Attachment 1 - VHCIP Steering Committee Meeting Agenda 4-16-14

VT Health Care Innovation Project
Steering Committee Meeting Agenda

April 16, 2014 10:00 am- 12:00 pm
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	10:00-10:05	Welcome and Introductions	Al Gobeille and Mark Larson	Attachment 1: Agenda
2	10:05-10:15	Public Comment	Al Gobeille and Mark Larson	
3	10:15-10:20	Minutes Approval	Al Gobeille and Mark Larson	Attachment 3: March Minutes
4	10:20-10:30	Core Team Update	Anya Rader Wallack	
5		Policy Request: 1. None at this time		
6	10:30-11:00	Financial Requests: 1. HIE/HIT Work Group Spending Proposal	Georgia Maheras	Attachment 6a: Powerpoint Attachment 6b: Proposal (previously distributed)
7	11:00-11:50	Status Reports from Work Group Chairs: a. Care Models: Bea Grause and	Work Group Chairs	Attachment 7: Status Report

		Renee Kilroy b. DLTSS: Deborah Lisi-Baker and Judy Peterson c. HIE/HIT: Brian Otley and Simone Rueschemeyer d. Payment Models: Don George and Stephen Rauh e. Population Health: Karen Hein and Tracy Dolan f. Quality and Performance Measures: Cathy Fulton and Laura Pelosi g. Workforce: Robin Lunge and Mary Val Palumbo		
8	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille and Mark Larson	Next Meeting: May 14th 10:00am-12:00pm in Williston

Attachment 3 - Steering Committee Meeting Minutes 3-5-14

VT Health Care Innovation Project
Steering Committee Meeting Minutes

Date of meeting: March 5, 2014 at DVHA Large Conference Rm - 312 Hurricane Lane, Williston

Call in: 877-273-4202 Passcode: 8155970

Attendees: Mark Larson, and Al Gobeille, Co-Chairs; Anya Radar Wallack, Core Team Chair; Georgia Maheras, AoA; Bob Bick, Howard Center; Peter Cobb, VT Assembly of Home Health and Hospice Agencies; Tracy Dolan, AHS-VDH; Nancy Eldridge, Cathedral Square & SASH; John Evans, VITL; Catherine Fulton, VT Program for Quality in Health Care; Bea Grause, VT Assn of Hospitals and Health Systems; Jackie Majoros, VT Legal Aid; Todd Moore, One Care; Mary Val Palumbo, UVM; Judy Peterson, Visiting Nurse Assn of Chittenden and Grande Isle; Simone Rueschemeyer, Behavioral Health Network of VT; Debbie Ingram, VT Interfaith Action; Sharon Winn, Blue Cross, Blue Shield; Julie Wasserman, AHS; Alicia Cooper, Steve Maier, Kara Suter, Luanne Poirier and Erin Flynn, DVHA; David Martini, DFR; Marybeth McCaffrey, Jen Woodard, DAIL; Frank Reed, AHS-DMH, Dale Hackett, Consumer Advocate; Annie Paumgarten, Pat Jones, Spenser Weppler, GMCB; Don George, BCBS; Brendan Hogan, Bailit Health Purchasing; Michael Curtis; Melissa Bailey; Nelson LaMothe and George Sales, Jessica Mendizabal, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome & Introductions	Al Gobeille called the meeting to order at 1:04 pm	
2 Public Comment	Al Gobeille asked for public comment and no comments were offered.	
3 Minutes Approval	Bob Bick moved to approve the minutes. Simone Rueschemeyer seconded the motion and the minutes were approved unanimously.	
4 Core Team Update	Anya Rader Wallack updated the group on the Core Team's upcoming meetings. They are reviewing the Grant Program applications and will meet twice next week to discuss and make final decisions. Georgia Maheras added that March 25th is the official announcement date for the	

Agenda Item	Discussion	Next Steps
	grant awards. Anya noted that Vermont will have a site visit from CMMI in May and Steering Committee members may be asked to participate in the visit.	
5 Policy Request	1. <u>Quality and Performance Measures (QPM) Work Group Proposed Standard relating to Shared Savings Program/ACO measure review and modification (attachment 5).</u> Pat Jones reviewed the recommendation from the VHCIP QPM work group for the "Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs". Pat explained that the quality measures are in in four categories: 1) Payment measures, where payments are tied to ACO performance that determines how much they receive in shared savings; 2) Reporting measures where performance doesn't impact the payment, as long as ACOs comply with reporting requirements; 3) Pending measures which are harder to collect and the data source has not yet been identified; and 4) Monitoring and Evaluation measures relating to the cost of care and utilization which are considered key indicators the group wanted to keep track of, but because VT traditionally performs well in these areas, they were not placed in another category. The standard in the recommendation outlines a process that allows for changes to that measure set for years two and three of the Medicaid and Commercial Shared Savings ACO Programs. The QPM work group will review the measures, with input from other VHCIP work groups by July 31, 2014. They will present a recommendation to the Steering Committee for recommendation to the Core Team and Green Mountain Care Board (GMCB) for final approval. . The QPM work group will consider pending and new measures in the first quarter of this calendar year (Jan-March). For other measures, targets and benchmarks, the group would begin reviewing in April 2014. There is a provision for ad-hoc changes to measures if there is a change in clinical guidelines or if ACOs have concerns about measures. Dale Hackett asked how to the group plans to stay in sync with federal government changes to the Medicare Shared Savings ACO Program measure sets and reporting dates. Pat responded that she will look into any standardized timeframe proposed by CMMI. Todd Moore offered that the	

