATA QUALITY & REPOSITORY

As previously stated, in 2010, Bi-State received and implemented a grant to work with the eight existing health centers to: (1) ensure select FQHC data is structured, reliable, and complete and (2) partner with VITL to build Admission Discharge Transfer (ADT), Continuity of Care Document (CCD), Lab, Radiology, and other interfaces to connect FQHCs and their hospital partner's data in the VHIE. Utilizing data collection tools such as a common measurement grid, common element grid, workflow, staffing structure and more, the FQHCs went through a data mapping process and they engaged in intensive, rapid cycle improvements with each of their health centers, focusing on the quality of data and work of the IT staff. The data quality work to take place in this proposal will be based on lessons learned and in consultation from Bi-State.

Based on conversations with VITL, there may be existing infrastructure for a data repository function that could be leveraged at VITL and that the development of this data repository would then enable feeds into VHIE (along with overcoming the 42 CFR Part 2 barrier). When we conduct the architectural design and build, we will involve the necessary stakeholders including VITL, AHS, DA/SSA staff. Through that process we will make the best determination about whether it can be housed at VITL or not. The VITL infrastructure build-out would leverage the opportunity for other provider agencies to store data at VITL as well. Instead of building our own infrastructure, it is our intent to use the emerging VITL data warehouse and analytics tools to manage our data and perform required reporting and potentially analytics. The feasibility of that will be determined by VITL's ability to meet our needs and VITL's ability to build its data warehouse and analytics tools. The existing VITL infrastructure has the necessary server capacity, security, interfacing capability and core data warehousing and data quality tools. To this infrastructure, VITL plans to add data collection tools which can extract data from EHRs and analytics in the next 12 months. VITL already has plans to implement clinical interfaces for patient demographics (ADT) and care summaries (CCDs) for the designated agencies as part of its DVHA grant. This data will flow through the VITL interface engine and be collected in the VITL data warehouse. In addition to this clinical data, VITL will extract additional clinical data that is not available in the standard care summary (CCD) using a special data extraction tool. These tools have been successfully used by the FQHCs to help build their SAFTINet warehouse. To augment the core clinical data VITL will build custom interfaces to collect the MSR data using the states standard format. BHN and VITL have already begun discussion about the feasibility of this project.

Activities	Measureable Process	Outcome Measures	Performance Period	Evaluation Method	Responsible Org/Person
NEED: All designated agencies in Vermont are using electronic health records (at different levels of functionality), but due to inconsistent and non- standard data capture, reporting from these systems is difficult within the agencies and comparative reporting across the network is difficult.					
GOAL A: Ensure high quality clinical data for population health and quality/outcome reporting from DA/SSAs					
STRATEGY: Provide system-wide support and promulgate best practices to ensure that agencies' EHR data is structured, reliable and complete.					
OJECTIVE A.1: Identify data and reporting needs and create data dictionary					
Convene network members and stakeholders to bring them up to speed on the data environment. Engage consultants.		Majority members attend kick off meeting	Qtr 1, Year 1	Meeting attendance	BHN Director
Engage Statewide Informatics Director (PM)/Quality Staff	Contract signed, within budget		Qtr 1, Year 1	Contract signed	BHN Director
Identify most critical data elements and required data structure based on information needed for reporting	List of current reporting requirements		Qtr 2, Year 1	Review of work documents	Informatics Director, Quality Staff Vermont Council

Activities	Measureable Process	Outcome Measures	Performance Period	Evaluation Method	Responsible Org/Person
and improvement (CMS (PQRS/NQF), Meaningful Use, ACO, State Master Grant etc., comparative reporting and benchmarking, participating in standards-based VHIE)	gathered; structured list of critical data elements developed				Outcomes Group
Create Data Dictionary	Data dictionary created and distributed	Outcome measures align with requirements	Qtr 3, Year 1	Review of work documents	Informatics Director
OBJECTIVE A.2: To enable NCSS to pilot discovery process for measurement and HIE and to develop toolkit for statewide use					
Create measure spreadsheets, inclusive of sorting and checking measures and development of measure elements grid	Numerator and denominator for all performance measurements are developed		Qtr 2, Year 1	Review of work documents	NCSS Pilot and Informatics Director
Create swim lanes to identify points within workflows	Visit and staff structures are developed		Qtr 2, Year 1	Review of work documents	NCSS Pilot and Informatics Director
Run through user story exercise to identify key data to be shared with treatment providers – care coordination enhancement	User stories are developed and data is identified		Qtr 2, Year 1	Review of work documents	NCSS Pilot and Informatics Director
OBJECTIVE A.2: To utilized tools statewide and conduct current state EHR capability analysis for DAs/SSAs					
Conduct trainings on toolkit		100% of DA/SSAs receive training	Qtr 3, Year 1		Informatics Director/ Quality Staff
Conduct agency specific review and identify gaps		≥ 80% complete	Year 1	Review of work documents	Informatics Director/ Quality Staff
Work with developmental disability agencies to identify a common EHR platform to allow for efficiencies	Electronic health record selected and procured		Qtr 1, Year 1	Review of work documents	BHN Director/VITL
Document and report to stakeholders	Ongoing reporting to stakeholders following communication plan		Year 1		BHN Director/ Quality Staff

