

***Vermont Strategic and Operational Plans  
(VSOP)***

**Approved June 13, 2013**

**Version 1.4**



**Vermont State Agency of Human Services,  
Department of Health Access, Division of Health Reform**



**Vermont Information Technology Leaders, Inc.**

## Revision History

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<b>1.0</b>	<b>5/08/2012</b>	<b>Bequette</b>	<b>Initial Draft submitted</b>
<b>1.1</b>	<b>6/12/2012</b>	<b>Bequette</b>	<b>Added Revision History; Added discussion of Project Management Plan topics; Updated TOC.</b>
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<b>1.3</b>	<b>10/29/2012</b>	<b>Bequette</b>	<b>Updated Revision History and TOC; Added milestones and dates to Evaluation Plans; Updated Template 2 of the Security Discussion to reflect an approved Consent Policy which is incorporated as Appendix D; Updated Program results.</b>
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## *i. Introduction - Vermont SOP in Context*

Vermont has issued four versions of its State HIT Plan (VHITP), the most recent being version 4.6 and currently approved by the Office of the National Coordinator (ONC). As is explained in the current VHITP, the context of health reform in Vermont both pre-dates HITECH and expands beyond HITECH in describing the plan for health care transformation in Vermont.

With the release of ONC's Program Information Notice ONC-HIE-PIN-002 on February 8, 2012, there is now a need for Vermont to submit its Strategic Operations Plan for Vermont's Health Information Exchange (HIE) to address the planning requirements included in that PIN in a timely manner.

Vermont's VHITP has a broader scope than that required by ONC. It addresses planning requirements codified in law to address aspects of HIT/HIE not necessarily required by ONC. More recently, Vermont's Act 48 introduced additional requirements for the VHITP to include the creation of a Health Benefits Exchange.

We consider it important to have a single documented plan, so that the threads connecting HIT/HIE expectations and requirements by different sources can be clearly identified and understood in relationship to each other. Also, the simple act of referring to "the plan" will not be an ambiguous statement if there is a single plan.

Issuing this Vermont Strategic Operations Plan (VSOP) for the HIE is a temporary measure, though we have attempted to address most of the requirements of the PIN with this release. We are already planning the full update of the VHITP, including public and stakeholder engagement, and will incorporate this SOP into that document. We will continue to update the SOP document to meet ONC expectations, and will of course share the VHITP when that document becomes available.

## *ii. Preface to the SOP Revision*

Although our first SOP was approved just 6 months ago, the rate of change in the Vermont Health Care Reform landscape warrants a few comments by way of introduction. As we continue to work on expanding the HIE in Vermont and promote the many characteristics of a healthy HIE as understood through ONC resources (ePrescriptions; clinical exchange; lab exchange; Public Health HIT initiatives; and more), Vermont continues to pursue other related initiatives on many fronts.

Vermont's Health Benefit Exchange is on track to launch on October 1, 2013, and to meet its subsequent critical dates as well. The EHR Incentive Program is functioning at a high level of performance, with over \$25,000,000 awarded to date, many providers transitioned from adoption to Meaningful Use, and an audit program poised for implementation. Vermont is one of the first round of State Innovation Grant (SIM) recipients and will be demonstrating different payment reform models in the coming time frame, with anticipated participation from the HIE to achieve the operational performance required to support these models.

Health Information Exchange, both the noun and the verb, are now being given early consideration in all new proposed projects and when workflow improvements are being considered. Examples include a project to improve outcomes and cost reductions with the dually eligible population, and a grant proposal recently submitted to SAMHSA. Data liquidity remains a guiding principle for a key architectural component for the future, and HIE is one instrument to help achieve that flow of quality data.

Terry Bequette  
State HIT Coordinator

### iii. *Preface to the First SOP*

We are pleased to provide this initial document, *Vermont Strategic and Operational Plans*, as step one of a comprehensive approach to revisiting the *Vermont Health Information Technology Plan* (VHITP). As a reminder, Vermont’s first State HIT Plan, published in July 2007, was praised by then National Coordinator Dr. David Brailer as “an outstanding document” and a “model for the nation.” Successive updates were made in 2008 and 2009, with the most recent version (4.6) formally submitted in October 2010 and approved in November of that year.

From the vantage point of 2012, the series of 30 public meetings which led to the original 2007 edition are indeed now in the distant past, especially considering the significant evolution of HIT and HIE technologies and policies. While we have conducted general stakeholder meetings on a regular basis (monthly or bi-monthly, depending on the season and agenda) since shortly after passage of the HITECH Act in 2009, our focus has been more on “advancing the plan” than on stretching our thinking to new directions or areas.

When presented with the relatively tight turn-around time in PIN-002 for updating the plan, I worried that we could miss an opportunity for a deeper dive. As State HIT Coordinator, I felt a strong desire, indeed a responsibility, to revisit the embedded assumptions of the State’s HIT policy, as represented in the current plan. Given the dynamic changes in HIT and in health care and health reform as a whole, this is a moment to pause and ask some hard questions, to engage in an in-depth discussion with Vermonters – providers, patients, and policy makers – about the role IT can play in enabling the transformation of health and health care.

Vermont appreciates ONC’s support of our planned year-long community engagement process, where we will challenge our assumptions and expand our horizons to ensure that all Vermonters, not just a narrow subset of IT and health policy insiders, have the opportunity to give voice to their needs and desires for infrastructure and services that provide meaningful, user-friendly access to health information and communication tools.

Over the next month, we will be launching a web site and other on-line tools to support public engagement and start the first of a series of “town hall” meetings designed to inform and enliven the next VHITP and provide “real time” views into its revision and expansion. We look forward to collaboration with you and ONC colleagues to bring the national HIT perspective to Vermont, as well as to share Vermonters insights with you. Thank you for your support.

Hunt Blair  
Deputy Commissioner – Division of Health Reform  
State HIT Coordinator

## 1. Changes in HIE Strategy

Appendix A – “Changes in HIE Strategy” is attached and documents some changes in HIE strategy that have occurred since the last version of this SOP was published 6 months ago. The Sustainability Plan is updated as are sections of the document addressing Privacy and Security and Evaluation Plans. The Project Management Plan is also updated.

