Vermont Health Care Innovation Project
Health Data Infrastructure Meeting Agenda

September 21, 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	9:00-9:05am	Welcome and Introductions; Minutes Approval	Simone Rueschemeyer & Brian Otley	Attachment 1: Draft July 20, 2016, Meeting Minutes	Approval of Minutes
2	9:05-9:10am	Project Updates: • Brief Sustainability Update • Recent Conference: ONC Clinical Quality Measurement	Georgia Maheras & Sarah Kinsler		
3	9:10-9:25am	Event Notification System Update	Julia Sanders (PatientPing)	Attachment 3: PatientPing Update	
4	9:25-9:45am	Data Utility Update	David Healy and Rachel Block	Attachment 4: Data Utility Project Update	
5	9:45-10:00am	Telehealth Pilot Update	Jim Westrich		
6	10:00-10:15am	Home Health Agency VITLAccess Rollout and Interface Build Update	Larry Sandage and Susan Aranoff	Attachment 6: DLTSS Gap Remediation Project Update	
7	10:15-10:40am	Universal Transfer Protocol/Integrated Communities Care Management Learning Collaborative Update	Erin Flynn	Attachment 7: Update – UTP/Transitions of Care	
8	10:40-10:55am	VCN Data Repository Update	Ken Gingras	Attachment 8: VCN Data Repository Update	
9	10:55-11:00am	Public Comment Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	**Next Meeting - RESCHEDULED**: **Friday, October 28, 2016, 3:00-5:00pm, Waterbury**	

Attachment 1: Draft July 20, 2016, Meeting Minutes

Vermont Health Care Innovation Project
HDI Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, July 20, 2016, 9:00am-11:00am, 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 9:05am. A roll call attendance was taken and a quorum was present. *May and June Meeting Minutes:* Nancy Marinelli noted that a sentence in the June meeting minutes is incomplete. Nancy Marinelli moved to approve the May and June meeting minutes by exception. The minutes were approved with four abstentions (Heather Skeels – May; Peggy Brozicevic – June; Randy Connelly – May and June).	
2. Project Updates	Sarah Kinsler provided project updates: • Our Performance Period 3 budget and activities were approved by our federal partners in late June. Performance Period 3 runs from July 1, 2016-June 30, 2017.	
3. Brief Sustainability Update	Sarah Kinsler provided a brief update on SIM Sustainability planning: • A contractor, Myers & Stauffer, came on board in July to support our SIM sustainability planning, including convening this sub-group and gathering stakeholder input. • In August, we'll be convening a sub-group of private sector stakeholders to inform our SIM sustainability planning process. This group will pull from all of our SIM work groups and key constituencies. Interested parties should email Sarah (sarah.kinsler@vermont.gov) or Georgia Maheras (georgia.maheras@vermont.gov) to volunteer. • Myers & Stauffer will distribute a quick online survey to all SIM participants in early August to assess sustainability priorities.	
4. Connectivity Targets	Larry Sandage presented a proposal for Health Information Exchange Connectivity Criteria for Vermont (Attachment 4). • This proposal presents a methodology for identifying VHIE connectivity targets. The aim for this meeting is to validate this methodology.	

Agenda Item	Discussion	Next Steps
	The group discussed the following: • Dale Hackett asked for an explanation of one-way vs. two-way connections. Larry clarified that some providers share information into the VHIE, while others gather information from the provider portal. • Brian Isham asked whether we've defined "connectivity" for the purpose of this project. Larry replied that his broad definition is that the EHR vendor has to be able to pass usable, meaningful, formatted information to the VHIE for use at the point of care and/or for population-level analyses. • Heather Skeels asked Larry to clarify a previous comment that there is currently minimal need to connect eye care providers. Larry replied that the vast majority of eye care providers don't have the technical ability to connect or the resources to connect. Heather noted that this means that diabetic eye exam measures will be hard to meet. Jennifer Egelhof added that optometrists are becoming more advanced. Larry noted that the State encourages all providers to connect to the VHIE, but it takes significant resources and the State needs to be able to make a case for return on investment. • On Slide 5, "Count" is the cumulative number of connections. In some cases, this represents more than one connection per connected provider; there are about 300 providers connected to the VHIE now. Kate Pierce noted that there will eventually be a saturation point. • Heather Skeels commented that she's seeing many providers switching EHRs, which requires VITL to redo existing connections, and asked how these are counted. Larry replied that we refer to these reconnections as "replacement interfaces" – either when providers switch EHRs, or when EHRs are very significantly updated. This constitutes 30-40% of VITL's work annually. Slide 5 includes replacement interfaces; Slides 6 and forward include new interfaces only as replacement interfaces are challenging to estimate with the data available. On Slide 5, 902 is the count of existing interfaces, which may include replacement interfaces. • Kate Pierce asked whether these include both inbound and outbound interfaces. Larry replied that it does. • Dale Hackett asked about the cost of replacement interfaces, noting this is a significant amount of work. Larry agreed, and noted he would add estimated replacement interfaces to connectivity criteria going forward. • Brian Isham commented that it would be helpful to see VHIE utilization side-by-side with growth of interfaces to help tell this story. Larry replied that VITL's annual report includes data on the number of messages exchanged annually, which is in the tens of millions. Brian suggested that including the trend here would demonstrate ROI. Brian Otley agreed and suggested this drill down to specialty/message type to show which connections are most valuable. Georgia Maheras added that we expect to have some of this data in the next few months and more in the next fiscal year. • Slide 8 – Kate Pierce asked whether this is relevant to sending data to the VHIE or receiving data from the VHIE. Larry clarified that this is about receiving data from the VHIE. • Dale Hackett noted that information can be entering the VHIE to support quality measurement, but not necessarily be supporting improvements at the point of care. Larry replied that this is out of the scope of	