OBJECTIVE A.3: To remediate data quality					
Work with each agency on improving data quality (structured, complete, semantic standards compliant)		# agencies able to provide quality data	Qtr 3, 4 Year 1	Review of work documents	Informatics Director/ Quality Staff
Develop system-wide policies and procedures as needed for data quality	Policies and procedures are consistently applied across stakeholders	# or % policies developed and consistently applied across stakeholders	Qtr 4, Year 1	Review of work documents	BHN Director/ Quality Staff
Re-evaluate agency-specific data quality	Review of agency data systems		Qtr 1, Year 2	Review of work documents	Informatics Director/ Quality Staff
OBJECTIVE A.4: To inform the network providers of documentation requirements moving forward					
Develop communication plan	Review plan by network members	Plan developed	Qtr 4, Year 1		BHN Director
Provide DA/SSA specific education around workflow redesign	Presentation developed	75% satisfied with educational opportunity	Year 2	Survey	Informatics Director/Quality Staff
NEED: Access to a reliable data source of up-to-date and standardized data for all DAs/SSAs is essential for all network members and stakeholders (reporting, enhanced care management, inclusion in ACOs, benchmarking, quality improvement)					
GOAL B: Aggregate data for individual agency and network-wide analysis and reporting through adoption of a data repository					
STRATEGY: Develop a secure data repository populated with demographic, service and clinical data from agencies EHR systems.					
OBJECTIVE B.1: To conduct a needs assessment to identify characteristics of a desired solution for data repository					
Convene network members and other stakeholders	Monthly meetings	% stakeholders attending	Quarterly	Review of minutes	BHN Director/NCSS Pilot
<i>Research and resolve issues related to 42CFR Part 2(Link to Part 2 Project)</i>	<i>Policy related to 42CFR Part 2 written and accepted</i>		<i>See ACTT 42 CFR Part 2 Proposal</i>	<i>Review of work documents</i>	<i>BHN Director in conjunction with Part 2 Team *Part of a separate proposal but linked</i>
Confirm, finalize and document data analytic and reporting needs and review in subsequent years	Final documents developed		Qtr 4, Year 1 Qtr 3, Year 2	Final documents presented to key stakeholders	Informatics Director
Assess cost and benefit of repository options and other data collection options and conduct architectural design process	ROI created		Qtr 4 Year 1	Review of ROI	Informatics Director/VITL
Agree on direction and roadmap for repository and statewide health information exchange		Majority approval by stakeholders	Qtr 4 Year 1	Signed agreements in place	BHN Director/Informatics Director/VITL
Confirm, approve and document scope, cost and timeline of repository		Majority approval by stakeholders	Qtr 4 Year 1	Signed agreements in place	BHN Director/Informatics Director/VITL
OBJECTIVE B.2: To execute repository project					
Acquire necessary staff for data repository if necessary (internal and/or contract staff) See budget	Number of staff identified		Qtr 4 Year 1	Staff engagement	BHN Director
Begin process for purchase or contracting of data repository			Qtr 4 Year 1		Informatics Director /BHN Director

Confirm data sets and data transfer methods	Project plan confirms information		Qtr 1 Year 2	Review of final data set	Informatics Director
Obtain estimates from agencies' EHR vendors for data feeds to repository	RFP defined and distributed	Requested information returned within 30 days	Qtr 1 Year 2	Review of working documents	BHN Director
Ensure data security	Conversations and meetings occur to formulate agreements	Signed BBAs and Data Sharing Agreements with agencies and vendors	Qtr 1, Year 2	Signed agreements in place	Informatics Director
Approve project plan	Project plan approval given by stakeholders		Qtr 1, Year 2	Signed agreements in place	BHN Director
EHR vendor contracting (volume discounts) with agencies' vendors for data feeds to repository	agreements written and executed		Qtr 1, Year 2	Signed agreements in place	Informatics Director
Design, develop and test data feeds according to rollout schedule		# stakeholders participating in test environment	Qtr 2, Year 2	Data reporting	Informatics Director
Develop policies and procedures for data management and privacy	Policies and procedures are consistently applied across stakeholders	# or % policies developed and consistently applied across stakeholders	Qtr 2, Year 2	Review of work documents	Informatics Director
Populate historical data and verify accuracy		% Historical data successfully populated	Qtr 3 Year 2	Review of reports	Informatics Director
Develop and test queries, reports, data transmissions	Testing process developed and implemented		Qtr 3 Year 2	Report of work documents	Informatics Director
Acquire and install end user components		# End users with all needing equipment installed	Qtr 3 Year 2	Query of stakeholders	Informatics Director
Conduct end user acceptance testing		# End users able to transmit data successfully	Qtr 3 Year 2	Review of reports	Informatics Director
Begin running reports in live environment		# Reports successfully run	Qtr 4 Year 2		Informatics Director
Conduct project evaluation and final reporting			Year 1 Year 2	Review of work documents, satisfaction surveys	BHN Director, Informatics Director and Quality Staff
Develop full implementation and sustainability plan for repository	Stakeholders develop coherent plan		Qtr 3 Year 2	Plan developed and approved	BHN Director Informatics Director

STAKEHOLDERS/CUSTOMERS

- All designated and specialized service agencies and their clients (both billable and non-billable)
- All community partners including, but not limited to: FQHCs, Home Health and Hospice Agencies, AAAs, SASH, hospitals, private practitioners
- The Agency of Human Services (DMH, DVHA, DOH, ADAP, DAIL etc.)
- Blueprint
- OneCare
- CHAC
- Vermonters who are accessing the community-based system of care

TEAM MEMBERS (to include)

Name	Position/Role
Simone Rueschemeyer	Director BHN, Grant Manager
Council/BHN Outcomes Group	
Council IT Directors Group	
TBD	BHN Informatics Director/Project Manager
TBD	BHN Quality Staff
TBD	VITL Staff/Consultant
Steve Maier	DVHA
Nick Nichols, Brian Isham	DMH
Heather Skeels Elise Ames	Bi-State Primary Care Association/HIS PROs Consultants
Amy Putnam	NCSS, CFO, TBD
TBD	DAIL
TBD	DOH/ADAP
Brendan Hogan	Bailit Health Purchasing
Nick Emlen, Marlys Waller	Vermont Council

BUDGET

COST SUMMARY	TOTAL	Year 1	Year 2	
BH Data Repository*	\$692,278	*Not to exceed. Over \$100,000 less if we utilize VITL. See side by side comparison. See chart below for two options.		
Legal	\$25,000	\$20,000	\$5,000	
DS Infrastructure	\$400,000	\$400,000		Unified EHR for 5 DS agencies. *Actual @\$900,000
DA IT/Pilot Work	\$387,560	\$387,560		IT/Data Staff at each site for 3 month for data quality remediation work (rest in-kind) + pilot site
2 yr. Part-Time Quality Staff	\$90,000	\$45,000	\$45,000	*Includes Overhead
2 yr. System Informatics Director	\$240,000	\$120,000	\$120,000	*Includes Overhead/Project Manager
2 yr. BHN Admin Oversight	\$42,000	\$21,000	\$21,000	*Includes Overhead / BHN Director
IT Consultation	\$60,000	\$50,000	\$10,000	IT Consultation
Travel	In-Kind			
IT Staff beyond data quality remediation	In-Kind			
Council Outcomes Group	In-Kind			
Council IT Directors Group	In-Kind			
TOTAL	\$1,939,838			*Data hosting and Database admin. Cost will be ongoing and included in sustainability plan.

