VHCIP DLTSS Work Group Meeting

Agenda 6-18-15

VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, June 18, 2015; 10:00 PM to 12:30 PM

4th Floor Conference Room, Pavilion Building

109 State Street, Montpelier

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from May 28, 2015	Yes
2	10:10 - 10:25	**Learning Collaborative Curriculum Development and Training** Deborah Lisi-Baker		
3	10:25 – 11:15	**LTSS Information Technology Assessment Findings Report (ACTT Project 2)** Beth Waldman, Bailit Health Purchasing	• Attachment 3: LTSS Information Technology Assessment	
4	11:15 – 11:45	**SCÜP Project Update** Erin Flynn and Larry Sandage	• Attachment 4: SCÜP Presentation	
5	11:45 – 12:00	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker	Next Meeting: Thursday, Thursday, July 30, 2015 10:00 am – 12:30 pm, DVHA Large Conference Room 312 Hurricane Lane, Williston	

Attachment 1b

May Minutes

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, May 28, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:03am. A roll call attendance was taken and a quorum was not present. A quorum was present after the second agenda item. Deborah Lisi-Baker entertained a motion to approve the April 30, 2015, meeting minutes. Susan Aranoff moved to approve the minutes by exception. Ed Paquin seconded. The minutes were approved with three abstentions.	
2. DLTSS-Specific Core Competencies	Deborah Lisi-Baker introduced the six draft DLTSS-Specific Core Competency briefs, authored by Susan Besio of PHPG. These drafts incorporate initial feedback and edits by Julie Wasserman and Deborah Lisi-Baker, and further feedback and edits from Erin Flynn, Sarah Kinsler, Sue Aranoff, and Beth Waldman. (See Attachments 2a-2f.) Susan Besio requested specific feedback from the DLTSS Work Group members in writing by June 8th. Susan reminded the group of the intent of these briefs: to create six foundational/source documents on which to build training curriculums, educational materials, and other products for providers and other audiences. Format and framing could change for each purpose and audience. The briefs focus on providing definitions and explaining key concepts, with concrete examples. While the original intent was to provide information targeted to medical care providers, the briefs were written so they could be relevant to all health care, services and support providers. Regarding specific briefs, Susan noted that the term "care management practitioners" was used because this is a catch-all term to refer to any professional that is performing functions around care coordination and integration, recognizing that this may include many different job titles. Susan also noted that the brief regarding Universal Design incorporates accessibility but is conceptually broader. The group discussed the following. • Susan Aranoff suggested that providers need resources like this and are likely to appreciate them – Allan Ramsay of GMCB remarked yesterday that he is excited to see these resources. Susan Besio noted that the	**Members will provide feedback on the briefs by Monday, June 8th; please track all changes in Word documents or send bulleted comments via email.** **Joelle Judge will resend the briefs following the meeting.**

Agenda Item	Discussion	Next Steps
	DLTSS Work Group leadership team intends to request provider feedback on these, and would love recommendations on providers who might be willing to review. • Erin Flynn suggested posting these on our website once final; though they are not training materials in their current form, they may be useful resources. Susan Besio suggested we may want to make GMCB, the Medical Society, and others aware of these resources. • Mike Hall noted that disability literacy and competency of managed care entities is a critical issue as more states move to managed long-term care; MCOs often do not have a history of working with individuals with disabilities or elders. States have addressed this through MCO selection processes and contracts with MCOs. Mike suggests that these could also be a helpful resource for ACOs. Julie Wasserman noted that DAIL is advocating for language about disability competency and universal design in ACO contracts currently being negotiated. Mike noted that a number of states have developed contract language that could be helpful to review; Truven has created model contract language that is publicly available. • Susan Aranoff noted that Care Management Standards developed by the CMCM Work Group, which include language about accessibility and universal design, are also being discussed in Year 2 Medicaid ACO contract negotiations. DAIL is working to get standard definitions from these briefs included in ACO contracts, and suggested that it would be very helpful to use consistent definitions across VHCIP and in other applications where possible. • Nick Nichols noted that recent Vermont legislation addressed the use of person-first and respectful language regarding disabilities within Vermont Statutes, and suggested Susan Besio review this legislation to ensure the briefs are consistent with it. • Mary Alice Bisbee suggested Susan Besio review the Secretary of State's disability awareness pamphlet. • Dale Hackett commented that education is great, but that changing practice is more important. He suggested that in-service trainings would be a good next step, perhaps through the Integrated Communities Care Management Learning Collaborative. Deborah Lisi-Baker noted that these briefs could be a foundation for that future training among others. Dale suggested that UVM Medical School could be a good opportunity for training future clinicians. Susan Besio and Suzanne Santarcangelo noted that UVM residency training does include mock sessions and interviews – this could be a good opportunity. Jason Williams noted that the residency is open to feedback and is happy to connect us. • Barb Prine suggested new sections to specifically note traumatic brain injury (TBI) and autism-spectrum disorder. She also suggested discussing refugee status in the cultural competency brief. Barb noted that there is also overlap between refugee/New American populations and people with disabilities. Deborah Lisi-Baker agreed. Susan Besio noted that the writing group considered creating a separate brief for people with mental health disorders but felt this was stigmatizing, and felt they would have needed to write a full set of six briefs specifically for mental health disorders; she invited input on how to strengthen that aspect within the existing briefs. • Dale Hackett noted that the intent is as important as the wording and needs to be clear. • The term "invisible or hidden disabilities" was suggested to refer to mental health disorders and autism-	

