Vermont Health Care Innovation Project

Health Data Infrastructure Meeting Agenda

May 18, 2016, 9:00-11:00am

Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex

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

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	9:00-9:10am	Welcome and Introductions; Minutes Approval	Simone Rueschemeyer & Brian Otley	Attachment 1: Draft March 16, 2016, Meeting Minutes	Approval of Minutes
2	9:10-9:15am	Project Updates • Legislative Update	Georgia Maheras		
3	9:15-10:15am	Event Notification System Update and Demonstration	Jay Desai (PatientPing)	Attachment 3: PatientPing	
4	10:15-10:55am	VCN Data Repository Update	Ken Gingras (VCN)	Attachment 4: Data Repository Update	
5	10:55-11:00am	Public Comment Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	Next Meeting: Wednesday, June 22, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex	

Additional Materials: Shared Care Plans & Universal Transfer Protocol Final Report

Attachment 1: Draft March 16, 2016, Meeting Minutes

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

Pending Work Group Approval

Date of meeting: Wednesday, March 16, 2016, 9:00am-10:30am, Ash Conference Room, Waterbury State Office Complex, 280 State Drive, Waterbury.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Simone Rueschemeyer called the meeting to order at 9:01am. A roll call attendance was taken and a quorum was present. Nancy Marinelli made a comment on the minutes – on page 4, change HHA to AAA. Lou McLaren noted the Craig Jisenski was also in attendance. Nancy Marinelli moved to approve the February minutes by exception. Lou McLaren seconded. The minutes were approved, with one abstention (Heather Skeels).	
2. Update: PatientPing	Julia Sanders from PatientPing provided an update on implementation of the Event Notification System and plans for launch. • PatientPing is making great progress in planning for rollout. • A launch event is being planned for early April (date TBD), likely in Montpelier. It will focus not just on Patient Ping as the ENS but more broadly on health care reform activities in Vermont. • As PatientPing plans for launch, data is flowing from VITL to PatientPing – providers can being signing up for "pings" now. • PatientPing is working with OneCare and CHAC – a kick-off discussion with OneCare is this afternoon, and CHAC is working on a training event for providers. They are also working to connect with post-acute facilities and organizations. PatientPing is also planning local forums with providers and community health teams. The group discussed the following: • Will rollouts with OneCare and CHAC include all providers who have agreements with those ACOs? CHAC is rolling out PatientPing with full roster of attributed lives. CHAC is managing all socialization with their	

Agenda Item	Discussion	Next Steps
	providers about what this system means. OneCare is launching a tiered approach, focusing on top 5,000 ED utilizers. They are working to plan a pilot with this highest-risk population. • Will MVP lives (and others excluded from the ACO model) be excluded from the model, or will this include all patients that these providers are seeing? This model will not be limited to the ACO realm; the ACOs are a starting place. Georgia noted that the next step in rollout will be targeting the Blueprint; ACOs/attributed lives were an easy starting place but not the end goal. The State's contract with PatientPing aims to have half of Vermonters' providers receiving pings. • Pings include admission/discharge/transfer information. • Funding for PatientPing is 70% State/30% provider. After the initial State funding period, responsibility for funding this will fall to providers. • What is the patient engagement component? There is minimal member involvement; they may not even realize it exists. • How will ENS connect to home- and community-based services system? Initial targets are facilities like nursing homes and SNFs, but HCBS providers are a next step. PatientPing has a marketing plan to target these providers. PatientPing has been working with statewide provider groups and networks to connect with these providers, and will ensure that these provider types receive information about launch.	
3. Discussion and Next Steps: Shared Care Plan Solution	Georgia Maheras provided an update on the Shared Care Plan (SCP) project (Attachment 3). • This builds on significant work over the past year. Project team identified business and technical requirements through significant research and interviews with three communities around the state. There are at least six solutions in some phase of deployment in the state, with major barriers to implementation (sign-on fatigue, consent policy and architecture issues), and sustainability as a significant issue. • Possible solutions include a policy solution to address consent architecture and policy; or technical solutions. Field of technical solutions is crowded, with solutions from the State (MMISCare), ACOs (OneCare's Care Navigator solution), VCHIP at UVM, and individual communities (Windsor, Newport, and Bennington). • Staff recommendation: Do not pursue technology solution at this time; instead focus on consent and remaining HDI initiatives. The group discussed the following: • Are we okay with there being multiple solutions in the state because care plans are likely to be regional/local? It may be that in a year or more we decide to consolidate or pursue a single solution, but given SIM's timeline and funding constraints, the HIT Plan is a natural space for this to land in the meantime. • Who are the owners where local communities are pursuing these solutions? Hospitals. VCHIP is a Robert Wood Johnson Foundation-funded grant. • Stefani Hartsfield suggested a presentation/demonstration from each of the six solutions in six months. The group was receptive to this idea.	

Agenda Item	Discussion	Next Steps
	• Lou McLaren noted that local control and multiple solutions might be appropriate, given the local flexibility we've historically granted to CHTs/HSAs. • Gabe Epstein noted that a technological solution may be able to accommodate multiple forms. Stefani cautioned against developing incompatible solutions in regions across the state, and instead seeking a flexible unified solution. • Simone Rueschemeyer agreed that we should revisit this topic in six months. • Georgia thanked the staff who have worked on this, especially Larry Sandage, Erin Flynn, Shashi Kumar, Sue Aranoff, and Gabe Epstein. A final report will be released after final edits. Lou McLaren gave credit to staff and leadership for making the hard decision not to seek a solution at this time.	

4. Current Policies and Proposed Changes to 42 CFR Part 2 Requirements	Rachel Block presented research and analysis on the Substance Abuse and Mental Health Services Administration's (SAMHSA) proposed changes to 42 CFR Part 2 requirements (Attachment 4). Georgia noted that this is informal policy guidance and not legal advice. The State will be providing comments to SAMHSA (not yet written).
	• Rachel added two caveats:
	  o This is a proposed rule – it is out for comment. Within the body of the document, there are specific areas where they have invited comments. Final rulemaking will consider these comments. There could be significant changes based on comments. There is no timeline for publishing the final rule.
	  o This presentation focuses specifically on key provisions relevant to this group; it is a high-level.
	• Consent form: Examples included many ways patients could denote understanding, and included from whom and to whom information will flow, and how much and what kind of information will be shared.
	• Where does Part 2 Apply? The proposed rule makes more explicit the definition of to whom the rule applies, an area of confusion and conflicting readings in the past.
	• E-Rx and Prescription Drug Monitoring Program: SAMHSA chose not to address this.
	
	The group discussed the following.
	• Dale Hackett asked: does care setting matter within the rule? Rachel noted that this is a more complicated issue than it might appear, and suggested an offline discussion.
	• Do patients get to decide how much information is shared, and with whom? Rachel's interpretation is that this varies, though patients, in choosing to sign the consent, are choosing to share. Mike Gagnon noted that a more flexible "check box" approach would be technically complicated to implement.
	• Ken Gingras commented that the proposed change modernizes the rule from on-paper information sharing to transactional, ongoing exchange. His interpretation is that the rule is not so granular as to be impossible to implement. Rachel suggested that we need three lenses for this: legal (have we met the legal standard of what is described, is there a document to demonstrate that the law is being followed); feasibility (for providers and others); and patient preference.
	• Lou McLaren provided an example of how insurers have dealt with similar issues for many years. The process is unwieldy, but carriers have been managing to deal with specific, discrete data sets for years. A simple yes/no is too limiting for patients. MVP audits provider files within mental health and substance
		Follow up on VHCURES questions raised by Lou McLaren.