DATA REPOSITORY COSTS				
Service	Creating a DA/SSA Repository		Integrating with the VITL Repository	
	Cost	Assumptions	Cost	Assumptions
Database and Analytics Software - monthly fees	\$ 72,000	hosting fees at \$3000/month for 12agencies; assume fees begin at first productive use beginning (24 months)	\$ -	Would utilize the VITL data warehouse
Repository Design & Setup (database, query engine, reports, measures)	\$87,500.00	Vendor/consultant fee: Setup and configure, 500 hours at \$175/hr., vendor staff	\$125,000.00	Consulting fees to set up a separate data mart for the DAs
Transaction Engine software for interface - upfront fees	\$75,000.00	commercial product	\$21,000.00	Would utilize the VITL interface engine but need 12 new connections at \$1750 ea
Transaction Engine software for interface - monthly fees	\$15,000.00	hosting fees at \$1500/month for 12 agencies; assume 24 months	\$24,000.00	VITL infrastructure wil need upgrade
Repository to VITL data feeds (set-up)	\$35,000.00	Vendor fee: configure ADT & CCD interfaces, 200 hours * 175/hr.	\$0.00	Not needed when using VITL. Vendor fees for clinical interfaces (ADT, CCDs) are funded in DVHA grant.
Client software (end user access)	\$6,578.00	2 copies/agency + BHN * 299 ea.	\$57,500.00	Visual Analytics Tools for DA's (3 users)
EHR data feeds to repository for 12 participants	\$96,000.00	EHR vendor cost: Average 8K/agency for 12 agencies for data feed to repository	\$0.00	Covered by VITL
EHR Extraction Tools	\$60,000.00	For interfaces to the VITL data warehouse (Cina)	\$60,000.00	For interfaces to the VITL data warehouse (Cina)
Database Administration	\$109,200.00	Assumed Staff Cost: .5 FTE for 2 years * \$70/hr.	\$130,000.00	Assumed VITL staff cost: .25 FTE at \$125/hr
VITL Staff Time (interfaces and data analytics)	\$130,000.00	Assumed Staff Cost: .25 FTE for 2 years * \$125/hr	\$130,000.00	Assumed Staff Cost: .25 FTE for 2 years * \$125/hr
Analytics Tools Training	\$6,000.00		\$7,500.00	Training for 3 users
			\$0.00	VITL has already done the Data Use Agreements and BAA
Total	\$692,278.00		\$555,000.00	

ACTT PROJECT 2: LTSS DATA PLANNING

NARRATIVE

Introduction

We propose an additional investment in planning to better understand and design how LTSS providers will engage with the Vermont Health Information Exchange (VHIE) to: exchange information, report to Accountable Care Organizations (ACOs), and engage in analytics for population health management and enhanced and efficient care coordination. With contracted assistance, LTSS providers will identify data and reporting needs as LTSS providers are integrated into ACOs.

The LTSS providers involved with *Advancing Care through Technology: Long Term Services and Support Phase One Planning project (LTSS Planning)* include the Area Agencies on Aging, Adult Day Provider, Designated Agencies for Developmental Services and Mental Health Services, Home Health Care Agencies, Residential Care Homes and Nursing Homes.

In addition, this consortium of providers is working with leadership within the state Agency of Human Services as well as with contractors for the state. The LTSS Planning project is divided into three sections: data identification and reporting needs; information technology gap analyses; data selection and reporting needs.

Long Term Services and Supports Background

Vermont is nationally known for its long term services and supports system Vermont's system has moved in a direction of balancing the need for quality institutional care with increasing quality home and community based services. For several decades up until 2005, Vermont had a series of section 1915c waivers and a section 1115 waiver as the authorities for Medicaid. Since 2005, Vermont has had two section 1115 Medicaid waivers known as Choices for Care and Global Commitment to Health. Under the Choices for Care waiver, individuals who are both clinically and financially eligible for long term care Medicaid have had an equal entitlement to access either nursing home services or home and community based services. Under the Global Commitment to Health section 1115 Medicaid waiver several former section 1915c waivers are included such as: Developmental Services program, Community Rehabilitation and Treatment program and Traumatic Brain Injury program.

In addition to state and federal funding through Medicaid, LTSS provider also receive a variety of other funding sources including not limited to: Medicare, Commercial Long Term Care Insurance, Veterans Benefits, State and Federal Grants, Federal Older American Act Funding, Section 110 Vocational Rehabilitations Funding among other sources. These funding sources pay for other program requirements and do not pay for advances in technology.

The individuals who are served by these LTSS providers are adults of all ages, both frail elders and younger individuals with disabilities. The services provided for these individuals include and are not limited to: social support; functional assistance with activities of daily living ADLs (eating, bathing, dressing, toileting and transfer); employment supports, housing supports, case management, meals on wheels, congregate meals, adult day services, assistance with instrumental activities of daily living (shopping, cooking, cleaning, money management).

Vermont's Long Term Services and support provider vary in size and information technology capability.

Some providers are larger and have access to or may be planning access to electronic medical or health records. Most are smaller and have limited access to technology and would likely be able to use lower tech options of communicating with other LTSS, Behavioral Health and Medical providers.