Agenda Item	Discussion	Next Steps
	federal measures should remain static for at least the next few years and has not seen any movement to add new measures. Bea Grause asked if this review process will add measures, and retire any that are no longer helpful, trying to keep the administrative burden static. Pat responded that the process does allow for measures to be taken away and added. The group discussed how the QPM work group was coordinating efforts with the DLTSS, Payment Models, and Population Health work groups. There was concern about the short timeframe for measure review and that the measures don't reflect LTSS. Pat Jones stated the QPM work group is well aware that this category of measures needs more information. John Evans asked if the QPM work group plans to poll or assess providers to figure out what data they should be collecting, and if providers have Electronic Health Records (EHRs) and if they are actually using them (not suggesting a full gap analysis but understanding it would be important information to consider as the group moves forward). Pat expressed that the QPM work group is always interested in using electronic mechanisms for collecting data and that chart reviews are not the preferred method because they are only a sample of the data. Peter Cobb made a motion to adopt the recommendation which was seconded by Debbie Ingram. The motion passed unanimously.	
6 Financial Requests	1. <u>Population Health Work Group Spending Proposal (attachment 6a)</u>: Georgia Maheras presented the proposal on behalf of the Population Health work group to continue an existing contract with Jim Hester. Jim has been working with the work group for 6 months. The work group proposes to hire Jim for an additional year, not to exceed an amount of $28,000. Todd Moore asked if there are specific deliverables under the contract. Georgia Maheras explained that in addition to attending the work group meetings Jim vets materials and serves as a liaison between CMMI and the work group. He has presented on payment models, which will	

Agenda Item	Discussion	Next Steps
	become more specific over the next year. Work may also include development of white papers and other documents. This work, and his expertise, is outside the scope of any other member of the work group. Jim would also participate in other work group discussions as necessary. Bob Bick paused to clarify the protocol for meeting attendees when they are directly affected by the outcome of a proposal recommendation. Georgia Maheras stated that depending on the type of contract in question it may be necessary to have the potential vendor/beneficiary in the room during the initial discussion to clarify technical questions, however they must leave the room at the time of voting. The Steering Committee staff will identify a consistent protocol for future proposals. Mark Larson moved for the Steering Committee to approve the proposal and Bob Bick seconded the motion. Todd Moore confirmed that the contract maximum was in fact $28,000. The motion passed unanimously. 2. <u>HIE/HIT Work Group Spending Proposal (attachment 6b):</u> The group discussed the HIE/HIT Work Group Proposal which contains three separate, but related projects: 1) DA/SSA Data Quality and Repository; 2) LTSS Data Planning; and 3) Universal Transfer Form (UTF) Planning. The following key points were made: • There is an additional $120,000 that must be added to the budget to pay for an IT Project Manager to support these three activities. • Gap analyses have been performed for some but not all LTSS, some of which use EHRs, while others don't. The budget for the gap analysis in the proposal is to assess whether additional gap analyses would be useful. It also helps the group understand different low tech and high tech ways to connect the providers. The funding is not to actually perform the gap analyses. The proposal should be revised to make this clear. • This proposal does not address data related to children. The HIE/HIT Work Group should determine how to capture that information in the future. • The HIE/HIT Work Group recommendation intends to use VITL for the data repository architecture and design.	

Agenda Item	Discussion	Next Steps
	• The third part of the proposal is for the planning of the UTF. It is to understand what resources it would take to design and create this form. o Primary care service providers will be added to the development team, as well as providers in bordering states. o The deliverable will be a Project Charter, which is a planning document, to develop the electronic form. The Charter will look at all the aspects that go into the design of the form (considering piloting the program in a smaller area, verses all of Vermont, etc.) o Staff working on the UTF will need to connect with the Workforce Work Group to make sure the form is reflective of that other work group's processes. The Chairs requested that Steering Committee members who stand to benefit from the proposal leave the room due to conflicts of interest. Mark Larson moved to commit $2.6 million for the proposal with the stipulation that at the next Steering Committee meeting the HIE work group returns with an update on deliverables, phases for deliverables and an updated budget. After discussion, Steering Committee members suggested amending the motion to state that the approval is conditional pending a more detailed proposal to be presented to the group the following month. Mark amended the motion, which was seconded by Bea Grause. Peter Cobb, Nancy Eldridge and Mary Val Palumbo abstained and the motion passed.	
7 Next Steps, Wrap-Up and Future Meeting Schedule	The meeting adjourned. The next meeting will be Wednesday, April 16th 10 am – 12 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Attachment 6a - Advancing Care Through Technology Presentation

