Vermont Health Care Innovation Project
HDI Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, September 21, 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	Georgia Maheras called the meeting to order at 9:05am. A roll call attendance was taken and a quorum was not initially present. A quorum was *July Meeting Minutes:* Heather Skeels moved to approve the July meeting minutes by exception; Nancy Marinelli seconded. The minutes were approved with no abstentions.	
2. Project Updates	Georgia Maheras provided project updates: • Brief Sustainability Update: Hired a contractor, Myers & Stauffer, to support this effort. Multiple components: a survey for stakeholders, a private sector stakeholder group, and a parallel State leadership group. A draft will be released in early November for stakeholder review and comment, and will be presented to every work group in November for review and discussion. We will also host a webinar as an additional opportunity for comment. All feedback will be documented; the stakeholder group will reconvene to consider responses to comment and make a recommendation to the Core Team for approval. The final plan will be approved in Spring 2017 to ensure the new Governor's administration has an opportunity to review. Feel free to contact Georgia or Sarah Kinsler to provide input. • ONC Clinical Quality Measurement Conference: ONC recently held a conference with states to support peer learning around clinical quality measurement. They hope to develop some toolkits as well as influence ONC policy. This was a very interesting meeting; Georgia is synthesizing notes from Vermont's team. We are also inviting a few key contacts to come to Vermont so we can learn from them: Dr. David Kendrick, who specializes in using electronic clinical quality measures for practice transformation, and Lucia Savage, ONC's Chief Privacy Officer, who specializes in explaining HIPAA and other privacy rules.	
3. Event Notification System Update	Brian Manning from PatientPing provided an update on rollout of our Event Notification System (Attachment 3). • PatientPing's Event Notification System uses data from the VHIE to provide notifications (pings) to providers on a patient's care team when the patient transitions between care settings.	

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	• Status Update: PatientPing is providing pings on over 56,000 CHAC members, and 4,200 high-risk OneCare members. Pings to date: 44,771 total. • New providers continue to sign on to receive pings. The group discussed the following: • Arsi Namdar asked whether HHAs are being notified, and whether there has been progress in working with EMRs, especially big players like McKesson. Brian noted that PatientPing gets admission, discharge, and transfer information through the VHIE. HHAs have a dynamic census; they send their census to PatientPing in real time; for 90 days following service through an HHA, the HHA will get a ping of the patient has an admission, discharge, or transfer. PatientPing does integrate with many EMRs and receives information directly from EMRs. Pings can't currently be consumed through EMRs (only through a web interface), but PatientPing is working on an API for this. • Susan Aranoff asked whether numbers on slide 3 under the VITL bullet are unduplicated – CHAC and OneCare numbers are subsets of 44,771, the total number. Brian responded that this is correct. • Dale Hackett asked how many of the CHAC patients are high-utilizers so he can compare to the OneCare number. Brian did not have that data but could pull it. He noted that PatientPing is tracking CHAC's entire population, but only a sub-set of OneCare's population. He commented that PatientPing is building new features that will allow the identification of high-risk patients in real-time based on utilization, rather than waiting for claims data. • Chris Dussault noted that AAAs and SASH don't have access to the VHIE because they are not included in the definition of a health care provider in statute. Brian clarified that organizations don't need to be able to access the VHIE to receive updates on the patients they are tracking. SASH is receiving pings. Stefani Hartsfield noted that SASH can only see ADT information by contracting PatientPing – a slice of the full information in the VHIE. • Susan Aranoff asked whether PatientPing is working with AAAs in other states. Brian responded that this is not currently occurring; it hasn't come up as much in other states. • Nancy Marinelli asked whether PatientPing is working with residential care homes, assisted living residences, adult day providers, traumatic brain injury providers, or other types of long-term care providers. Brian responded that this hasn't happened yet. Nancy suggested that these providers, many of whom are Choices of Care providers, should be added to the list for future discussions.	
