Attachment 1 - 3-20-14 Disability and LTSS Work Group Meeting Agenda

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
(Rescheduled from March 13th 2014 Due to Weather)
Thursday, March 20th 2014; 9:00 AM to 11:00 AM
AHS Training Room, 208 Hurricane Lane, Williston, VT
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Action
1	9:00 – 9:05	**Welcome and Introductions** Deborah Lisi-Baker and Judy Peterson	• Attachment 1: Meeting Agenda	
2	9:05– 9:15	**Approval of DLTSS Charter** **(Pending adequate member representation)** Deborah Lisi-Baker and Judy Peterson	• Attachment 2a: Draft DLTSS Charter • Attachment 2b: DLTSS Core Principles	
3	9:15 – 9:25	**Draft DLTSS Work Plan** Deborah Lisi-Baker and Judy Peterson	• Attachment 3: Draft DLTSS Work Plan	
4	9:25 – 10:15	**DLTSS Quality and Performance Measures** Alicia Cooper, SIM Quality Oversight Analyst	• Attachment 4a: DLTSS Quality and Performance PPT • Attachment 4b: AHS DLTSS Proposed Measures • Attachment 4c: AHS Surveys • Attachment 4d: Pending Measures Review • Attachment 4e: Pending Measures Review DLTSS Specific	
5	10:15 – 10:45	**DLTSS HIE "ACTT" Grant Proposal** Marybeth McCaffrey and Brendan Hogan	• Attachment 5a: ACTT Grant Proposal • Attachment 5b: ACTT Q&As • Attachment 5c: ACTT Motion	
6	Time permitting	**Work Group Membership List and Roles** (Voting member vs alternate)	• Attachment 6: DLTSS Member List	
7	Time permitting	**Review of Meeting Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 7: DLTSS Meeting Minutes 2-20-14	

8	10:45 – 11:00	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson		

Attachment 2a - Disability and LTSS Work Group Charter

VT Health Care Innovation Project
"Disability and Long Term Services & Supports" Work Group
Charter

March 20, 2014

FINAL DRAFT

EXECUTIVE SUMMARY

The Disability and Long Term Services and Supports Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the past two years. The goal of the Disability and Long Term Services and Supports Work Group (DLTSS) is to incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, related chronic conditions and those needing long term services and supports. The VHCIP Disability and LTSS Work Group will:

- develop recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, related chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- develop recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, related chronic conditions and those needing long term services and supports;
- develop recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- develop recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports;
- continue to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

SCOPE OF WORK

1. Recommend care model elements and strategies that improve beneficiary service and outcomes for people with disabilities, related chronic conditions and those needing long term services and supports.
2. Identify provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve people with disabilities, related chronic conditions and those needing long term services and supports.

3. Identify mechanisms to incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports to achieve a more integrated and seamless delivery system.
4. Incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
5. Identify Medicare/Medicaid/commercial insurance coverage and payment policy barriers that can be addressed through Vermont's health care reform efforts to improve integration of care for people with disabilities, related chronic conditions and those needing long term services and supports.
6. Identify mechanisms to minimize the incentives for cost-shifting between Medicare, Medicaid and commercial payers.
7. Incorporate representation from Commercial Insurers into the VHCIP Disability and Long Term Services and Supports Work Group.
8. Recommend incentives for ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions.
9. Identify DLTSS quality and performance measures to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports. These quality and performance measures shall be consistent with the core principles articulated in State law and regulation: the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012).
10. Identify technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.

DELIVERABLES

1. Inclusion of new members on the DLTSS Work Group, including representation from commercial payers.
2. Recommendations for model of care elements and strategies that can be integrated and aligned with other VHCIP models of care.
3. Recommendations for payment methodologies that: a) incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; b) incentivize ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and c) reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.

4. Action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group efforts.
5. Action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies.
6. Action plan for inclusion of DLTSS quality and performance metrics to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports.
7. Recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.
8. Other activities as identified to assist successful implementation of payment and care models to best support people with disabilities, related chronic conditions and those needing long term services and supports.

MILESTONES (Timeline subject to change)

<u>March – August 2014</u>

- Review the core principles of the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012) as they relate to quality and performance measures and desired outcomes.

- Complete action plan for inclusion of DLTSS quality and performance metrics to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports.

- Make recommendations for model of care elements and strategies for people with disabilities, related chronic conditions and those needing long term services and supports.

- Complete action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group activities.

<u>September – December 2014</u>

- Make recommendations for payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; incentivize ACOs to reinvest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports; and reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.

- Make recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.

January – April 2015

- Complete action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies for people with disabilities, related chronic conditions and those needing long term services and supports.

- Other activities as identified to support successful preparation and implementation of payment and care models to best support people with disabilities, related chronic conditions and those needing long term services and supports.

MEMBERSHIP REQUIREMENTS

The Disability and Long Term Services and Supports Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the Work Group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Deborah Lisi-Baker, Disability Policy Analyst
  dlisibaker@gmail.com

- Judy Peterson, VNA of Chittenden & Grand Isle Counties
  Peterson@vnacares.org

Work Group Staff:

- Erin Flynn, Department of Vermont Health Access
  Erin.Flynn@state.vt.us

- Julie Wasserman, AHS Vermont Dual Eligible Project
  Julie.Wasserman@state.vt.us

Consultants:

- Susan Besio, Pacific Health Policy Group
  sbesio@PHPG.com

- Brendan Hogan, Bailit Health Purchasing
  bhogan@bailit-health.com

Additional resources may be available to support consultation and technical assistance to the Work Group.

WORK GROUP PROCESSES

1. The Work Group will meet monthly.
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting.
6. The Work Group Co-Chairs will preside at the meetings.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

_____ Date: _____

Project Sponsor/Title

Attachment 2b - DLTSS Core Principles

DLTSS CORE PRINCIPLES
Developmental Disabilities Act 174
Mental Health Care Reform Act 79
Choices for Care Act 56

DEVELOPMENTAL DISABILITIES ACT 174 (1996)

§ 8721. Purpose

It is the policy of the state of Vermont that each citizen with a developmental disability shall have the following opportunities:

(1) To live in a safe environment with respect and dignity.

(2) To live with family or in a home of his or her choice.

(3) To make choices which affect his or her life.

(4) To attend neighborhood schools, be employed, and participate in activities, to the extent that this purpose is not construed to alter or extend rights or responsibilities of federal laws relating to special education.

(5) To have access to the community support and services that are available to other citizens.

§ 8724. Principles of service

Services provided to people with developmental disabilities and their families shall foster and adhere to the following principles:

(1) Children's services. Children, regardless of the severity of their disability, need families and enduring relationships with adults in a nurturing home environment. The quality of life of children with developmental disabilities, their families and communities is enhanced by caring for children within their own homes. Children with disabilities benefit by growing up in their own families; families benefit by staying together; and communities benefit from the diversity that is provided when people with varying abilities are included.

(2) Adult services. Adults, regardless of the severity of their disability, can make decisions for themselves, can live in typical homes and can contribute as citizens to the communities where they live.

(3) Full information. In order to make good decisions, people with developmental disabilities and their families need complete information about the availability, choices, and costs of services, how the decision making process works, and how to participate in that process.

(4) Individualized support. People with developmental disabilities have differing abilities, needs, and goals. To be effective and efficient, services must be individualized to the capacities, needs, and values of each individual.

(5) Family support. Effective family support services shall be designed and provided with respect and responsiveness to the unique needs, strengths, and cultural values of each family and the family's expertise regarding its own needs.

(6) Meaningful choices. People with developmental disabilities and their families cannot make good decisions without meaningful choices about how they live and the kinds of services they receive. Effective services shall be flexible so they can be individualized to support and accommodate personalized choices, values, and needs and assure that each recipient is directly involved in decisions that affect that person's life.

(7) Community participation. When people with disabilities are segregated from community life, all Vermonters are diminished. Community participation is increased when people with disabilities meet their everyday needs through resources available to all members of the community.

(8) Employment. The goal of job support is to obtain and maintain paid employment in regular employment settings.

(9) Accessibility. Services must be geographically available so that people with developmental disabilities and their families are not required to move to gain access to needed services, thereby forfeiting natural community support systems.

(10) Health and safety. The safety and health of people with developmental disabilities is of paramount concern.

(11) Trained staff. In order to assure that the goals of this chapter are attained, all individuals who provide services to people with developmental disabilities and their families must receive training as required by section 8731 of this title.

(12) Fiscal integrity. The fiscal stability of the service system is dependent upon skillful and frugal management and sufficient resources to meet the needs of Vermonters with developmental disabilities.

MENTAL HEALTH CARE REFORM ACT 79 (2012)

This act strengthens Vermont's existing mental health care system by providing a continuum of flexible and recovery-oriented treatment opportunities, which are fully integrated with substance abuse, public health, and health care reform initiatives, consistent with the goals of parity. A clinical resource management system is established to coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system. The clinical resource management system shall facilitate an array of functions, including the use of coordinators to assist emergency service clinicians in the field, the use of an electronic bed board to track available bed space, the coordination of patient transport services, access by individuals to a mental health patient representative, and the periodic review of individuals' clinical progress. The overall effectiveness of the mental health care system shall be the subject of an annual report by the department of mental health (DMH), which shall focus on the utilization of services within the system, the adequacy of the system's capacity, individual experience, and the performance of the system as compared to national standards.