Agenda Item	Discussion	Next Steps
	this work, but that producing the CCD interfaces discussed on Slide 9 will mean significant progress in this area. The quality of the data the State and VITL receive is a different issue. • Leah Fullem noted that projects from 2019 forward for Nursing Homes and Specialty Care is 0 for CCDs, with a lot of interfaces for vaccinations and similar. She commented that clinical summaries are what we need most for these providers, and asked whether estimates are based on current connection types rather than additional data types. Larry thanked Leah for this comment noted that putting future emphasis on CCD interfaces, especially for new provider types, is a good goal for the State as we set targets. Nancy Marinelli added that ADT is a critical data type for LTSS providers; we should look at ROI and what different data types actually do for Vermonters and providers. • Larry encouraged work group members to share additional comments, specific use cases, and priorities with him or others on the HDI Work Group team. • Simone Rueschemeyer suggested noting that these are movable numbers – TBD for some data types after 2017, for example, instead of 0. • Kate Pierce noted that Slide 11 indicates no CCD interfaces for Specialty, but North Country is sending neurology and other specialty information from its practices. Larry suggested this information is categorized elsewhere. Georgia suggested that individuals should follow up with Larry with information like this.	
5. Home Health Agency VITLAccess Rollout and Interface Build	Larry Sandage, Susan Aranoff, and Holly Stone provided an update on the Home Health Agency VITLAccess rollout and interface build (Attachment 5). The group discussed the following: • Susan Aranoff commented that Simone Rueschemeyer was critical in making this work successful, as was Peter Cobb (who retired on June 30), Holly Stone (the SIM project manager on this project), and Arsi Namdar.	
6. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	Paul Forlenza noted that the VHITP was presented to the Green Mountain Care Board earlier this spring, and has been discussed by that group a number of times. He asked about next steps for the Plan. Georgia Maheras replied that the Board's plate is very full in the summer; we have provided all information requested, but it's not clear when or how they will take the plan back up again. For those interested in progress, the Green Mountain Care Board publishes detailed agendas every Wednesday; we will also provide subsequent updates to this group as we have them. **August meeting is cancelled.** **Next Meeting:** Wednesday, September 21, 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

Minutes 20-Jul-16

Member		Member Alternate			
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff	Gabe	Epstein		AHS - DAIL
		Nancy	Marinelli		AHS - DAIL
Joel	Benware	Dennis	Boucher		Northwestern Medical Center
		Jodi	Frei		Northwestern Medical Center
		Chris	Giroux		Northwestern Medical Center
Peggy	Brozicevic	Eileen	Underwood		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				OneCare Vermont
Michael	Gagnon	Kristina	Choquette		Vermont Information Technology Leaders
Ken	Gingras				Vermont Care Partners
Eileen	Girling	MaryKate	Mohlman		AHS - DVHA
		Jennifer	Eglehoff		
Dale	Hackett				Consumer Representative
Emma	Harrigan	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
Kaili	Kuiper				VLA/Health Care Advocate Project
Kelly	Lange	James	Mauro		Blue Cross Blue Shield of Vermont

VHCIP Health Data Infrastructure Work Group Member List

Member		Member Alternate		Minutes		20-Jul-16
First Name	Last Name	First Name	Last Name			Organization
Kim	McClellan	Randy	Connelly ✓	A	A	DA - Northwest Counseling and Support Services
		Chris	Kelly			
Arsi	Namdar					Central Vermont Home Health and Hospice
Brian	Otley ✓					Green Mountain Power
Kate	Pierce ✓					North Country Hospital
Darin	Prail ✓	Diane	Cummings			AHS - Central Office
Simone	Rueschemeyer ✓					Vermont Care Network
Julia	Shaw ✓	Lila	Richardson			VLA/Health Care Advocate Project
Heather	Skeels ✓	Kate	Simmons	A		Bi-State Primary Care
Roger	Tubby ✓					GMCB
Chris	Smith ✓					MVP Health Care
Russ	Stratton					VCP - HowardCenter for Mental Health
	28		20			

QV

	Meeting Name:	VHCIP HDI Work Group Meeting	
	Date of Meeting:	July 20, 2016	
	First Name	Last Name	
1	Susan	Aranoff	here
2	Joanne	Arey	
3	Ena	Backus	
4	Susan	Barrett	
5	Jed	Batchelder	
6	Joel	Benware	
7	Richard	Boes	
8	Dennis	Boucher	
9	Jonathan	Bowley	
10	Jon	Brown	
11	Peggy	Brozicevic	here
12	Martha	Buck	
13	Shelia	Burnham	here
14	Wendy	Campbell	
15	Narath	Carlile	
16	Kristina	Choquette	
17	Peter	Cobb	
18	Randy	Connelly	here
19	Amy	Cooper	
20	Alicia	Cooper	
21	Steven	Cummings	
22	Diane	Cummings	
23	Becky-Jo	Cyr	
24	Mike	DelTrecco	

25	Molly	Dugan	
26	Chris	Dussault	here
27	Jennifer	Egelhof	here
28	Nick	Emlen	
29	Karl	Finison	
30	Kim	Fitzgerald	
31	Erin	Flynn	here
32	Paul	Forlenza	here
33	Jodi	Frei	
34	Leah	Fullem	here
35	Michael	Gagnon	
36	Daniel	Galdenzi	
37	Lucie	Garand	
38	Christine	Geiler	
39	Ken	Gingras	
40	Eileen	Girling	
41	Chris	Giroux	
42	Stuart	Graves	
43	Dale	Hackett	
44	Mike	Hall	
45	Emma	Harrigan	
46	Paul	Harrington	here
47	Stefani	Hartsfield	
48	Kathleen	Hentcy	
49	Lucas	Herring	
50	Jay	Hughes	
51	Brian	Isham	here