Agenda Item	Discussion	Next Steps
	abuse to ensure they have completed MVP's form related to information sharing with primary care and that the patient has declared whether information can be shared. Rachel noted that if a general designation is used in consent (Porter Hospital, for example), there must be a policy to ensure only treating providers are accessing information. • Ken Gingras commented that there are significant tensions between the needs of carriers and the real-time needs of technology like VITL's. • Susan Aranoff commented that she believes that technology will catch up to people's rights to medical privacy. Granularity may be technologically challenging, but informed consent is key when waiving rights. • Georgia commented that the State's process for gathering comments is being led by Alan Sullivan. He is convening departments of AHS, as well as Assistant Attorney's General to those departments, Steve Maier, and Georgia. This group will also connect back with IT folks, and will gather feedback from others to inform this process as we are today. Comments are due April 11th, so any other thoughts that this group would like the State to consider should be communicated before that date. • Simone Rueschemeyer noted that Vermont Care Partners will submit comment. VITL will as well. • Georgia's understanding is that ONC hoped for additional clarity from SAMHSA, and that one purpose of comment is to ask questions and identify areas of conflict or concern. Steve Maier added that "general designation" is a new piece of the rule – a designation could be made to an HIE or similar entity. There would need to be documentation of disclosure and ensure that only treating providers can access data. • Ken Gingras suggested a discussion among stakeholders about how disclosure and other requirements could impact the VHIE. • Lou McLaren asked how the recent Supreme Court decision in Gobeille v. Liberty Mutual impacts VHCURES and possibly these conversations. She asked whether Craig Jones's presentation from the 2/17 meeting could be revisited in the future in this light. Georgia noted that we can get information quickly about how much of VHCURES is self-insured, and look to GMCB for a statement or reaction. • Richard Slusky asked if this group has submitted official comment on the HIT Plan. Georgia clarified that it was discussed iteratively at least three times, but that there were no official comments submitted. Georgia offered to provide meeting minutes to GMCB if appropriate, and will connect with GMCB leadership.	
5. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	Susan Aranoff commented that a State Medicaid Director letter was released on February 29th clarifying federal match availability for HIT projects for non-Meaningful Use Eligible providers. Georgia replied that Vermont is working to set itself up to take advantage of this by submitting two documents (SMHPD and IAPD) which will be approved sequentially. Once these are approved, we can start to request draw down of federal match. She also noted that Vermont was on the leading edge of pushing for flexibility in federal Medicaid funds, and we need to ensure that seeking flexibility in this area doesn't result in less flexibility in other areas. Our goal is to maximize federal dollars. **Next Meeting:** Wednesday, April 20, 2016, 9:00-11:00am, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury.	

VHCIP Health Data Infrastructure Work Group Member List

Member		Member Alternate		Minutes	Wednesday, March 16, 2016
First Name	Last Name	First Name	Last Name		Organization
Nancy	Marinelli ✓	Susan	Aranoff		AHS - DAIL
		Gabe	Epstein ✓		
Joel	Benware	Dennis	Boucher		Northwestern Medical Center
		Jodi	Frei		Northwestern Medical Center
		Chris	Giroux		Northwestern Medical Center
Eileen	Underwood	Peggy	Brozicevic ✓		AHS - VDH
Amy	Cooper				HealthFirst/Accountable Care Coalition of the Green Mountains
Steven	Cummings				Brattleboro Memorial Hopsital
Mike	DelTrecco				Vermont Association of Hospital and Health Systems
Chris	Dussault	Angela	Smith-Dieng		V4A
		Mike	Hall		Champlain Valley Area Agency on Aging / COVE
Leah	Fullem ✓	Abe	Berman		OneCare Vermont
Michael	Gagnon ✓	Kristina	Choquete		Vermont Information Technology Leaders
Eileen	Girling	Mary Kate	Mohlman		AHS - DVHA
Dale	Hackett				Consumer Representative
Emma	Harrigan	Tyler	Blouin		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
		Brian	Isham		AHS - DMH
Paul	Harrington				Vermont Medical Society
Stefani	Hartsfield ✓	Molly	Dugan		Cathedral Square
		Kim	Fitzgerald		Cathedral Square and SASH Program

VHCIP Health Data Infrastructure Work Group Member List

Member		Member Alternate		Minutes	Wednesday, March 16, 2016
First Name	Last Name	First Name	Last Name		Organization
Kaili	Kuiper ✓	Trinka	Kerr		VLA/Health Care Advocate Project
Brian	Otley ✓				Green Mountain Power
Kate	Pierce				North Country Hospital
Darin	Prail	Diane	Cummings ✓		AHS - Central Office
Kim	McClellan ✓	Todd	Bauman		DA - Northwest Counseling and Support Services
		Randy	Connolly		DA - Northwest Counseling and Support Services
Ken	Gingras ✓	Russ	Stratton		VCP - Behavioral Health Network of Vermont
~~Sandy~~	~~Rousse~~ ←	Arsi	Namdar ✓		Central Vermont Home Health and Hospice
Julia	Shaw	Lila	Richardson		VLA/Health Care Advocate Project
Heather	Skeels ✓	Kate	Simmons		Bi-State Primary Care
Roger	Tubby ✓	Pat	Jones		GMCB
Chris	Smith ✓	Lou	McLaren ✓		MVP Health Care
Kelly	Lange	James	Mauro		Blue Cross Blue Shield of Vermont
	26		27		

VHCIP Health Data Infrastructure Work Group
Attendance Sheet 3/16/2016

	First Name	Last Name		Organization	Health Data Infrastructure
1	Susan	Aranoff	✓ SVM AM	AHS - DAIL	M
2	Joanne	Arey		White River Family Practice	A
3	Ena	Backus		GMCB	X
4	Susan	Barrett		GMCB	X
5	Todd	Bauman		DA - Northwest Counseling and Support Se	MA
6	Joel	Benware		Northwestern Medical Center	M
7	Tyler	Blouin		AHS - DMH	MA
8	Richard	Boes		DII	X
9	Dennis	Boucher		Northwestern Medical Center	MA
10	Jonathan	Bowley		Community Health Center of Burlington	X
11	Jon	Brown	✓ JAB	HSE Program	X
12	Peggy	Brozicevic	Phone	AHS - VDH	M
13	Martha	Buck		Vermont Association of Hospital and Healt	A
14	Shelia	Burnham		Vermont Health Care Association	X
15	Wendy	Campbell		Planned Parenthood of Northern New Engl	X
16	Narath	Carlile			X
17	Kristina	Choquete		Vermont Information Technology Leaders	MA
18	Peter	Cobb		VNAs of Vermont	X
19	Amy	Coonradt		AHS - DVHA	S
20	Amy	Cooper		HealthFirst/Accountable Care Coalition of t	M
21	Diane	Cummings	✓ DCC	AHS - Central Office	S
22	Steven	Cummings		Brattleboro Memorial Hopsital	M
23	Becky-Jo	Cyr		AHS - Central Office - IFS	X
24	Mike	DelTrecco		Vermont Association of Hospital and Healt	M
25	Molly	Dugan		Cathedral Square and SASH Program	MA
26	Chris	Dussault	Phone	V4A	M
27	Jennifer	Egelhof	JE.	AHS - DVHA	X
28	Nick	Emlen		DA - Vermont Council of Developmental an	X
29	Gabe	Epstein	GE	AHS - DAIL	MA

30	Karl	Finison		OnPoint	X
31	Jamie	Fisher		GMCB	X
32	Kim	Fitzgerald		Cathedral Square and SASH Program	MA
33	Erin	Flynn		AHS - DVHA	S
34	Paul	Forlenza		Centerboard Consultingt, LLC	X
35	Judith	Franz		Vermont Information Technology Leaders	X
36	Jodi	Frei		Northwestern Medical Center	MA
37	Leah	Fullem	Phone	OneCare Vermont	M
38	Michael	Gagnon		Vermont Information Technology Leaders	M
39	Daniel	Galdenzi		Blue Cross Blue Shield of Vermont	X
40	Joyce	Gallimore		Bi-State Primary Care/CHAC	X
41	Lucie	Garand		Downs Rachlin Martin PLLC	X
42	Christine	Geiler		GMCB	S
43	Ken	Gingras		Vermont Care Partners	M
44	Eileen	Girling		AHS - DVHA	M
45	Chris	Giroux		Northwestern Medical Center	MA
46	Al	Gobeille		GMCB	X
47	Stuart	Graves		WCMHS	X
48	Dale	Hackett	Phone	Consumer Representative	M
49	Mike	Hall		Champlain Valley Area Agency on Aging / C	MA
50	Emma	Harrigan		AHS - DMH	M
51	Paul	Harrington		Vermont Medical Society	M
52	Stefani	Hartsfield		Cathedral Square	M
53	Kathleen	Hentcy		AHS - DMH	MA
54	Lucas	Herring		AHS - DOC	X
55	Jay	Hughes		Medicity	X
56	Brian	Isham		AHS - DMH	MA
57	Craig	Jones		AHS - DVHA - Blueprint	X
58	Pat	Jones		GMCB	S
59	Joelle	Judge		UMASS	S
60	Kevin	Kelley		CHSLV	X
61	Trinka	Kerr		VLA/Health Care Advocate Project	MA
62	Sarah	Kinsler		AHS - DVHA	S
63	Kaili	Kuiper		VLA/Health Care Advocate Project	M
64	Kelly	Lange		Blue Cross Blue Shield of Vermont	M
65	Charlie	Leadbetter		BerryDunn	X
66	Kelly	Macnee		GMCB	MA
67	Carole	Magoffin	Phone	AHS - DVHA	S