Vermont's LTSS providers are the front line for frail elders and individuals with disabilities. They will be uniquely qualified to provide the medical community, especially primary care providers, with information in as a real time basis as possible about the state of the person that they both serve. For example either a van driver or an adult day program staff may learn something about a participant's health status (like challenges with diabetic medications) and can in consultation with a primary care office to resolve the issue in a more real time way if communication between the LTSS provider and the primary care provider is improved.

Vermont has recently embarked upon a new ACO effort through its Medicaid program contracting with two existing Medicare ACOs: OneCare and Community Health Accountable Care/CHAC. In 2015, the State anticipates bringing in Medicaid eligible beneficiaries who qualify for Medicaid by meeting eligibility criteria for being Aged, Blind or Disabled (ABD). Many of these individuals receive medical and non-medical from providers throughout Vermont. This project will allow the state to define and track data that shows outcomes related to the ABD population in the Medicaid ACOs and other VHCIP payment test models involving this population. The ability to better define and track data will have implications beyond the Medicaid ACOs and will likely lead to better integration of information across providers and improvements in care for Medicaid ABD eligible Vermonters.

LTSS providers in Vermont have undergone two analyses to determine readiness and opportunities to engage in health information exchange. In September 2012, H.I.S. Professionals conducted an analysis to identify: Opportunities for Home Health Agency Participation in the Vermont Health Information Exchange on behalf of the Vermont Assembly of Home Care and Hospice Agencies. In June 2013, H.I.S. Professionals assessed opportunities in a document entitled: Health Information Technology in Vermont Long Term Care Facilities – Current State and Opportunities on behalf of the Vermont Health Care Association.

Themes from the H.I.S. professionals analysis of LTSS providers:

For Nursing homes

- 26 Nursing home and Residential care home providers had an Electronic health record (of 66 providers surveyed)
- 4 different vendors service these providers including: point click, high-tech software, American data system and Elder mark
- Many facilities without EHRs are not planning on purchasing an EHR due to lack of resources both financial and staffing to both implement and run EHR systems.

For Home Health providers

- The VAHHA members identified that it would be valuable to receive electronic notification from hospitals that a patient on home care service has been admitted to a hospital emergency room or as an inpatient. The VAHHA members identified that it would be valuable to receive demographic and summary of care information electronically upon transition of care – both at initial referral and when information is updated by other providers.

PROJECT OBJECTIVES

Moving beyond the knowledge gained from these analyses, an additional investment in planning needs to occur to better understand and design how LTSS providers will engage with the VHIE to: exchange information, report to ACOs, and engage in analytics for population health management and enhanced and efficient care coordination. With contracted assistance, LTSS providers will identify data and reporting needs as LTSS providers are integrated into the Medicaid Accountable Care Organization (ACO) in 2014 and 2015. This work will also support exchange of information for LTSS providers for Medicare and other insurance.

This project team will review a list of existing long term care service and support measures that have been collected by the Agency of Human Services Quality Assurance and Quality Improvement team as part of Vermont's Global Commitment to Health 1115 Medicaid waiver. The list needs to be narrowed to select measures that will assist both the state and federal government in determining the impact of the Medicaid ACO in coordination of services for individuals who are eligible for Medicaid under Aged, Blind and Disabled eligibility requirements and receive behavioral health and long term service and support services. Collecting this information and using the data to inform the state on improvements that have occurred in the Medicaid ACOs will have impacts that go beyond the ACOs themselves. Establishing the capability to collect LTSS measures can potentially help with outcomes for Non-ACO members that are served by the same LTSS providers.

In addition, with contracted assistance, the LTSS providers will update and/or conduct information technology gap analyses for each provider, relative to enabling or remediating its ability to electronically submit data to VITL on LTSS measures. Some provider groups will need to have analyses updated, such as 10 Home Health Agencies, 22 Skilled Nursing Facilities and 68 Residential Care Facilities. Other providers and provider groups may need to have analyses both started and completed, including all 5 Area Agencies on Aging and 14 Adult Day Centers and all of the remaining SNF and RCHs.

HIGH LEVEL WORKPLAN

The LTSS data planning process will begin by identifying the data and data reporting needs of ACTT Partnership, as described in Part A below. Concurrent with the activity described in Part A, the planning process will also include updating and/or conducting LTSS Information Technology Gap Analyses and Development of budgets for remediation, as described in Part B below. Once Parts A and B are completed, the planning process for LTSS Data Transmission and Storage Analysis, Implementation Plan and Budget will take place, as described in Part C below.

Part A Workplan - LTSS Data Planning

- In May 2014, review Behavioral Health and Long Term Services and Supports measures that have been proposed for use in the Medicaid ACO program for consideration by the following VHCIP workgroups:
 - a. Quality Measures Workgroup
 - b. Disability and Long Term Care Services and Support Workgroup
 - c. Care Management and Care Models Workgroup
 - d. Population Health Workgroup.

- Form a subgroup of individuals from these workgroups to develop and recommend a limited list of both outcome and process measures. The subgroup will prioritize a limited list of no more than 5-8 measures that reflect process and outcome changes that advance the triple aim for LTSS health integration using the following criteria:

Attribute	Description
<i>Importance</i>	Impact on health, costs of care; Potential for improvement, existing gaps in care, disparities
<i>Evidence</i>	Scientific evidence for what is being measured
<i>Validity</i>	Does the measure capture the intended content?
<i>Reliability</i>	Precision, repeatability
<i>Meaningful Differences</i>	Is there variation in performance? Is there room for improvement? Include both qualitative and quantitative measures.
<i>Feasibility</i>	Susceptibility to errors or unintended consequences • Note: outside expertise may be needed to determine feasibility of potential measures.
<i>Costs of data collection</i>	Burden of retrieving and analyzing data
<i>Usability</i>	Testing to see if users understand the measure • Results should be usable as strategies for improving care
<i>Actionable</i>	Results of measurement should be used for quality improvement.
<i>Standardized</i>	Measures should be based on national standards and calculated using consistent methods.