## 2: Sustainability Plan

This Sustainability Plan creates the conditions for sustainability of information exchange in Vermont and also outlines viable business plans for the sustainability of services we are directly providing or funding.

Before considering the topic of sustainability it is important to understand the context of health reform, including the utilization of HIE, in Vermont. This understanding needs to consider both what the context represents, and what it does not represent.

The context is documented as part of the Program Evaluation Plan (Section 3) in this SOP, because background and context was a required element of the evaluation plan. That context is not repeated here, but a few key points are derived from that description:

1. Vermont’s health reform efforts pre-date HITECH and Vermont was committed to and had the structure and the funding established for a health information exchange;
2. Vermont’s Blueprint for Health is an early implementation of a patient centered medical home concept, and is supported by founding legislation and subsequently supported by legislation for expansion. It is the goal of the Blueprint for Health program to have every Vermont person participating in a Blueprint practice. Payment reform has also been implemented as part of the Blueprint for Health program, adding elements of an accountable care organization;
3. The Blueprint for Health program establishes a clinical data repository in support of evidence-based practice and a learning health system. Measure sets are established and clinical data is collected for a number of chronic conditions and acute conditions are now being addressed as well. Essentially the Blueprint for Health program represents an early adoption of Meaningful Use of HIT;
4. The Blueprint is also staffed to provide facilitation and project management assistance to practices as they implement their EHR systems and begin to move data through the exchange and into the repository. Hundreds of thousands of such transactions occur each month and there is much expansion to go. Essentially the Blueprint represents an early implementation of REC-like services;
5. Vermont is actively engaged in activities intended to expand the participants in HIE beyond the initial population of hospitals, medical providers, laboratories and pharmacies. We are funding analyses of technical exchange gaps that exist for a variety of providers not eligible for EHR incentive payments, including mental health agencies, home health agencies, and long-term care providers such as nursing homes and residential care facilities. And we are engaging these providers in use case discussions to effect improvement in transitions of care and improved workflows across the provider spectrum.

It is also important to realize what Vermont's context does not represent:

1. Vermont is not a State with a heterogeneous approach or structure for HIE – we have a single HIE, established by law, and mandated to provide specific services to the Vermont health care environment;
2. Vermont is not a state with multiple RECs. Vermont has a single REC to assist providers with the adoption and meaningful use of their EHR technology. More significantly, the REC is organizationally a part of VITL. This structure has provided great synergy between the Blueprint program and the REC program, as VITL also has staff dedicated to the Blueprint expansion and to supporting provider organizations in meeting their Blueprint participation expectations;
3. Vermont is not a state where significant elements of the State Government are separated from HIE efforts. The Department of Vermont Health Access (DVHA) (administers the State Medicaid program) has responsibility for the major aspects of health reform in Vermont. DVHA includes the Division of Health Reform (DHR), of which the Deputy Commissioner, Hunt Blair, remains the State HIT Coordinator. DHR administers a grant funding mechanism to VITL, since DVHA is the Grant recipient of the Cooperative Funding Agreement. Further, the Blueprint for Health program is organizationally within DVHA. There is good visibility at all times into these efforts across the participating organizations;
4. Vermont is not a state where funding mechanisms have not been considered and addressed. Vermont has a Multi-Payer Claims Database which includes data from all payers who cover more than 200 lives in Vermont. In addition to collecting this data from these payers, a fee is collected which is the primary source of funds for the State HIT Fund, also administered by DHR.

From the outset the Vermont HIE was developed as an essential utility to support the transformation of health care that was reflected in the very first State HIT Plan and which has been expanded in the three subsequent versions published since. As an essential requirement for transformation the HIE needs to be available without the impediment of fees or subscriptions, and to date there are no such fees assigned to participants. To the contrary, a number of incentive programs have been implemented to encourage expansion and participation. As the HIE helps us meet the triple aim exemplified by the Blueprint for Health program (improving the health of populations; improving the experience of care; reducing per capita healthcare costs) the overall cost to the State is offset by overall savings from an improved delivery model. Some early results, based on the early years of Blueprint implementation, are bearing this out with data indicating fewer hospital readmissions and fewer emergency room visits.

## **2.1 Conditions for Sustainability of Health Information Exchange**

As described above, Vermont is fully engaged in advance care transformation models and payment reform initiatives that will have an ongoing demand for exchange. As the Blueprint program expands to all primary care providers the amount of data transactions through the exchange will increase dramatically. The Blueprint, through its requirements for clinical data, represents a deliberate incentive to adopt health IT and HIE on the part of practices. There are incentives for participation and there is help available to join this transformation.

Vermont's approach beyond the Blueprint program is based on attraction rather than requirement

of participation. Outreach and education are the primary mechanisms to build attraction, and VITL plays a key role in our outreach efforts. This includes an annual summit which is well attended by the provider community. Dr. David Blumenthal delivered a keynote address two years ago, and Dr. Farzad Mostashari will be a keynote speaker at the 2012 summit in September. We have benefited from good participation from ONC and CMS in these summits and have had a very positive response to this as well.

Additional attention will be paid to the business sustainability aspects of our sustainability plan in future annual updates. As currently enacted, the payer fee described above sunsets in 2015 and we will anticipate and address that next year.

The guideline for the sustainability plan also notes that ONC expects that all grantees will meet the Meaningful use exchange needs of eligible providers, including those serving Medicaid patients and rural and underserved communities. ONC recognizes that there is a potential tension between offering services that are self-sustaining and serving communities and providers with the fewest resources. The guideline further suggests that one way Grantees can resolve this tension is by offering affordable and easy-to-adopt exchange options.

Vermont certainly endorses this expectation, as witness the context comments introducing this section of the SOP. The savings aspect of the triple aim is an important element of our sustainability plan. Vermont has a substantial Medicaid population and addressing the exchange needs of our Medicaid providers is critical to managing the cost of serving our Medicaid population. Additionally, Vermont is completely rural, with the exception of the Burlington city area. The Blueprint is now active in all 13 Health Service Areas of Vermont, with a minimum of 1 hospital and 2 practices signed up for each area. Many of the Blueprint practices in these areas are FQHCs, and many of these FQHCs have qualified for EHR incentive payments in the first year of Vermont's EHRIP program. Once again, the synergy of the Blueprint as the enabler of Vermont's health care transformation and the REC services offered by VITL is resulting in an outcome that specifically addresses a concern in the ONC guideline.