This act establishes a geographically-diverse system of mental health care with treatment opportunities that vary in degree of intensity. Peer services, provided by individuals with personal experience of living with a mental health condition or psychiatric disability, are at one end of this spectrum. This act empowers the commissioner of mental health to contract for peer services that are aimed at helping individuals with mental illness achieve recovery through improved physical and mental health, increased social and community supports, and avoidance of crises and hospitalizations. More specifically, the commissioner is authorized to develop peer-run transportation services and a nonemergency telephone response line.

This act also expands and strengthens Vermont's network of community mental health services. Designated agencies, with support from the DMH, shall improve emergency responses, noncategorical case management, mobile support teams, adult outpatient services, and alternative residential opportunities. In addition, the DMH is authorized to contract for at least four short-term crisis beds in designated agencies to prevent or divert individuals from hospitalization when clinically appropriate, as well as a voluntary five-bed residence for individuals experiencing an initial episode of psychosis or seeking to avoid or reduce reliance on medication. Other community services authorized in this act include housing subsidies for individuals living with or recovering from mental illness.

CHOICES FOR CARE ACT 56 (2005)

I. Purpose and Scope

A. The “Choices for Care” Medicaid waiver operates as a Research and Demonstration Project authorized under Section 1115(a) of the Social Security Act. This program provides long-term care services to elderly or physically disabled Vermont adults who are found eligible by the Department of Disabilities, Aging and Independent Living (the Department or DAIL). The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to either nursing facility care or home and community-based services, consistent with their choice. The Choices for Care waiver is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

II. General Policies

A. Long-term care services shall be based on person-centered planning and shall be designed to ensure quality and protect the health and welfare of the individuals receiving services.

B. Long-term care services shall be provided in a cost-effective and efficient manner, preventing duplication, unnecessary costs, and unnecessary administrative tasks. The Department shall manage long-term care services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals.

C. The Department shall administer the Choices for Care waiver in accordance with these regulations, the CMS terms and conditions, and applicable state and federal law.

D. Eligible individuals shall be informed of feasible service alternatives.

Attachment 3 - DLTSS Work Plan

Work Plan for DLTSS Work Group – DRAFT 3/20/14

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Finalize Work Group logistics: Charter, membership, meeting schedule, resource needs, etc.	• Redraft Charter following VHCIP standardized template • Review membership list: each entity should assign 1 voting member (+ backup), others can be "interested parties" • Identify representation from commercial payers and other entities • Distribute 2014 monthly meeting schedule • Develop resources identified as needed by Work Group	• Approve Charter for official use • Provide input on and final approval of membership list • Identify information /resources needed to inform discussions and decision-making • Identify mechanisms for broader beneficiary engagement	February - April 2014 and on-going (for development of resources for Work Group)	• Charter scheduled for March Work Group approval • Membership list: 1. Need to identify representation from commercial payers, others 2. Need to finalize membership list • 2014 Meeting Schedule has been distributed	• Final Charter • Comprehensive membership list • 2014 meeting schedule • Resources are adequate to accomplish objectives • Successful beneficiary engagement
Complete Action Plan for Inclusion of DLTSS Quality and Performance Metrics and review performance on an on-going basis	• Develop on-going list of currently collected AHS measures • Develop timeline (short and long-term) for incorporating DLTSS input into Quality and Performance Measures Work Group activities • Identify DLTSS quality and performance measures for Years 2	• Review core principles of Developmental Disabilities Act, Choices for Care regulations, and Mental Health Care Reform Act as they relate to quality and performance measures and desired outcomes • Review list of currently collected	February - July 2014 and on-going (for performance measure review)	• Initial list of currently collected AHS measures needs to be fleshed out • Timeline and recommendations to be presented at March DLTSS Work Group meeting • Initial list of DLTSS quality and performance measures needs to be discussed,	• Recommended DLTSS Quality and Performance Measures to be incorporated /adapted into the Medicaid ACO Standards for Years 2 and 3 • Reduction of preventable hospitalizations, ER visits and nursing home admissions;

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	and 3 of Medicaid ACO • Develop a plan to incorporate/adapt DLTSS Quality and Performance Measures into the VHCIP Quality and Performance Measures Work Group deliverables • Develop materials for Work Group Review of ACO / provider performance on DLTSS-specific measures and DLTSS-related measures (e.g., preventable hospitalizations, ER visits, and nursing home admissions; appropriate use of medications; and rebalancing the use of institutional vs home and community-based care)	AHS measures • Review Quality and Performance Measures Work Group process, criteria, and accomplishments to date • Discuss timeline (short and long-term) for incorporating DLTSS input into Quality and Performance Measures Work Group activities • Make recommendations to incorporate DLTSS Quality and Performance Measures into the VHCIP Quality and Performance Measures Work Group • On an on-going basis, review ACO and provider performance on DLTSS-specific measures and DLTSS-related measures and provide input to VHCIP leadership regarding performance		critiqued, and refined • Action plan for inclusion of quality and performance metrics needs to be developed	appropriate use of medications; and rebalancing the use of institutional vs home and community-based care

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Recommend DLTSS Model of Care Elements	• Review DVHA Duals Model of Care with Work Group • Develop DLTSS Model of Care PowerPoint • Develop a plan for incorporating/adapting the elements of the Duals Care Model into the VHCIP Care Models/Care Management Work Group activities	• Review DLTSS Model of Care Elements; elicit feedback and approval • Review, provide input on, and approve a plan for incorporating /adapting the elements of the DLTSS Care Model into the VHCIP Care Models/ Care Management Work Group activities	January - July 2014	• DVHA Duals Model of Care presented to DLTSS Work Group in January 2014 • DLTSS Model of Care Elements to be presented at April DLTSS Work Group • DLTSS Model of Care Elements to be presented at May Care Models/Care Management Work Group	• Successful incorporation of DLTSS Model of Care into service delivery for people with disabilities, related chronic conditions and those needing long term services and supports
Recommend technical and IT needs to support new payment and care models for integrated care	• Collaborate with the VHCIP HIE Work Group on development and approval of the ACTT proposal for DLTSS providers • Draft memo regarding HIT needs to support new payment and care models for DLTSS integrated care to include both high-tech and low-tech solutions/options • Determine process for collaborating with the VHCIP HIE Work Group to include relevant DLTSS HIT needs.	• Review ACTT grant proposal • Review and provide input on memo regarding DLTSS HIT needs for inclusion by the VHCIP HIE Work Group. • Review and provide input on process for collaborating with the VHCIP HIE Work Group to include relevant DLTSS HIT needs. • Receive status reports on progress regarding DLTSS HIT needs	March - December 2014 and on-going	• ACTT grant proposal to be presented at March DLTSS Work Group • VCHIP HIE Work Group recommended ACTT grant proposal (with conditions) to be sent to VHCIP Steering Committee March 5, 2014	• Initial planning funding and subsequent implementation funding of the ACTT proposal and successful completion of grant activities • Completed memo on DLTSS HIT issues • Action plan for inclusion of these issues in HIE Work Group activities

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	• Provide on-going status reports to DLTSS Work Group on progress regarding HIT needs				
Complete Action Plan for inclusion of person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group activities	• Develop a list of items (e.g. accessibility of information and services, training for professionals, etc.) • Develop a strategy for identified items, including incorporation into VHCIP Work Group efforts • Develop an approach to monitor whether incorporation of these items occurs over the long term	• Review, provide input on, and approve strategy for inclusion of person-centered, disability-related, person-directed, and cultural competency issues into VHCIP activities • Receive status updates on incorporation of identified items	March – August 2014 and on-going (for status updates)	• Dual Eligible Work Group list of person-centered, disability-related, person-directed and cultural competency items will inform this work	• List of person-centered, disability-related, person-directed, and cultural competency items • Action plan for inclusion of identified items into VHCIP Work Group efforts • Action plan for monitoring whether items are incorporated into VHCIP activities • Vermont health care reform initiatives are person-centered, disability-related, person-directed and culturally sensitive
Recommend payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and	• Collaborate with the VHCIP Payment Models Work Group as it determines the methodology for bundled payments,	• Review and provide input on payment model designs as they relate to DLTSS (i.e., design of bundled payment, blended	September -December 2014	• Activities have not yet begun	• Finalized payment methodologies that incentivize providers to integrate medical care with DLTSS service delivery

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
long term services and supports	blended payment mechanisms, and Episodes of Care • Research payment methodologies that promote flexible service delivery models that integrate medical/DLTSS care • List current DLTSS provider payments that may prove challenging to bundle and describe the challenges (e.g. nursing home payments, CRT/DS payments, others) • Develop recommendations for integrated provider reimbursement mechanisms for medical/LTSS services	payment mechanisms, Episodes of Care, and integrated reimbursement mechanisms) • Review and provide input on payment methodologies that promote flexible service delivery models • Provide recommendations to VHCIP Payment Models Work Group for integrated provider reimbursement mechanisms for medical/LTSS services			• Incorporation of payment models in VHCIP Payment Models Work Group that enable flexible service delivery models into VHCIP Care Models and Care Management Work Group deliverables.
Recommend incentives for ACOs to reinvest savings to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and promote appropriate use of medications	• Research and develop a list of incentives that encourage ACOs to reinvest savings to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and promote appropriate use of medications	• Review and provide input on list of incentives developed by supporting staff • Recommend strategies for incorporation of incentives into the Payment Models and Care Models/Care Management Work Groups' deliverables	September -December 2014	• Activities have not yet begun	• Incorporation of ACO incentives into payment and service delivery models