68	Georgia	Maheras		AOA	S
69	Steven	Maier		AHS - DVHA	S
70	Nancy	Marinelli		AHS - DAIL	M
71	Mike	Maslack			X
72	James	Mauro		Blue Cross Blue Shield of Vermont	MA
73	Kim	McClellan		DA - Northwest Counseling and Support Se	MA
74	Lou	McLaren		MVP Health Care	MA
75	MaryKate	Mohlman		AHS - DVHA - Blueprint	M
76	Todd	Moore		OneCare Vermont	X
77	Stacey	Murdock		GMCB	X
78	Arsi	Namdar		VNA of Chittenden and Grand Isle Counties	MA
79	Mark	Nunlist		White River Family Practice	X
80	Miki	Olszewski		AHS - DVHA - Blueprint	X
81	Brian	Otley		Green Mountain Power	C/M
82	Annie	Paumgarten		GMCB	S
83	Kate	Pierce		North Country Hospital	M?
84	Darin	Prail		AHS - Central Office	X
85	David	Regan		GMCB	X
86	Paul	Reiss		HealthFirst/Accountable Care Coalition of t	X
87	Lila	Richardson		VLA/Health Care Advocate Project	MA
88	Laurie	Riley-Hayes		OneCare Vermont	A
89	Greg	Robinson		OneCare Vermont	MA
90	Sandy	Rousse		Central Vermont Home Health and Hospice	M
91	Simone	Rueschemeyer		Vermont Care Network	C/M
92	Tawnya	Safer		OneCare Vermont	X
93	Larry	Sandage		AHS - DVHA	S
94	Julia	Shaw		VLA/Health Care Advocate Project	M
95	Kate	Simmons		Bi-State Primary Care/CHAC	MA
96	Heather	Skeels		Bi-State Primary Care	M
97	Richard	Slusky		GMCB	M
98	Chris	Smith		MVP Health Care	M
99	Mary	Smith		AHS - DOC	X
100	Angela	Smith-Dieng		V4A	MA
101	Russ	Stratton		VCP - HowardCenter for Mental Health	M
102	Richard	Terricciano		HSE Program	X
103	Julie	Tessler		VCP - Vermont Council of Developmental a	X
104	Bob	Thorn		DA - Counseling Services of Addison County	X
105	Tela	Torrey		AHS - DAIL	X

106	Tim	Tremblay		AHS - DVHA - Blueprint	X
107	Matt	Tryhorne		Northern Tier Center for Health	X
108	Roger	Tubby ✓		GMCB	M
109	Win	Turner		CVMC	X
110	Eileen	Underwood		AHS - VDH	M
111	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
112	Julie	Wasserman	JW	AHS - Central Office	S
113	Richard	Wasserman, MD, MPH		University of Vermont - College of Medicine	X
114	Ben	Watts		AHS - DOC	X
115	David	Wennberg		New England Accountable Care Collaborati	X
116	Kendall	West		Bi-State Primary Care/CHAC	X
117	James	Westrich ✓		AHS - DVHA	S
118	Bradley	Wilhelm		AHS - DVHA	S
119	Gary	Zigmann		Vermont Association of Hospital and Healtl	X
					119

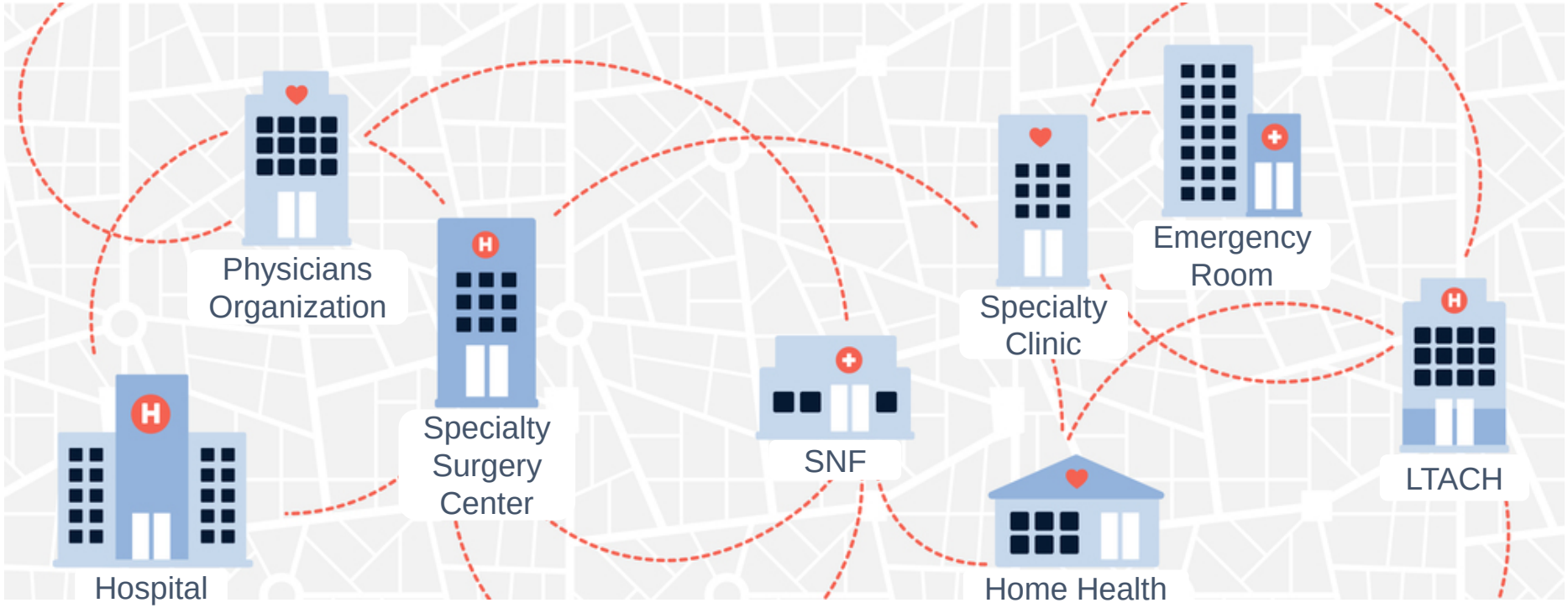
Attachment 3: PatientPing

PATIENTPING

Connecting providers to seamlessly coordinate patient care

THE PATIENTPING VISION: COORDINATE CARE EVERYWHERE

Our vision is to create a national care coordination community



By connecting providers through real-time admission and discharge notifications, we aim to help providers transform the way care is delivered

PATIENTPING: ENABLING COMMUNITY-BASED CARE COORDINATION

PINGS

Providers receive real-time notifications ("Pings") when patients are admitted or discharged anywhere

Who gets Pings? Care coordinators, hospital social workers, case managers, primary care physicians, practice managers, or any other provider
On which Patients? ACOs, bundles, commercial risk lives, all patients discharged from a hospital or other facility, or any other patient roster
When and Where? When patients are admitted to/discharged from any ER, hospital, SNF, LTACH, home health agency, or any other facility

POINT-OF-CARE GUIDELINES

Admitting facilities receive guidelines from the care team upon admission and discharge

Who sees Guidelines? Admissions coordinators and other providers at hospitals, SNFs, home health agencies, and other admitting providers
What's in a Guideline? Patient's full care team with contact information, instructions on how to work with care team, and history of hospital and other facility visits

Pings + Guidelines is a lightweight care coordination solution that empowers providers to improve quality and meaningfully impact total cost of care