VITL's annual report, January 15, 2013, addresses the specific topic of sustainability for the HIE. From the Executive Summary of that report:

**“Financial Sustainability:** The availability of state funding for building the health information network has been beneficial in that it has enabled VITL to proceed without asking health care organizations to pay a subscription or transaction fee, eliminating a financial barrier to providers participating in the network. VITL does recognize the need to transition from state funding to a self-sustaining model. VITL will need to accelerate development of the network to demonstrate increasing value to users. Once accomplished, VITL can then quantify the value being delivered and begin the transition to self-sustainability. In the meantime, VITL is exploring its ability to offer new services.”

In the Section of the VITL annual report that discussed financial sustainability in more detail, the outline of VITL's sustainability plan is described:

“VITL has already demonstrated value to early users of the health information network. At the same time, VITL recognizes the need to transition from state funding to a self-sustaining model. Providers will be more willing to pay for the

services they receive from the health information network if it is demonstrating value in the short-term from a day-to-day clinical decision making standpoint, and in the long-term as coordination of care, data analysis, and assuming increased risk for outcomes becomes more prevalent under health reform. VITL will need to accelerate development of the network to demonstrate increasing value to users. Once accomplished, VITL can then quantify the value being delivered and begin the transition to self-sustainability.

“At the same time, VITL is exploring its ability to offer new services. These include serving as the health IT infrastructure for accountable care organizations and other forms of governmental and payer health care delivery models. VITL is investigating the development of an image archiving service — the ability to store radiology images needed for historical and trend comparisons. Image archiving is a cost that hospitals currently bear individually and can be offered more cost-effectively by consolidating hospital storage requirements into one source. VITL is also evaluating ways to provide on-going technology services to individual providers after HER implementation, as well as ways to leverage VITL’s current and planned technology to support the coordination of care across a community of providers.

“Over the next two years VITL will be working diligently to deliver a health information network to Vermont that is highly valued, can be leveraged to improve care delivery by providers and increase patient engagement in a new era of health reform, while at the same time seeking to offer new services designed to improve efficiencies and reduce the cost of care.”

The State will be working with VITL to develop the outlined sustainability strategy and together we will develop a transition plan for a funding model that is sustainable for both the State of Vermont and for VITL.

## **Section 3: Evaluation Plan**

### **Executive Summary and Introduction**

Vermont’s HIE Program Evaluation Plan is developed to document and organize evaluation activities and reported outcomes of those activities. While this plan is required as part of satisfying a requirement to conduct an annual state-level program evaluation, the evaluations that will be undertaken as part of this plan will contribute to the ongoing expansion and improvement of the HIE. The evaluation plan thus serves a strategic purpose, while the evaluation activities will serve a tactical purpose.

The background and context of health care transformation in Vermont is presented in some detail, and provides the historical evolution of the current landscape. This transformation has been

expanded over time, always with the engagement and support of Vermont's legislative and executive branches of government, and with significant engagement and support of the people of Vermont. HITECH fits within the context of Vermont's transformation and has contributed to the pace of our efforts. An evaluation of the HIE program in Vermont will provide valuable insight into the effectiveness of HIE in Vermont and the effectiveness of HIE as a critical component of our health care transformation.

### 3.1 Background and Context

What follows is derived from the current approved version of Vermont's Health Information Technology Plan, specifically the discussion of the Vermont environment in the first section of that plan. This description is updated to reflect the influence of Vermont's Act 48 on HIT in Vermont.

Vermont is recognized as a national leader in the alignment and integration of Health Information Technology (HIT), Health Information Exchange (HIE), and reform of the health care delivery system. The state continues to expand HIT adoption and HIE connectivity statewide, building on a seven year base of planning, consensus building, governance refinement, and creation and early implementation of a standards-based technical architecture.

Funding and authorization for the Vermont Information Technology Leaders, Inc. (VITL), a 501c3 not-for-profit corporation charged with developing statewide HIE, was included in the 2005 Budget Act and appropriations continued in each subsequent annual state budget. Passage of the HITECH Act and other components of the American Recovery & Reinvestment Act (ARRA) supporting investments in HIT and HIE, as well as additional federal health reforms enacted in the Affordable Care Act (ACA), position Vermont to build on its work to date and to expand the scope, scale, and speed of the state's HIT-HIE and health reform implementation.

Health information exchange and technology are a consistent focus of Vermont health policy attention, but always in the broader context of enabling transformative delivery system change. Because of that systems approach, meaningful use of HIT has been built into Vermont's vision from the outset. For instance, the Vermont HIE Network (VHIEN) operated by VITL, is a critical conduit for the Vermont Blueprint for Health IT infrastructure, enabling both personalized and population-based care coordination and management for the Blueprint's integrated primary care medical homes and community health teams.

The state of HIT in Vermont reflects the continuation of a roadmap and a vision resulting from a seven year public/private collaboration. That conversation began with a 2004 HIT Summit convened by the state hospital association that led to the 2005 legislation that charged the group that became VITL with development of the *Vermont Health Information Technology Plan* (VHITP), starting an extended dialogue and consensus building process that was well underway when Vermont's landmark health reform legislation passed in 2006. The scope of the VHITP then expanded accordingly to incorporate the state's comprehensive health reform vision.

Vermont's commitment to promoting the growth of HIT and HIE meant seeking resources beyond state appropriations. Voluntary contributions from insurance carriers to an EHR pilot fund administered by VITL in 2007 validated the demand from physician practices for financial and technical assistance to implement HIT, but the pilot's scale was too limited.

Realizing the state's ambitious goals could not be achieved without more formal, systemic investment in HIT, Vermont instituted its Health IT Fund in 2008. A fee (2/10ths of 1%) paid on all health insurance claims generates annual revenues for the state Fund which then provides grants to support HIT and HIE. The Fund sunsets after seven years, meaning it will be available through 2015.