ACTT PARTNERS

ADVANCING CARE THROUGH TECHNOLOGY

UPDATE FOR THE VHCIP STEERING COMMITTEE

APRIL 16, 2014

Recommendation from the HIE/HIT Work Group

- The HIE/HIT Work Group recommended approval of three projects:
  - Project 1: Data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. This project has two phases – a planning and an implementation phase. Cost: $1,949,046
  - Project 2: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000
  - Project 3: Universal Transfer Form Protocol Planning. Cost: $215,072

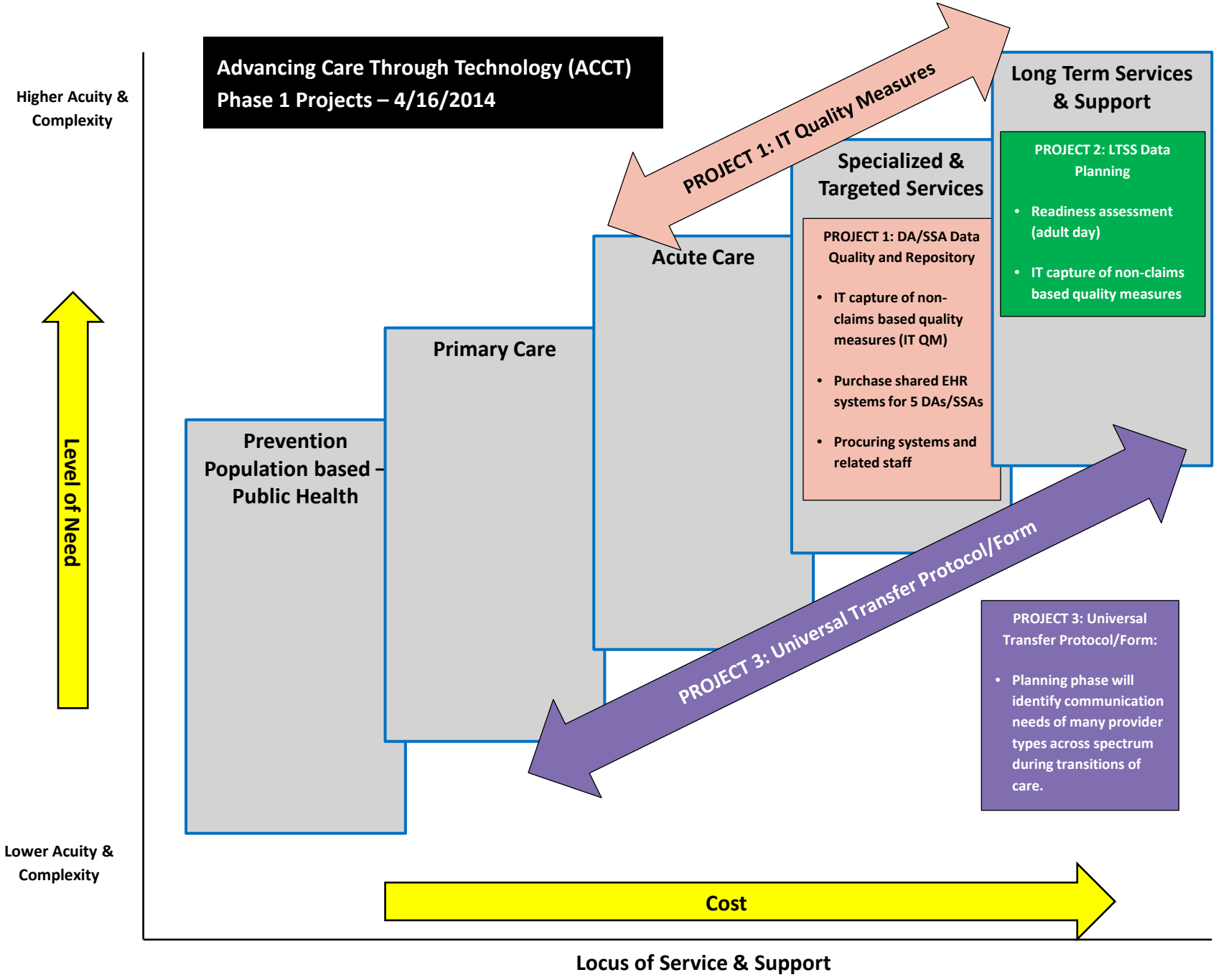
Additional request for Steering Committee consideration:

- Overall Project Management for these three projects: $120,000

Total requested: $2,462,118

ACTT Goals
Improve DLTSS information exchange

- **Source Systems**: improve utilization, functionality and interoperability of the DLTSS source systems providing data for the exchange of information
- **Data Quality:** improve DLTSS data quality and accuracy for the exchange of information
- **Communication**: improve ability to exchange information
- **EHR Integration**: align and integrate Vermont's DLTSS electronic health information systems


Advancing Care Through Technology (ACCT)
Phase 1 Projects – 4/16/2014
Higher Acuity & Complexity
Level of Need
Lower Acuity & Complexity
Locus of Service & Support
Cost
PROJECT 1: IT Quality Measures
Prevention Population based – Public Health
Primary Care
Acute Care
Specialized & Targeted Services
Long Term Services & Support
PROJECT 1: DA/SSA Data Quality and Repository
IT capture of non-claims based quality measures (IT QM)
Purchase shared EHR systems for 5 DAs/SSAs
Procuring systems and related staff
PROJECT 2: LTSS Data Planning
Readiness assessment (adult day)
IT capture of non-claims based quality measures
PROJECT 3: Universal Transfer Protocol/Form
PROJECT 3: Universal Transfer Protocol/Form:
Planning phase will identify communication needs of many provider types across spectrum during transitions of care.