- Convene stakeholders.
- By early June, capture comments and responses in a written report to be submitted by the subgroup with proposed limited Measures list to the QM workgroup for approval and advancement to the Steering Committee and Core Team.
- By November 2014, determine and propose a phase 2 budget to the VHCIP HIT-HIE Workgroup for IT needs in implementing the collection and reporting of information tied to the agreed upon measures.

Deliverables	Est. Date
Kick off planning meeting with ACTT partners, state staff and contractors	May 2014
Create a detailed report from kickoff meeting –	May 2014
Give presentations to a series of VHCIP workgroups	June and July 2014
Update measures list and develop a process for prioritizing measures	July and August 2014
Work with ACOs on agreeing upon measures that work across both ACOs and ACTT providers	July 2014 through October 2014
Develop and propose Phase 2 –budget for implementing measures and IT resources necessary to implement the measures	November 2014

Part B Workplan - Update and Conduct LTSS Information Technology Gap Analyses and Develop Remediation Budget

- Work with Vermont Health Care Association (VHCA), Vermont Assembly of Home Health and Hospice Providers (VAHHA), Vermont Association of Area Agencies on Aging (VAAAA),

Vermont Association of Adult Day Services (VAADS), on updating and/or conducting information technology gap analyses.

- Conduct and update gap analyses for as many of the providers listed in item 1 above as necessary to assure effective means of assuring provider has the ability to electronically submit data to VITL on LTSS measures.
- Determine and propose a phase 2 budget for IT needs remediating as many gaps in IT for all providers listed in item 1 above as practicable. The budget should take into consideration both short-term low-tech implementation work and longer term high-tech implementation. The phase 2 budget should take into consideration other funding sources that could pay for IT remediation.

Deliverables	Est. dates
Work with state staff and all ACTT provider networks who have previously been interviewed for IT gap analysis and reach out to remaining members to complete IT gap analysis	May 2014-September 2014
Create a findings report	October 15, 2014
Work with state staff and Area Agencies on Aging and Adult Day Centers on conducting IT gap analysis	May 2014-September 2014
Create a findings report	October 15, 2014
Create a phase 2 budget request based on information found in phase one and taking into consideration both low-tech and high –tech options	November 1, 2014

Part C Workplan: LTSS Data Transmission and Storage Analysis, Implementation Plan and Budget (Deliverables: Not Funded until Sections #1 and #2 are completed)

- Use the gap analyses to inform work on identifying and developing data transmission, exchange and storage requirements for ACTT providers
- Create a Transmission and Storage Plan that includes options for both short-term low-tech and longer-term high-tech implementation options.
- When creating the Transmission and Storage Plan create a process that promotes both exchange of information and exchange of data in the most effective and cost efficient manner based on a provider by provider “as-is” program analysis compared to future program work where ACTT providers are connected with the Medicaid ACOs in 2015.
- Create a Phase 2 budget for implementing data transmission and storage analysis plan

Draft Deliverables	Est. dates
Use gap analysis information to create outline for a data transmission and storage analysis plan	November 2014
Work with state staff and ACTT providers to complete data transmission and storage analysis plan	November 2014
Use plan to create a phase 2 budget request based on finding from phase one taking into consideration both low-tech and high-tech options	November 2014

BUDGET

Phase 1 – Workplan Part A and Workplan Part B - all costs for six months of planning with VITL, H.I.S professionals and other contractors and/or LTSS provider stipends as needed.

Contractor	Hourly rate	# of hrs for 6 months	Total
Project Management	\$214/hour	140	\$30,000
VITL	\$200/hour	240	\$48,000
IT Consultation	\$250/hour	240	\$60,000
Other contractors and/or LTSS provider stipends			\$40,000
Total			\$178,000

STAKEHOLDERS/CUSTOMERS

- People receiving services
- All of the Associations listed previously as well as the providers in these associations
- Agency of Human Services
- Department of Disabilities, Aging and Independent Living
- Department of Mental Health
- Department of Health
- Department of Vermont Health Access
- Green Mountain Care Board
- Medicaid ACOs

TEAM MEMBERS

Name	Position/Role
Brendan Hogan – Bailit Health Purchasing	Project Manager
Marybeth McCaffrey – DAIL	DAIL lead
Nancy Marinelli – DAIL	DAIL Data and IT
Tela Torrey – DAIL	DAIL Data and IT
Brian Isham – DMH	DMH Data and IT
Alicia Cooper – DVHA	DVHA Quality Improvement
Amy Putnam – NCSS	DA rep
Heather Johnson	ADRC rep
Sheila Burnham	VHCA rep
Arsi Namdar	VAHHA rep
Lisa Viles	AAA rep
Trevor Squirrel	BIA rep
Virginia Renfrew	Adult Day rep.
Mike Gagnon	VITL rep
Simone Rueschemeyer – BHN	Member
Steve Maier – DVHA	Member
Terry Bequette – AHS	IT assistance
Larry Sandage – DVHA contractor	Staff/consultant assistance - IT

ACTT PROJECT 3: UNIVERSAL TRANSFORM FORM

NARRATIVE

This project proposes to improve care integration by developing and implementing a common communication tool: a Universal Transfer Form (UTF Form). The UTF requires financial support and a partnership between several types of providers across the care continuum. It will support modernized exchange of information essential for effective transitions for people with the most complex, chronic, and long-term needs for services and support. Specifically, the focus will be on transitions for people who qualify for Medicaid by meeting eligibility criteria as Aged, Blind or Disabled (ABD). The work also will benefit those who qualify for Medicare and who purchase commercial health insurance. A primary focus on the cohort that qualifies for Medicaid simply assures that the UTF meets the needs of people with the most complex, chronic and long-term needs for services and supports.

Vermont providers receive an estimated \$850M per year¹ to deliver a diverse range of services² to help about 40,000 Vermonters³ live as independently as possible. Today the mode of communication between these various types of providers remains manual via paper, fax or telephone. This project is a significant opportunity to improve comprehensive and integrated service delivery and care coordination. The UTF will enable bi-directional electronic and other types of improved communication to support people with the most complex, chronic and long-term needs for services and supports needs on the health continuum.