Agenda Item	Discussion	Next Steps
	spectrum disorder.	
3. DAIL Timeline for Addressing CMS's New Home- and Community-Based Services (HCBS) Waiver Regulations	Susan Aranoff presented on CMS's new Home- and Community-Based Services (HCBS) waiver regulations, and provided an update on DAIL's timeline for addressing them. (See Attachment 3.) • Review Draft with External Stakeholders at DAIL Advisory Board: June 11 • Review Draft with External Stakeholders at DDS Standing Committee: June 18 • Develop Final Draft: June 30 • Public Comment Process Begins: July 1 • Review Final Draft with AHS Performance Accountability Committee: July 3 • Review Final Draft with Medicaid and Exchange Advisory Board: July 15 • Public Hearing: July 23 • Draft of Revised Comprehensive Quality Strategy Submitted to CMS: July 31 The group discussed the following. • Julie Tessler asked which parts of the new regulations are mandated by CMS and which are a result of Vermont's priorities. Susan Aranoff responded that there are others working on this who might be able to answer. She suggested that comment be submitted through the official comment process. Deborah Lisi-Baker noted that the June meeting may include a more in-depth presentation on this topic but that it would be "educational" in nature, providing background information on the regulations, as Georgia has clarified that any broader discussions on the State's implementation of these regulations should be done outside the SIM/VHCIP activities. • Dale Hackett expressed concern that this might not capture services that are needed but not currently covered. Susan Aranoff noted that unpaid services are included in "services provided." • Nicole LeBlanc commented that it is critical to avoid siloes in service delivery, and that the HCBS regulations address conflict-free case management. • Jackie Majoros noted that conflict-free case management provisions may require changes; also, definitions of home- and community-based settings are critical. Jackie believes this requires a broader discussion to see how these new rules fit into broader waivers, not just Choices for Care, and to plan for how to ensure Vermont is in compliance. Susan Aranoff noted that the Transition Plan is the process by which the State will determine whether it is in compliance; the phase-in period is lengthy. • Deborah Lisi-Baker suggested that this discussion be tabled for another forum when more information is available from DAIL/AHS. • Mike Hall noted that CMS criteria and standards are critical to understanding the changes and Vermont's interpretation/response. He hopes the draft will be available for public review soon. Susan Aranoff noted that the public comment period is the ideal time for this review. • Georgia Maheras noted that this issue is outside of VHCIP's jurisdiction, but that it is appropriate to use the distribution list for this group to disseminate information.	
4. Payment	Alicia Cooper provided an update on the activities of the Payment Models Work Group. (See Attachments 4a and	**Joelle Judge will**