4. Data Utility Update	David Healy and Rachel Block, both part of the contracted HDI Work Group support team from Stone Environmental, provided an update on the Data Utility project (Attachment 4). • State HIEs vary significantly, but there's still much to learn from other states! • Key topics are governance, functions, and HIE/HIT program sustainability. • Key state roles (themes Rachel has identified and categorized across states): States have taken varied approaches to each of these roles.	

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	• Georgia Maheras noted that results of this work will be part of transition documents for the next Administration; we are likely to have final results by the end of the year. • Georgia invited members to email her with comments or feedback. The group discussed the following: • Susan Aranoff asked whether any states are dealing with cost and expense through regulation, and what states' roles are. Rachel replied that states are relying on this opportunity to maximize Medicaid match funding. New York has an HIT fund similar to Vermont's, and is considering whether or how they want to continue this in the future, but New York and Vermont are the exception to the rule. Some payers are creating incentive payments to particular providers for HIE participation, but this is market-based. Susan asked whether any states are regulating provider HIE access costs, noting that this is becoming a necessity for providers, and that the VHIE has a monopoly. Rachel replied that one other state has granted a monopoly to regional HIEs, and there's a component of statewide coordination for statewide patient lookup. The state has not regulated participation costs, but the basic service package regional HIEs are providing is regulated. Arsi Namdar noted that most HIE services have been free for providers so far; introducing costs for HIE services will be very hard for providers. Georgia noted that this is not the path Vermont is planning to take; this service is a utility and should be funded appropriately in a way that allows us to maximize federal funding opportunities.	
5. Telehealth Pilot Update	Georgia noted that it's been quite a while since we've had an update on this topic. Delays in contracting have delayed this project, which will wrap up in 2017. Jim Westrich provided an update on the telehealth pilots. • DVHA received several RFP responses and selected two to pursue as pilots. The two selected pilots were with the Howard Center and VNAs of Chittenden and Grand Isle Counties. • Howard Center pilot is to do remote dosing for clients with opiate addiction who are receiving particular therapies. Secure dispensers of medication, plus video technology to monitor dosing, allows patients to receive medication at home. Howard Center has selected a vendor for video technology, and has scheduled a staff training for later this month. Clinical staff will do video review and are creating clinical workflows for this; Howard Center is also selecting appropriate clients for this pilot. • VNAs of Chittenden and Grand Isle Counties leads the second pilot, partnering with Franklin County Home Health and Central Vermont Home Health and Hospice. This pilot will share telemonitoring information, as well as other information, through the VHIE. Arsi Namdar added: This pilot is working with McKesson and Honeywell to install VHIE interfaces; they are currently in testing. Data will go from the system, to field nurses' laptops, to the VHIE system.	
6. Home Health Agency VITLAccess Rollout and Interface Build Update	Larry Sandage and Susan Aranoff provided an update on the Home Health Agency VITLAccess rollout and interface build (Attachment 6). • The goal is to connect HHAs to the VHIE through interfaces and allow them to access to clients' broader health records stored in the VHIE through VITLAccess.	

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	• This project initially included AAAs in its scope, but legal issues have prevented us from pursuing this path; this work is on hold. • Slide 4: Should be titled "VITL Interface Implementation" • Larry noted that Arsi Namdar has been a huge asset to this team. Susan Aranoff seconded that Arsi has been a wonderful partner, as has Holly Stone, who is the project manager. Arsi noted that this has been a very satisfying project to work on.	