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Recommend mechanisms to reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.	• Research and develop a list of mechanisms to reduce the incentive to cost shift among payers • Develop indicators to gauge level of cost shifting among payers	• Review and provide input on list of mechanisms to reduce the incentive to cost shift • Review and provide input on indicators of cost shift	September-December 2014	• Activities have not yet begun	• Finalized list of mechanisms to reduce the incentive to cost shift among payers • Indicators to measure cost shift • Reduction of cost shifting among Medicare, Medicaid and commercial payers
Complete Action Plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies for people needing DLTSS services	• Research and develop list of current barriers in Medicare, Medicaid and commercial coverage and payment policies • Prioritize the barriers that can be acted upon dependent upon federal or state statutory and or regulatory requirements • Develop strategies to address these barriers • Work with CMS, DVHA and commercial insurers to obtain approval to implement strategies, if applicable	• Review and provide input on list of current barriers • Review, provide input on, and approve strategies for addressing coverage and payment barriers	January - April 2015	• Initial list of barriers identified by Dual Eligible Service Delivery workgroup in summer/fall 2011	• Completed list of current Medicare, Medicaid, and commercial coverage and payment barriers • Action plan to implement strategies to address coverage and payment barriers

Attachment 4a - DLTSS Quality and Performance PPT

Quality Measurement of Disability and Long Term Services & Supports (DLTSS) in the Vermont Medicaid Shared Savings Program

VHCIP Disability & Long Term Services and Supports Work Group Meeting

March 20, 2014

Outline

I. VHCIP Quality Performance Measures Workgroup (QPM WG) - ACO measure selection
II. QPM WG - Standards for Measure Review
III. QPM WG - Timeline for considering new or modified ACO measures
IV. QPM WG - ACO measure set review
V. DLTSS WG - Action items: recommendations to QPM WG

I. ACO MEASURE SELECTION IN THE QPM WG

ACO Quality Measure Selection Process

- Over the course of nine months (January 2013-October 2013), the **ACO Measures Work Group** met every two weeks
  - Broad, statewide stakeholder involvement
- Two sub-groups also held several meetings:
  - Patient Experience of Care Survey Sub-group
  - End-of-Life Care Measures Sub-group
- Work continues (November 2013-Present) in **VHCIP Quality and Performance Measures (QPM) Workgroup**

ACO Quality Measure Selection Process

QPM Work Group Participants:

- Identified priority measures for consideration
- Focused on measures in various domains, with national specifications, with benchmarks, and with opportunities for improvement
- Identified concerns about measures
- Eliminated measures through application of criteria and extensive discussion
- Compromised
- Expressed widespread support, but not quite unanimity

Criteria for Selecting Measures

- ✓ Representative of array of services provided and beneficiaries served by ACOs
- ✓ Valid and reliable
- ✓ NQF-endorsed measures with relevant benchmarks whenever possible
- ✓ Aligned with national and state measure sets and federal and state initiatives whenever possible
- ✓ Focused on outcomes to the extent possible
- ✓ Uninfluenced by differences in patient case mix or appropriately adjusted for such differences
- ✓ Not prone to effects of random variation (measure type and denominator size)
- ✓ Not administratively burdensome
- ✓ Limited in number and including only measures necessary to achieve state's goals (e.g., opportunity for improvement)
- ✓ Population-based
- ✓ Consistent with state's objectives and goals for improved health systems performance

Measure Use Terminology: Core

Payment

- Performance on these measures will be considered when calculating shared savings.

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings.

Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect. These may be considered for inclusion in future years.

Measure Use Terminology: M&E

Monitoring

- These are measures that all participants would benefit from tracking and reporting. They are distinctive from Reporting and Payment in that they will have no bearing on shared savings; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the plan or state-level. Data for these measures will be obtained from sources other than the ACO (e.g., health plans, state).

Utilization & Cost

- These measures reflect utilization and cost metrics to be monitored on a quarterly basis for each ACO. Data for these measures may be obtained from sources other than the ACO.

II. QPM WG STANDARDS FOR MEASURE REVIEW

Review of Payment & Reporting Measures

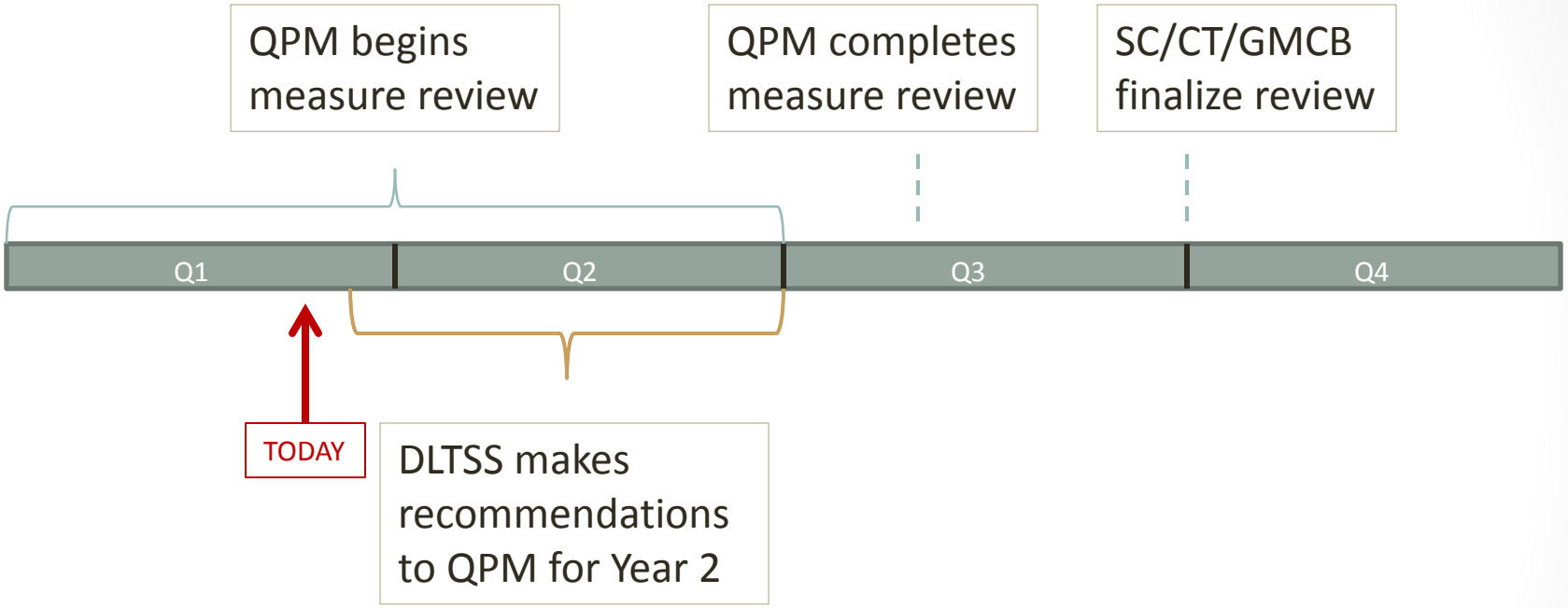
- The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** beginning in the second quarter of each pilot year. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO 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 or dropped for the next pilot year. The VHCIP QPM WG will make recommendations for changes. 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.

Review of Pending Measures

- The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending and consider any new measures for addition** to the set beginning in the first quarter of each pilot year. If the QPM WG 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. 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.

III. PROCESS TIMELINE

2014 Timeline



DLTSS WG Meeting (Q1-Q2, 2014)	QPM WG Meeting (Q1-Q2, 2014)
March 20	March 24
April 24	April 28
May 22	May 29
June 19	June 23

IV. YEAR 1PAYMENT, REPORTING, M&E AND PENDING ACO MEASURES

Year 1 Payment Measures – Claims Data

Commercial & Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Claims Data

Commercial & Medicaid

- Ambulatory Care-Sensitive Conditions Admissions: COPD*
- Breast Cancer Screening*
- Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
- Appropriate Testing for Children with Pharyngitis

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Clinical Data

Commercial & Medicaid

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
  - *HbA1c control**
  - *LDL control**
  - *High blood pressure control**
  - *Tobacco non-use**
  - *Daily aspirin or anti-platelet medication**
- Diabetes HbA1c Poor Control*
- Childhood Immunization Status
- Pediatric Weight Assessment and Counseling

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Survey Data

Commercial & Medicaid

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care

Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate

UTILIZATION & COST

- Total Cost of Care
- Resource Utilization Index
- Ambulatory surgery/1000
- Average # of prescriptions PMPM
- Avoidable ED visits- NYU algorithm
- Ambulatory Care (ED rate only)
- ED Utilization for Ambulatory Care-Sensitive Conditions
- Generic dispensing rate
- High-end imaging/1000
- Inpatient Utilization - General Hospital/Acute Care
- Primary care visits/1000
- SNF Days/1000
- Specialty visits/1000

- Annual Dental Visit

Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
- Influenza Immunization*
- Tobacco Use Assessment and Tobacco Cessation Intervention*
- Coronary Artery Disease (CAD) Composite*
- Hypertension (HTN): Controlling High Blood Pressure*
- Screening for High Blood Pressure and Follow-up Plan*
- Cervical Cancer Screening
- Proportion not admitted to hospice (cancer patients)
- Elective delivery before 39 weeks
- Prenatal and Postpartum Care
- Care Transition-Transition Record Transmittal to Health Care Professional
- How's Your Health?
- Patient Activation Measure