Currently home health agencies, nursing/rehabilitation facilities, and hospitals support the highest volume of people moving from one setting to another. Technical planning support is needed to assure consistent, coordinated progress to meet the goal of a UTF. This planning support will be used to engage a collaborative of different types of providers and people who want to develop standardized transfer information. To the extent feasible, solutions considered will be based on reusable and expandable technology, such as continuity of care documents (CCD) based on emerging national standards of information related to transitions. It will assist multiple types of providers to examine their current transfer communication processes.

Investment in planning for the design, development and implementation of a standardized form enabling the bi-directional exchange of information specific to transfers between different types of providers meets two of the HIW workgroup goals. The ability to exchange information electronically between several types of providers on the health continuum will enable enhance care coordination, focus on prevention rather than intervention, and improve the overall quality of care being provided.

PROJECT OBJECTIVES

The planning process will result in a detailed description of an improved transfer system between at least 3 types of providers, including one reliant on web-based tools and who has no intent to adopt an electronic medical or health record system in the future.

¹ ACTT Medicaid enrollees account for 55.2% VT Medicaid costs (\$1.18 billion) and roughly, 25% of VT Medicare costs (\$1.35 billion).

² Services include mental health, substance abuse, developmental disability, personal care, social support, prescriptions, and medical.

³ This group includes people who are eligible for Medicaid because they meet eligibility as aged, blind, or disabled, and is inclusive of those who receive Medicare as well as Medicaid.

HIGH LEVEL WORK PLAN

Technical support for the planning process will enable providers, and other interested parties, to identify the current challenges, future vision, and communication bridges to more seamless delivery of services and supports during care transitions. The plan will include proposed solutions for professionals, families, and consumers. For professionals, it will take into consideration those with and without electronic health record (EHR) systems; the UTF must support providers with high-tech and low-tech infrastructures. For consumers and their chosen supporters, the UTF must convey information relevant and understandable to their care transition. Once implemented, the UTF will enhance care coordination and improve the overall quality of care provided.

For the period April 2014-August 2014 we will develop a detailed project charter that supports the design of a Universal Transfer Form (UTF).

By October 2016, contingent on available funding, we will design, develop and fully implement Universal Transfer Form that can be transmitted electronically and by paper between Vermont providers with the greatest number of transitions between settings to assure seamless delivery of services and supports (“a successful transition”).

The Contractor shall provide support for planning activities and decision-making for development of a Universal Transfer Form including, but not limited to, the following activities:

- Research the unified information transfer forms other states have designed and the processes they have used to implement it
- Define constituencies and create the communication strategy and materials for outreach
- Reach out to and engage stakeholders
- Conduct use case analyses (process maps) to show what happens at the intersection of agency transitions
- Analyze the use case data to create a unified map of effective information transfer and gaps in information transfer
- Convene the Learning Collaborative and define and facilitate their work processes
- Work with the Learning Collaborative to design the initial uniform information transfer form, to define the processes for measuring successes and gaps, and to consider the technologies to be used that meet the needs of EMR users and those that don't use EMRs
- Run scenarios using the form
- Pilot the form with the agencies
- Work with the Learning Collaborative to deliver not only a form but mechanisms to continually evolve the form and keep it current.

Deliverable for Phase One - A detailed Project Charter that includes the following sections:

PROJECT OVERVIEW

PROJECT OBJECTIVES

PROJECT SCOPE

IN SCOPE

OUT OF SCOPE

DELIVERABLES PRODUCED

ORGANIZATIONS AFFECTED OR IMPACTED
 PROJECT ESTIMATED EFFORT/COST/DURATION
 ESTIMATED COST
 ESTIMATED PROJECT OVERSIGHT COST
 AMENDMENT TO “ESTIMATED COST”
 ESTIMATED EFFORT
 ESTIMATED DURATION
 PROJECT ASSUMPTIONS/ CONSTRAINTS
 ASSUMPTIONS
 CONSTRAINTS
 PROJECT RISKS
 PROJECT APPROACH
 PROJECT MANAGEMENT
 PROJECT ORGANIZATION
 PROJECT APPROVALS

Project Milestones	Est. Date
1. Funding request for Planning work (Phase 1) to HIE Workgroup	Feb- March 2014
2. Detailed project charter	April-August 2014
3. Funding request for Design work (Phase 2) to HIE Workgroup	Aug- September 2014
4. Project Design & Potential Solutions	Oct-December 2014
5. Funding request for Solution Procurement (Phase 3) to HIE Workgroup	January 2015
6. Procure software	March-May 2015
7. Signed contract in place	June 2015
8. Pilot software	July – September 2015
9. Make required adjustments and plan statewide implementation	Oct– December 2015
10. Statewide implementation	Jan – October 2016

BUDGET

This is a request for Phase One Funding for Planning of a Universal Transfer Form: The budget request is for Phase 1 and totals \$215,072. Once a detailed plan is prepared, funding will be requested for design, development and implementation of the UTF project, as outlined in the table of Milestones above.

Contractor	Hourly rate	# of hours for 4 months	Total
*Project Management	\$214/hour	48	\$10,272
VITL	\$200/hour	24	\$ 4,800
Contractor/ project consultant	\$250 /hour	640	\$ 160,000
*Other consultants and LTSS provider stipends			\$ 40,000
Total			\$ 215,072

STAKEHOLDERS

- People receiving services
- Taxpayers
- All of the Associations listed previously as well as the providers that belong to these associations
- Agency of Human Services
- Department of Disabilities, Aging and Independent Living
- Department of Mental Health
- Department of Health
- Department of Vermont Health Access
- Green Mountain Care Board
- ACOs (Commercial, Medicare, Medicaid)