Given this history and preparation, Vermont was ideally positioned for the evolution in federal HIT policy contained in ARRA. In response to the passage of the federal HITECH Act, the Vermont legislature clarified the roles and responsibilities for HIT policy and HIE governance in Act 61 of 2009. Responsibility for coordination and oversight of HIT-HIE planning, which had originally been delegated to VITL, now sits with the Department of Vermont Health Access, in its Division of Health Care Reform. The Department is the home of Vermont Medicaid, and the Division is also responsible for the State Medicaid HIT Plan (SMHP) and administration of the Medicaid provider incentive program for meaningful use of electronic health records (EHR).

This evolution of governance reflects an understanding that emerged over time and was ratified in the 2009 legislation, with both private and public HIT stakeholders agreeing that policy guidance and coordination rests with the state, while operation of the state level HIE is best done outside state government. 18 V.S.A. chapter 219 § 9352 designates VITL, a private, non-profit corporation, as the exclusive statewide HIE for Vermont. The law also reserves the right for local community providers to exchange data.

In order to fully understand the scope of Vermont's HIT-HIE vision and the state environment, it is essential to understand the larger system reform agenda. Guiding legislation calls for a highly coordinated and integrated approach to healthcare statewide, with an emphasis on wellness, disease prevention, care coordination, and care management, with a particular focus on primary care.

Vermont's Blueprint for Health is leading this transformation through an integrated delivery model that includes patient centered medical homes supported by community health teams, and financed through a multi-insurer payment reform structure. These teams include members such as nurse coordinators, social workers, and behavioral health counselors who provide support and work closely with clinicians and patients at the local level. The teams also include a public health specialist dedicated to community assessments and implementation of targeted prevention programs.

Cost effective care depends on health information being available when and where it is needed, so Vermont's system reforms are built on the premise of ubiquitous, multi-dimensional health information exchange. In addition to encouraging EHR adoption and HIE linkages to labs and hospitals, the Blueprint has invested in the creation of a web-based clinical registry and visit planning templates, as well as population reporting tools linked to EHR and PHR systems through the HIE.

In 2010, in Act 128, the Vermont legislature codified the developmental work conducted through the Blueprint's pilots, defining the components of medical homes, community health teams, and payment reform in statute. Act 128 also sets an ambitious expansion schedule for the Blueprint: by July 1, 2011, there shall be at least two medical homes in each of the state's 13 hospital service areas (HSA) and by October 1, 2013, the Blueprint shall expand statewide to primary care practices – including pediatric practices – to serve every Vermonter.

The statute also requires hospitals, which operate most of the clinical laboratory services in the state, to maintain interoperable connectivity to the HIE network as a condition in their annual budget approval process. As critical hubs of health care activity, the state's community hospitals play an essential role in supplying health information to the Blueprint practices and patients, and to the health care system as a whole. Taken together, the state's delivery system reforms and HIT-HIE policy create a supportive environment for eligible Vermont providers to meet the meaningful use requirements established by ONC and CMS.

In short, the environment for the HIT-HIE growth to be supported by ONC and CMS could not be better. Key policy decisions for advancing and expanding HIE and delivery system reform throughout the state are made. The broad brush design is complete. Funding from the State HIE Cooperative Agreement program, leveraged with the resources such as the ARRA Sec. 4201 and traditional Medicaid IT resources are enabling the state and VITL to finalize the operational design and rapidly implement statewide connectivity to the VHIEN.

VITL's support of provider EHR deployment will continue creating the end user capability to contribute to and meaningfully use information available through the HIE. Funding through the Regional HIT Extension Center (REC) Sec. 3012 Cooperative Agreement, complemented by ARRA Section 4201 funds targeting some additional supports for Medicaid providers will accelerate the deployment of EHR systems statewide.

Together, these programs will support the ongoing transformation of the health care delivery system, promote adoption for meaningful use of HIT, and expand HIE integration with state public health IT systems, public EHR portals, PHR gateways, connectivity to the National Health Information Network (NHIN) and support for deployment of NHIN Direct.

In 2011, with the passage of Act 48, the context of HIT in Vermont was again expanded, and once again it was in the interest of additional transformation of health care in Vermont. Section 10 of Act 48 directed the secretary of administration or designee (Hunt Blair as the Deputy Commissioner of Health Reform and as the State HIT Coordinator has been designated) to "review the health information technology plan required by 18 V.S.A. § 9351 to ensure that the plan reflects the creation of the Vermont health benefit exchange; the transition to a public-private universal health care system pursuant to 33 V.S.A. chapter 18, subchapter 2; and any necessary development or modifications to public health information technology and data and to public health surveillance systems, to ensure that there is progress toward full implementation."

Prior to Act 48, the realm of Health Information Technology (HIT), per 18 V.S.A. § 9351, was generally considered to include electronic medical record (EMR), electronic health record (EHR), and medical practice management (scheduling and billing) systems, as well as Health Information Exchange (HIE), public health IT, and electronic prescribing (e-Rx) systems.

Act 48, Sec. 10 requires a review of the scope of HIT to ensure that the full range of information technology related to health care reform is included. The *Vermont Health Information Technology Plan* (VHITP) will now serve as the operational planning document, not just for HIT, but for the comprehensive portfolio of HIT and Health Reform IT systems, known now as Vermont's Health Services Enterprise portfolio. The portfolio includes underlying common IT shared services and tools, the Health Benefit Exchange (HIX), Eligibility & Enrollment (E&E) systems, Financial Management systems, public health information, health data, and health surveillance technologies, and the full Medicaid Management Information System (MMIS) or Medicaid Enterprise Solution (MES) architecture.

The entire Health Services Enterprise portfolio is being designed and procured, adapted, and/or upgraded in order to meet both current and near-term needs and to ensure that over the coming years, the Enterprise components will transition to support Vermont's envisioned public-private universal health care system.

As such, the portfolio represents not just "building the exchange," procuring "a new MMIS," or expanding HIT. It is a vision for how to wire the "neural network" of Vermont's health system, creating a data utility that provides real time, and close-to-real time, clinical and financial information for the management of the health care system *as a system*.

The HIE is a critical component of this portfolio. It is in the context of the portfolio, and our responsibilities and commitments as an ONC Grantee, that we develop this Evaluation Plan.