- Frequency of Ongoing Prenatal Care
- Percentage of Patients with Self-Management Plans
- Screening, Brief Intervention, and Referral to Treatment
- Trauma Screen Measure
- Falls: Screening for Future Fall Risk*
- Pneumococcal Vaccination for Patients 65 Years and Older*
- Use of High Risk Medications in the Elderly
- Persistent Indicators of Dementia without a Diagnosis

**Medicare Shared Savings Program measure*

V. ACTION ITEMS FOR DLTSS WG

Objectives

- To develop a proposal for a **short-term** (~3 year) strategy for inclusion of DLTSS quality measurement for the Vermont Medicaid SSP pilot

- Identify measures that can be used to assess quality of care for the DLTSS populations within the ACOs while minimizing administrative and financial burden on ACOs, payers, and providers

- Complement longer-term initiatives to connect DLTSS providers to the HIE

TODAY

DECISION POINT 1

- **Do we want to recommend analysis of one or more of the following existing Core Payment measures for DLTSS subpopulations within the people attributed to Medicaid ACOs?**
  - All-Cause Readmission
  - Follow-Up After Hospitalization for Mental Illness (7-day)
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
  - Chlamydia Screening in Women
  - Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)

DECISION POINT 2

TODAY

- **Do we want to recommend that some key measures being collected by AHS related to DLTSS be provided to ACOs and included in ACO Monitoring and Evaluation (M&E) reports?**
  - See list of AHS measures for DLTSS programs

DECISION POINT 3

- **Do we want to recommend the inclusion of 'Pending' ACO measures and/or new DLTSS measures as 'Payment' or 'Reporting' measures in the ACO Core Measure set for future program years?**

- Discussions for future meetings:
  - Proposed changes for Year 2 must be presented to the QPM WG for consideration in the first and second quarters of 2014
  - Proposed changes for Year 3 must be presented to the QPM WG for consideration in the first and second quarters of 2015

DLTSS WG Meeting (Q1-Q2, 2014)	QPM WG Meeting (Q1-Q2, 2014)
March 20	March 24
April 24	April 28
May 22	May 29
June 19	June 23

Attachment 4b - Potential DLTSS Measures

Measure Source	Measure	Measure Description	Information Source
Duals Demo Quality Withhold Measure Y2-3	LTSS Rebalancing	Ratio of HCBS utilization to institutional utilization (number of people and expenditures) in identified LTSS subpopulations	Claims
LTSS Scorecard	Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities	Proportion of Medicaid LTSS and home health spending for older people and adults with physical disabilities (defined as nursing homes, personal care, aged/disabled waivers, home health, and other programs used primarily by older people and adults with physical disabilities) going to HCBS, including Medicaid and state-funded services.	Claims
LTSS Scorecard	Percent of new Medicaid LTSS users first receiving services in the community	Proportion of Medicaid LTSS beneficiaries in measurement year who did not receive any LTSS in the previous year who in the first calendar month of receiving LTSS received HCBS only and not institutional services.	Claims
LTSS Scorecard	Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community	The number of participant-months (divided by 12) of Medicaid LTSS for adults age 65+ or age 21+ with a physical disability divided per 100 persons age 21+ with a self-care difficultly at or below 250% of the poverty threshold, or of any age living in a nursing home. 250% of poverty was chosen in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300% of SSI.	Claims
LTSS Scorecard	Percent of long-stay nursing home residents with a hospital admission	Percent of long-stay residents (residing in a nursing home relatively continuously for 100 days prior to the second quarter of the calendar year) who were ever hospitalized within six months of baseline assessment.	Claims/Clinical Record
Duals Demo Quality Withhold Measure Y1	Percent of Enrollees stratified to medium or high risk with a completed initial assessment within 90 days of enrollment	Proportion of beneficiaries receiving an initial assessment within 90 days of enrollment who were classified as being either medium or high risk.	Claims/Clinical Record
LTSS Scorecard	Percent of home health patients with a hospital admission	Percent of home health care patients who were hospitalized for an acute condition.	Claims/OASIS
Duals Demo Quality Withhold Measure Y2-3	Reducing the risk of falling*	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	Clinical Record
LTSS Scorecard	Percent of high-risk nursing home residents with pressure sores	Percent of long-stay nursing home residents impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 1–4) on target assessment.	Clinical Record/MDS
LTSS Scorecard	Percent of long-stay nursing home residents who were physically restrained	Percent of long-stay nursing home residents who were physically restrained daily on target assessment.	Clinical Record/MDS
LTSS Scorecard	Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients	Percent of home health episodes of care in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care for patients assessed to be at risk for pressure ulcers.	Clinical Record/OASIS

*NOTE: Several other NQF-endorsed measures relating to falls are available for consideration. This particular measure was included in the VT Duals Demonstration measure set.

Attachment 4c - AHS DLTSS Measures and Surveys by Program

Program	Measures	Description
AHS: Strategic Plan	Rate of fall-related deaths among older adults[1]	Number of fall-related deaths per 100,000 adults age 65+
DMH: Community Rehabilitation and Treatment (CRT)	Employment rates for clients of CRT[2]	Percent of clients employed Average annual earnings ($) per employed client
	Inpatient psychiatric utilization for clients of CRT[2]	Total inpatient psychiatric days among CRT clients Average number of inpatient psychiatric days per enrolled client population
	Potentially avoidable ER visits for clients of CRT[2]	Percent of clients with potentially avoidable ER visit
	Average length of service for clients of CRT[2]	Average length of client CRT services in years
DAIL: Attendant Services Program (ASP)	*No program-specific measures reported*[3]	
DAIL: Choices for Care (CFC)	Rebalancing long-term care[4]	Relative percent of nursing home residents and HCBS participants, with change needed to achieve at least 50% HCBS use
DAIL: Developmental Disability Services	People Served Living at Home with Family[5]	Total number of people
	People with Developmental Disabilities Receiving Supported Employment to Work[5]	Total number of people Number of people in Integrated Employment program per 100,000 population

[1] http://humanservices.vermont.gov/copy_of_ahs-results-scorecard
[2] http://mentalhealth.vermont.gov/report/pip/service#crt
[3] http://ddas.vermont.gov/ddas-programs/programs-asp-default-page#publications
[4] http://ddas.vermont.gov/ddas-publications/publications-cfc/cfc-qrtrly-data-rprts/cfc-data-report-sept-2013-1
[5] http://ddas.vermont.gov/what-s-new/whats-new-documents/annual-report-sfy-2012

	Vermont State Hospital Utilization by People Diagnosed with Developmental Disabilities[5]	Total number of patient days per year
	People with I/DD who Reside in Nursing Facilities[5]	Total number of people Percentage of total population residing in Nursing Facilities Percentage of total population with I/DD receiving residential supports
DAIL: Traumatic Brain Injury Program	*Nothing reported since 2008 'Final Report on Implementation Grant'*[6]	

[6] http://ddas.vermont.gov/ddas-programs/tbi/programs-tbi-default-page#publications

Program	Survey	Description
DMH: Community Rehabilitation and Treatment (CRT)	CRT client satisfaction survey[7]	A survey of consumers served by CRT programs in Vermont, part of a larger effort to monitor CRT program performance from the perspective of service recipients.
DAIL	Vermont Long Term Care (LTC) Consumer Survey[8]	A survey of consumers receiving the following long-term care programs/services regarding their satisfaction with services and quality of life: • Choices for Care (CFC) Case Management Services • Personal Care Services o Consumer-Directed Personal Care Services o Surrogate-Directed Personal Care Services o Agency-Directed Personal Care Services • Homemaker Services • Adult Day Services • Attendant Services Program • Traumatic Brain Injury Program • Home-Delivered Meals Program
DAIL: Attendant Services Program (ASP)	*Assessed as part of Vermont LTC Consumer Satisfaction Survey*	
DAIL: Choices for Care (CFC)	CFC HCBS Consumer Survey[9] *(part of Vermont LTC Consumer Satisfaction Survey)*	A survey of consumers of the long-term services system and provides data on specific CFC services. Several specific questions were added to the survey to more fully measure outcomes around choice, personal goals and maintaining health.
	CFC Nursing Facility and ERC Resident Satisfaction Survey[7] *(part of Vermont Health Care Association resident satisfaction survey)*	A survey of CFC participants in nursing facilities, assisted living facilities, and ERCs to evaluate measures of information dissemination, access, experience with care and quality of life.

[7] http://mentalhealth.vermont.gov/sites/dmh/files/data/satisfactionsurvey/DMH-2012_CRT_Satisfaction_Survey.pdf
[8] http://ddas.vt.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/ltc-consumer-satisfaction-survey-2013-1
[9] http://ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/umass-cfc-evaluation-report-of-years-1-7-may-2013

DAIL: Developmental Disability Services	DDS client satisfaction survey[10]	The information from the survey offers a profile of clients served by DDS, and helps identify what people feel is important to their quality of life and how the program can provide the best support possible.
DAIL: Traumatic Brain Injury Program	*Assessed as part of Vermont LTC Consumer Satisfaction Survey*	

[10] http://ddas.vermont.gov/ddas-publications/publications-dds/publications-dds-documents/dds-publications-satisfaction-reports/consumer-survey-report-2013-2

Attachment 4d - Pending Measures Review

VT Quality and Performance Measures Work Group
Review of 22 Pending Measures
February 25, 2014 Draft

#	Measure name	Reason designated as Pending	Considerations for Review
Core- 3/ MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	The claims-based HEDIS measures "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) is a year one payment measure. The plan was to use that measure for payment until this clinical data-based was ready to be used for payment, at which point, it will replace LDL screening. However, HEDIS is considering retiring "Cholesterol Management for Patients with Cardiovascular Conditions" in 2015 to align with the latest ACC/AHA guidelines, which focus on statin therapy for patients with established ASCVD and not on LDL-C control or LDL-C screening. • NQF #0075 • MSSP • No national benchmark available. • Change in national guidelines: In November 2013, the American College of Cardiology/American Heart Association (ACC/AHA) Task Force on Practice Guidelines released updated guidance for the treatment of blood cholesterol. The new guidelines: o Remove treatment targets for LDL-C for primary or secondary prevention of atherosclerotic cardiovascular disease (ASCVD).