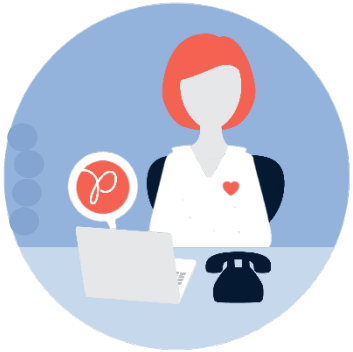
HOW IT WORKS

Patient arrives at admission site

Admitting provider sees care guideline and visit history

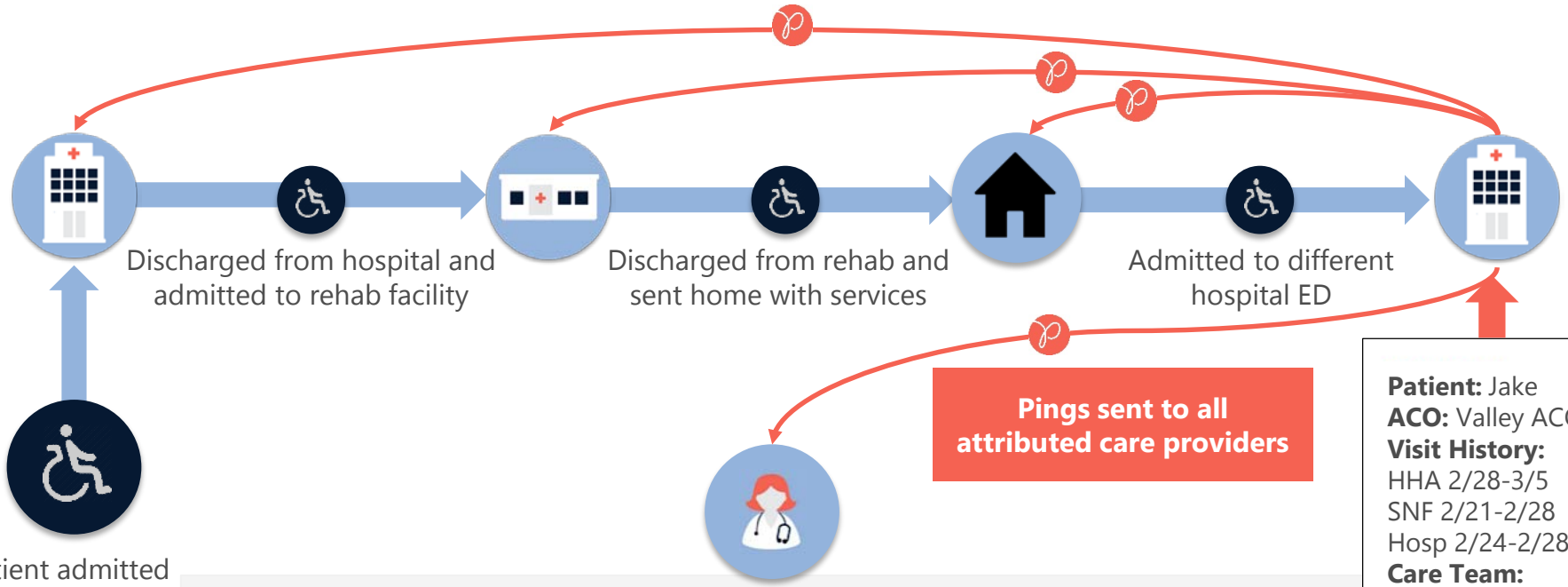
Patient's care team receives Ping

Ping is routed to admin, practices or providers

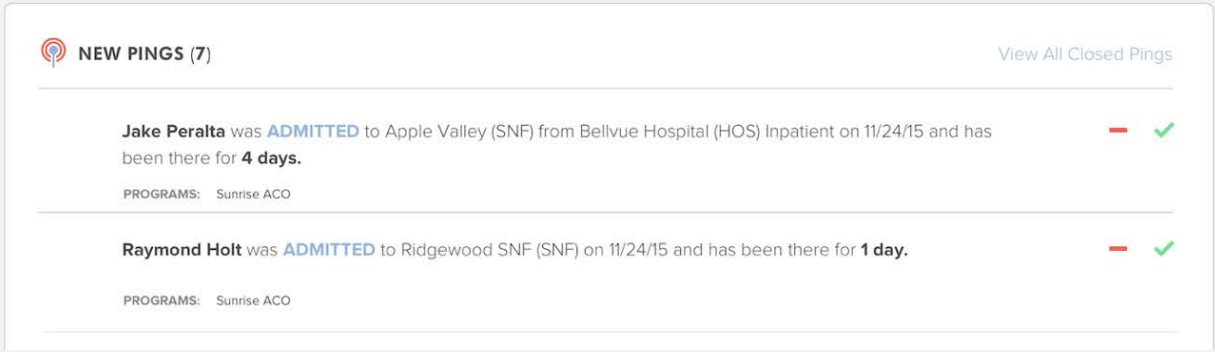


PATIENTPING: CONNECTS PROVIDERS

As patient passes through system, notifications are sent to every member of care team



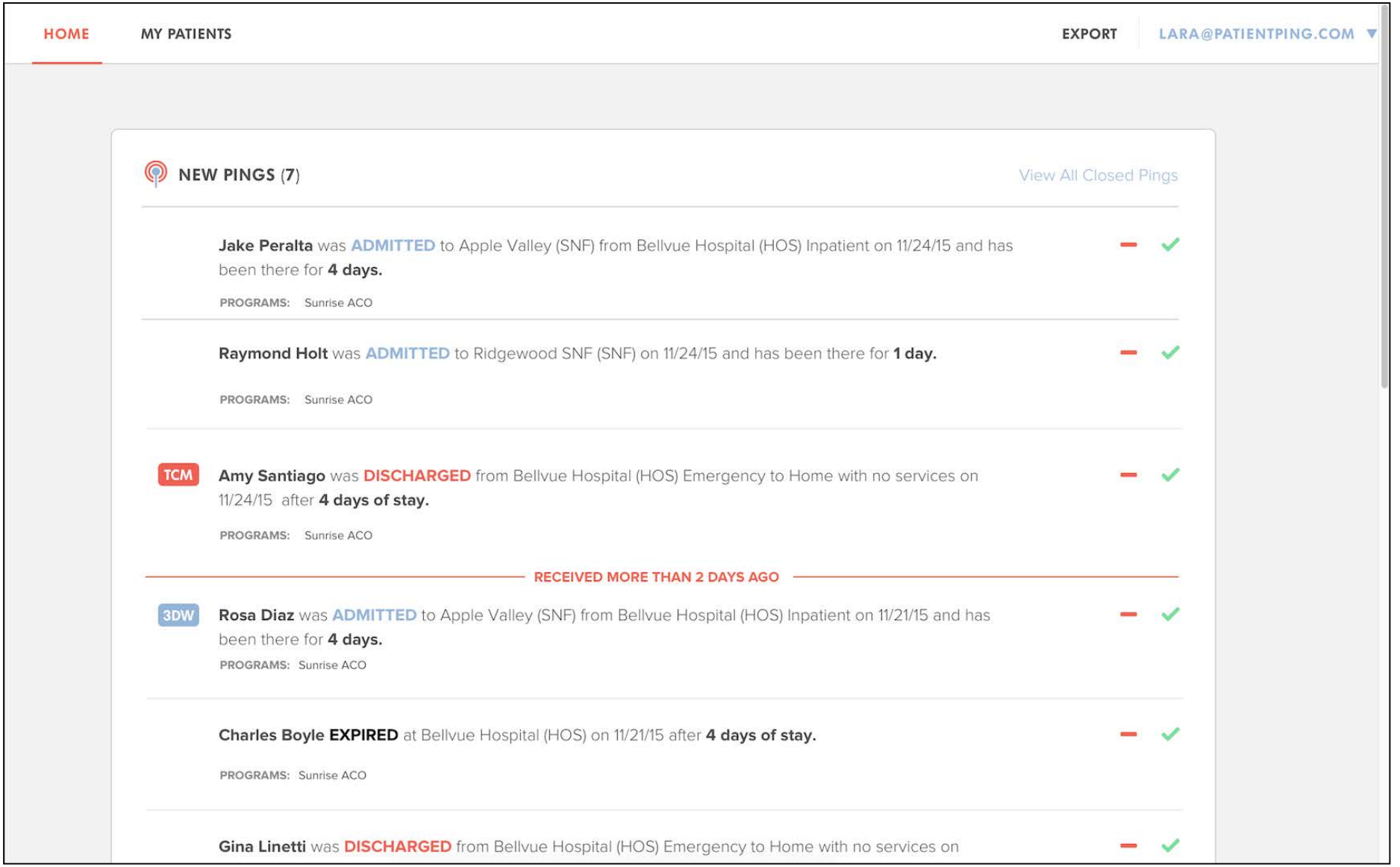
Patient: Jake
ACO: Valley ACO
Visit History:
HHA 2/28-3/5
SNF 2/21-2/28
Hosp 2/24-2/28
Care Team:
PCP: Dr. Jane
Hospitalist: Dr. B
SNFist: Dr. C
Home Aide: Mr D
Instructions:
High risk, call ACO nurse at 555-4567