Agenda Item	Discussion	Next Steps
Models Work Group Presentation	4b.) She briefly reviewed major topics of discussion of the Payment Models Work Group over the past year: • *Proposed changes to the Blueprint for Health payment methodology.* Recommendations were made prior to this issue being decided at the Legislature. Additional funding from the Legislature ended up being less than originally hoped. Recommendations will go to the Blueprint Executive Committee next week. • *Changes to Vermont Medicaid Shared Savings Program (VMSSP) Year 2 Gate & Ladder Methodology.* Changes align with Medicare Shared Savings Program (MSSP) and reflect Year 1 experience. Three major changes: increase to minimum threshold for savings eligibility (aligns VMSSP with Commercial Shared Savings Program); switch from percentage of points earned to absolute points earned; and introduction of bonus point for significant improvement over past performance in addition to points for performance compared to national standards (aligns with MSSP). • *Episodes of Care (EOC) Sub-Group.* Formed to consider how EOCs could be implemented going forward. o Are there any episodes that have risen to the top? Alicia clarified that there are successful examples of EOC analytics as well as payment models based on EOCs. Conversations have been high level so far, but early analyses looking at 2012 data for the State showed key areas with high variation and opportunities to improve quality, including heart disease/congestive heart failure and diabetes-related conditions. o Susan Aranoff noted that she's been pushing for at least one chronic condition to be included if the State moves forward with a contract to perform more analyses. o Dale Hackett noted that variation and care delivery models might impact variation in cause and utilization and suggested that the CMCM Work Group could provide valuable input. o Alicia noted that staff are gathering more information before the sub-group reconvenes. o Dion LaShay asked what EOCs cover – medical only? Alicia responded that it depends on the episode – additional services could be included depending on the episode. • *Next Generation ACO Overview.* CMS recently introduced a new ACO model, which includes higher risk and higher potential reward for ACOs that choose to participate and are selected by CMS. There are various tracks ACOs can choose, each with different methodologies. o What kind of flexibility is available for Next Gen ACOs? There is summary information available; it will be distributed following this meeting. • *Monitoring Year 1 VMSSP Payments.* Analyses to be completed this summer will determine whether ACOs are eligible for savings, and how much; compare projected per-beneficiary spending and actual spending; and provide information on quality performance. o Is Lewin planning to do population-specific sub-analyses? Yes, but they're currently focused on getting the methodology right for the full population. The DLTSS Work Plan includes providing input on this; Alicia will put it on Lewin's radar once the population-wide calculations are completed. • In the coming months: o Update on Year 3 Total Cost of Care for the ACOs o Vermont Bundled Payment for Care Improvement (BPCI) Nursing Home Bundled Payment	**distribute the Next Generation ACO Summary**

Agenda Item	Discussion	Next Steps
	presentation (also in the DLTSS Work Group Workplan and others; perhaps a combined presentation or webinar) o Value-Based Purchasing Report from PHPG o EOC discussions continue o Continued work to align Payment Models Work Group plans with All-Payer Model discussions The group discussed the following. • EOC/bundled payment definitions. Mike Hall noted that bundles are a form of capitation because providers can realize savings if they spend less to provide services than expected; he suggests bundled payments include a "warranty" to ensure complications or readmissions are addressed within the bundle or episode cost. Dale Hackett suggested that EOCs are based on fee-for-service, but that as an individual, he cares most about receiving the services he needs and that this could be a rate setting issue. Alicia noted that there are a lot of details about model and episode design that can impact it, and that she hopes to learn more from BPCI/Nursing Home Bundled Payment Initiative and others. • Sam Liss asked whether, if EOCs/bundled payments are extended to long-term and chronic care, bundles will be more complex than for acute episodes. Alicia agreed and noted that there are other places that have done this and developed strategies for this: Arkansas focuses mostly on acute episodes to avoid these complexities, but others use a calendar year as a recurring period for chronic care episodes. • Ed Paquin noted that some long-term services are already paid for using bundles. He noted that in acute care, fee-for-service payment rewards complications, but with a large population we should be able to figure out how much to budget per episode – this is how insurance works. Deborah Lisi-Baker noted that bundles will hopefully discourage unnecessary care and encourage comprehensive care. • Mike Hall commented that fee-for-service payments are volume driven, as are HCBS waiver services. Mike feels there are possibilities to do bundled payment, or per-member per-month (PMPM) payment, for certain types of long-term services across providers. • Deborah Lisi-Baker noted that we've had initiatives to work with practices on chronic care for years, but the materials on best practices in dealing with conditions like diabetes and COPD, for example, need not include guidance on best practices or interventions to address caring for patients with other chronic conditions and disabilities, such as mental health conditions, for example – these differentials would be helpful for episode planning. Alicia responded that this is a common challenge that many are still working to find a good solution to. Some episode models have criteria that exclude individuals from episodes if an individual has co-morbidities that require more care than the standard. Alicia suggested that there are other ways to approach this, and that there are opportunities to do Vermont-specific episode construction • Dale Hackett asked for more information about how payments would work; Alicia responded that there are options for payers, and that this is still to be determined. • Sam Liss and Mike Hall discussed how bundles and PMPM payment could incentivize preventive care. Mike suggested that bundles need severity or risk adjustment to avoid provider cherry picking.	