#	Measure name	Reason designated as Pending	Considerations for Review
			○ Recommend high- or moderate-intensity statin therapy based on patient risk factors. ○ The stated rationale for removing LDL-C treatment targets is that no studies have focused on treatment or titration to a specific LDL-C goal in adults with clinical ASCVD. The majority of randomized controlled studies confirming the efficacy of cholesterol reduction in improving clinical outcomes in patients with clinical ASCVD used a single fixed-dose statin therapy to lower LDL-C levels.
Core-30	Cervical Cancer Screening	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0032 • HEDIS benchmark available • Change in HEDIS specifications for 2014: ○ Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age. ○ Removed coding tables and replaced all coding table references with value set references. ○ Added the hybrid reporting method for commercial plans.
Core-31/ MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	• Clinical data-based measure. Need to	• NQF #0068 • MSSP

#	Measure name	Reason designated as Pending	Considerations for Review
		develop HIT systems to be able to pull data directly from EHRs.	• No national benchmark available.
Core-32	Proportion Not Admitted to Hospice (Cancer Patients)	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #215 • No national benchmark available.
Core-33	Elective Delivery Before 39 Weeks	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0469 • No national benchmark currently available. • HEDIS is considering the addition of an "Early Elective Delivery" measure.
Core-34	Prenatal and Postpartum Care	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #1517 • HEDIS benchmark available
Core-35/ MSSP-14	Influenza Immunization	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0041 • MSSP • No national benchmark available. • Need to consider how to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events, etc.)
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0028 • MSSP • No national benchmark available.

#	Measure name	Reason designated as Pending	Considerations for Review
Core-37	Care Transition-Transition Record Transmittal to Health Care Professional	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #648 • No national benchmark available.
Core-38/ MSSP-32-33	Coronary Artery Disease (CAD) Composite	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0074 • MSSP • No national benchmark available.
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0018 • MSSP • HEDIS benchmark currently available but with proposed specification changes, there is the possibility that there won't be a published benchmark for 2015. • Minor changes to HEDIS specs in 2014. • Proposed big changes to HEDIS specifications in 2015: The proposed measure aligns with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age related BP thresholds. The total rate will be used for reporting and comparison across organizations. • Changes to national guidelines: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of hypertension. The new guidelines: o Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. o Keep the BP treatment goal for patients 18–59 at <140/90 mm Hg.

#	Measure name	Reason designated as Pending	Considerations for Review
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Not NQF endorsed • MSSP • No national benchmark available.
Core-41	How's Your Health?	• Need to develop measure specifications. • Need to develop a pilot program to test the measure among interested providers.	• Not NQF endorsed • No national benchmark available.
Core-42	Patient Activation Measure	• Need to develop measure specifications. • Need to develop a pilot program to test the measure among interested providers.	• Not NQF endorsed • No national benchmark available.
Core-43	*Frequency of Ongoing Prenatal Care (Medicaid only)*	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid-only measure. • NQF #1391 • HEDIS benchmark available
Core-44	*Percentage of Patients with Self-Management Plans (Medicaid only)*	• Need to develop measure specifications based on the NCQA standard. • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid only measure. • Not NQF endorsed • No national benchmark available.

#	Measure name	Reason designated as Pending	Considerations for Review
Core-45	*Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*	• Need to develop measure specifications. • Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs. • If using claims-based specifications, work with providers to implement new codes.	• Medicaid-only measure. • Not NQF endorsed • No national benchmark available.
Core-46	*Trauma Screen Measure (Medicaid only)*	• Need to identify an appropriate measure that relates to screening children for trauma. • Develop appropriate measure specifications. • Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs	• Medicaid-only measure. • Not NQF endorsed • No national benchmark available.
Core-47/ MSSP-13	*Falls: Screening for Future Fall Risk (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Clinical data-based measure. Need to	• Medicaid-only measure. • NQF #0101 • MSSP • No national benchmark available. • Duals-specific measure (consider denominator size without duals)

#	Measure name	Reason designated as Pending	Considerations for Review
		develop HIT systems to be able to pull data directly from EHRs.	
Core-48/ MSSP-15	*Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid-only measure. • NQF #0043 • MSSP • Duals-specific measure (consider denominator size without duals) • There is a survey-based HEDIS benchmark available but not a clinical data-based measure.
Core-49	*Use of High Risk Medications in the Elderly (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program.	• Medicaid-only measure. • NQF# 0022 • HEDIS • Duals-specific measure (consider denominator size without duals)
Core-50	*Persistent Indicators of Dementia without a Diagnosis (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Develop appropriate measure specifications.	• Medicaid-only measure. • Not NQF endorsed • No national benchmark available. • Duals-specific measure (consider denominator size without duals)

#	Measure name	Reason designated as Pending	Considerations for Review
		• Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	

Attachment 4e - Pending Measures Review DLTSS Specific

VT Quality and Performance Measures Work Group
Review of 22 Pending Measures
February 25, 2014 Draft

DLTSS Specific Measures

#	Measure name	Reason designated as Pending	Considerations for Review
Core-32	Proportion Not Admitted to Hospice (Cancer Patients)	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #215 • No national benchmark available.
Core-35/ MSSP-14	Influenza Immunization	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0041 • MSSP • No national benchmark available. • Need to consider how to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events, etc.)
Core-37	Care Transition-Transition Record Transmittal to Health Care Professional	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #648 • No national benchmark available.
Core-44	*Percentage of Patients with Self-Management Plans (Medicaid only)*	• Need to develop measure specifications based on the NCQA standard. • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid only measure. • Not NQF endorsed • No national benchmark available.

#	Measure name	Reason designated as Pending	Considerations for Review
Core-45	*Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*	• Need to develop measure specifications. • Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs. • If using claims-based specifications, work with providers to implement new codes.	• Medicaid-only measure. • Not NQF endorsed • No national benchmark available.
Core-47/ MSSP-13	*Falls: Screening for Future Fall Risk (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid-only measure. • NQF #0101 • MSSP • No national benchmark available. • Duals-specific measure (consider denominator size without duals)
Core-48/ MSSP-15	*Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Clinical data-based	• Medicaid-only measure. • NQF #0043 • MSSP • Duals-specific measure (consider denominator size without duals) • There is a survey-based HEDIS benchmark available but not a clinical data-based measure.

#	Measure name	Reason designated as Pending	Considerations for Review
		measure. Need to develop HIT systems to be able to pull data directly from EHRs.	
Core-49	*Use of High Risk Medications in the Elderly (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program.	• Medicaid-only measure. • NQF# 0022 • HEDIS • Duals-specific measure (consider denominator size without duals)
Core-50	*Persistent Indicators of Dementia without a Diagnosis (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Develop appropriate measure specifications. • Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid-only measure. • Not NQF endorsed • No national benchmark available. • Duals-specific measure (consider denominator size without duals)

Attachment 5a - ACTT Proposal to VHCIP

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.