52	Craig	Jones	
53	Pat	Jones	
54	Joelle	Judge	here
55	Kevin	Kelley	
56	Chris	Kelly	
57	Sarah	Kinsler	here
58	Kaili	Kuiper	
59	Andrew	Laing	
60	Kelly	Lange	
61	Charlie	Leadbetter	
62	Carole	Magoffin	
63	Georgia	Maheras	phone
64	Nancy	Marinelli	here
65	James	Mauro	
66	Kim	McClellan	
67	MaryKate	Mohlman	
68	Arsi	Namdar	
69	Mark	Nunlist	
70	Miki	Olszewski	
71	Brian	Otley	here
72	Kate	Pierce	phone
73	Luann	Poirer	
74	Darin	Prail	here
75	David	Regan	
76	Paul	Reiss	
77	Lila	Richardson	
78	Simone	Rueschemeyer	here

79	Tawnya	Safer	
80	Larry	Sandage	here
81	Suzanne	Santarcangelo	
82	Julia	Shaw	here
83	Kate	Simmons	
84	Heather	Skeels	here
85	Chris	Smith	here
86	Holly	Stone	here
87	Russ	Stratton	
88	Richard	Terricciano	
89	Julie	Tessler	
90	Bob	Thorn	
91	Tela	Torrey	
92	Matt	Tryhorne	
93	Roger	Tubby	here
94	Win	Turner	
95	Eileen	Underwood	here
96	Beth	Waldman	
97	Julie	Wasserman	
98	Richard	Wasserman, MD, MPH	
99	Ben	Watts	here
100	David	Wennberg	
101	Kendall	West	
102	James	Westrich	here

Julie Corwin - DVHA

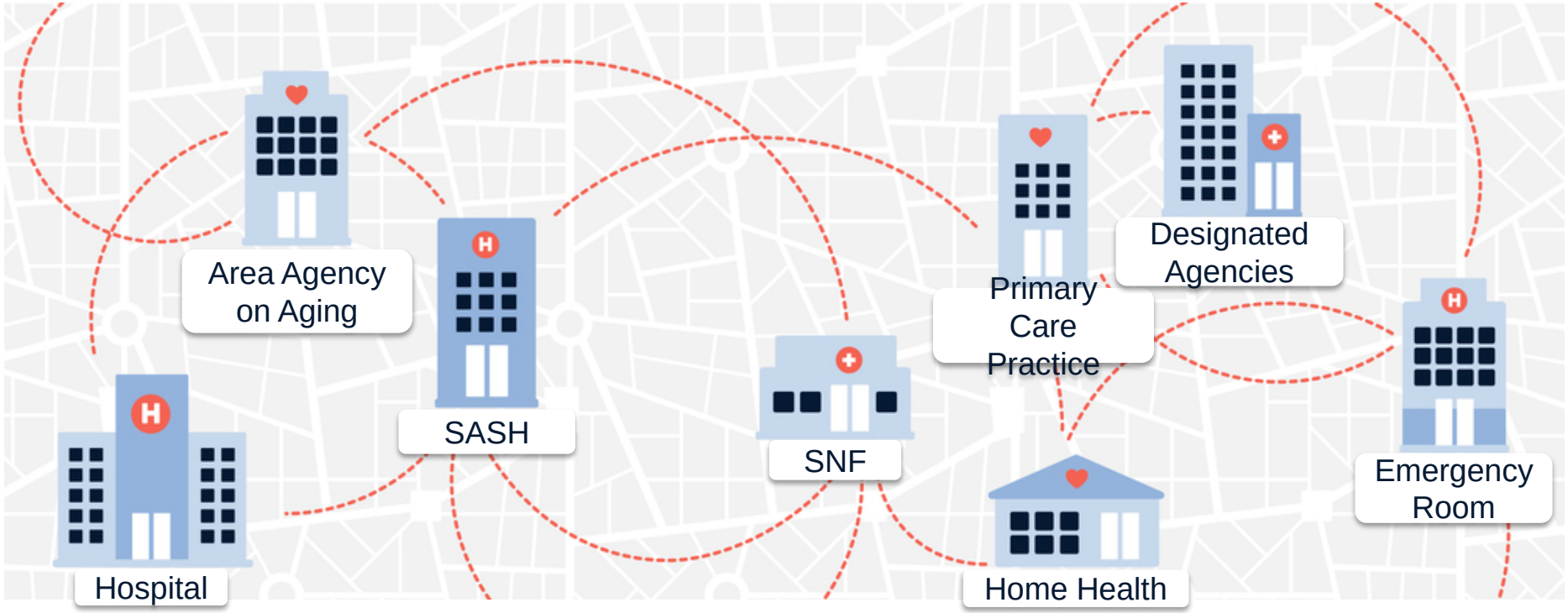
Attachment 3: PatientPing Update

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 VERMONT IMPLEMENTATION

Live community members:

- CHAC: 56,055 patients
  - Received 36,466 Pings to date
  - 27 out of state facilities have sent Pings on CHAC patients
- OneCare: 4,200 patients
  - Received 7,440 Pings to date
- VITL: 15 hospitals
  - 44,771 Pings sent to date
  - 36,264 Pings sent to CHAC
  - 7,405 Pings sent to OneCare
  - 1,102 Pings sent to Care Programs in other states

PATIENTPING VERMONT IMPLEMENTATION

Community members in implementation:

- SASH: ~4,000 patients
  - Will be receiving Pings on statewide population
- FQHCs: Many FQHCs are exploring Pings for full patient panels
  - Mountain Health Center
  - The Health Center
- VNAs: pending VITL feeds, will be sending data to generate Pings
  - CVHHH
  - Franklin County Home Health
  - Rutland Area VNA and Hospice
  - VNA of Chittenden and Grand Isle
  - VNA and Hospice of Vermont and NH

PATIENTPING VERMONT IMPLEMENTATION

Community members in discussion:

- Community Health Centers of Burlington
- Hospitals
  - Hospital case management teams have been introduced to their no-cost access, available to all facilities that send admission and discharge data to PatientPing
- Bayada
- Remaining 5 VNAs
- Statewide SNFs
- AAAs
- Independent Primary Care Providers

PATIENTPING VERMONT IMPLEMENTATION

Implementation horizon:

- Onboarding hospital users as Ping senders and receivers
- Expanded use of PatientPing for full patient panels across all FQHCs
- Continued conversations with OneCare re: onboarding full roster for community benefit
- Growth within post-acute community

Attachment 4: Data Utility Project Update

Data Utility Project Update

HDI Work Group

September 21, 2016

Project Background

- Stone Environmental team is providing subject matter expert consulting services for several HIE planning activities
- One deliverable focuses on research and report on health data utility activities in other states and regions
- This information can be used by Vermont as points of comparison for similar functions and to support future planning and implementation

Research Design

- States and regions of interest identified by state and federal staff
- Primary source of information is interviews with key state and HIE staff
- Additional research through state and HIE websites, ONC website, and other resources (e.g., health policy and HIT newsletters)

List of States

- Colorado
- Delaware
- Maine
- Maryland
- Michigan
- New York
- Rhode Island
- Washington

General Topics

- Governance
  - State role
  - SDE role if applicable
  - Law, regulations
  - Policy bodies
- Functions
  - "Core services"
  - Care management
  - LTC and BH integration
  - Public health
  - Links to APCDs
  - Data analytics
- Sustainability
  - Current and future funding models

Summary of Key State Roles

- Regulations and policy for health information exchange (Regulation);
- Prioritization and allocation of resources for HIT initiatives (Strategy);
- Management oversight including contracting using federal and state funds (Administration);
- Coordination of HIT implementation including focus on standards, adoption and use (Operations)

Next Steps

- Review governance findings with HIT governance work group
- Summarize HIE functions and funding models for future review
- Identify specific topics of interest in other states for detailed follow-up
- Develop recommendations with state input

DISABILITY AND LONG TERM SERVICES AND SUPPORTS DATA GAP REMEDIATION PROJECT:

Susan Aranoff, Esq.

Larry Sandage

September 21, 2016

Project Overview

- Implement VITLAccess for Home Health Agencies including Bayada.
  - VITLAccess is a provider portal that allows access to health care providers to patient care information from other entities.

- Develop Interfaces from Home Health Agencies' (HHAs) Electronic Health Records (EHRs) to the Vermont Health Information Exchange (VHIE) .
  - An interface is the "connector" that allows information to flow from a provider's electronic health record system to the VHIE.

In Summary:

- **Allow the information to flow and be shared**
- **Provide access to the client's health record**

Status - VITLAccess

- VITLAccess:
  - Phase One – February 15, 2016 to June 30, 2016
    - Profile, Enroll, & Launch* 305 HHA Users from 4 HHA Health Care Organizations (HCOs) onto VITLAccess - **Complete**
  - Phases Two and Three – July 1, 2016 to December 31, 2016
    - Phase 2 – Profile, Enroll, & Launch an additional 170 HHA Users from 3 HHA HCOs onto VITLAccess – **In Progress**
    - Phase 3 – Profile, Enroll, & Launch an additional 125 HHA Users from 5 HHA HCOs onto VITLAccess – **Not Yet Started**
- *Definitions:
  - Profile: Introductory meeting and role definition.
  - Enroll: User designation and technical set up of users.
  - Launch: Training and Go-Live

VITLAccess Implementation

- For Interfaces:
  - Phase One – February 15, 2016 to June 30, 2016
    - Initial Discovery phase to determine vendor capability - **Complete**
      - Total of 12 agencies using 5 different EHRs.
  - Phases Two and Three – July 1, 2016 to December 31, 2016 – **In Progress**
    - Five HHAs either ready to proceed or getting ready to proceed with CCD (Continuity of Care Documents or clinical) interfaces.
    - Two HHAs coordinating with their vendor schedule to accommodate 12/31/16 timeline.
    - Two HHAs deferred.

Attachment 6: DLTSS Gap Remediation Project Update

Attachment 7: Update – UTP/Transitions of Care

HDI Work Group Update: UTP/Transitions of Care

Erin Flynn
ACO and Practice Transformation Director
Department of Vermont Health Access
Erin.Flynn@Vermont.gov

Background: Universal Transfer Protocol

- A Universal Transfer Protocol would allow Vermont's provider organizations to exchange critical data across the care continuum in a timely way as they work together in a team-based, coordinated model of care; particularly when people transition from one care setting to another
- History: Project began as Advancing Care Through Technology (ACTT) in January 2014. Data gathering in three communities, as well as through interviews with key statewide partners. UTP and Shared Care Plan efforts merged in 2015 due to similar program goals, then split again in Spring 2016
- After decision not to pursue technology solution, UTP sent to Practice Transformation Work Group to further identify and implement needed workflows and processes at the community/provider level

Background - Practice Transformation Work Group

- "Integrated Communities Care Management Learning Collaborative":
  - Formed to learn about and implement promising interventions to better integrate cross-organization care management for at-risk people; improve communication between organizations; reduce fragmentation, duplication, and gaps in care; and determine if interventions improve coordination of care
  - Finishing up second year, 11 total communities participating statewide
  - Team members typically include: people in need of care management services and their families, primary care practices participating in ACOs (including care coordinators), designated mental health agencies and developmental services providers, visiting nurse associations and home health agencies, hospitals and skilled nursing facilities (including their case managers), area agencies on aging, Blueprint community health teams and practice facilitators, SASH, ACOs, VCCI, commercial insurers, AHS partners

The Learning Model:

Pre-Work

The learning collaborative uses the plan-do-study-act (PDSA) quality improvement model.