Project 1
DA/SSA Data Quality and Repository

- Phase 1:
  - Identify data and reporting needs and create data dictionary for DA/SSA system
  - Enable pilot discover process for measurement and HIE and develop toolkit for statewide use
  - Utilize tools statewide and conduct current state EHR capability analysis for DAs/SSAs
  - Procure unified EHR for five developmental disability agencies in consultation with VITL
  - Conduct architectural design process with VITL and necessary stakeholders to identify characteristics of, and infrastructure for, desired solution for data repository (potential ability to leverage VITL statewide infrastructure)
- Phase 2:
  - Begin quality remediation of identified data elements that relate to VHCIP models being tested
  - Begin DA/SSA connectivity to HIE through VITL
  - Execute repository project based on phase one decision

Project 2
Planning for DLTSS Data Reporting

- Update and/or Conduct DLTSS Provider Information Technology Gap Analyses and Develop a Remediation budget
  - Review existing reports related to information technology gap remediation work
  - Work with VITL
- Convene meetings with DLTSS providers and provider associations to assess current IT systems
- Create a report of analyses that need to be conducted
- Create a complete plan for conducting IT gap remediation analyses based on work under this project maximizing low-tech and high-tech solutions as appropriate
- Planning work related to non-claims based measures for DLTSS programs

Project 3
Planning for Universal Transfer Protocol/Form

- Technical support for a planning process to develop a uniform transfer form/protocol.
  - Look at low-tech and high-tech solutions
- This 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.
- Develop the functional requirements around the realistic and useable exchange of information during transitions of care between different types of providers

BUDGET

PROJECT	COSTS
Project1: *Phase 1* Data gathering for Designated Agencies and Specialized Service Agencies. *	$799,184
Project 1: *Phase 2* Remediation and Repository *	$1,149,862
Project 2: LTSS Data Planning/Provider IT Gap Analyses *	$178,000
Project 3: Universal Transfer Form *	$215,072
Program management	$120,000
TOTALS	**$2,462,118**

*All projects include funds for VITL

Attachment 6b - 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.

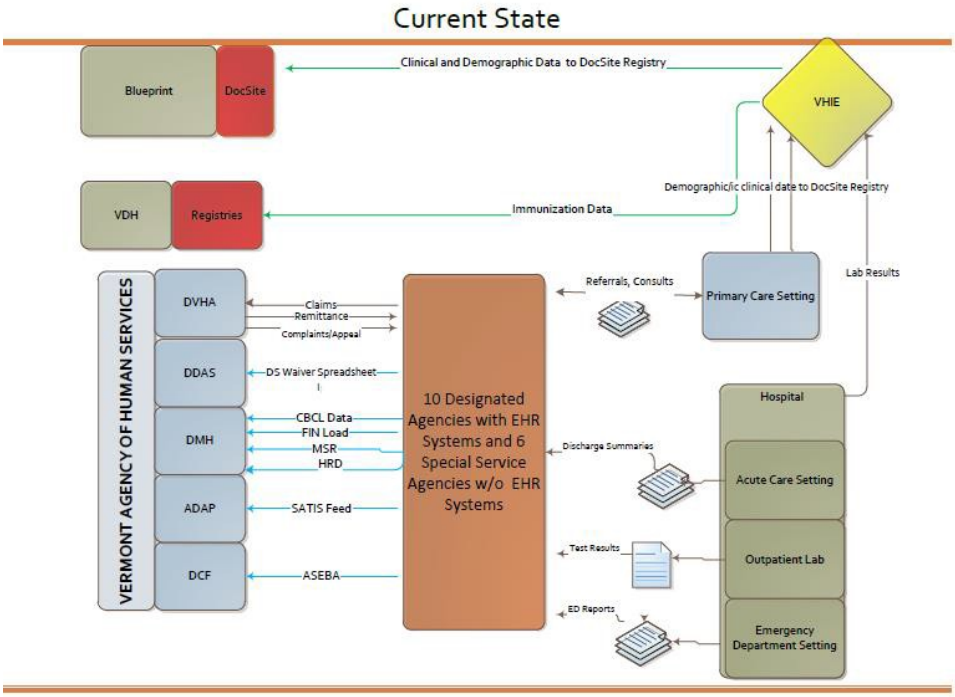
Behavioral health measures, even nationally, are not as advanced as those within the medical industry though the designated agencies are being required to report numerous measures. The National Quality Forum recently launched a new project entitled "Behavioral Health Endorsement Maintenance" seeking 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 7 - VHCIP Work Group Status Reports