Agenda Item	Discussion	Next Steps
	• Deborah Lisi-Baker hopes that the Payment Models Work Group is considering these disability-specific concerns. • Susan Aranoff noted that including bundles for common/linked co-morbidities would be a good step for reducing overall costs, even though this is challenging for analytics. • Joy Chilton commented that early intervention opportunities should be included in EOCs.	
5. Public Comment/Next Steps	There was no additional public comment. **Next Meeting:** Thursday, June 18, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

Attachment 3

LTSS Information Technology Assessment

LTSS Information Technology Assessment

Findings and Recommendations

Presented by
Beth Waldman, Senior Consultant

DLTSS Work Group

June 18, 2015

bailit health

Presentation Topics

- Project Focus
- IT Capacity Across LTSS Providers
- Ongoing Related Activities
- Opportunities
- Next Steps

Project Focus

- HIS conducted this study for the State
- Purpose of project was to:
  - Update 2012 LTSS Information Technology Assessment; and
  - Review IT capacity at additional LTSS providers
    - Level of electronic collection and/or transfer of information

Types of LTSS Providers Interviewed

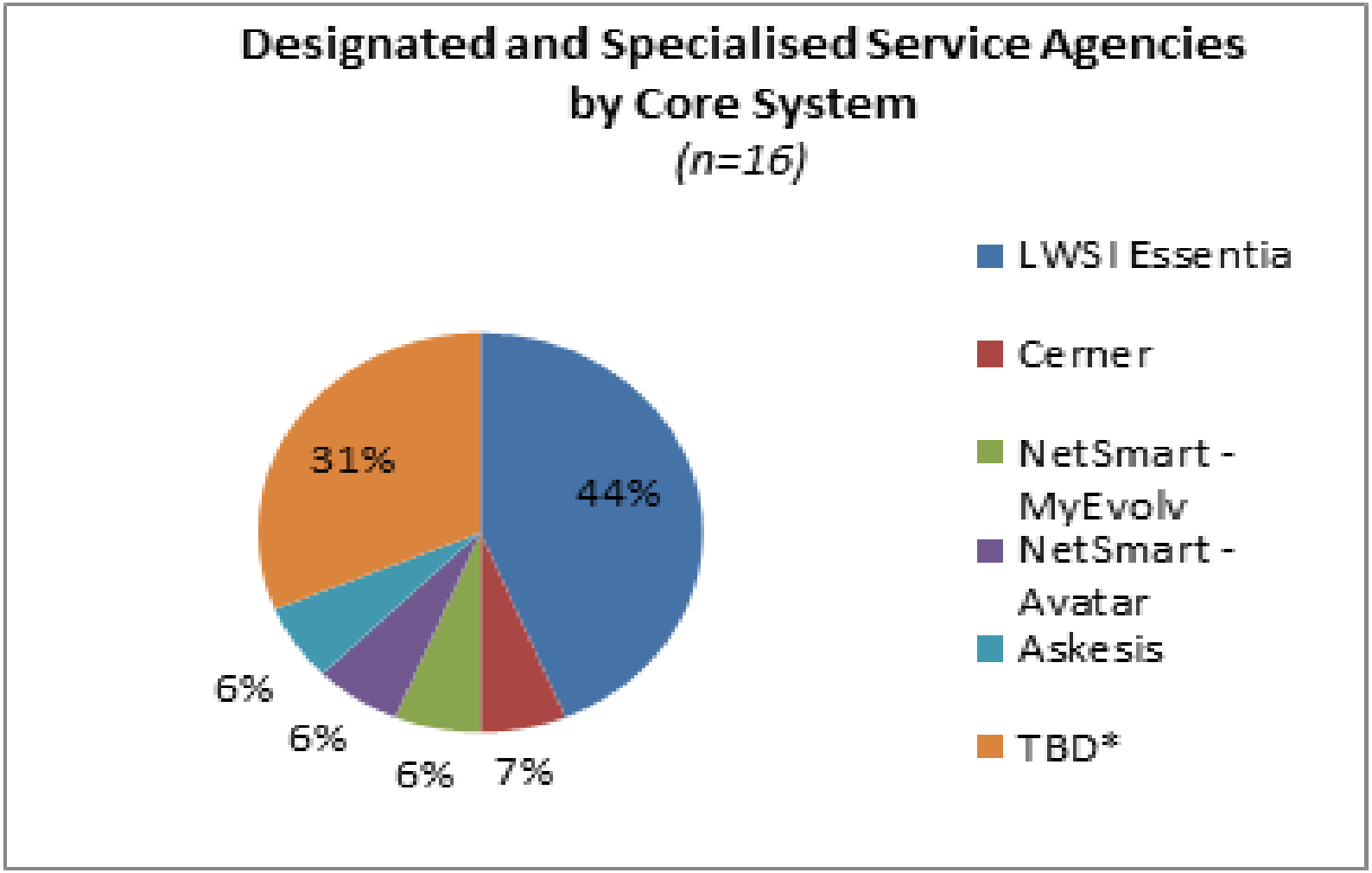
- HIS conducted over 100 interviews including:
  - Vermont Area Agencies on Aging (5)
  - Adult Day Providers (12),
  - Designated Agencies & Specialized Services Agencies(11),
  - Home Health Care Agencies (10),
  - Traumatic Brain Injury Providers (2),
  - Long Term Residential Care Providers (54), and
    - Long Term Residential Care Homes,
    - Nursing Homes,
    - Assisted Living Residences
  - Vermont Center for Independent Living.