### 3.2 Aims of the Program Evaluation

Vermont's Program Evaluation will:

1. Describe the approaches and strategies used to facilitate and expand health information exchange in the program priority areas and other areas as appropriate for Vermont's strategy. Program priority areas that will be included are:
  - a. Laboratories participating in delivering electronic structured lab results
  - b. Pharmacies participating in e-prescribing
  - c. Providers exchanging patient summary of care records
  - d. Public Health HIE-facilitated updates to Vermont's Immunization Registry, Syndromic Surveillance, and reportable lab results
  - e. Providers participating in the EHR Incentive Payment program
  - f. Providers participating in DIRECT exchange of records
2. Identify and understand conditions that support and hinder implementation of these strategies, including consideration of the following:
  - a. Governance model impact on program priority areas
  - b. Engagement with stakeholders impact on program priority areas
  - c. Impact of the combination of Vermont's Blueprint for Health program and the Vermont Medicaid EHR Incentive Payment program on program priority areas
  - d. Other conditions that may be identified as the evaluation plan is executed.
3. Analyze HIE performance in each of the key program priority areas:
  - a. Identify and document progress with the program from the start of the program
  - b. Assess participant adoption and use, including measured provider adoption, and analyze the impact of adoption on such things as transitions of care, patient safety, and duplicate lab test ordering.
4. Assess how key approaches and strategies contributed to progress in these areas, including lessons learned.
5. Additional key evaluation questions that we seek to address:
  - a. What is the synergy between Blueprint expansion facilitation resources and REC

- facilitation resources? Are there changes that should be considered in either of these programs that would lead to a better overall outcome?
- b. What has been the impact of Vermont's subsidization of e-prescribing transaction fees on the increase in the number of providers doing e-prescribing and on the total number of e-prescriptions written?
  - c. Other key evaluation questions will be added as we revise this evaluation plan.

### 3.3 Evaluation Framework

Vermont's evaluation framework considers critical program elements associated with the HIE and evaluates the mechanisms by which those program elements, either in a direct relationship or in a mediated relationship, result in desired outcomes. This framework will be initially and sufficiently developed to support appropriate evaluation of the program priority areas as described in section 3.1 above. Program elements for consideration include:

1. Governance
2. Stakeholder engagement
3. Grants and funding
4. Technical infrastructure, including DIRECT and Query

The framework will address and, if possible, account for alternative factors that could explain the outcome. Again where possible, measurements associated with program components and outcomes will be identified. For example, measuring the impact of VITL's connectivity incentives for Pediatric and Family Practices, or measuring the impact of connectivity incentives for critical access hospitals.

### 3.4 Evaluation Methods

Evaluation methods will include:

- Study Design for each Aim or Research Question of interest, and will include both qualitative and quantitative components. For quantitative analysis, the use of comparison or control groups or designs that assess change over time will enhance the validity of the findings.
- Study Population will describe the population chosen for each Aim or Research Question evaluation and the criteria for inclusion or exclusion. We anticipate that in many cases, e.g., any questions involving hospitals, we will attempt a census participation rather than a sample participation, as many study populations will be small in size.
- Data sources and data collection methods will be described for each key evaluation question. These may include surveys, analysis of existing data, focus groups, stakeholder groups, interviews, and audit log data from our HIE vendor.
- Data analysis will be described in terms of the analytic methods used, including sample size if appropriate.

### 3.5 Timeline for Evaluation Plans

The following table describes a program evaluation plan for program priority areas and other significant program aims or goals. Milestones with dates are identified for each evaluation plan

in the table.

**Table 1: Program Evaluation Plan for Program Priority Areas and Other Significant Program Goals**

Aims of evaluation	Framework to Assess	Evaluation Methods			
		Study Design	Study Population	Data Sources / Collection Methods	Data Analysis
Laboratories participating in delivering electronic structured lab results (eSLR)	Numbers and percentages of labs sending eSLRs; numbers and percentages of all lab orders being sent as eSLRs; Governance model impact; Impact of adoption on health outcomes and related results.	Utilize existing data sources to evaluate the adoption rate; Conduct a survey of labs to estimate total lab transmissions; Design a survey or analytical tool to identify the impact.	Primary: hospital and commercial laboratories, as lab order processors (the number is manageable and all will be included); Secondary: hospitals and other providers, as consumers of lab results.	HIE records for lab participation and lab orders sent as eSLRs; Survey data for total lab orders being sent.	2-3 providers or provider organizations per lab will be sampled to engaged as part of determining the impact of eSLRs;
<p>Milestones:                      6/1/2013: Identify existing data sources;                      7/1/2013: Survey design completed;                      8/1/2013: survey tools developed and pre-survey communications;                      9/1/2013: survey conducted and all information is gathered;                      10/1/2013: data analysis and report of survey results.</p>					
Pharmacies participating in e-prescribing (eRx)	Numbers and percentages of pharmacies adopting eRx; Numbers and percentages of providers adopting eRx; Numbers and percentages of all prescriptions being ordered through eRx; Impact of adoption on health outcomes and related results.	Utilize existing data sources to evaluate the adoption rate; Design a survey or analytical tool to identify the impact.	Pharmacies, hospital and community based.	SureScripts Data for Vermont;	Review SureScripts data for all years; Develop an analytical report of progress by year.
<p>Milestones:                      7/31/2013: Determine qualitative parameters suitable for determining the impact of eRx on health outcomes; Determine suitability of SureScripts data for quantitative measures;                      8/31/2013: Develop a qualitative survey instrument for use with providers and pharmacists; determine if different survey instruments are required for different populations; utilize web-based survey tools, as interviews will not be conducted for this this effort.                      9/28/2013: Identify survey participants and obtain email addresses for notifications; conduct the survey.                      10/31/2013: Review survey results and report findings. Also develop an analytical report of progress by year based on SureScripts data.</p>					