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VT Health Care Innovation Project
Care Models and Care Management
Work Group Status Report

Date: April 2, 2014
Co-Chairs: Bea Grause and Nancy Eldridge

The Care Models and Care Management (CMCM) Work Group held its monthly meeting on March 11, 2014. At that meeting, the CMCM workgroup listened to a joint presentation from the Blueprint- VCCI-SASH and ACOs on a proposed Care Management Learning Collaborative. This presentation was at the conceptual level. The presenters walked through the high-level goals, highlights of their background research and next steps. Members of the CMCM requested regular updates as this work continues. Michael Bailit presented a summary from a survey monkey aimed at prioritizing the CMCM work group's activities. Workgroup members appeared to agree with the findings that showed a predominance of support for addressing fragmentation and focusing on the relationship between social and medical issues.

CMCM Work Group co-chairs met with the DLTSS Work Group co-chairs to discuss their related work and prepare for a presentation to the CMCM WG by the DLTSS WG in May. Deborah Lisi-Baker will craft a memo to the Core Team seeking clarification on language in the ACO Medicaid agreements pertaining to what entity has ultimate authority over care management models.

The CMCM WG spent several hours with DVHA and GMCB staff discussing the VHCIP Master Work Plan and the care management standards for ACOs.

The Population Health WG will present at the April CMCM WG meeting to help us define "the demand side" of care management.

VT Health Care Innovation Project
DLTSS Work Group Status Report

Date: April 2, 2014

Co-chairs: Judy Peterson & Deborah Lisi-Baker

1) **WG Project updates this month: (if possible contrast to master timeline and work plan)**

The DLTSS Work Group met on March 20th, 2014. We briefly reviewed our revised work plan and discussed how it relates to the broader project work plan Anya has prepared. The primary agenda item was an orientation to the VHCIP's work on quality and performance measures, in preparation for making recommendations to the QPM Work Group. Areas we have been asked to address are: recommendations regarding subpopulation analysis of particular measures, recommendations of pending measures to prioritize because of their importance to individuals with DLTSS needs, and recommendations of new measures to adopt because of their significance in improving services and outcomes for this population of key subgroups.

DLTSS Work Group members also identified additional information they felt would be important to have prior to making recommendations to the QPM Work Group. Staff and consultants are now preparing this information, which will be reviewed at upcoming meetings. Deborah Lisi-Baker gave an initial report on our interests and concerns to the QPM workgroup outlining our intent to provide additional information and recommendations in the next few two months.

2) **Planned accomplishments for next month/future : (if possible contrast to master timeline and work plan)**

Our April meeting will include a final vote on the DLTSS Charter and Work Plan, a presentation by Scott Wittman of PHPG on DLTSS expenditures in Medicaid, work on developing our recommendations to the QPM Work Group, and reviewing the Care Model developed by the Duals Stakeholder group prior to its presentation to the CMCM Work Group in May. We are in the process of scheduling an extra May meeting to continue our

preparation of recommendations to the QPM Work Group and reviewing related background materials and policy issues. Planned activities include presentation and discussion of an updated information table on Vermont ACOs, review of the ACTT Grant Proposal, and review of the DLTSS FAQ document developed by DAIL. Some of this work will continue in our regularly scheduled May meeting or in June.

3) Issues/risks that need to be addressed:

The underlying issues and concerns of the DLTSS Work Group is a desire to fully understand how the project's work on the ACO shared savings model, on quality and performance measures, and on care models and standards will affect DLTSS populations and programs, both within ACOs and within the context of state policy and practice.

4) Other matters:

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VT Health Care Innovation Project
HIE Work Group Status Report

Date: April 9, 2014
Co-Chairs: Simone Rueschemeyer & Brian Otley

1) WG Project updates this month: (if possible contrast to master timeline and work plan)
    - Brought the Advancing Care through Technology (ACTT) proposal to the Steering Committee. Will present to the Steering Committee again on April 16 2014.
    - Provided updates to the HIE WG on the Status of the Population-based Collaborative HIE proposal and the ACTT proposal.
    - Numerous meetings with VITL to align activities
    - Continued discussions on the HIE WG Work Plan goals and gaps in meeting those goals. Discussion around what we have done and what we have left to do, including: HIT Plan, telemedicine, provider grants, and more. Discussion around patient portals
    - Discussed telemedicine and types of additional information needed for next month's meeting
    - Briefly discussed the types of provider grants that would be coming to the workgroup for assessment and how they relate to the work plan.
    - Presentation by VITL on Data Warehousing Roadmap. This was the beginning of a conversation about the warehouse. Many questions were asked and responded to and participants were very interested in the topic. This will be discussed further at the next meeting.