TEAM MEMBERS

Name	Position/Role
Brendan Hogan – Bailit Health Purchasing	Project Manager
Marybeth McCaffrey – DAIL	DAIL lead
Jen Woodard – DAIL	DAIL project management support
Nancy Marinelli – DAIL	DAIL Data
Tela Torrey – DAIL	DAIL IT
Brian Isham – DMH	DMH Data and IT
Alicia Cooper – DVHA	DVHA Quality Improvement
Heather Johnson	ADRC rep
Sheila Burnham	VHCA rep (nursing homes and residential care)
Arsi Namdar	VAHHA rep
Lisa Viles	AAA rep
Trevor Squirrel	BIA rep
Virginia Renfrew	Adult Day rep
TBD	Hospital rep
Mike Gagnon	VITL rep
Steve Maier – DVHA	Member
Terry Bequette – AHS	IT assistance
Larry Sandage – DVHA contractor	Staff/consultant assistance - IT

APPENDIX A – ACTT Project 4: 42 CFR Part 2

This project charter is being included as an appendix because no VHCIP funding is being requested at this time. There are several important inter-relationships and inter-dependencies between this project and other ACTT projects and we expect that development and implementation of the HIE and Part 2 Project will require VHCIP funding in the future.

HIE AND PART 2 PROJECT CHARTER

EXECUTIVE SUMMARY

The overall purpose of this project is to develop a plan for implementation of a 42 CFR Part 2-compliant HIE and consent architecture that will enable the legal and appropriate exchange of drug and alcohol diagnosis and treatment information broadly across Vermont.

PURPOSE/PROJECT DESCRIPTION

Scope of Work

The scope of work is to develop a plan for implementation of an architecture to support 42 CFR Part 2 generated data. The plan will identify scope of implementation, funding, resources, functionality and timeframe. The intent is to use existing Medicity infrastructure, however, the proposal will not be constrained by a Medicity only solution. Further, the intent is to implement solutions as quickly and carefully as possible.

Initiation

- Investigation/ Research/ Discovery
 - Document program and HIE Part 2 designs from RI and other states as may be appropriate
 - Information from and site visit to RI
 - Technology review – current and potential capabilities and constraints
 - Legal review – assessment of law and policies and changes that would be required to enable this project
- Design and Options Recommendations
 - Legal review
 - Technology review
 - Business Process review
- Develop an implementation plan

PROJECT JUSTIFICATION

Vermont's Full-Spectrum Providers (e.g., mental health, home health, long-term care, and other community providers) need to be fully engaged and connected with health information exchange if we are to achieve our broad health reform objectives. Some of these providers (and others such as FQHCs) operate at least some of the time as federal 42 CFR Part 2 programs. We (i.e., the State, VITL, community providers) need to work aggressively to address and resolve issues around HIE and Part 2 for at least the following reasons:

- Existing programs and initiatives, including the Blueprint for Health and Hub & Spoke, are already being constrained
- New reforms, including those under VHCIP (a.k.a. SIM), depend on the increased engagement of (and the sharing of health information from and with) designated agencies and other community providers, and even the basic connection of these entities to the VHIE will require the resolution of practical, technological, and legal issues.
- One of the Governor's top priorities for this next year will be to make changes and more progress with substance abuse treatment programs.
- The DAs and other community providers (including FQHCs) are clamoring for us to engage with them and others to work through these issues.

RISKS

- Legal constraints
- Technology constraints
- Funding and resources
- Engagement, acceptance, and capabilities among providers
- Federal Education Rights Privacy Act (FERPA) considerations

DELIVERABLES

- A logical architecture for a legal and technical approach to storing and sharing drug and alcohol diagnosis and treatment information broadly across Vermont.
- An implementation plan, to include:
 - Budget
 - Resources
 - Schedule
 - Functionality
 - Risk
- Identify project team for the implementation

SUMMARY MILESTONES

- Phase 1 completion within 3 months

BUDGET

The project will use in-house staff, and will be funded by existing operating budgets of the respective entities.

VITL legal counsel will be funded by VITL. Any other legal counsel will be funded by DVHA.

STAFFING

Project Chairs: Steve Maier and Mike Gagnon

Project Staff Resources:

- State: Terry Bequette, Larry Sandage, Martha Csala, Bessie Weiss, Howard Pallotta
- VITL: John Evans, Sandy McDowell, Carol Kulczyk
- Legal: Anne Cramer
- Provider Community: Simone Rueschemeyer, Amy Putnam, Heather Skeels (and/or someone else representing FQHCs)

OTHER RESOURCES

- Consultant: Katie McGee, Linn Freedman (attorney from RI), Michael Lardiere (National Council for Behavioral Health)
- Federal: SAMHSA, ONC

Additional Attachment - VITL Contracting

Source of Funds	Summary Scope of Work	Deliverables	Amount	Time for project completion
<i>DVHA Base Contract</i>			<i>All budget numbers reflect those in the most recent recast VITL budget</i>	<i>Current contract ends 6/30/14. DVHA and VITL are beginning discussions regarding FY15 contract and prioritization of items that will be in that contract.</i>
Core Operations in Support of State HIE Services	Core operations including support personnel, legal fees, rent, etc...	HIE must remain operational. Includes Medicity sub-contract.	\$2,557,824	
Patient Consent Policy-Related Activities	Personnel and contracts related to changes in patient consent policy for data entering and moving through the VHIE. This includes pilot participation awards.	Work collaboratively with the State to develop a new patient consent policy to propose to the GMCB. Implement any changed policy.	\$265,302	
Enhanced HIE	Evaluate the patient portal market and provide DVHA with a report about this market.	Patient portal market report.	\$75,000	6/30/14
HIE Technology Infrastructure	Maintain and manage the Master Person Index (MPI). Maintain a hosted environment to support current capabilities, and planned capabilities to support	Ensuring the implementation of technological solutions to ensure the hosted environment operates so that the VHIE works.	\$475,854	6/30/14