Aims of evaluation	Framework to Assess	Evaluation Methods			
		Study Design	Study Population	Data Sources / Collection Methods	Study Design
Providers exchanging patient summary of care documents (PSOC)	Numbers and percentages of hospitals and other providers exchanging patient summary of care documents; Blueprint providers exchanging data through the clinical data repository (with access and consent); Providers exchanging data and records through the VHIE's ProAccess capability; Governance model impact; Impact of adoption on health outcomes and related results.	Utilize existing data sources to evaluate the participation rate for providers; Conduct a survey of sampled providers to compare participating and non-participating providers to determine barriers and issues to exchanging PSOC.	Hospitals and professional providers in clinical care situations;	HIE records for PSOC exchanged through the HIE; HIE records of provider enrollment, practices connected; DIRECT reporting;	Review records of providers enrolled in the HIE compared to those exchanging PSOC; Sample providers in two categories: exchanging and not exchanging, to determine barriers and issues; and for those exchanging to determine impact.
<p><b>Milestones:</b>            9/31/2013: Clarify objectives of this evaluation and engage the Blueprint for Health program in this determination; determine all populations and sub-populations of interest (hospitals; providers by type or status; etc.); review all Blueprint improvement activities (referred to as 'sprints') as a source of information to this effort; identify possible issues related to the HIE as factors impacting PSOC exchange;            11/31/2013: With representation from the Blueprint staff, from the VHIE, and from our clinical data repository (DocSite), develop categories of information to be gathered through a survey from specific populations and sub-populations;            1/31/2014: develop multiple survey instruments as required to cover the spectrum of populations and identified information categories; include quantitative elements as possible, but the survey is considered likely to be more qualitative at this time;            2/28/2014: Identify survey participants and obtain email addresses for notifications; conduct the survey; be mindful of overlap with other surveys being considered for evaluating other issues (e.g., eRx);            4/30/2014: Review survey results and report findings.</p>					

Aims of evaluation	Framework to Assess	Evaluation Methods			
		Study Design	Study Population	Data Sources / Collection Methods	Data Analysis
Vermont Department of Public Health (VDH) HIE-facilitated updates to Vermont's Immunization Registry, Syndromic Surveillance, and Reportable Lab Results	Connections established for exchange of relevant information between the HIE and VDH; Providers submitting relevant information to VDH through the HIE.	Utilize existing data sources to evaluate the participation rates for providers; Sample survey of providers to evaluate barriers and issues to providing VDH-related data via HIE vs. other methods.	Providers in clinical care situations.	VDH and HIE data related to the relevant categories.	Review data related to participation and rate of adoption; Sample providers not participating via the HIE to determine barriers and issues.
<p>Milestones:</p> <p>12/31/2012: <b>(Completed)</b> Resolve issues of scope and data integrity related to ADT and MPI (Master Person Index) that have temporarily slowed progress with the Immunization Registry project; Insure that the transfer protocol (PHIN-MS) between the VHIE and VDH is in production and supported;</p> <p>2/28/2013: <b>(Completed)</b> Complete data integrity activities and implement ADT transfers from VDH to VHIE, and begin transfer of VZU immunization messages from VHIE to VDH;</p> <p>3/31/2013: <b>(Completed)</b> Activate VZU immunization message flows from provider EHRs to VDH through the VHIE; determine if additional on-boarding activities are required to stimulate participation and overcome associated technical issues;</p> <p>6/30/2013: Complete a project plan to address Reportable Lab Results; schedule milestones associated with these projects in a future SOP update;</p> <p>12/31/2013: Conduct a web-based survey of providers to determine participation and rate of adoption of the Immunization Registry update from EHR to VDH; analyze the data for issues to be addressed and identify these in a report.</p> <p>Note: VDH has in place an architecture for receiving Syndromic Surveillance information that does not involve the VHIE. It is their intent to continue with the current solution.</p>					

Aims of evaluation	Framework to Assess	Evaluation Methods			
		Study Design	Study Population	Data Sources / Collection Methods	Data Analysis
Providers participating in the EHR Incentive Payment Program (EHRIP)	Numbers and percentages of hospitals and eligible professionals participating in the EHRIP (Medicaid and Medicare); Number and percentages of Blueprint providers participating in the EHRIP; Impact of participation on health outcomes and related results; Impact of incentives on adoption rates of Certified EHR Technology (CEHRT)	Utilize existing data sources to evaluate the participation rates for providers and hospitals; Conduct a survey of sampled providers to compare participating and non-participating providers to determine barriers and issues to participating in the EHRIP; Include in the survey, as a subclass analysis, the impact on outcomes associated with participation.	Hospitals and providers participating in the EHRIP; Similar, for participation in the Blueprint with and without participation in the EHRIP; Similar, for providers not participating in EHRIP who are also not participating in the Blueprint.	CMS records documenting participation in the EHRIP; State of Vermont records documenting Blueprint participation; REC records for information on efforts to engage other providers.	Review data to summarize results in the categories of providers described; Sample providers in four categories: EHRIP only; Blueprint only; EHRIP and Blueprint; neither EHRIP nor Blueprint.
<p>Milestones:</p> <p>6/30/2013: Completed discussions with State staff (Blueprint, DVHA), and others supporting the infrastructure for exchange (VITL and DocSite) to identify desired or perceived impacts of EHRIP participation on health outcomes and related results; identification of measures or indicators of such outcomes for inclusion in a survey of providers. In particular, evaluate the value of eCQM data from providers attesting to Meaningful Use with respect to the data currently in the clinical data repository. State Medicaid EHRIP programs have an opportunity to require the electronic submission of CQM data from attesting providers (as is already a requirement for providers attesting under the Medicare program);</p> <p>8/31/2013: development of a qualitative survey to determine barriers and issues to participation in the EHRIP program, and to determine the perceived relationship of the EHRIP program to outcomes; identification of survey populations and gathering of contact information;</p> <p>9/30/2013: Conduct a web-based survey of providers to determine the desired information related to barriers and issues;</p> <p>10/31/2013: From EHRIP application and payment information, combined with Medicaid and Blueprint information on participating providers, develop a quantitative analysis of the EHRIP program results;</p> <p>12/31/2013: Complete survey results analysis and prepare a report, comparing the analytical analysis results with the survey results by population.</p>					