2) Planned accomplishments for next month/future: (if possible contrast to master timeline and work plan)
    - Present additional information to the Steering Committee on the ACTT proposal to pass on to the Core Team
    - Telemedicine: additional clarity, additional information, criteria development and solicitations
    - Continued discussion around the VITL Data Warehouse
    - Continued discussion around the patient portal
    - Grant Program referral assessment and recommendations
    - Referrals from QPM
    - Evaluation

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VT Health Care Innovation Project

- Link to the Vermont Health Information Strategic Plan
- Continued updates from ACTT and Population-based proposals

3) Issues/risks that need to be addressed:
There is a lot of need and there are a lot of great ideas. How activities are prioritized and how they link to the overall state plan as well as how they connect to other workgroup initiatives should be continually assessed.

4) Other matters: none at this time

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VT Health Care Innovation Project
Payment Models Work Group Status Report

Date: March 11, 2014
Co-Chairs: Don George & Stephen Rauh

The Payment Models Work Group will hold its next monthly meeting on April 7, 2014. The primary focus of this meeting is to facilitate discussion and finalize approach to the next phase of EOC program development. Consultants from Brandeis will present a variety of approaches and facilitate discussion. The goal will be to, through this discussion, better inform and finalize the analytic work plan that will support the EOC program design phase that will occur over the coming months. The co-chairs and staff will also be meeting in late April to further develop the strategic approach to incorporation of other related work into the work plans and clearly define "asks" of other work groups (like quality and performance work group for example).

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VT Health Care Innovation Project
Population Health Work Group Status Report

Date: April 1, 2014
Co-Chairs: Tracy Dolan & Karen Hein.

1) WG Project updates this month:

- During our March Working Group meeting we
  - Prioritized a review of the current ACO measures with an eye toward the possibility of adding measures that reflect a stronger prevention/population health focus. This focus for the March meeting was in part based on the schedule of the Measures group who indicated that they would be looking at the year 2 measures for the ACOs. PHWG presented criteria for selecting population health measures among those that were previously labelled as 'pending' measures among the ACO measures. The group then reviewed measure sets and identified an initial set of population health measures to recommend for ACOs
  - A smaller group met and reviewed the measures and further narrowed them down using the framework of the State Health Improvement Plan
  - Our staff person, Heidi Klein, presented our initial recommendations to the Measures working group during their March meeting and the group had a rich discussion as a result. Determinations on year 2 measures for ACOs have not yet been made.

- We developed a scope of work to address our third goal which involves *Identifying and disseminating current initiatives in Vermont and nationally where clinical and population health are coming together. Identifying opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.*
- We made plans to present at the Care Models Working Group in May.
- The proposal for a consultant to support the work around our objective related to paying for population health was approved by the steering committee.

2) Planned accomplishments for next month/future :

In the next 2-6 months, we hope to

a) post an RFP for a consultant support in work related to our third objective (described above), namely highlighting examples of accountable health communities and other models of care based in communities.

b) explore new financing mechanisms for paying for population health and prevention;

c) consider measures outside of the ACO framework that will help move efforts toward upstream prevention

d) reach out to other Working Groups to determine shared priorities

3) Issues/risks that need to be addressed :

none

4) Other matters :

none

* DAIL is anticipating accepted offers by the end of January 2014.

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VT Health Care Innovation Project
Quality & Performance Measures Work Group Status Report

Date: March 2014
Co-Chairs: Laura Pelosi & Cathy Fulton

1) **WG Project updates this month:** (if possible contrast to master timeline and work plan)

The first three items listed on the Work plan have been completed to date; The following items were addressed during the March 24, 2014 Workgroup meeting:

- Quality & Performance Measures Workgroup Work Plan was approved by the entire workgroup as presented on March 24.
- Criteria for Measure Selection were reviewed; previous ACO workgroup criteria were presented and discussed; also presented were other criteria and selection principles used in other programs such as NQF, CMS, Maine Medicaid and Oregon's Medicaid Metrics. A crosswalk of criteria was also reviewed. Michael Bailit presented a Measure Selection Criteria worksheet tool. Following discussion, the group agreed to modify this worksheet for our purpose of evaluating each criterion for measure selection under consideration for our workgroup currently. Group members were asked to review the current Criteria List to rate each criterion using the modified worksheet tool. The group's responses will be aggregated to create a prioritized list of criteria for discussion at the next meeting.
- Measure recommendations from the DLTSS and Population Health workgroups were submitted for consideration in payment reform programs.
- The Office of the Health Care Advocate submitted recommendations for consideration in the measure review process.
- A request from the Howard Center for a substance abuse screen such as CAGE was submitted for consideration.

2) **Planned accomplishments for next month/future**: (if possible contrast to master timeline and work plan)

- Implement a measure review process to address all measures for consideration, adjudicate all requests and prepare recommendations for the full workgroup to review and discuss.
- Finalize criteria selection and prioritization for use in reviewing submitted measures.

3) **Issues/risks that need to be addressed**:

- Finalize sampling methodology with sufficient time to implement necessary changes in procedures for providers and insurers; this item remains on the "to do" list for resolution. Discussion indicated that this will potentially be addressed by the analytics contractor.