REPORT ON LTSS CAPACITY

Overview of Findings

Provider	IT Capacity
Designated Agencies and Specialized Services Agencies	Some capacity; working on joint procurement of EHR
Home Health Agencies	Many agencies have capacity
Long Term Residential Care Settings	Many have some electronic capacity – either full EHR or for Resident Management
Adult Day Centers	No EHR; heavy reliance on paper
Area Agencies on Aging	Use SAMS (CM and financial management)
Vermont Center of Independent Living	CIL Management Suite (case notes)
Support and Services at Home (SASH)	DocSite Clinical Registry
TBI Providers	No EHR; heavy reliance on paper

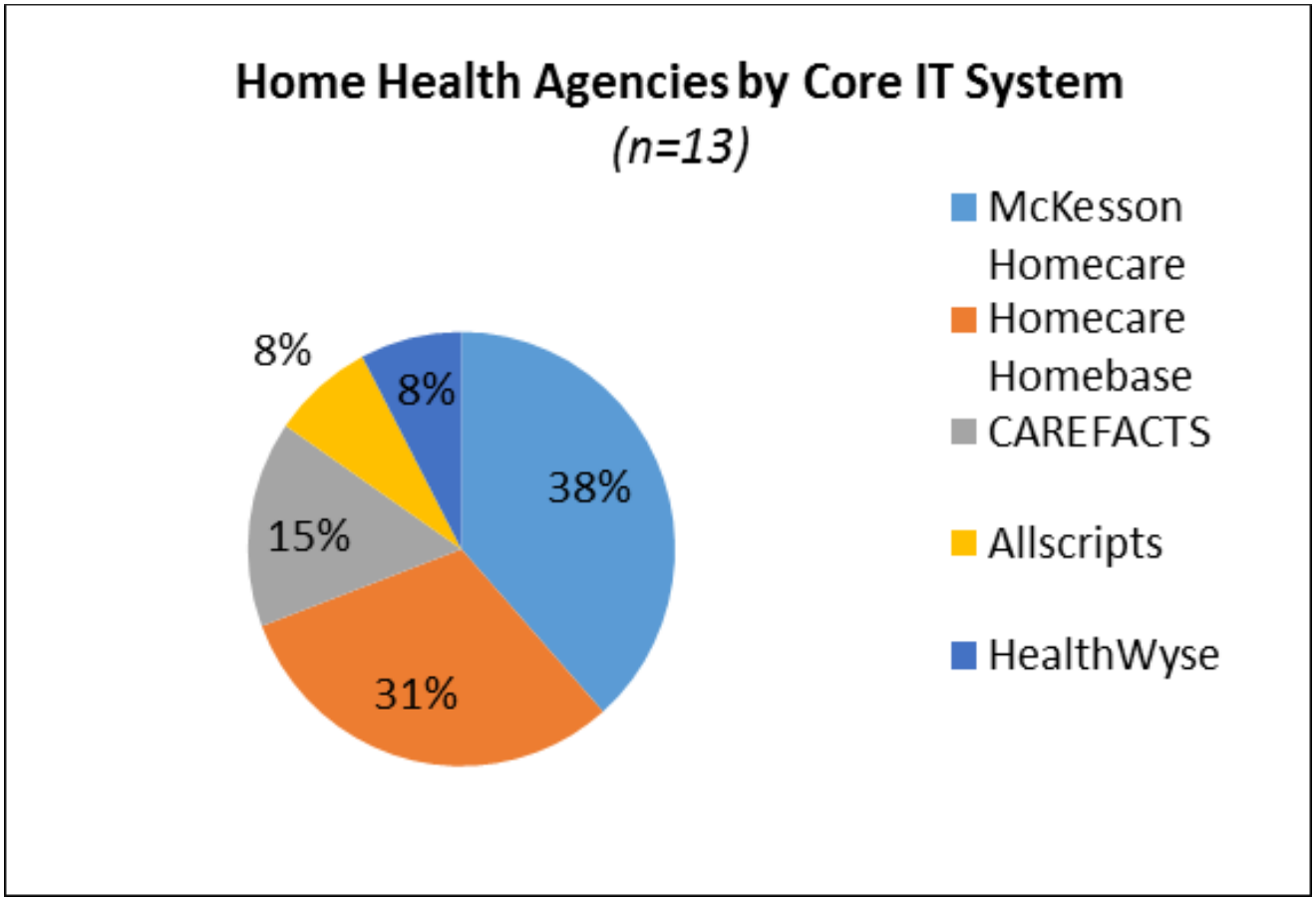
Designated Agencies and Specialized Services Agencies(1 of 2)