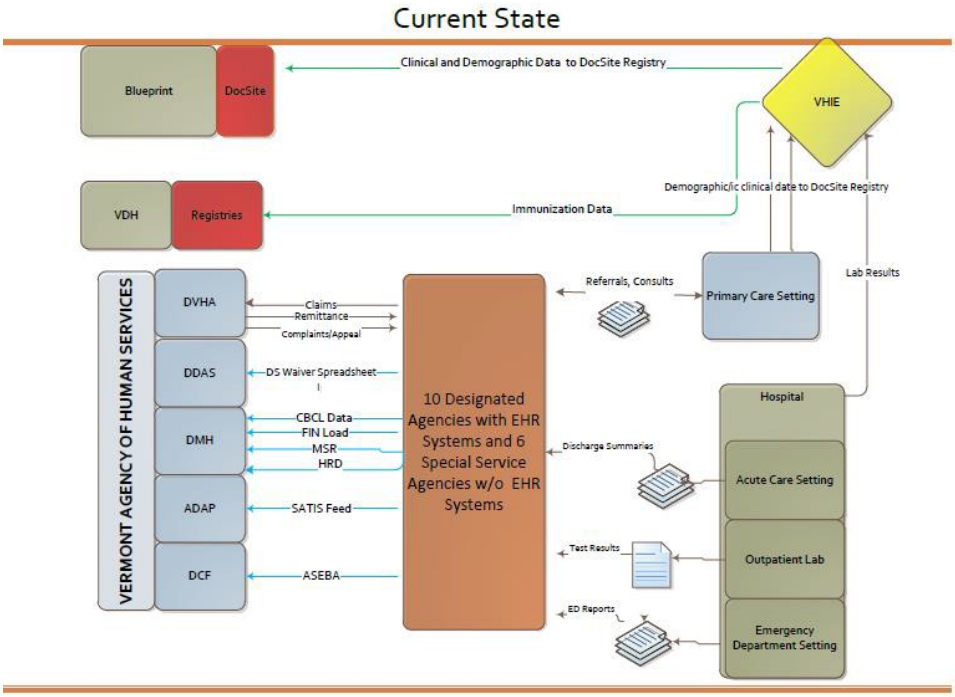
Behavioral health measures, even nationally, are not as advanced as those within the medical industry though the designated agencies are being required to report numerous measures. The National Quality Forum recently launched a new project entitled "Behavioral Health Endorsement Maintenance" seeking 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		$\geq$ 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 communicatio n 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
Research and resolve issues related to 42CFR Part 2(Link to Part 2 Project)	*Policy related to 42CFR Part 2 written and accepted*		*See ACTT 42 CFR Part 2 Proposal*	*Review of work documents*	*BHN Director in conjunction with Part 2 Team* **Part of a separate proposal but linked*
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			Qyr 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 Contracts 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 stakeholder s	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				
	Creating a DA/SSA Repository		**Integrating with the VITL Repository**	
Service	**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
Importance	Impact on health, costs of care; Potential for improvement, existing gaps in care, disparities
Evidence	Scientific evidence for what is being measured
Validity	Does the measure capture the intended content?
Reliability	Precision, repeatability
Meaningful Differences	Is there variation in performance? Is there room for improvement? Include both qualitative and quantitative measures.
Feasibility	Susceptibility to errors or unintended consequences • Note: outside expertise may be needed to determine feasibility of potential measures.
Costs of data collection	Burden of retrieving and analyzing data
Usability	Testing to see if users understand the measure • Results should be usable as strategies for improving care
Actionable	Results of measurement should be used for quality improvement.
Standardized	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 year[1] to deliver a diverse range of services[2] to help about 40,000 Vermonters[3] 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

Attachment 5b - ACTT Proposal to VHCIP_Questions and Answers

Questions related to the 2/5/2014

ACTT Partners Presentation

Project A:

- What is the work to be performed here?

The work to be performed here is to create a digital form that would allow transfers from one setting to another to proceed more smoothly for the person who is moving from hospital to nursing home or nursing home to their home with home health services. This form is an informational tool that would allow the systems and people representing the systems/providers to communicate more effectively and reduce people "bouncing back" from nursing home or community to the hospital.

- What is the deliverable?

The deliverable will be a detailed plan that outlines what information would be useful and necessary in facilitating better transfers from hospitals to nursing homes and nursing homes to individual homes with home health care services.

- What is the effort?

The effort would include several months of planning that would include: hospitals, nursing homes, home health agencies, and technical resources, such as VITL. The product would be a plan to submit funding for a phase 2 project where a digital form could be created and piloted.

- Is this a paper form?

The format of the form, whether it is paper or electronic or both, will be determined through the design and planning effort.

- Is this an electronic form?

The format of the form, whether it is paper or electronic or both, will be determined through the design and planning effort.

- Does a transition of care standard exist?

Similar work has occurred elsewhere, so Vermont would be building upon work that has been done already in other states, including Massachusetts, New York and New Jersey. We are also aware of the emerging work on the national level to standardize this information, so we also will take that into account.

- Who generates the form?

Providers will determine which personnel is best suited to do this work at their facility.

- Who receives the form?

It may vary from provider to provider. For example, it could be a case manager or an admission nurse, or someone else.

- Can the form transit through HIE?

That would be an ideal solution, however other lower tech options will also be considered

- I am not clear on the real-life scenario where the form gets used and improves the care episode. How were the cost estimates developed for this project?

For example, individuals who transfer have some kind of a surgery, such as a hip replacement, and the person goes from a hospital to a nursing home and subsequently from a nursing home to home with home health services, the likelihood of information being shared completely with staff, the family member and the individual themselves is very low. Misinformation and misunderstanding of information can often occur. If a form is shared between settings and with the family and individual themselves, this form should help to facilitate communication and improve outcomes.

Cost estimates are needed and funding is being requested for a planning phase so cost estimates can be developed.

- Will the development of a unified information transfer form be expanded beyond the long term support services populations? Comments made following the presentation indicated that this initiative should be coordinated with the Pan ACO proposal. Will the ACTT team build upon work already started in this area such as the transitions work being done under the HRSA grant by the Rural Health program as well as the Healthcare Acquired Infections transitions work?

This effort is intended to help very directly bridge the medical world and the world of long-term services and supports. This effort will build upon any existing work such as is mentioned in the question. 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 <u>also will benefit</u> 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 solution for UTF meets the needs of people with the most complex, chronic and long-term needs for services and supports.

- The presentation mentions "immediately measureable costs and penalties for inefficiencies." What exactly does this mean? How are costs measured and what are the penalties?

Under the Affordable Care Act, Medicare began financially penalizing hospitals that have higher-than-expected rates of 30-day readmissions for select conditions. By offering an inducement to lower preventable readmissions, the Hospital Readmissions Reduction Program aims to improve care

coordination and reduce unnecessary spending. In contrast, hospitals may be financially rewarded for readmissions under the current fee-for-service system.

More information about how the costs are measured and the penalties are available here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Project B:

- Who will receive the data quality services? Is it all the providers on slide 3? What is the work to be done specifically? Not clear what the work effort is that drives the cost estimate. Where did the cost estimate come from?

The details of this project are still being determined. The preliminary cost estimates come from work of the DA/SSAs and would be specific to their needs. It does not preclude other LTSS providers from receiving funding as the ACTT providers will be working with VITL and State staff in March to get more estimates.

Project B/C: For the Designated and Specialized Service Agency System: Data Quality Initiative and Data Repository

- Who will receive the data quality services?

All sixteen designated and specialized service agencies. The State of Vermont relies on sixteen independent, non-profit designated and specialized service agencies (DAs/SSAs) 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 approximately 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) and children with severe emotional disturbance (SED waiver program) who would otherwise be at risk of institutional placements. Additionally they provide a range of child, youth and family services, crisis services and outpatient services.

- What is the work to be done specifically? Not clear what the work effort is that drives the cost estimate. Where did the cost estimate come from?

The detailed work plan demonstrates the work effort. All designated and specialized service 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. 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, DMH, AHS and other, 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.

Deliverables include: Move system-wide clinical workflows "above the line" in structured data fields within EMRs to build accurate measurements with the correct numerators and denominators; 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 by the DA/SSAs and potentially 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; Build interfaces with VITL, ACOs, State HIT etc.

The cost estimate was based on system-wide efficiencies and conversations with EHR vendors as well as with VITL and IT consultants. The work and thus cost estimates are also based on Bi-State Primary Care Association promising practice of developing a data dictionary and data quality assessment and remediation. In addition to a one time infrastructure cost, the majority of the cost is in staffing and consultation to bring it to fruition.

- How much of this work can leverage existing VITL capabilities / technologies?

Based on conversations with VITL, we believe there is an infrastructure for a data repository structure that could be leveraged at VITL and that the development of this data repository would then enable feeds into VHIE (along with overcoming 42 CFR Part 2 barrier). When we conduct the architectural design and build, we will involve the necessary stakeholders including VITL, AHS, DA/DS staff. Through that process we will make the best determination about whether it can be housed at VITL or not. The VITL infrastructure build 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 reality 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 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 state's standard format. BHN has already approached VITL and begun the discussions and

hopes that that the end result will find every efficiency possible for our system of care and the care delivery system at large in Vermont. Regardless, the ability to collect DA/SSA data in a central place is critical for the DA/SSAs to be able to fully participate in the health reform and quality improvement efforts.

- What is going into this CDR?

Structured data from all DA/SSAs – clinical, demographic and service (eventually). The development of the data dictionary will inform the data entering into the CDR.

- What are the systems feeding into the CDR?

The systems feeding in are the sixteen designated and specialized service agencies but according to VITL the infrastructure build would enable other provider organizations to submit and aggregate data.

- What are the systems that the CDR is feeding?

Ideally AHS, ACOs and their analytic platforms through the gateways, the VHIE, Results Based Accountability Dashboards, Care Management tools, the VHIE and more.

- It is not clear how this project fits into the overall HIE landscape.

For interoperability with the VHIE, with ACOS, to report to funders in a uniform way, to demonstrate value through RBA and more, the DA/SSAs need to produce data feeds in a uniform (and ideally central and efficient) manner. The repository or warehouse is a conduit for which we can get that data. A large piece of utilization of HIE is to conduct quality improvement based on data. Without being able to aggregate our data, it becomes very difficult to utilize the data to benchmark and improve care. Without the data flowing in structured and reliable manner to the VHIE, enhanced care coordination becomes much more challenging as does reporting in a uniform and efficient manner. DA/SSAs need to also be able to overcome the barrier of 42CFR Part2 if the overall HIE landscape is to be fully successful.

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 Care Delivery models. The ACTT DA/SSA Data quality and Repository project works 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*

Project D:

- Is the assumption here that VITL's HIE will be adapted to accommodate 42 CFR Part 2? This isn't the creation of a separate HIE is it? Are there unique privacy requirements here that do not exist for the VITL HIE?

Yes, the assumption is that VITL's HIE technology will need to be adapted to accommodate 42 CFR Part 2. There will likely also need to be changes in operational protocols and patient information and outreach efforts related to gathering and managing consents. The details of how best to accomplish these changes will be figured out in the initial planning phase of this project.