Learning Session I
(Teams gather for a face-to-face meeting)

Action Period
community teams working together to implement change)

Learning Session II
(Teams gather for a face-to-face meeting)

Action Period
community teams working together to implement change)

Learning Session III
(Teams gather for a face-to-face meeting)

Action Period
community teams working together to implement change)

Learning Session IV
(Teams gather for a face-to-face meeting)

Spreading the Change

Learning Session: "Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations"

- September 6th and 7th in Rutland and Waterbury
- Expert Faculty: Dr. Terrence O'Malley, MD, internist/geriatrician at Massachusetts General Hospital (former consultant to the UTP project)
- Learning Goals:
  - Identify high priority transitions in each community
  - Identify needed information for both senders and receivers
  - Identify a process for exchanging standardized information whenever a transition occurs
- Community Teams Worked in Groups to:
  - Understand where the person is in the system of care, identify and prioritize common transitions in care
  - Determine information each team member needs during a transition of care
  - Use electronic tools to facilitate the connected care community

Step 1: Build a Transitions Grid

- Use a transitions grid to map out all possible senders and receivers in a community.

Example: Sender-Receiver Grid

	Individual/ Family	Police/EMR	Employment	Housing	Transport	ED	Behavioral health	PCP	Legal aid	Medicaid/ Payers	Family supports	Home modification	Respite	In patient	Therapy	Other	Other
Individual/Family																	
Police/EMR																	
Employment																	
Housing																	
Transport																	
ED																	
Behavioral health																	
PCP																	
Legal aid																	
Medicaid/Payers																	
Family supports																	
Home modification																	
Respite																	
In patient																	
Therapy																	
Other																	
Other																	

Step 2: Identify Highest Priority Transitions

- Use criteria (frequency, urgency, value) to identify the highest priority transitions.

Prioritized Transitions by Volume (V), Clinical Instability (CI) and Time-Value of Information (TV)

Transitions From (Senders) \ Transitions to (Receivers)	In Patient	ED	Out patient Services	LTAC	IRF	SNF/ECF	HHA	Hospice	Amb Care (PCP)	CBOs	Patient/ Family
In patient				V – H CI – H TV – H	V – H CI – H TV – H	V – H CI – M TV – H	V – H CI – M TV – H	V – H CI – L TV – H	V – H CI – M TV – H	V – H CI – L TV – H	V – H CI – M TV – H
ED				V – H CI – H TV – H	V – H CI – H TV – H	V – H CI – H TV – H	V – H CI – M TV – H	V – M CI – M TV – H	V – H CI – L TV – H	V – M CI – L TV – H	V – H CI – M TV – H
Out patient services				V – H CI – H TV – H	V – H CI – M TV – H	V – H CI – M TV – H	V – H CI – M TV – H	V – L CI – L TV – H	V – H CI – L TV – H		V – H CI – L TV – L
LTAC	V – H CI – H TV – H	V – H CI – H TV – H	V – H CI – H TV – H		V – M CI – M TV – H	V – H CI – M TV – H	V – H CI – M TV – H	V – M CI – M TV – H	V – H CI – M TV – H	V – H CI – M TV – H	V – H CI – M TV – H
IRF	V – H CI – H TV – H	V – H CI – H TV – H	V – H CI – M TV – H	V – L CI – H TV – H		V – H CI – L TV – H	V – H CI – L TV – H	V – L CI – M TV – H	V – H CI – L TV – H	V – H CI – L TV – H	V – H CI – L TV – H
SNF/ECF	V – H CI – H TV – H	V – H CI – H TV – H	V – H CI – M TV – H	V – M CI – H TV – M	V – L CI – M TV – M	V – L CI – M TV – M	V – H CI – M TV – H	V – M CI – M TV – M	V – H CI – L TV – M	V – H CI – M TV – H	V – H CI – L TV – H
HHA	V – H CI – H TV – H	V – H CI – H TV – H					V – L CI – L TV – L	V – M CI – L TV – L	V – H CI – L TV – L	V – H CI – L TV – L	V – H CI – L TV – L
Hospice	V – L CI – H TV – H	V – M CI – H TV – H				V – M CI – M TV – M	V – L CI – L TV – M	V – L CI – L TV – M	V – L CI – M TV – L	V – M CI – L TV – L	V – L CI – M TV – M
Ambulatory Care (PCP)	V – M CI – H TV – H	V – H CI – H TV – H				V – L CI – M TV – H	V – M CI – M TV – M	V – L CI – L TV – H	V – L CI – L TV – M	V – M CI – L TV – M	V – L CI – L TV – L
CBOs											
Patient/Family											

Black circles = highest priority
Green circles = high priority

Step 3: Build Your Data Set

- Begin with your highest priority transitions
- Start a community wide conversation: Who currently receives what data and information, if any? Who needs to receive information that isn't? Are you getting information that you don't need? What do you need that you aren't getting?
- Start with what your community partners need to ensure continuity of care, look to your shared care plan for ideas, and map to national data sets/standards whenever possible
- Identify and engage your IT people!