Care guidelines to the point of care upon admit

REAL-TIME PINGS

Lightweight, clean panel to track patient visits anywhere



PINGS: FLEXIBLE ROUTING

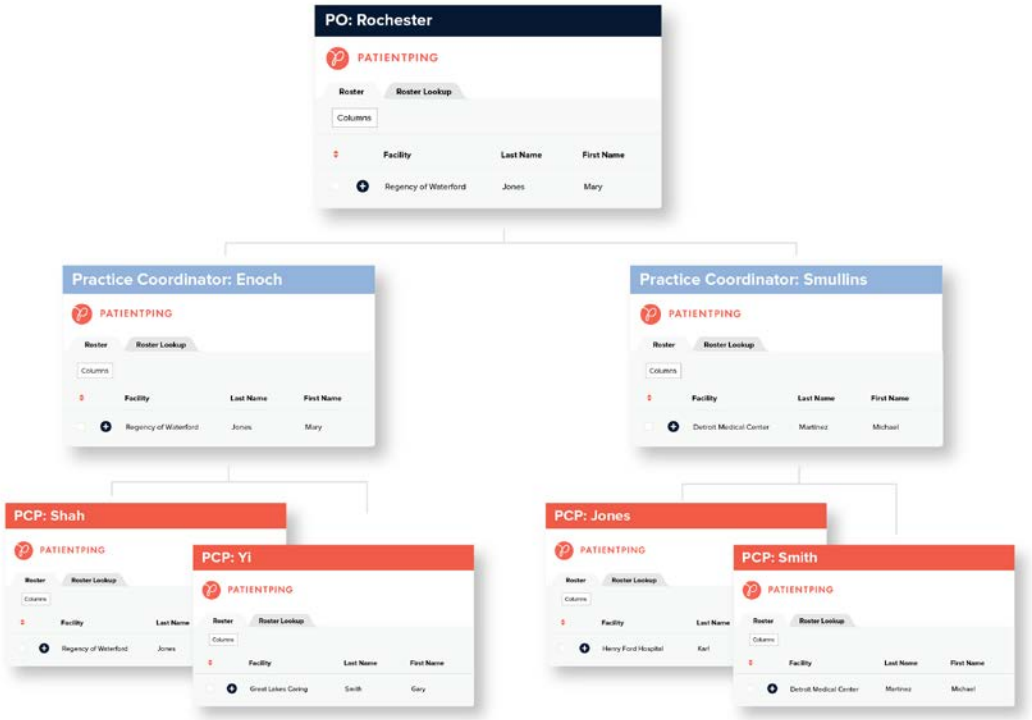
ACO/Health Plan

↓

Practice

↓

PCP/Nurse



PatientPing Web Application

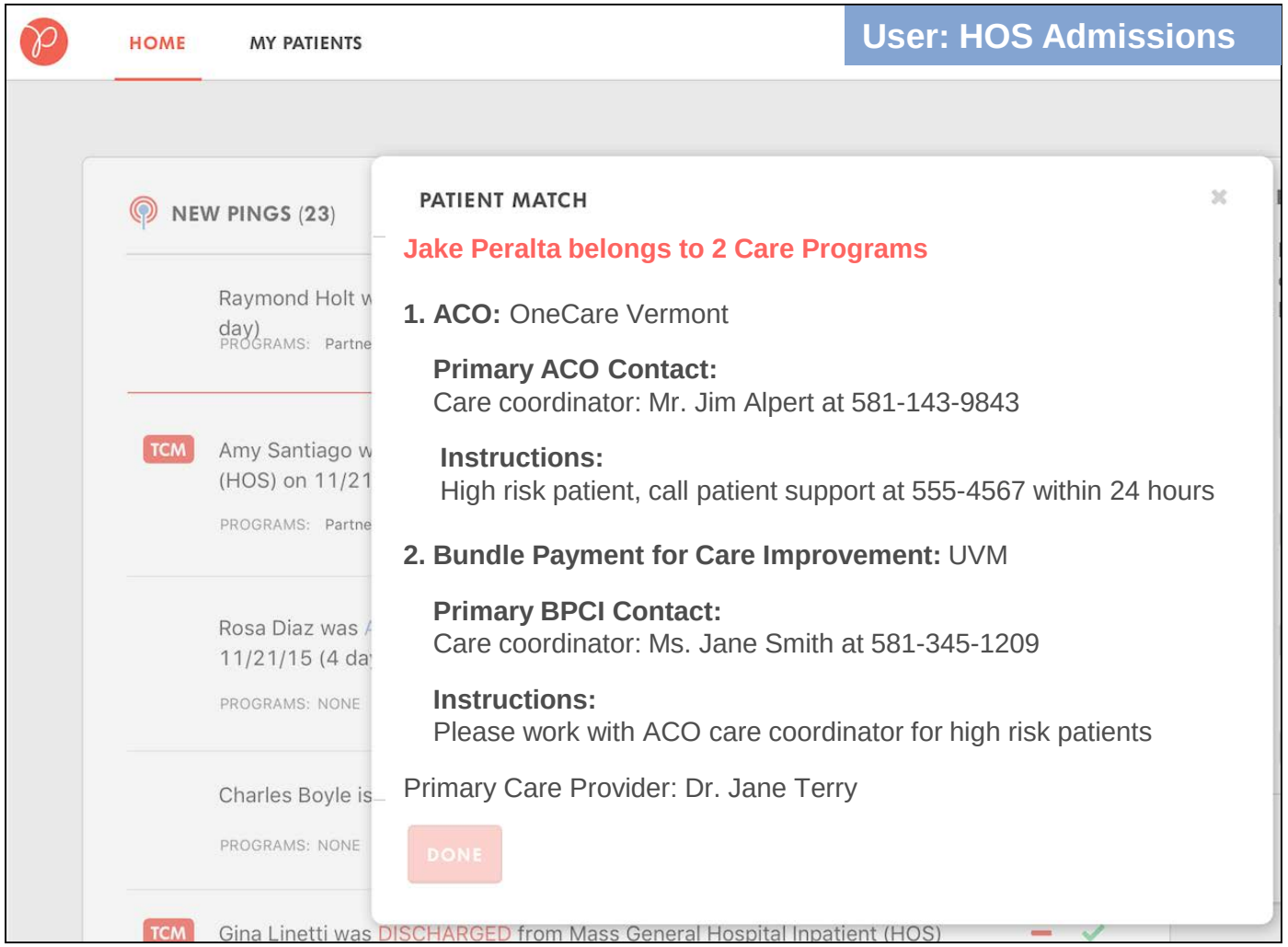
Mobile Notification

Existing System Integration

Equip practices and physicians to better manage care by sending them real-time Pings on their patients through a variety of mechanisms

CARE GUIDELINES AT ADMISSION SITE

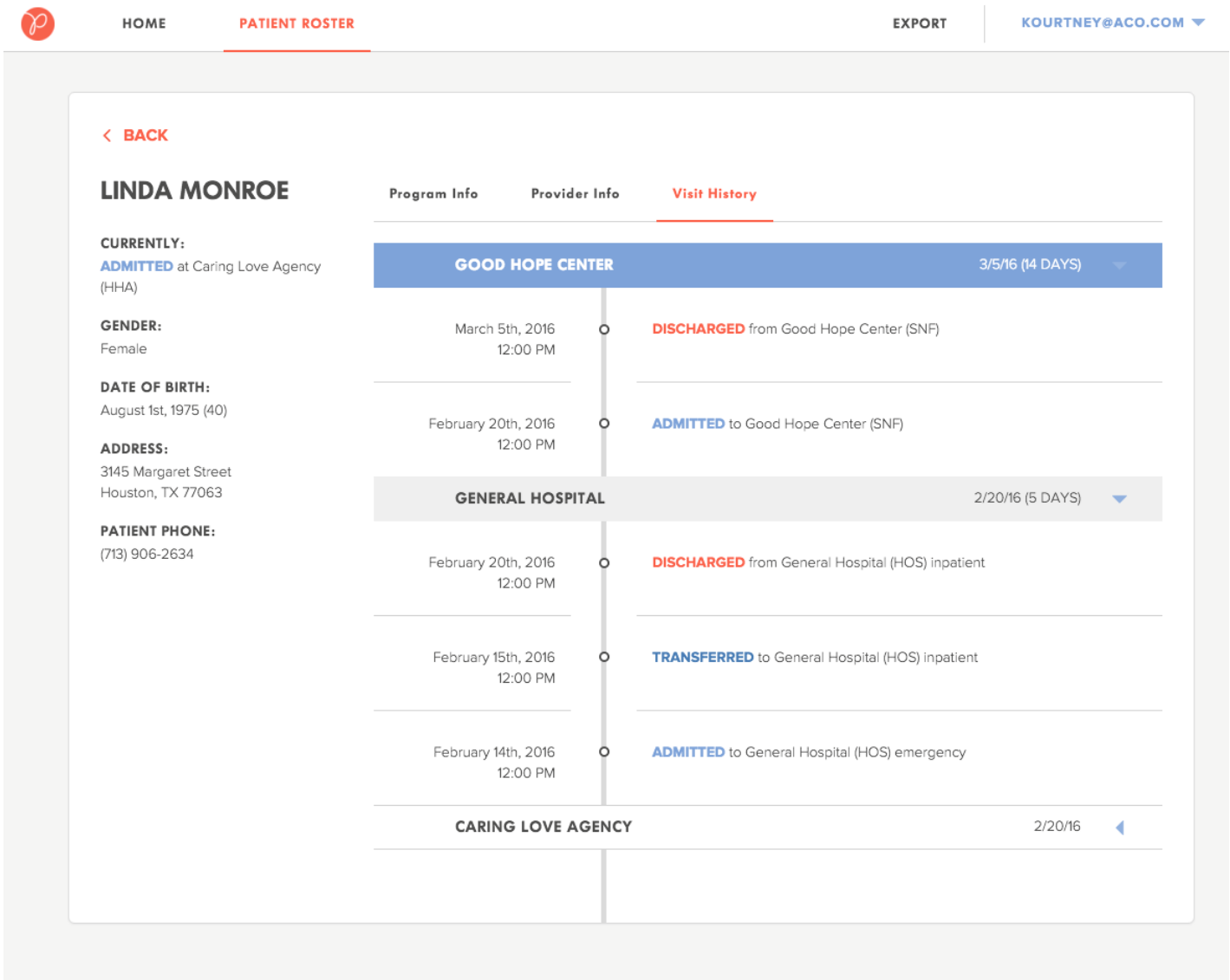
Automatically share care information with full care team