	Consent, Analytics, Interface Engine, and other Grantee services as identified.			
HIE Services Infrastructure	Consulting and federal evaluation for enhanced FIP security to VHIE.	Evaluation of readiness for enhanced FIP security and plan for achieving enhanced security.	\$75,000	6/30/14
New HIE Services	Various HIE services identified by VITL and the State jointly. Examples include: clinical analytics system design and planning and design of the event notification system.	Completion of these services as specified in Change Order or Task forms agreed upon by VITL and the State.	\$237,000	6/30/14
HIE Connectivity Expenses	Development of interfaces between providers and the VHIE.	75 new net interfaces to Health Care Organizations	\$1,221,489	6/30/14
<i>SIM Funding Committed August 2013</i>				<i>This work is currently slated to end on 6/30/14. It is possible to extend beyond 6/30/14 if necessary.</i>

Regional Extension Services	Provides resources so that VITL staff can go into practices and train clinicians to input quality data into their electronic health records. "Sprint Data Quality Improvement Initiatives"	These sprint data quality improvement initiatives will be comprised of five (5) remediation Sprints, fifteen (15) onboarding Sprints, and (five) 5 manual Sprints. Areas of focus are: Blueprint data quality improvement services; continuing Primary Care services in support of Meaningful Use Stage 2 attestation; providing Specialty Care services in support of Meaningful Use Stages 1 and 2 Attestations; and providing services to non-EHR providers to include long term care, mental health, home health and specialists.	\$346,346	6/30/14
Hospital Interface Acceleration: 2 Move-in Models	Planning, assessment, design, build and implementation of interfaces between the electronic medical record systems of two hospitals and the VHIE. This includes an investment in infrastructure to support redesigned care processes.	Successful interface implementation with FAHC and one community hospital.	\$100,000	June 30, 2014

Dedicated SET team	Medicity/VITL Team designed to accelerate the connectivity between healthcare providers and the VHIE network. Connectivity is for: -patient centered medical homes and other primary care providers - accountable care organization providers - mental health and substance abuse providers - other specialty care providers - long term care providers	Successful connectivity through development of new interfaces for transmission of admission, discharge, transfer, lab and other data.	\$590,000	June 30, 2014
Connectivity Criteria Development	Develop and recommend Connectivity Criteria to the Green Mountain Care Board as required by Act 79 of the Acts of 2013.	Criteria developed and submitted to the GMCB.	\$60,000	June 30, 2014
Design work for uber-portal	Funding for design of options that minimizes multiple access and authentication steps for healthcare providers ("single sign-on" technology).	Development of a plan that would minimize authentication, while providing significant data to clinicians looking at the following data sources: practice EHRs; hospital EHRs; Docsite; VITLAccess and Med history; other analytics sources like the Northern New England Accountable Care Collaborative; and other data sources identified by the state.	\$75,000	June 30, 2014
Consultant to assist SOV develop HIT-HIE Plan	Provide assistance to the State for HIT/HIE plan revision	Providing assistance to the State.	\$6,500	June 30, 2014

<i>SIM HIE Proposal</i>				
Gap Analysis	Identify the gap among state-wide ACO data requirements and data capacity.	Creation of a list of data gaps and ways to remediate those gaps. This list will then be used to prioritize remediation of all of the gaps.	\$75,000	Q1-Q4 2014
Support	Provide system and customer support	VITL has a service center that provides support to customers. This provides access to this service center for 11 months and includes customer support to ACO participants and encompass: patient identity management; interface maintenance, upgrades and replacement; continuously measuring and improving data quality; and the provision of a 24x7 support center.	\$794,298	11 months from start date.
Event Notification	Install a system (designed under the DVHA Agreement) that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters	Successful installation of a system that will provide event notification of admission, discharge and transfer data to all clinicians who have the ability to receive information from the HIE (this will potentially impact every provider in the state). Clinicians will be receiving these events.	\$625,000	Q1 2014- Q4 2014 As
Gateway Build	Build the technical architecture to support movement of data from source systems to analytics destinations	Completion of technical architecture so that data flows from HIE to ACO analytics partners.	\$1,529,500	Q1 2014- Q2 2015

<i>ACTT Proposal</i>				
DA/SSA Data Quality and Repository	Use integrated efforts and technology to enable: data quality, enhanced reporting, population and individual health management and improvement; and connectivity to the state-wide HIE for Vermont's DAs/SSAs.	Build the tools to document data development decisions and provide a roadmap to gain control of data integrity for the long-term. Develop toolkit for use statewide and for use by other community-based providers. Design and build the data warehouse to support system-wide data as it continues to be developed. Build out reporting module to meet the performance measurement criteria	\$1,939,838	Q4 2015
LTSS Data Planning	Conduct a gap analysis of existing long term care service and support measures	Determine and propose a phase 2 budget and scope to remediate data needs to report on LTSS measures	\$178,000	Q4 2014
Universal Transfer Form Planning	Identify the current challenges, future vision, and communication bridges to provide a more seamless delivery of services and supports during care transitions.	Produce a detailed description of an improved transfer system between at least 3 types of providers, including one reliant on web-based tools and who has no intent to adopt an electronic medical or health record system in the future	\$215,072	Q3 2014

Additional Attachment - Advancing
Care Through Technology Propoal
Motion 2.26.14

Motion that passed the HIE/HIT Work Group

Move that we recommend approval of the ACTT Partnership's proposal, scope of work and funding as described in the documents entitled: Advancing Care through Technology (ACTT) dated February 26, 2014 to the Core Team for consideration and approval at an amount not to exceed \$2,492,910 with the following stipulations:

- a. Identification that DVHA is the contracting agent for these projects and will work with the ACTT Partners to implement them.
- b. The State will investigate whether there are more financially beneficial ways to fund this work besides using SIM funds, such as 90/10 federal match for information technology projects;
- c. DVHA, VITL and the ACTT Partners will provide an analysis to the Steering Committee, Core Team and HIE/HIT Work Group ensuring there is no duplication of tasks with those currently being conducted by VITL.

Proposed ACTT Proposal Modifications at Steering Committee:

The Steering Committee recommends the addition of a requirement for IT Project Management for the three projects. The funding for this contract would be *in addition* to the proposed budget, at an estimated cost of \$120,000/year.