Homework

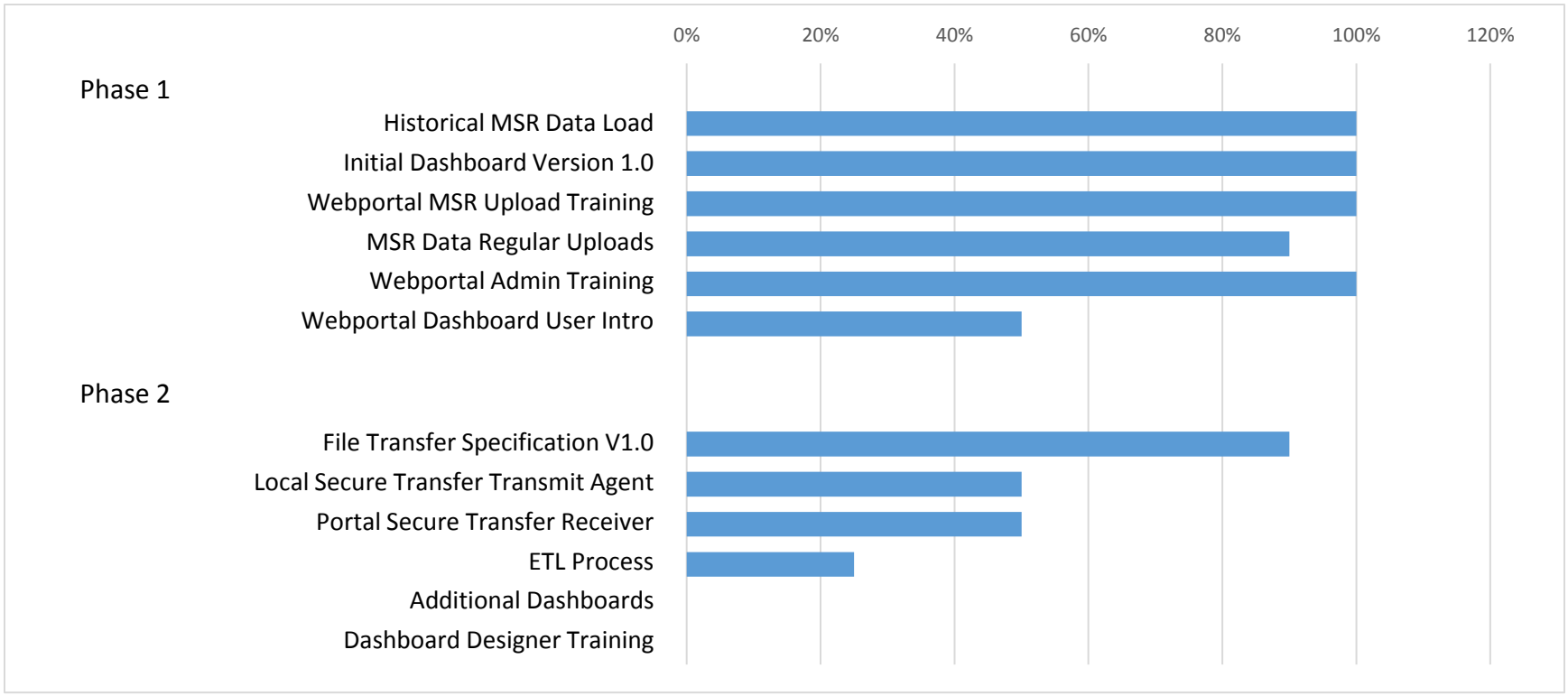
Over the next several months communities will be implementing PDSA cycles to:

- Identify priority exchanges
- Identify essential data elements
- Identify information exchange process
- Focus on “N of 1” to test system change
- Select data elements from standardized national data sets for electronic exchange (even if exchange is not electronic)
- Repeat for next high risk population