Designated Agencies and Specialized Services Agencies(2 of 2)

- All DAs have EHRs – working to expand to all programs.
  - Certified under 2011 and 2014 ONC Rules.
  - Significant work over last several years to improve functionality.
  - Two ongoing pilot projects on integrating data between DAs and primary care providers.

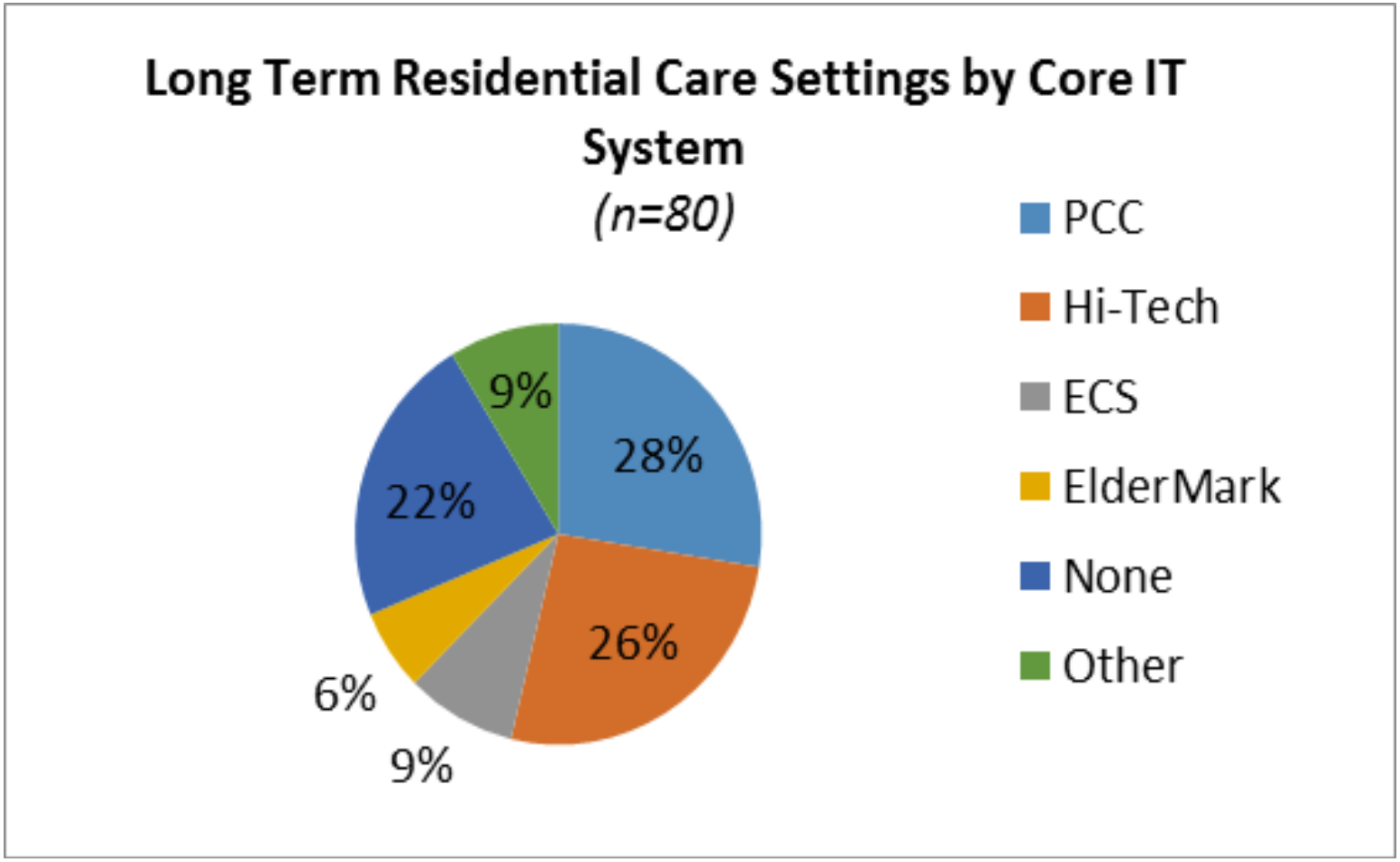
Home Health Agencies (1 of 2)



Home Health Agencies (2 of 2)

- Significant progress since 2012 report.
- Low user satisfaction with current EHRs.
- Some HHAs use VITLAccess with additional interfaces being planned.
- Continue to have difficulty with accessing information from referral sources and obtaining sufficient physician authorization.