Aims of evaluation	Framework to Assess	Evaluation Methods			
		Study Design	Study Population	Data Sources / Collection Methods	Data Analysis
Providers participating in the DIRECT exchange of records	Numbers and percentages of hospitals and other providers exchanging via DIRECT; Impact of adoption on health outcomes and related results. Vermont is also implementing an alternate solution to secure messaging with a solution called ProviderLink, which will also be evaluated here.	Utilize existing data sources to evaluate the participation rate for providers; Conduct a survey of sampled providers to compare participating and non-participating providers to determine barriers and issues to exchanging records.	Hospitals and professional providers in clinical care situations;	HIE records obtained through HISP for DIRECT transactions; HIE records obtained through HISP of provider enrollment, practices connected; Other DIRECT reporting data.	Sample providers in two categories: participating and not participating in DIRECT, to determine barriers and issues; and for those participating, to determine impact.
<p>Milestones:            (Note that Vermont's DIRECT capability has been put in production for just a few months. The evaluation work will not begin until the program has been actively in service for at least 8 months)</p> <p>7/31/2013: Complete discussions with sponsoring organizations (VITL for DIRECT; Blueprint for ProviderLink) to identify desired or perceived impacts of these two solutions on health outcomes and related results; Identify measures or indicators of such outcomes for inclusion in a survey of provider and provider organizations;</p> <p>9/30/2013: Design of a quantitative and qualitative survey to determine levels of utilization as well as issues and barriers to participation in these solutions;</p> <p>10/31/2013: conduct a web-based survey of providers to determine the desired data and information;</p> <p>12/31/2013: From HIE utilization records related to DIRECT, and from utilization information available for ProviderLink, do a quantitative analysis of utilization by provider population;</p> <p>1/31/2014: Complete survey results analysis and prepare a report, comparing the analytical analysis results with the survey results by population.</p>					

## . Privacy and security Framework

The ONC Program Information Notice “Privacy and Security Framework Requirements and guidance for the State health Information Exchange cooperative Agreement Program” (ONC-HIE-PIN-003, March 22, 2012) establishes updated guidelines for privacy and security and for including a Privacy and Security Framework discussion in Strategic and Operational Plans. The guidance in ONC-HIE-PIN-003 builds from the privacy and security and governance recommendations of the Health IT Policy Committee as well as the *Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health information*. The core domains of the security framework are:

1. Individual Access
2. Correction
3. Openness and transparency
4. Individual Choice
5. Collection, use and disclosure limitation
6. Data quality and integrity
7. Safeguards
8. Accountability

Appendix C, derived from Appendix A of the ONC-HIE-PIN-003, is attached. The Appendix provides Templates to provide, for each of the core domains, a description of Vermont’s approach and where the domain is addressed in policies and practices; a description of how stakeholders and the public are made aware of the approach, policies and practices; and a description of the gap area and process and timeline for addressing the gaps. Two Templates are provided in the Appendix, to address these core domains for the HIE Architectural Model for Point-to-Point Directed Exchange (Template 1) and to address these core domains for the HIE Architectural Model for Data Aggregation (HIE entities that store, assemble or aggregate individually identifiable health information, whether centrally or in a federated model (Template 2).

Vermont has just implemented a DIRECT solution, currently being tested with a few practices. Consequently we have not commented in Template 1. Given the timing, we will comment on Template 1 at the next SOP annual update in January 2014. Template 2 was completed for the previous revision to the SOP.

Appendix D is Vermont’s current approved Policy on Patient Consent for Provider Access to Patient health Information Through the VHIE. VITL has the responsibility for introducing and implementing this consent policy throughout the provider community. A detailed project plan is in place, funded through the State’s grant to VITL, and the outreach and education work is underway.

## 5. Project Management Plan

The previous version of Vermont’s HIT Plan discussed HIE Connectivity (Lab results; Clinical summaries; e-Prescribing; Act 128 requirements); Blueprint for Health rollout plans; and a number of initiatives to be included in Vermont’s State Medicaid HIT Plan (SMHP). Accompanying tables and graphs presented Connectivity plans and schedules for the HIE and for

the Blueprint rollout.

In the two years since that version of the plan was approved significant progress has been made in all areas of that project management plan. Progress is reported in quarterly and semi-annual updates and is briefly described here as a reference for project management plans for the remainder of the year.

1. HIE Connectivity

- a. HIE technology: VITL (Vermont Information Technology Leaders, Inc.) who operates the State's HIE, undertook a major project to replace the underlying HIE platform and successfully migrated from the GE HIE technology to Medicity. This was a major technology project which affected all providers currently connected to the HIE.
- b. Implementation of a DIRECT solution for Vermont: a DIRECT solution has been implemented and is being piloted with a few providers at this time.
  - i. **The DIRECT solution was implemented in February, 2013 and is now available to all providers.**
- c. Laboratory results: 8 of 16 labs (14 hospitals and 2 commercial labs) are now sending results in a structured format.
  - i. **Plan for December 2012: 10 labs - 63%**
  - ii. **Update, May 2013: 13 now sending – 81%**
- d. Hospitals sharing care summaries with unaffiliated providers: 0 of 14, or 0%.
  - i. **Plan for December 2013: 14%** We mistakenly reported 5 of 14 hospitals doing this in our first revision. While the hospitals are sharing radiology images with unaffiliated providers they do not yet share care summaries outside their own networks of hospital-owned practices.
- e. Ambulatory providers sharing care summaries with other providers: 412 of 1000, or 41% (summary information submitted to clinical data repository where it is accessible based on consent, with most transactions occurring through the HIE).
  - i. **Plan for December 2012: 50%**
  - ii. **Update May 2013: 47% achieved**
- f. Pharmacies participating in e-prescribing: 135 of 145, or 93%.
  - i. **This situation is stable for now. We are not emphasizing adding more pharmacies but are instead concentrating on prescription volume transmitted electronically. We anticipate some growth in the number of pharmacies, though, and our year-end target is 95%.**
  - ii. **Update May 2013: 96%**

2. Blueprint for Health Expansion: The number of Blueprint practices has grown from 24 to 79, the number of providers has grown from 114 to 359, and the number of patients covered has grown from 101,000 to 353,000.