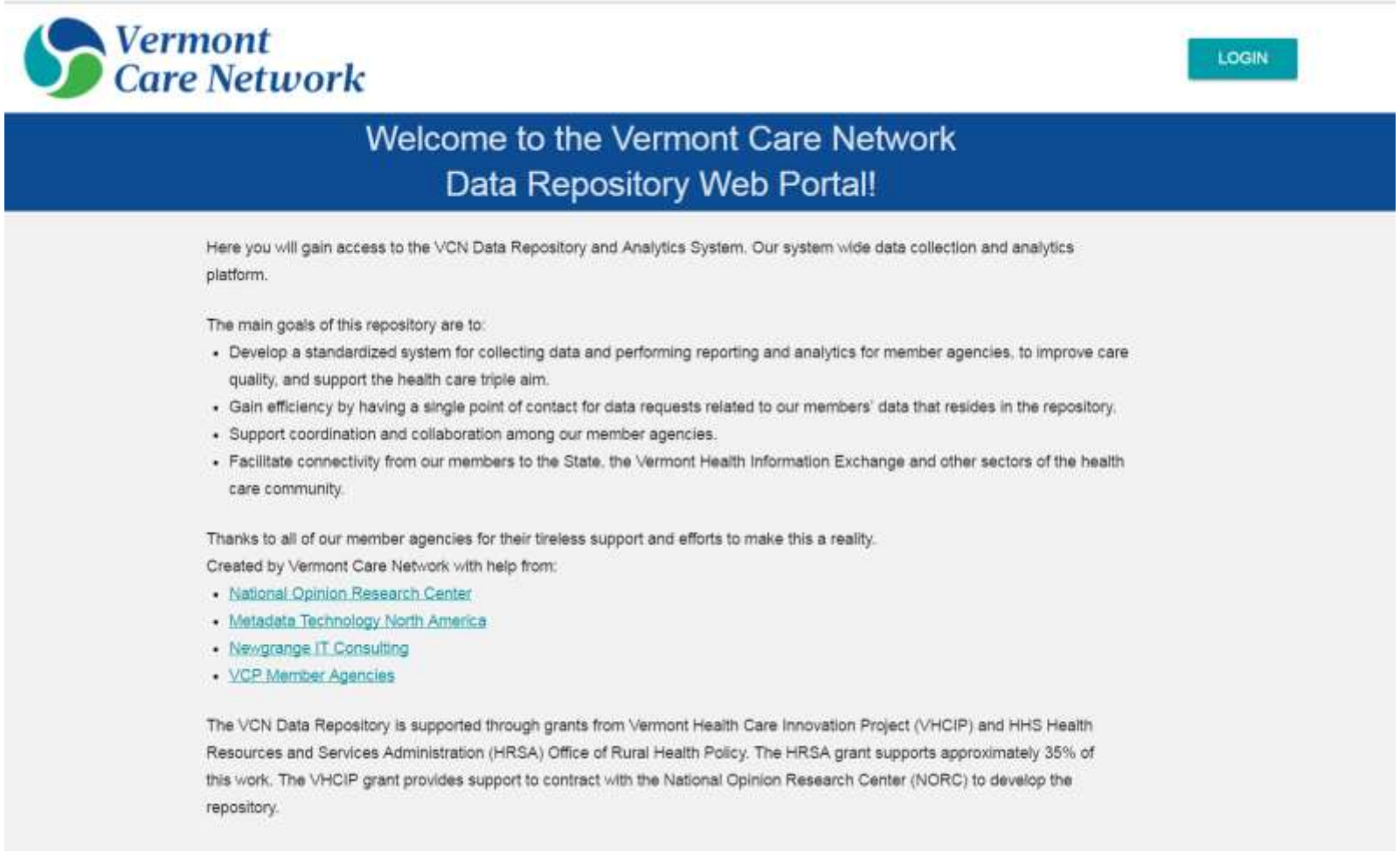
Questions? Feedback?

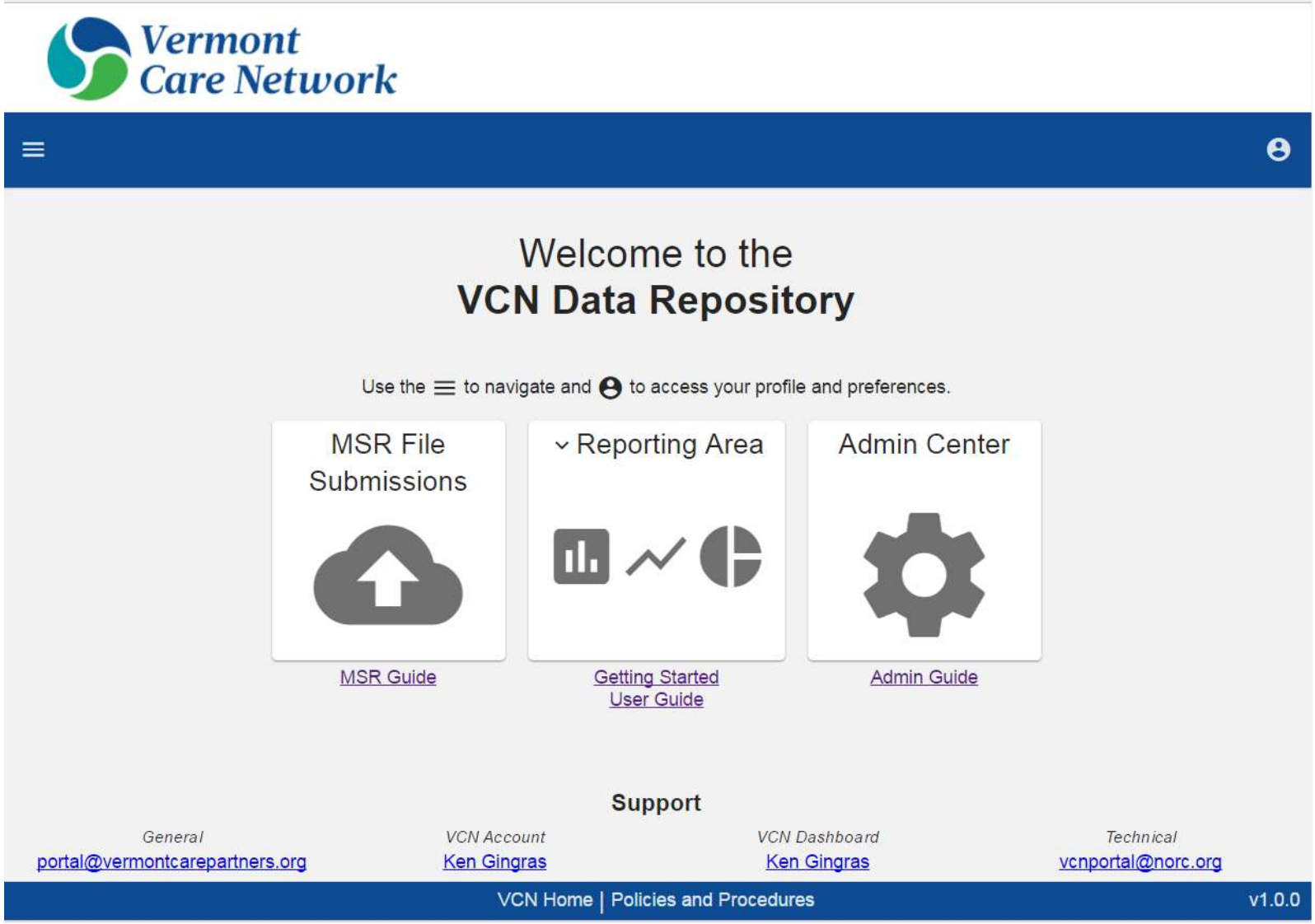
Attachment 8: VCN Data Repository Update