VISIT HISTORY AT ADMISSION SITE

Learn all other destinations patients have received care upon admission

User: HHA Registrar



COMMUNITY IMPACT

Improve quality of care by efficiently matching demand for healthcare with supply

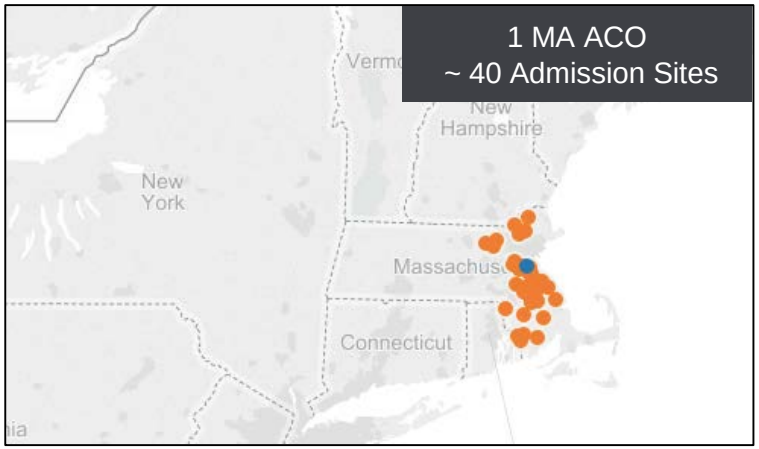
Improve quality of care by:

- Reducing Unwarranted Readmissions
- Reducing Excess Hospital and SNF length of stay
- Reducing Home Health Recertification Rates
- Reducing Unnecessary ER to Inpatient Conversions
- Optimizing use of Post-Acute Care (LTACH, IRF, SNF, HHA)

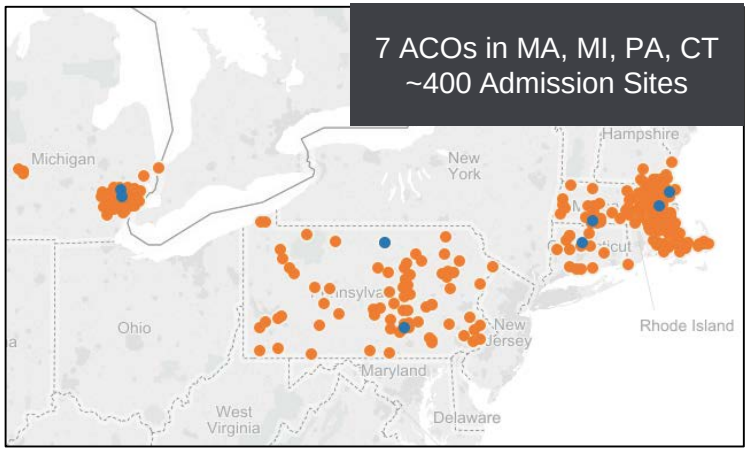
PatientPing is currently supporting care transformation efforts in MI, MA, CT, VT, NH and PA with expansion now ongoing in NJ, IL, CA, TX, FL and others.

PATIENTPING GROWTH OVER TIME: RAPID NETWORK DENSITY [TBU with Vermont]

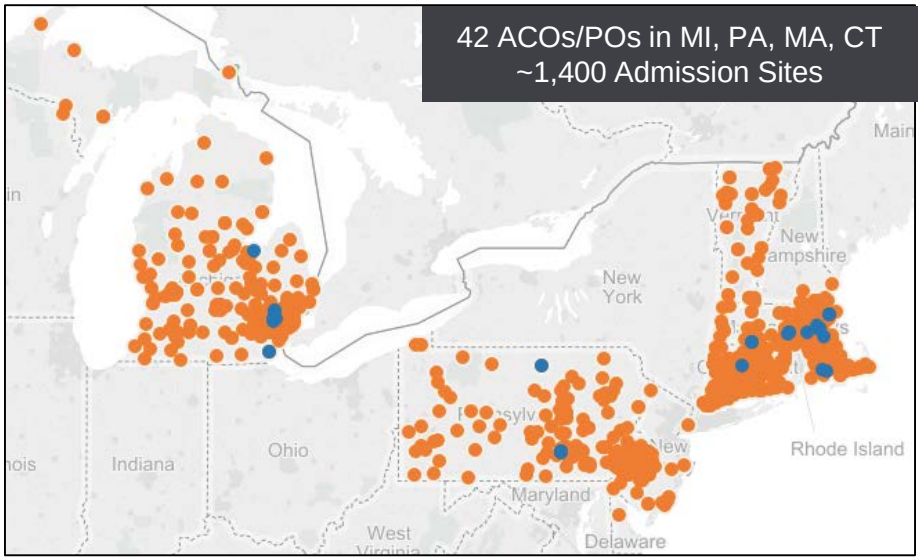
March 2014



March 2015



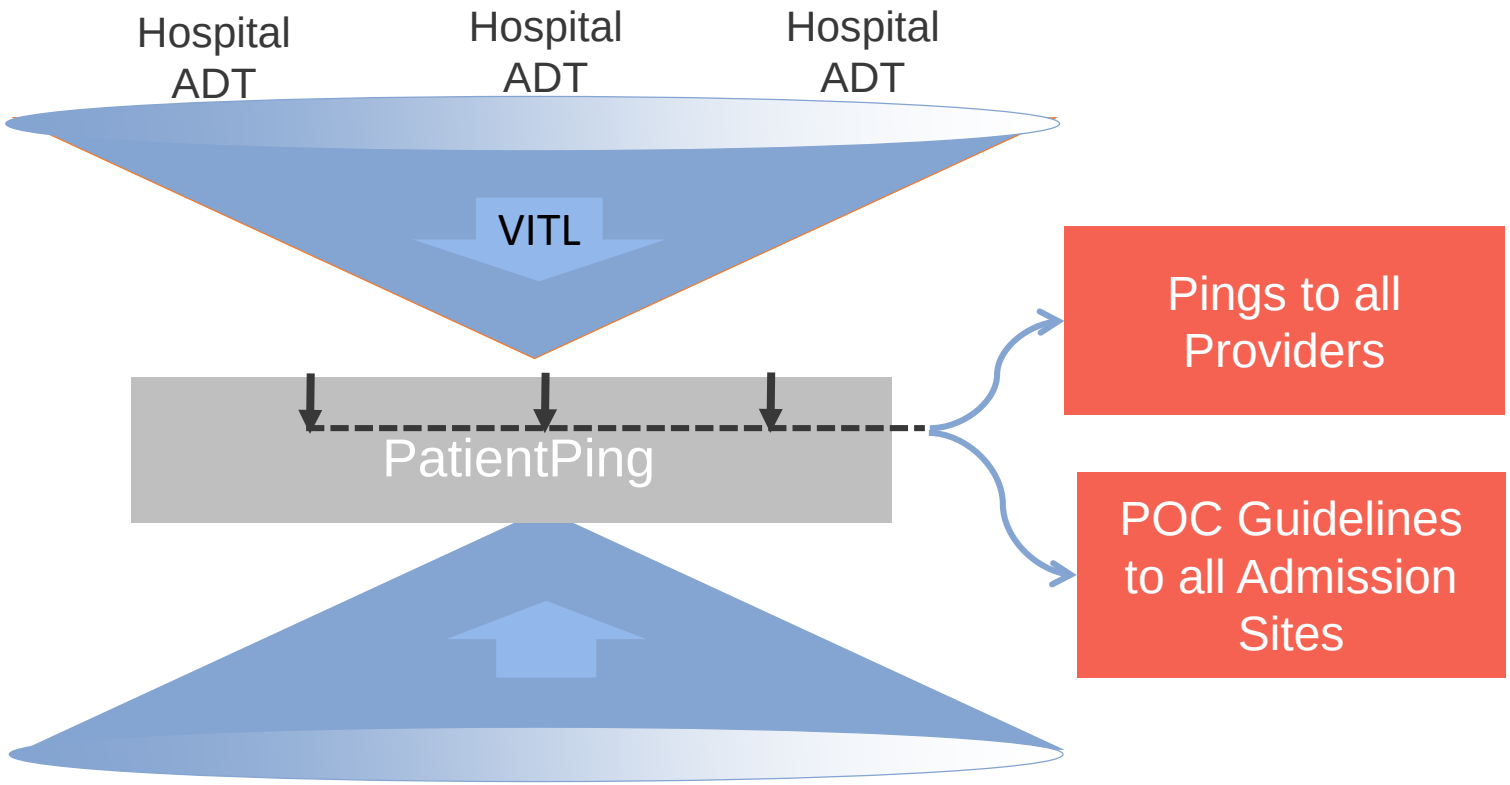
March 2016



VERMONT ROLL-OUT PROGRESS

TBU

ACTIONABLE NOTIFICATIONS



Dynamic Admission Site Patient Rosters via ADTs:
SNFs, HHAs, LTACHs, IRFs, PCP/Specialists, Urgent Care Clinics, Bundled Payment Facilities, and more