Long Term Care Residential Facilities (1 of 2)



Long Term Residential Care Facilities (2 of 2)

- Hi-Tech is being purchased by Wescom/PointClickCare.
  - Not being supported as of September 30, 2015.
  - Facilities using this need new solution.

Adult Day Centers

- Varying levels of technology depending on the size of their organization.
  - The larger agencies maintain participant, caregiver, volunteer, and donor computer records using standard tools like MS Access, Word and Excel.
  - Intake and assessment data is recorded on paper forms. Daily medical recordkeeping is performed using pre-printed forms for handwritten recording of vital signs, medication use and provider notes.
- No use of EHRs to store data in structured formats.
- No mechanism for information to be shared or exchanged electronically with others involved in the participant's care.

Areas Agencies on Aging

- Use the Harmony “Social Assistance Management System” (SAMS) system.
  - Primary case management and financial management database.
  - Also used to complete documentation required by Waiver programs and the Federal Older Americans Act.
  - Working to develop an electronic version of the Independent Living Assessment (ILA) form in SAMS.
  - SAMS licenses held by DAIL; and DAIL currently responsible for upkeep.
- Use a legacy reporting database(originally developed by the Champlain Valley AAA) to record client notes.

Vermont Center of Independent Living

- Uses the CIL Management Suite software from Q90 Corporation.
  - Tracks clients and services, including case notes and tracking progress towards goals.
  - Generates the federal 704 performance reporting required for recipients of Independent Living Center funding, including the independent living center (ILC) survey.
  - Web based solution -- does not interface to any other systems.

Support and Services at Home (SASH)

- Use a clinical registry (DocSite):
  - To perform assessments,;
  - Enter and monitor health information (medications, allergies; health team members);
  - Develop care plans; and
  - Make referrals.
- Not able to communicate electronically with other providers.
- DocSite system is also used by the Blueprint for Health (as a chronic care registry), and by Community Health Teams (to develop individualized health maintenance plans for patients seen in primary care settings.)

TBI Providers

- Documenting on paper forms.
- No use of EHR to store data in structured formats.
- No mechanism for information to be shared or exchanged electronically with others involved in the resident's care.

Quick Overview of Existing Projects

ONGOING RELATED ACTIVITIES

Acquisition and Implementation of a Medicaid Case Management System

- Functionality to support all AHS programs that provide care management services to Medicaid beneficiaries, including external partners.
- The Vermont Chronic Care Initiative will begin using the new system in 2015, with roll out to additional programs beginning in 2016.
- Additional planning and analysis is underway to determine the exact roll out approach, including potential replacement of existing systems (like SAMS, described below) used by LTSS providers for care management.

Vermont Care Networks (VCN) Data Quality and Data Repository Project

- Focused on collection, aggregating, and reporting of consistent, reliable and structured mental health data.
- Planned completion in 2016.

Migration of the Blueprint Clinical Registry System (DocSite)

- Migrating DocSite to VITL's infrastructure.
- SASH and other care teams will have the ability to access these services post-migration.

42 CFR Part 2 Compliant HIE

- Collaboration between DVHA and VITL.
- Looking for solution to allow health information protected by SAMHSA's 42 CFR Part 2 regulation to be transmitted and accessed with appropriate consent.

Shared Care Plans/Universal Transfer Protocol (SCÜP)

- First phase of project was completed in February.
- As next step, investigating the ability of diverse service providers to share information with each other electronically in a timely, standardized fashion across the continuum of care, using a common data set.

VITL Activity

- **VITLAccess:** assembles patient information received from health care organizations across Vermont and compiles the patient information into a single secure provider portal.
- **VITLDirect:** secure messaging service provided by VITL that can securely transmit a summary of care record for a single patient between providers. This function can be incorporated into any EHR that supports secure messaging.
- **VITLNotify:** a communication system being tested by VITL to proactively notify appropriate providers of a patient's clinical encounters.

Recommendations to the HIE/HIT Work Group (1 of 2)

- Work with Long Term Residential Care Homes to assist in selecting and contracting with new vendor through provision of TA in product review, developing cost analysis and developing implementation plan.
- Evaluate Adult Day Centers information-sharing technology and include as part of interoperability roadmap.
- Provide AAAs with proposal for hiring a dedicated resource to support use of SAMS.
- Continue to pursue a 42 CFR Part 2 compliant solution to enable information sharing for substance use.