High Level Summary
Data Repository Progress September 2016



Secure Web Portal Screenshot:




Vermont Care Network
Welcome to the
VCN Data Repository
Use the to navigate and to access your profile and preferences.
MSR File Submissions
Reporting Area
Admin Center
MSR Guide
Getting Started
User Guide
Admin Guide
Support
General
portal@vermontcarepartners.org
VCN Account
Ken Gingras
VCN Dashboard
Ken Gingras
Technical
vcnportal@norc.org
VCN Home | Policies and Procedures
v1.0.0

Vermont Care Network Analytics Platform

Agency: [redacted]
Reporting Period: 01.2014 - 06.30.2016

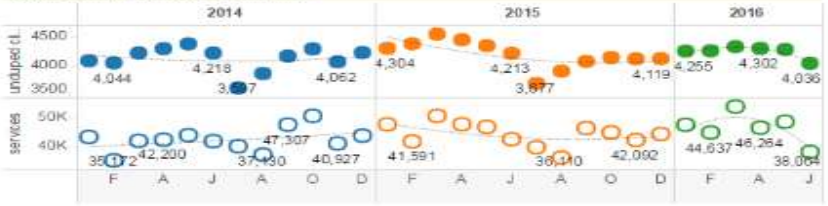
KPI Summaries | Demographic Analysis | Episode Analysis | Services Analysis | Crisis Services | Services by Cost Center | Crisis Bed Services | Staff Summaries | Client Summaries

Period: 1/1/2014 – 6/30/2016 | Age: 0 – 97 | Gender: (All)

% of Total Client & Services by Service Program

	unduped clients	% total clients	services	% total services
ADAP	4,975	39.77%	92,738	7.06%
CRT	772	6.17%	199,412	15.18%
DS	794	6.35%	558,456	42.53%
EMERGENCY	3,130	25.02%	34,545	2.63%
MH Adults	1,376	11.00%	27,146	2.07%
MH Children	3,732	29.83%	400,937	30.53%

Total Clients Trend by YearMonth



% of Total Client & Services by Service Program

	unduped clients	% total clients	services	% total services
Community 2	3,567	28.51%	246,990	18.81%
DA / SSA Site 1	11,966	95.64%	833,275	63.45%
Home 5	2,241	17.91%	160,549	12.23%
Inpatient Hospital 4	335	2.68%	967	0.07%
Nursing Facility 3	38	0.30%	395	0.03%
School 6	1,286	10.28%	71,058	5.41%

Services KPIs by Program Services

	ADAP	CRT	DS	EMERGEN..	MH Adults	MH Children
unduped clients	4,975	772	794	3,130	1,376	3,732
services	92,738	199,412	558,456	34,545	27,146	400,937
services / client	19	258	703	11	20	107
services / staff	536	804	844	219	348	596
avg duration	0.9	1.0	1.9	0.9	1.0	1.3
staff count	173	248	662	158	78	673

% of Total Client & Services by Service Program

	unduped clients	% total clients	services	% total services
ADAP - Individual Consult..	3	0.02%	389	0.03%
ADAP - Intensive Outpatie..	834	6.67%	11,224	0.85%
CERT B04	147	1.17%	30,797	2.35%
Clinical Assessment E02 ..	6,887	53.45%	9,102	0.69%
Community Supports B01	4,197	33.55%	387,701	29.52%
Community Supports B02	603	4.82%	26,949	2.05%
Consultation F01	113	0.90%	2,255	0.17%
Day Services - Not for DS ..	228	1.82%	22,650	1.72%
Emergency / Crisis Asses..	4,118	32.92%	20,079	1.53%
Emergency / Crisis Beds ..	1,178	9.42%	8,005	0.61%
Employer & Job Develop..	303	2.42%	8,807	0.67%

Episode KPI Trends (YbyY, QTbyQT)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	2015 Q3	2015 Q4
unduped clients	5,172	5,377	5,264	5,275	5,467	5,391	5,079	5,184
New Clients	1,622	1,577	1,603	1,677	1,572	1,550	1,583	1,704
Episodes	0	9	6	1	1	4	20	29
Admissions	643	598	586	617	488	573	572	642
Discharges	0	4	2	0	1	3	20	29

Vermont Care Network Analytics Platform
Agency [redacted]
Reporting Period: 01.2014 - 06.30.2016

KPI Summaries | Demographic Analysis | Episode Analysis | Services Analysis | Crisis Services | **Services by Cost Center** | Crisis Bed Services | Staff Summaries | Client Summaries

Period: 1/1/2014 – 6/30/2016
Age: 0 – 97
Gender: (All)
Cost Centers: Employment Services 53
Service Types: (All)
Service Programs: (All)

Services KPIs

	Employment Services 53
unduped clients	596
services	46,624
Episodes	3
Admissions	18
Discharges	1

Services by Cost Center and Service Type

	ACTIVE	INACTIVE	Grand Total
Clinical Assessment E02	7		7
Community Supports	136	7	138
Employer & Job Development	303		303
Employment Assessment	338		338
Job Training	122		122
Ongoing support to Maintain Employ..	334	2	334
Service Planning & Coordination	267	9	268
Unlicensed Home Providers / Foster F..	1		1
Grand Total	594	16	596

Total Services Trend by YearMonth