4) **Other matters**:

- Establishing a meeting schedule or marathon session to address the submitted measures for inclusion in the payment or pending measures sets in the time frame allotted for development of recommendations.

VT Health Care Innovation Project
Workforce Work Group Status Report

Date: April 2, 2014

Co-chairs: Mary Val Palumbo & Robin Lunge

1) **WG Project updates this month: (if possible contrast to master timeline and work plan)**
    - The WG reviewed the Workforce Strategic Plan recommendations in order to update the status of the work toward meeting each recommendation. The recommendation status was updated, but needs further consideration. The WG will also need to update the Strategic Plan for January as required by law.
    - The group reviewed the SIM grant criteria for spending, which includes data collection and analysis, but would not currently fund workforce training, loan repayment, or other programs of that nature.
    - Because this group is established for a dual purpose, the group also discussed establishing a process to solicit proposals to recommend to the Governor, understanding that this would need to be presented as a possible priority for state funding, but that there is no set amount of dollars.
    - The WG heard an update from VDH, then discussed and approved an updated workforce survey collection proposal:
        - The licensure schedule is every two years, but it's staggered and data will be gathered when professionals are licensed. Analysis will then be prioritized for that data.
        - There is currently one full time person working on this project and they are recruiting for a second. Dawn will report to the group in 2-4 months with an update and see whether or not they need to add another full time person.
        - The work group can conditionally approve the addition of another FTE or additional contract resources, so that the approvals can go through Steering and Core Team first, and then back to the work group to save time.

- The group discussed the following changes to the professional categories listed in the document presented by the Department of Health: Naturopath be changed to Naturopathic Physician and placed under primary care; Mental Health Licensed Professional Counselor be changed to Licensed Clinical Mental Health Counselor; Licensed Lay Midwife should be included; Alcohol and Drug Abuse Counselor should be changed to include Therapists and Substance Abuse Counselors.
- Medical assistants are not licensed or certified so they are not listed but this is an important area and may want to look at other ways to capture this data.
- The group approved the Department of Health's proposal for prioritization with the changes discussed subject to the Workforce work group getting a report back on potential additional resource needs..
- The group also approved VDH assembling a task force to determine what further analytic resources VDH needs. VDH will report back in the May meeting and present a proposal if needed.

- DAIL gave an update to the group on the first meeting of the Long Term Care (LTC) Subcommittee. The group met on March 24th and 10-12 attendees, in addition to staff, with more expected to attend the next meeting on May 5th. They plan to meet each month thereafter to develop recommendations to the Workforce work group. Brendan Hogan from Bailit Health Purchasing, Inc. will be acting as the lead and doing consulting work, looking at what constitutes direct quality care. The subcommittee acknowledges the importance of training, noting little has been done. They plan to collect the data around supply and demand from existing reports and providers. Hogan will compile and review the data at the next subcommittee meeting. Most of the data will come from the fiscal agent ARIS Solutions, the Department of Labor and agencies such as Home Health. Tasks for Hogan include creating an overall work plan and summaries of data supplied, recruitment retention, and training efforts. The LTC subcommittee will present to the work group again in September.
- The group discussed implementing a Symposium subcommittee and looking outside the US to understand recruitment in other single payer-like systems. Molly Backup and Deborah Wachtel will meet to discuss preceptorships, which may eventually form into a subcommittee

2) Planned accomplishments for next month/future : (if possible contrast to master timeline and work plan)

- The WG will begin meeting monthly due to the volume of work needed to be done. The group will revisit monthly meetings, which do pose a hardship for some members, in late summer.
- The WG will finalize the process to get project recommendations.
- The LTC Subcommittee will report on data and available information they have collected/analyzed.
- The WG will consider suggestions for additional members to represent other professions & make a recommendation which Robin will bring to the Governor.
- S.252 current directs the Administration to have a Workforce Symposium before November 15th. The group will hear back from the planning subcommittee.
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3) Issues/risks that need to be addressed :

- There is much interest in getting information about new care models & we need to be mindful not to do the work of the care models workgroup. This group should, however, coordinate with that workgroup and understand the future state, in order to make recommendations for how to plan for it.
- There is a lot of interest in funding proposal which are outside of the SIM grant funding.
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4) Other matters :

VHCIP Steering Committee 4-16-14 Meeting Additional Materials

To: Members of the VHCIP Core Team

From: Deborah Lisi-Baker, Co-Chair, Disability and Long Term Services and Supports (DLTSS) Work Group (formerly the Dual Eligible Work Group)

Date: April 11, 2014

I recently had the pleasure of participating in a joint meeting of the Co-Chairs of both the Care Models and Care Management (CM/CM) Work Group and the DLTSS Workgroup, along with a few other key staff and consultants. Our goal was to develop a shared plan for integrating the DLTSS Work Group recommendations on care models and standards that will be used by the VHCIP partners, including Vermont ACOs. I am writing this letter at the suggestion of the Joint Chairs: Bea Grause, Nancy Eldridge, Judy Peterson; but it is my own letter, rather than a document written for the group.