Project E:

- Which agencies will be part of this system implementation?

The agencies that will be a part of this implementation are five developmental disability agencies who have come together through ARIS. ARIS Solutions was created in 1996 as a cooperative effort among social service agencies to reduce expenses in the face of state-wide budget cuts without diminishing the level of valuable supports within the community. Their mission quickly expanded to help individuals and their families self-direct their own funding without the burden of dealing with state and federal payroll requirements. Over the years they have continually updated their services to meet the growing demands of a complex healthcare and social services system. Today, ARIS Solutions operates as a consortium of developmental disability services agencies. Although the agencies are separate legal entities, they share resources and utilize a team-based approach to providing services throughout the State of Vermont, including aggregating outcomes data and reporting to the State of Vermont. ARIS Solutions' strategic plan includes a goal of implementing an electronic health record system that will support their developmental disability services members. They have created an RFP and have vetted that as well as potential vendors with VITL to ensure interoperability.

- How will data quality be built into the implementation at the beginning so data quality mitigation doesn't ever need to happen?

Data quality is being built in up-front through the DA/SSA Data Quality Initiative.

- Is there any reason A thru D can't be accomplished by expanding the scope of the VITL ACO project? It feels like this proposal is creating capabilities in parallel to the VITL work is planning to do rather than coordinating and leveraging that work – how do we prevent separate, parallel efforts from occurring? Also – need more detail on how the cost estimates were generated. The numbers have the feel of being pulled out of the air rather than being based on technical assessments, scoping and insightful estimating.

We agree that expanding the VITL ACO work is important to assure success, especially when the state requires Medicaid ACOs to include individuals who are eligible for Aged, Blind and Disabled Medicaid eligibility groups in 2015. The ACOs need to have an ability to collect, share and act upon data from behavioral health and designated and specialized service agencies and other LTSS providers on behalf of the individuals that they serve. The VITL ACO project is fundamentally about using information they

already largely receive from the traditional medical providers (hospitals and physician practices) based on years of interface development work. The ACTT projects will enable important basic connectivity and data quality work that largely has not already happened for these provider groups. The hospitals and primary care have spent a number of years getting to where they are – they were the first "cohort". Without DA/SSA and LTSS providers, we are not truly impacting quality and cost.

VITL will be working closely with the state and DA/SSAs and LTSS providers on this work. The state intends to review any additional VITL work to make sure it is not duplicative. The estimates need to be refined with additional time with VITL and state staff.

- Does this proposal alter in any way any existing reporting / transfer of drug and alcohol treatment information?

No, existing legal requirements (for example, under 42 CFR Part 2) will remain in effect. Any new systems that enable the electronic exchange of drug and alcohol information will also need to meet the same legal requirements, and may lead to some changes in work flow or procedures at provider sites or VITL.

General Questions:

- How can this project be coordinated with the approved VITL work leveraging such efforts?

This project will be coordinated with the approved VITL work leveraging similar efforts by having state staff who are managing the VITL contract review and assure that no duplication of effort will occur. Additionally, none of the current planning phase work has been determined to be duplicative, but when recommendations are made, state staff will assure that SIM funds will pay for new and/or additional work.

- How does this coordinate upon the current Blueprint work and address arguments of duplicative efforts?

Structured, reliable and complete data that can be aggregated by Blueprint area, hospital service area, county or statewide, will benefit 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 DA/SSAs to align their work, their data and their quality improvement efforts more closely with the Blueprint for Health. This is also critical as the DAs/SSAs and the state continue to assess the feasibility of health homes for those with serious mental illness.

- If more information can be provided for financial analysis that would be important:

1. How many Vermonters will this touch?

Previous estimates of approximately 40,000 Vermonters who are categorically eligible for Medicaid by being Aged, Blind and Disabled have been discussed in this proposal. This proposal will touch a subset of those individuals and other individuals served by ACTT providers that are not eligible for Medicaid.

All sixteen designated and specialized service agencies. The State of Vermont relies on sixteen independent, non-profit designated and specialized service agencies (DAs/SSAs) 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 approximately 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) and children with severe emotional disturbance (SED waiver program) who would otherwise be at risk of institutional placements. Additionally they provide a range of child, youth and family services, crisis services and outpatient services. The DA/SSAs will be participating providers within the ACOs – as such, for analytics and enhance care management as well as to create efficiencies amongst providers, their services, their clients, their data needs to be integrated in order for the full story to be told . It is also necessary in order to fully assess the total cost of care to develop true payment reform that results in improved quality of service delivery and improved health outcomes of Vermonters.

2. What is a potential ROI? *even if only social ROI not financial

Return on Investment and social return on investment is difficult to calculate. However, Medicaid ABD eligible individuals have the highest per member per month spending among all Medicaid categorical groups. The potential have a positive ROI is high given this fact and that the ACOs will have the option of expanding their definition of Total Cost of Care to include LTSS in the Medicaid Shared Savings Program in 2015. From a social ROI and looking at the impact on individuals these projects can improve care for individuals. Two examples of this include:

First, the Unified Care Transfer form planning can help individuals directly by sharing information and reducing unnecessary repeat inpatient admissions.

Second, Gap analyses – in order to fully integrate services included in the expanded definition of the Total Cost of Care for the Medicaid Shared Savings Program, the providers that delivering these services need to be connected. Gap analyses need to continue and gap remediation (both low tech and high tech options) need to be considered. If someone is served by both an Area Agency on Aging case manager and an Adult Day Center, staff from both of these organizations will have information that if shared with their client's primary care provider would allow for comprehensive care management and improved health and LTSS outcomes.

Third, enabling the aggregation of quality data will allow for benchmarking and improvement in services provided. The exchange of information will result in enhanced and efficient care management for vulnerable populations.

3. How does this expand on current budget of state programs, is this duplicative of any current budget funding?

These proposals are not duplicative of state programs, rather the funding complements the work of state programs such as Choices for Care 1115 Long Term Care Waiver, and DVHA's historical support of the development of VITL and the VHIE

4. How in the end will this integrate with ACO work, Care Model work (which includes payers) and the statewide HIE concept? See previous responses.

The work of the ACTT providers integrates with the ACO work as ACTT providers will be part of ACOs in 2015 when ACOs have the option of adopting an expanded definition of the Total Cost of Care in the Medicaid Shared Savings Program. Additionally, the ACTT providers also serve individuals who have Medicare and other insurance so as a provider they serve a broader population and therefore the work that they do is broader than the ACO.

The state HIE is intended to be as inclusive as possible to include medical, mental health, developmental disability, behavioral health and LTSS providers so the work of this ACTT proposal is consistent with state HIE plans.

Attachment 5c - ACTT Proposal Motion

Motion that passed the HIE/HIT Work Group on February 26, 2014:

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.

Attachment 6 - DLTSS Member List 3-18-14

VHCIP DLTSS Work Group Member List

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

Bad Email Address
Need Email Address
No Email Address

	Last Name	First Name	Title	Organization	Email	Support for:	DLTSS	Affliation
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54	Poirer	Luann	Administrative Services Manager I	AHS - DVHA	Luann.Poirier@state.vt.us	Kara Suter	X	Gov Ops
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64	Tessler	Julie	Executive Director	Vermont Council of Developmental and	julie@vtcouncil.org		M	External
65	Thorn	Bob	Executive Director	Counseling Services of Addison County	rthorn@csac-vt.org		MA	External
66	Wallack	Anya	Chair	SIM Core Team Chair	Anya.Wallack@state.vt.us		X	Gov Ops
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69	Warner	Nancy		COVE	**Need Email Address**		M	External
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73	LaShay	Dion			**No Email Address**		M	External
							73	73

Attachment 7 - Disability & Long Term Supprt Services Minutes 02.20.2014

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: February 20, 2014 – 10am – 12:30pm; AHS Training Room, 208 Hurricane Lane, Williston, VT
Call in : 877-273-4202 Passcode 8155970
Attendees: Deborah Lisi-Baker and Judy Peterson, Co-Chairs; Peter Cobb, VT Assembly of Home Health and Hospice Agencies; Molly Dugan, SASH; Patrick Flood, Northern Counties Health Care; Larry Goetschius, Addison County Home Health & Hospice; Jeanne Hutchins, UVM; Trinka Kerr and Rachel Seelig, VT Legal Aid; Norman Ward, Todd Moore, and Vicki Loner, One Care; Carol Maroni, CHSLV; Julie Tessler and Marlys Waller, VT Council of Developmental and Mental Health Services; Jason Williams, Fletcher Allen; Joy Chilton, CVHHH; Sam Liss, Statewide Independent Living Council; Ed Paquin, Disability Rights Vermont; Dion LeShay, Consumer.
Anya Rader Wallack, Core Team Chair; Paul Bengtson, Core Team; Georgia Maheras, AoA; Marybeth McCaffrey, DAIL; Julie Wasserman, AHS; Pat Jones, GMCB; Alicia Cooper and Erin Flynn, DVHA; Brendan Hogan, Bailit Health Purchasing; Susan Besio, PHPG;
George Sales, and Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome & Introductions	Deborah Lisi-Baker opened the meeting at 10:04. Judy reviewed the agenda for today's meeting.	
2 Integrated Long Term Supports Pilot in Caledonia County: "Caledonia Duals Proposal"	Patrick Flood presented: The purpose of this presentation is to obtain initial feedback from the DLTSS Work Group which will be incorporated into a formal funding proposal. Collaboration in the North East Kingdom (NEK) is particularly robust, and Patrick credited Paul Bengtson's collegiality and organization (Northeastern VT Regional Hospital) for encouraging and facilitating this collaboration. This healthy collaboration among health care agencies in Caledonia County offers a great venue to pilot new techniques in providing service that ultimately improves care and lowers costs. The challenge: Consumers requiring long term services and supports present many complex	