Static Rosters from Risk-Bearing Entities
ACOs, Health Plans, Physician Organizations, PCMHs, others with attributed patients

SUPPORTING EFFORTS TO TRANSFORM CARE DELIVERY

1. Ping all providers with notifications across the full continuum of care
2. Deliver care guidelines at all admission sites
3. Build connected community of providers
4. Monitor quality performance improvement

A lightweight care coordination solution that empowers providers to improve quality and meaningfully impact total cost of care

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Attachment 4: Data Repository Update

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Vermont Care Network (VCN) Data Repository Update

Spring 2016

Vermont Care Partners

Major Phases

- Phase 1: Vermont Monthly Service Report (MSR) Data Imports
  - Initial analytics and data quality initiative
- Phase 2: Admit Discharge Transfer (ADT) Continuity of Care Document (CCD) Imports
  - Higher frequency
  - Additional analytics
- Phase 3: Data Repository Exports
  - State reporting
  - Accountable Care Organization (ACO) and other 3rd parties
  - Vermont Health Information Exchange (VHIE) contingent on Part 2 Solution

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Phase I MSR Data

Repository Data Tables

- Base tables are almost complete
- 24 months of historical data has been loaded
  - Calendar 2014 and 2015
- Extract, Transform and Load (ETL) process nearly complete
- Estimated completion May 2016

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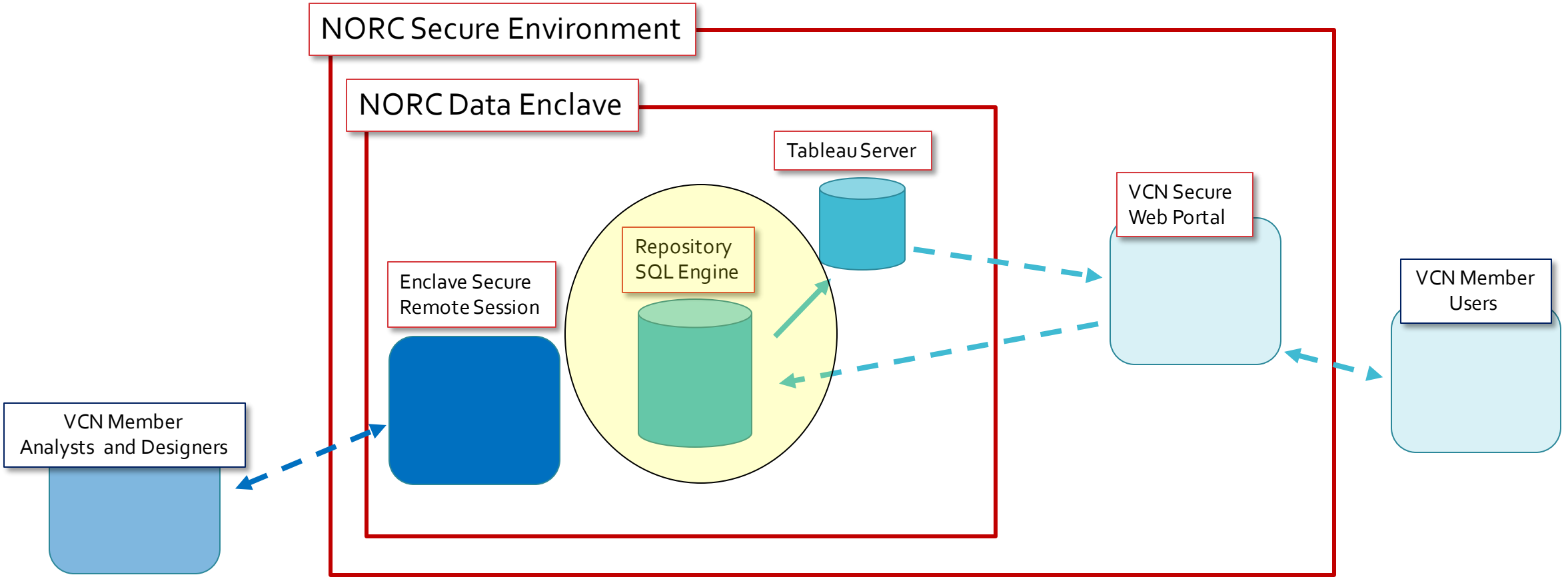
Simplified Security Concepts for VCN Data Repository



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Phase I MSR Data

Interfaces

- Security Administration for member agencies
- MSR Upload
  - Secure file transfer and feedback reports
- Dashboard Portal
  - Role based security

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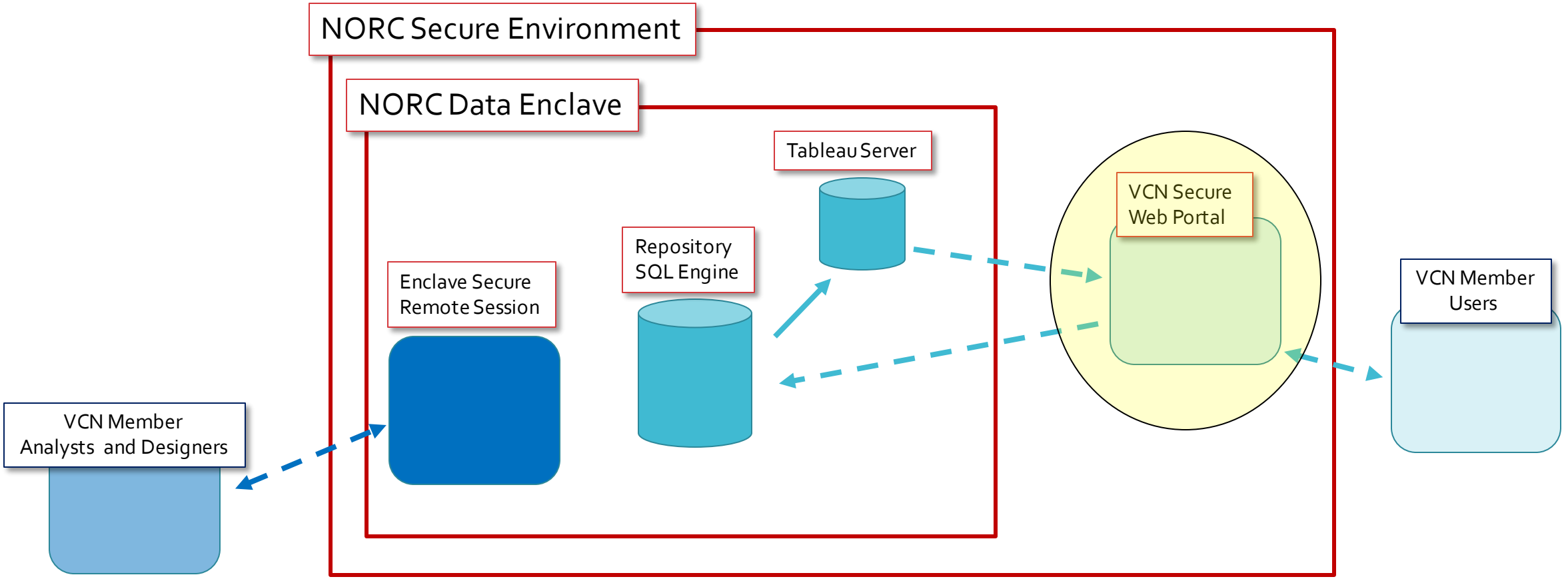
Simplified Security Concepts for VCN Data Repository in the National Opinion Research Center (NORC) Environment



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Phase I MSR Data

Data Analytics

- Base set of dashboards: Prototype 1 has been released.
- Prototype 2 is now under construction. Prototype 2 feedback will be the next step
- Estimated completion of prototype 2: May 2016