In preparation for our Joint Co-Chairs meeting, I reviewed our work groups' charters and workplans, Federal and State documents related to the purpose of the ACO shared savings programs in Vermont, and the concerns and issues raised by advocates and providers in both the earlier Duals Stakeholder Group and the current DLTSS Work Group.

One of the documents the Joint Co-Chairs discussed that I reviewed was the language in the State's existing contract with Medicaid ACO's, specifically Section VI, Care Management Standards, Item C. The language of this section raised questions that have a direct impact on the role of our work groups, the role of AHS, and the emerging role of the ACOs, particularly with regard to Medicaid services and the role of Designated Agencies operating under contract with AHS. We discussed this language and the Joint Co-Chairs asked me to follow up with the Core Team, to gain greater clarity on the expected role of the Work Groups and the VHCIP Core Team, the role of the Agency of Human Services and the role of ACOs in establishing and overseeing the implementation of any care models and standards that emerge from our VHCIP work.

The language in question is from the OneCare Medicaid ACO Contract which states in Section VI Care Management Standards, item C. on page 22 (see attached for Section VI in full):

> "… Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO."

Following the meeting, I was asked to contact Kara Suter who wanted to make sure I understood the intent of this language and did not take it out of context. I met with her and wrote up a summary for her review and edits, in order to make sure that I accurately understood and represented her explanation. Kara made

important points: that the contract is only intended to address implementation of the shared savings model, that the shared savings model does not even include most DLTSS services yet, and that it does not replace or supplant existing statutory roles and policies established by the State. She also noted that the State had started with more directive language, referring to the goal of having the ACOs adopt any care model and standards emerging from the VHCIP work groups and the Core Team, but had been advised by lawyers that this kind of aspirational language did not belong in contracts. I greatly appreciate the time Kara took to provide this background, which is very helpful; but I am left with many of my broader concerns unresolved.

Kara made it clear that the intention behind the language in question was that the State move quickly to develop the care management standards and models and that then these standards would become part of new language within the State's contracts with Medicaid ACOs. However, contracts are negotiated by both parties; there is nothing in place, that I know of, establishing the shared understanding that the VHCIP care model and/or standards will be adopted by the ACOs and the State.

Without the aspirational language, or some other policy document clarifying the State's intent and role in implementing care management standards or models, there is no formal requirement that the ACO and partnering providers abide by the model developed by the CM/CM team with input from other groups, including the DLTSS workgroup. The CM/CM Work Group and the DLTSS Work Group are moving forward in good faith, but even the language of the CM/CM Charter and Workplan is pretty vague and does not provide much clarity on how the State and ACOs will use the products of their work.

I believe the Care Management Standards in the State's Medicaid ACO Contract has had perhaps an unintended negative impact on the negotiations and language of ACO contracts with providers. Though I have not been able to review the actual contracts, I have heard providers express concern about the inappropriate role and authority of OneCare in care management decisions.

The lack of clarity on ACOs' role in implementing current statutory requirements leads to continual concern about the impact of the ACO model on existing systems and safeguards established for persons with disabilities receiving Medicaid-funded DLTSS services through AHS Departments and provider networks, as established in law, regulation and contract. There is uncertainty in terms of the role of AHS, and the commitment of the State to preserve programs and protections that have been built over the last 20 years.

The Joint CM/CM and DLTSS Co-Chairs have agreed that we need to disseminate overarching care model standards/criteria to guide all VHCIP Work Groups. The attached "Proposed DLTSS Model of Care Criteria" is a table of standards that can be used as a starting point.

I thank you for your consideration of these issues and ask that you reply with a written response.

With sincere thanks,

Deborah Lisi-Baker

Co-Chair, DLTSS Work Group

VI. Care Management Standards

A. The Contractor will maintain regular contact with Vermont Chronic Care Initiative (VCCI) to ensure that efforts around care management are well coordinated through regular and ad-hoc in-person and telephonic meetings; at minimum, the Contractor agrees to a meeting monthly but as frequently as both parties agree is needed.

B. The Contractor will maintain as needed contact with other Vermont Agency of Human Services (AHS) departments engaged in care management or care coordination activities particularly as it relates to federal mandates (e.g., Early Periodic Screening, Diagnosis, and Treatment) and vulnerable populations (e.g., Disabilities, Traumatic Brain Injury, Integrated Family Services). Examples of this contact will include but not be limited to: meetings (in-person and telephonic), educational outreach, partnering, launching or rolling out new or existing initiatives, and direct care coordination.

C. If requested, the Contractor will, no more frequently than annually and no sooner than 60 days from the request, participate with the State to create a written plan describing detailed approach to care management activities described above. Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS programs or procedures, AHS employees and contractors shall cooperate with and implement the Clinical Model or Care Model of the ACO for a mutually agreeable time frame. DVHA and AHS acknowledge that this cooperation is critical to ACO in order to meet the quality, patient experience and financial performance thresholds under this Agreement. In the event of a dispute regarding the Clinical Model or Care Model, the parties may invoke the Dispute Resolution process set forth in Section 5 of Attachment A.

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered **and Directed** Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