7. Universal Transfer Protocol/ Integrated Communities Care Management Learning Collaborative Update	Erin Flynn provided an update on work toward a Universal Transfer Protocol (UTP) through the Integrated Communities Care Management Learning Collaborative (Attachment 7). • When the decision was made not to pursue a technical solution for UTP in Spring 2016, it was decided that UTP goals would be pursued through workflow redesign, leveraging the Integrated Communities Care Management Learning Collaborative, a provider learning collaborative which has grown out of the Practice Transformation Work Group. • Erin reviewed content at the September 6-7 learning sessions, which focused in part on this topic, and walked through the steps participating providers took to identify key care transitions and the information they need to support care continuity through those transitions. The group discussed the following: • Dale Hackett and Nancy Marinelli asked for more information on the chart used at the learning sessions. The full curriculum from this learning session will be posted to the VHCIP website soon. • Erin described the process of identifying standard data elements for key information. • Susan Aranoff asked whether or how the key data elements have changed since the first UTP report that was put together by im21 in 2014. Erin noted that this work within the Learning Collaborative builds on the efforts to develop shared care plan templates. There was also a great deal of discussion about OneCare's Care Navigator tool, which is currently being rolled out. She believes we are further along, though this work isn't done. There is a feasible shared care plan solution being tested now in Care Navigator, which is a significant advance. Georgia Maheras added that we've done a lot of education within IT and in the provider sphere and implemented certain standards; providers are starting to understand the benefit of standardized data sets. Ken Gingras added that this is a reminder – it underscores the necessity of having a common language and broad standards that make are understandable across the state and the country. • Stefani Hartsfield commented that the decision not to endorse one shared care plan solution in 2015 and 2016 led us to this point. Terry O'Malley was able to describe this to people intimately involved in care management, which was very beneficial, but this group also needs to see and understand those slides. She requested that we send those slides to this group. Care team meetings that support better and more coordinated patient care are also a key success. • Erin noted that the Learning Collaborative will continue to hold shared learning events with Blueprint and ACO support – she expects this conversation will continue.	**Send Terry O'Malley slides from ICCMLC to group.**

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8. VCN Data Repository Update	Ken Gingras provided an update on the VCN Data Repository Project (Attachment 8). • Vermont Care Partners members are participating. • The data repository will include two years of historical MSR data. Based on this information, built a first dashboard. VCN has been working to develop a full list of metrics and compare to the MSR data. The first dashboard shows that VCN can answer many key questions about their system of care. Cross-referencing and standardization has meant the loss of some granularity and specificity. • VCN also did training to teach agencies how to securely upload data on a monthly basis after they send to DMH. Training is now complete; VCN is still working with agencies to make this a monthly habit. VCN is also doing training on using their monthly portal to set up and manage users and security levels. At least one person has been trained at all agencies, and this is currently rolling out so people can access initial dashboards and provide feedback. • Phase 2: Vendors are working to develop transmitting agents at each agency that allow secure transmission to the repository. VCN will also be developing additional dashboards; it also plans to train agency staff to develop and distribute their own dashboards. • Ken walked through a redacted screenshot of a dashboard. The group discussed the following: • Heather Skeels asked whether VCN is tracking who logs on so they can follow-up. Ken replied that the vendor should be able to provide that, but hasn't accessed it yet. Heather noted this has been very helpful for CHAC; Nancy Marinelli commented that this would also be helpful for agencies. • Dale Hackett asked how reliable the information in the dashboards is, and how this is communicated to users. Ken replied that data quality is a huge topic and something VCN is also working on. The data repository will allow VCN to work with administrators and agency IT folks to work backward to identify data quality issues. • Nancy Marinelli asked whether this will replace the MSR. Georgia noted that AHS is working on this through the Medicaid Pathway – rather than replacing the MSR, the way it's submitted may change to make information easier to submit, receive, and analyze. The audience for the DMH-submitted MSR report and the repository/dashboards are different at this point. This tool allows the agencies to get more feedback on the data they're submitting. In Phase 2, there will be new information daily to allow for more granularity and faster response.	
9. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	Dale Hackett asked whether other states have found sustainable funding solutions for ongoing maintenance and operations of systems. Georgia replied that this is an issue in every state due to restrictions in federal HIT funds. **Next Meeting – DATE CHANGED:** Friday, October 28, 2016, 3:00-5:00pm, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury. • Topics include connectivity targets and consent management; materials will be distributed early in October for written comment as well as for discussion at the work group meeting.	