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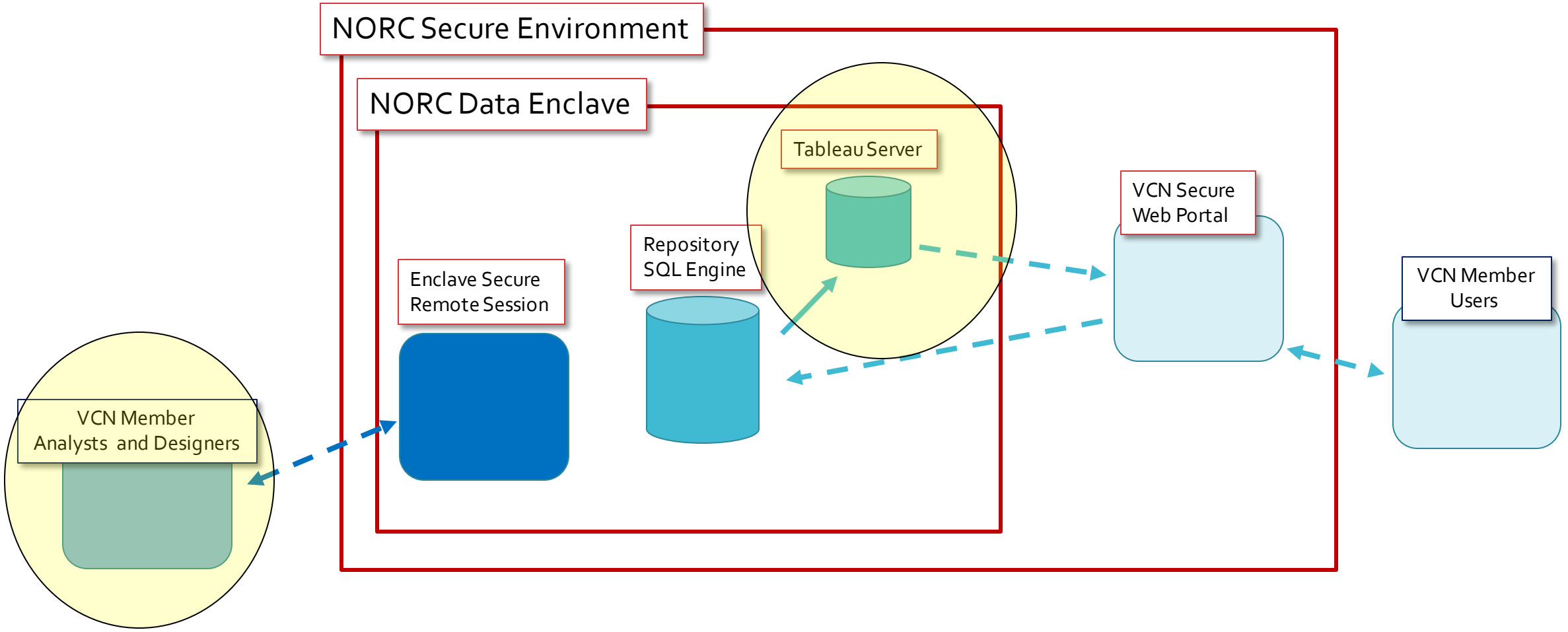

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Phase I MSR Data

Phase 1 Testing

- Security Role testing
- Review and feedback of repository schema
- Validating dashboard calculations and results
- Estimated completion: June 2016

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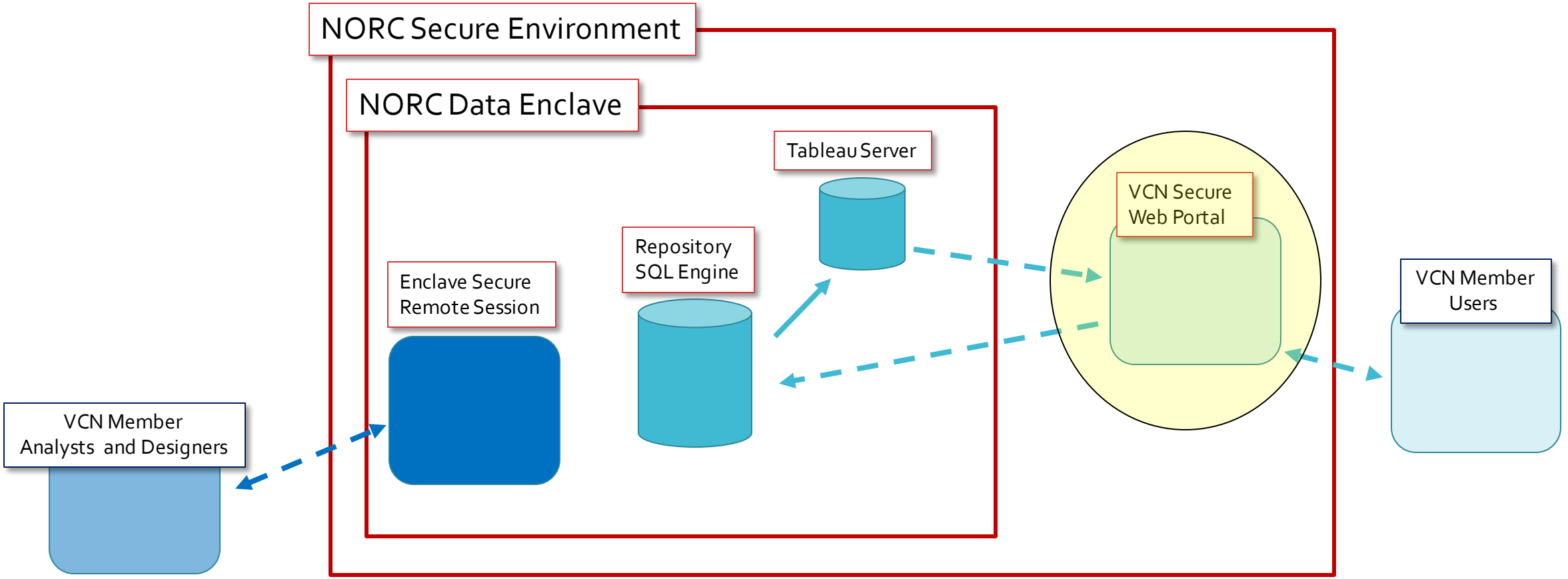

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Phase I
MSR Data

User Acceptance Testing (UAT) approval

- User Acceptance Testing will be conducted on:
  - MSR and Admin interface
  - Initial set of dashboards
- Estimated completion: July 2016

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Phase I
MSR Data

- Deploy
  - Make MSR and Admin interface live
  - Make initial set of dashboards available to end users.
  - Estimated completion: July 2016
- Training and User onboarding
  - Estimated completion: August 2016

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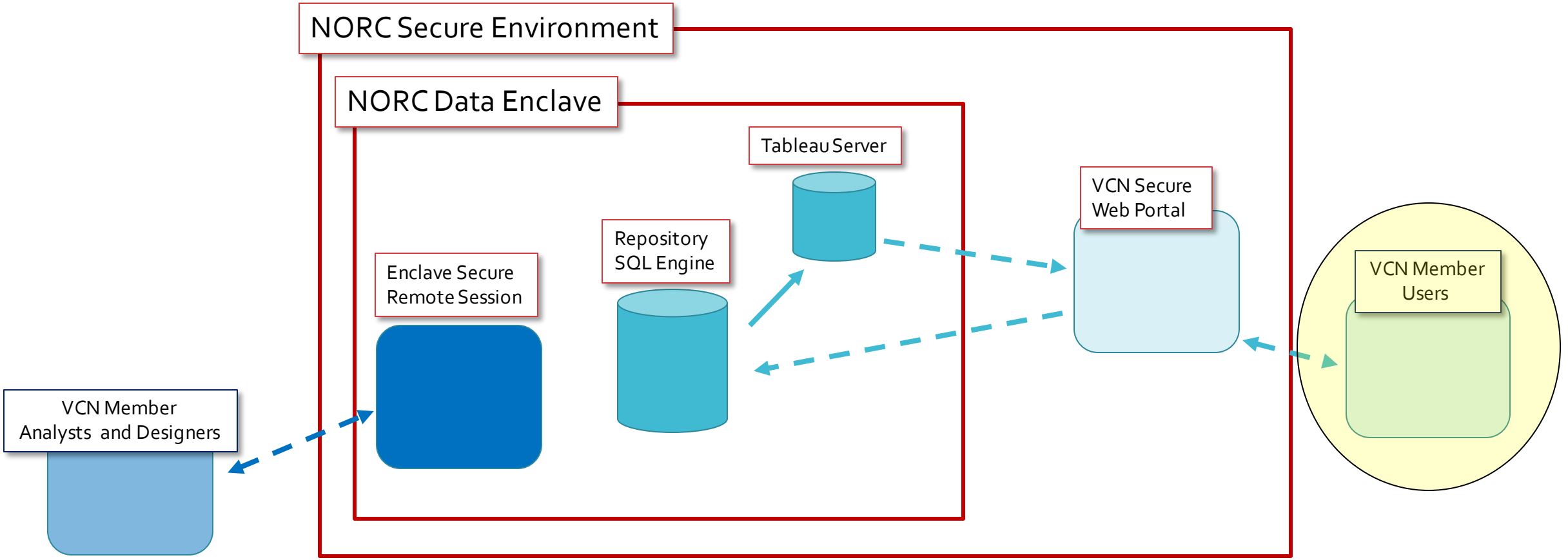

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