Recommendations to the HIT/HIE Work Group(2 of 2)

- Continue to support provider interfaces with VHIE.
  - Demographic and clinical interfaces for HHAs,
  - Lab interfaces for BH Providers and Long Term Residential Care Facilities, and
  - Immunization registries.
- Continue to pursue the Shared Care Plan/Universal Protocol project.
- Encourage expansion of use of SAMS in read-only mode for LTSS providers to view patient information (assessment, care plans, notes and schedules).
- Explore use of BridgeGate MDS to CCD transformation services.

Next Steps

- Report currently being finalized.
- HIT/HIE Work Group to consider potential for supporting some projects based on this assessment.

Attachment 4

SCÜP Presentation

SCÜP (Shared Care Plan/Universal Transfer Protocol) Project Update

Update to DLTSS Work Group

June 18, 2015

Project Overview: Shared Care Plans/Universal Transfer Protocol

VISION:

This project will provide a technological solution that supports Vermont's providers and caregivers in successfully navigating transitions between care settings.

This solution will support:

- Coordinating and managing patient care through transitions from one care setting to another
- Maintaining an up to date person-directed shared care plan that supports integrated care management across a multi-disciplinary team by capturing:
  - key elements of a person's clinical and non-clinical goals
  - primary functions of different members of their care team

SCP & UTP – What are they?

Shared Care Plans (SCP)

Shared care plans are a tool to document and share information necessary to identify issues that impact a person's health care needs, as well as the activities and accountable parties for addressing those needs in a multi-disciplinary team-based care setting.

Universal Transfer Protocol (UTP)

The universal transfer protocol is a paper-based or electronic form that allows providers to exchange a core set of patient information as patients transition between health care settings.

Why Both?

The data elements necessary for the are UTP very clearly aligned with the scope of Shared Care Plans, so it was a natural alignment of projects.

History/Background

- Seeks to address the goals of two projects:
  - Universal Transfer Protocol Project (one of the ACTT projects) in the HIE work group
  - Shared Care Plans as part of the integrated care management learning collaborative in the CMCM work group

- Strong overlap between the two tools, goal is to not create two disparate processes

- CMCM work group has heard that learning collaborative communities are struggling to share and update care plans across multi-disciplinary teams
  - Lack of HIT infrastructure
  - Lack of interoperability

- Project is focused on developing a solution to facilitate transfer of information during transitions of care, as well as support communication amongst a multi-disciplinary community based team.

4

Phases

1. Identify SCÜP Project Team & Perform Initial Outreach:
April, 2015

2. Develop Business Requirements: May – July, 2015

3. Develop Technical Requirements: May – September, 2015

4. Technology Proposal: August – October, 2015

Project Phase	April	May	June	July	August	September	October	November	December
Identify SCP/UTP Project Team & Initial Outreach	■								
Develop Business Requirements		■	■	■					
Develop Technical Requirements		■	■	■	■				
Technology Proposal					■	■	■		

Phase 2 – Develop Business Requirements

- Working with existing UTP and Shared Care Plan materials.

- Working with communities already engaged with the Learning Collaboratives or the Universal Transfer Protocol project:
  - Bennington
  - St. Johnsbury
  - Rutland
- Will engage other communities:
  - As internal resources are available
  - At validation points
  - In subsequent phases if approved

Phase 3 – Develop Technical Requirements / Technical Assessment

- Conducting national research
- Working with existing Vermont entities to learn from/leverage solutions:
  - MMIS Care Management team
  - VITL
  - Community providers with existing technical solutions that match or resemble SCÜP Use Cases
  - ACOs

Progress Update

- **Phase 1** *(Identify Project Team and Perform Initial Outreach):* Complete.
- **Phase 2** *(Business Requirements Gathering):* All communities engaged, currently collecting business requirements community by community.
- **Phase 3** *(Technical Requirements Gathering):* Currently Conducting National Research and working with existing Vermont entities to learn from/leverage solutions.

SCÜP Team:

- Leads:
  - Larry Sandage (contractor; subject matter expertise, HIT/HIE)
  - Erin Flynn (SOV lead; subject matter expertise, care models)
- Project Team:
  - Sarah Kinsler (SOV; contract management; project support)
  - Sue Aranoff (SOV; subject matter expert, DTLSS)
  - Steve Maier (SOV; subject matter expert, HIT/HIE)
  - Joelle Judge (contractor; project management)
  - Will Sipsey (Enterprise Architecture; Department of Information and Innovation)
  - Project team will consult with numerous provider representatives including: Laural Ruggles and Heather Johnson