Agenda Item	Discussion	Next Steps
	challenges. Gaps in the structured funding from the State and Federal government sometimes miss the mark in providing a unique and necessary service that, if provided, would serve to prevent and/or avoid system wide costs. This proposal will Identify the high-risk population, broadly defined as people with a high risk of being admitted to a hospital or nursing facility, or who are homeless, marginally housed, or in jail or recently released – and implement a support plan for each identified person. Through integration of services and flexibility of funding, we think we can achieve some of the goals discussed by the DLTSS Work Group. The Northeastern VT Regional Hospital will be the fiscal agent for Blueprint and other essential partners who have agreed to collaborate with the Pilot. Two examples of LTSS consumers who would benefit from the availability of flexible funding are aged people who near the cap of 90 days (Isn't it 6 months (180 days) in hospice, but still require 24/7 support; and transportation for people with disabilities to obtain food and address personal needs since only transportation for physician visits is currently reimbursable. Today's thoughts about the Caledonia proposal include 1 FTE designated to manage the collaboration among providers and agencies. The population focus will include Duals, but will not be limited to Dual eligible consumers. The health care structures in place today will provide service. Trinka Kerr asked how would the Pilot fit with ACO Shared Savings Program? E.g. The Pilot suggests that if successful, costs would be avoided and money saved – and the ACO would benefit. Patrick responded by saying that the impact on the Shared Savings (SSP) program is a secondary consideration. Paul agrees that he does not care about the ACO SSP money – it's not about the savings but more about serving the "at risk" population. Jackie Marjoros suggested that some of the partners listed will share in the ACO SSP and asked for clarification about the arrangement. Patrick responded that the savings to Medicaid and Medicare are not considered in the proposal, since the most important focus of the Pilot is to have a positive impact. Paul suggested that any savings generated by the ACOs could, perhaps, be reinvested in the Pilot creating long term sustainability. Deborah is pleased to see flexible funds and asked that the Pilot report out all interventions. Sam Liss asked if the Pilot is successful, what is mechanism to expand it across the state? Paul answered that the Blueprint sets the foundation for expansion and will link to community agencies willing to collaborate.	

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	Dion LeShay asked how will success be measured? And, how will the Pilot be expanded to new counties? Patrick answered that tracking basic outcomes would suffice; e.g. unnecessary hospitalizations, nursing home placements, homelessness, improved health outcomes, employment, and other measures consistent with what ACO's are tracking. Todd Moore stated that this is a great discussion. One Care wants commonality across the state – and would support this mission. Once successful measures are assessed, there's the obvious need for sustainable funding to implement. Deborah expressed her interest in measuring changes in providers' behavior. Judy expressed her interest in standardization of the intake and assessment process. Patrick shared that the Pilot is not trying to figure that out up front, instead the Pilot will inch its way toward addressing these concerns.	
3 Contractor Support	Georgia Maheras asked that Pacific Health Policy Group (PHPG) and Bailit Health purchasing leave the room to facilitate the Work Group's discussion of contractor support. Attachment 3 is a proposal to purchase services from contractors, considered as Type 1 funding in the SIM budget. The recommendation is $90,000 for 1 year each. Both contractors have provided technical support to the State and the Duals Demonstration Work Group for the last several years. In the new agreement proposed today, the contractors will shift their focus to provide technical support to the DLTSS Work Group and facilitate DLTSS collaboration with other VHCIP Work Groups. The estimated dollar obligation may be amended later in the project. The contracts could begin on March 1st; consequently the Core Team has been presented with this proposal and has preliminarily approved them, conditional on today's DLTSS Work group approval. Todd Moore moved to accept the contractor proposal; Marybeth McCaffrey 2nd: Motion Passed, Anya Rader Wallack abstained.	
4 New Name, Mandate & Charter for WG	Deborah credited Julie Wasserman for rewriting the former Duals Work Group Charter to include the broader Disability and Long Term Services and Supports mission. Julie presented the new Charter and asked for comments from the Work Group. Suggested edits included: Scope and Deliverables, add improve the quality of life, and add Act 79 as principles and values. Include language about the impact of social determinants of health, including employment. Scope #8: Todd Moore notes that the ACO Shared Savings program has no "fixed risk" for consumers with disabilities and chronic conditions. Marybeth McCaffrey moved to endorse the Charter pending the edits discussed. Trinka Kerr 2nd:	

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	Passed unanimously.	
5 Questions, Comments and Ideas on new mandate	Julie Wasserman documented comments received re the Work Group's new DLTSS mandate. Deb invites participants to continue to review and submit comments to Julie. The comments will continue to be shared with the WG.	
6 AHS LTSS Performance Measures	Alicia Cooper presented on quality measures. Vermont's definition of Disability and Long Term Services and Supports (DLTSS) reflects "A diverse range of medical, mental health, substance abuse, developmental disability, personal and social services that assist people with a physical, cognitive, or mental health disability to live more independently." Medicaid is the primary payer with 21% of beneficiaries spending 55% of the Medicaid budget. DLTSS programs in Vermont include Choices for Care, Developmental Disability services, Community Rehabilitation & Treatment, Attendant Services, and Traumatic Brain Injury. Quality measures focus on ensuring improvements in integration and coordination, person-centered planning, and re-balancing the delivery of care to reduce facility based care and increase home and community based services. It was noted that all DLTSS enrollees get basic Medicaid coverage and a subset who are Dually eligible also receive Medicare. A number of challenges exist for the DLTSS measure set. There are relatively few nationally recognized measures, and most are clinical and/or survey based. There is a significant lack of standard outcome measures, and significant limitations to easily collect measures through electronic information. It will be important to collaborate with other Work Groups, particularly Quality and Performance Measures, and Health Information Exchange. The Medicaid ACO's have the option to include DLTSS services in the "Total Cost of Care" in year #2. In Year #3, Medicaid ACO's will be required to include DLTSS in their Total Cost of Care. The objective is to develop a short term (3 year) strategy for DLTSS quality measurement for the Medicaid ACO Shared Savings Program (SSP). This strategy will rely on claims based measurements and leverage ACO Medicaid and AHS measures activities. The plan is to draft a framework to incorporate DLTSS measurement into the Medicaid ACO SSP: In Stage 1, Years 1-3 of the Medicaid ACO Program, Core Measures could be reported on DLTSS subgroups.. Stage 2, Years 2-3 of the Medicaid ACO Program, claims based DLTSS measures	

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	already tracked by AHS could be included in the ACO Monitoring and Evaluation reports. Stage 3, Years 2-3 of the Medicaid ACO Program, DLTSS Pending measures could be promoted to Reporting status. And in Stage 4, Year 3 of the Medicaid ACO Program, ACOs could either choose DLTSS measures from a menu or ACO's could be assessed on specific DLTSS measures. The overall goal is to recommend a set of DLTSS measures that cover the complex cadre of consumers. The next Quality and Performance Measures WG meeting is scheduled for 3/24/14.	
7 Public Comment	Joy Chilton noted in the handout Attachment 7 titled "Proposal for Quality Measurement of DLTSS in the Vermont Medicaid ACO SSP" - at the bottom of 1st page under Current Measurements, Oasis is listed which is only partially true, since measures are collected on a small segment of DLTSS consumers. Joy expressed concerns about flexibility, and would prefer distinct parameters particularly when conducting analysis on measures. Jackie Majoros referenced Attachment 6, page 2 citing the last line of the definition to help people "live more independently". Jackie asks what does that statement mean, suggests it is un-necessary, and did the Work Group agree on that element of the definition? Marybeth McCaffrey offered an AHS update stating that many questions are being asked about DLTSS. A list of FAQ's and responses will be drafted and shared to obtain input from the Work Group. Marybeth also offered an update concerning the HIE Work Group's potential recommendation of the ACTT proposal to the Steering Committee. The ACTT proposal was essentially created to complement the ACO Population-Based Collaborative HIE proposal. The HIE WG, which has representatives from Designated Agencies, Substance Abuse, Nursing Homes, and Long Term Care providers, proposed 5 different projects which would advance the exchange of health information. The 5 projects are in early stages - 1) A Unified Information Transfer Form would improve upon transitions in care forms which are currently conveyed by fax, email, and telephone. The proposal intends to improve that communication. 2) ACTT Data Quality & Needs intends to identify data and reporting needs and conduct a gap analysis. 3) Data Transmission and Storage will identify these requirements for ACTT providers. 4) Act 42 CFR Part 2 – Plan and implement compliant HIE and Consent Architecture to allow the exchange of drug and alcohol treatment information. 5) EHR Procurement for Developmental Disability Service Agencies will create a single uniform electronic health record for Developmental Disabilities providers.	

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	Sam Liss asked if the GMCB will have control over the Medicaid budget in 2015? Georgia indicates the Legislature controls the Medicaid appropriation. She also stated that the GMCB can make spending recommendations to the Legislature and Medicaid.	
8 Wrap up/ Next Steps	Next meeting : Thursday March 13, 2014; 312 Hurricane Lane - DVHA Large Conference Room	