- a. **Plan for December 2012: add 41 practices; 136 providers; and 131,000 patients covered by the Blueprint program.**

- b. **Update May 2013: 114 Practices; 466 Providers; 442,000 patients covered.**
3. Vermont SMHP components: some of the SMHP initiatives for which we have approval to proceed and have been implementing are mentioned below (we are commenting on those that relate most closely to the general topic of HIE):
- a. Implementation of Vermont's EHR Incentive Payment program (EHRIP): Vermont launched its EHRIP in October of 2011 and has now awarded 391 payments totalling approximately \$16,000,000.
    - i. **Plan for December 2012: Vermont intends to accomplish a Meaningful Use Acceleration Challenge goal of 500 payments by year-end, even though we did not implement a Meaningful Use version of our software until September.**
    - ii. **Update May 2013: Vermont has awarded more than 700 payments totaling approximately \$25,000,000.**
  - b. Development of a Vermont Department of Health (VDH) Immunization Registry and other public health reporting functions through the HIE.
    - i. **Plan for December 2012: Feeds to the Immunization Registry from the HIE are established. Data de-duplication processes are being finalized prior to production implementation of the exchange data streams. There are data integrity concerns being addressed before ADT files will be submitted from VDH to the VHIE. This project will extend into early 2013.**
    - ii. **Update May 2013: The link between the VHIE and VDH has been established and immunization messages are now flowing from providers through the VHIE to the Immunization registry at VDH. Outreach work is planned to encourage more utilization by provider organizations.**
  - c. Planning for the HIE participation of "full spectrum providers": Many providers are not specifically eligible for EHR incentive payments. Yet the effectiveness of health care delivery would be greatly enhanced if those providers were fully participating in the HIE. We consider such providers as mental health, substance abuse, behavioral health, long term care, and home health to be in this category which we have labeled full spectrum providers.
    - i. **Plan for December 2012: We have provided a grant to the Vermont Council representing Designated Agencies across the state who provide mental and behavioral health and some substance abuse treatment for the State. The grant provided for an assessment of HIT and the gaps that exist for HIE connectivity. A second grant has been given to an association of home health providers for the same purpose. That grant work is now completed. A third grant to an association of long-term care providers has just been awarded.**
    - ii. **Update May 2013: We are developing a strategy for funding the technical and workflow changes that will be required at all of these full spectrum providers to make health information exchange a reality. Vermont has also recently been awarded a State Innovation Model (SIM) Grant to test various payment models for coordinated and integrated health care. Incorporating the types of provider**

**organizations into coordinated care is a large part of that grant. We anticipate the initial implementation of the SIM grant to begin this fall.**

### **Staffing and Resource Discussion**

Vermont has minimal State employee staffing for HIE expansion. The State serves as a planning and coordination agent, with much of the direct work of HIE connectivity and functional capability performed by the HIE and the REC, both of which are in the organization of the Vermont Information Technology Leaders, Inc.

The Blueprint for Health is a program operated by the State with State staff resources. These Blueprint resources include project managers and facilitators who work directly with practices and with VITL to bring additional practices into the Blueprint program. This is significant, as the practices joining the Blueprint are doing so through the implementation of EHR technology and HIE connectivity.

The State also operates a clinical data repository which supports the Blueprint program and will support Meaningful Use of the EHR technology for providers. This repository is established and operated by a vendor, Covisint, with the repository product DocSite. DocSite is itself a certified EHR system, though not all modules are provided.

The Division of Health Reform (DHR), led by Deputy Commissioner Hunt Blair who also serves as the State HIT Coordinator, is responsible for administering the grant to VITL for HIE services and the contract with Covisint for the clinical data repository. Also, since DHR is part of the Department of Vermont Health Access (DVHA, the Medicaid program in Vermont), the EHR incentive payment program is also operated in DHR with a small State of Vermont staff.

Staffing within DHR is supported by funding arising from the SMHP and ONC grants. Blueprint staffing is State of Vermont funded.

### **Interdependency Discussion**

There are a few interdependencies in the project work currently planned for the remainder of 2012, and those are discussed here:

1. A more robust functioning exchange is obviously dependent on the numbers of providers who are connected to the exchange and prepared to utilize it. So plans to connect providers can impact the effectiveness of e-Prescribing; lab reporting; public health applications; and the incentive payment program.
2. Adding the full spectrum providers described above may be dependent on the addition of measure sets to the clinical data repository, in addition to the technology gaps that exist.
3. Meeting an ambitious goal of awarded incentive payments is dependent on a software upgrade to support Meaningful Use attestations.

### **Change Management and Issues Resolution Discussion**

HIE organization and operations in Vermont is structured to manage change and resolve issues with efficiency and effectiveness. Please see previous discussion of the organization of the Division of Health Reform and the Blueprint for Health, the dual role of the Deputy Commissioner of DHR as the State HIT Coordinator, the organizational location of DHR, the

Blueprint program, and the EHRIP all within the Department of Vermont Health Access, and the fact that the State has a single HIE and REC operated by the same entity, VITL. There are frequent status and planning meetings held to monitor all of the related activities associated with this SOP, and the parties necessary to address issues and implement change are directly engaged in these meetings. All entities (the Blueprint, VITL, DHR, and the Covisint data repository) utilize project managers and facilitators to plan and implement the detailed work of HIE expansion, and these staff resources provide the status information and agenda items for the planning and monitoring meetings, with full documentation of accomplishments and issues. Decisions are made in a timely fashion and are recorded in meeting minutes and further reflected in changed project plans.

### **Risks and Risk Mitigation Discussion (Likelihood 1-10 / Impact 1-10)**

#### **EHR Vendors not responsive to Interface issues (9/7)**

As we move to evaluating the effectiveness of HIE connectivity as reflected in the Blueprint for Health program and in the reporting effectiveness of the clinical data repository we see evidence of open interface issues with many EHR vendors. These are issues of data not being properly mapped or of data being lost. The reports from the repository that represent the value of participation for the practices are then incomplete or inaccurate and trust in the program is eroded. We are mitigating this issue with a focused project effort engaging primary providers in a specific health service area to identify and resolve such issues. Once such 'sprint' has been completed and another has been initiated, in two different parts of the state. In addition to improving a specific situation, much knowledge and insight is gained to inform the next such project and to work more closely with the EHR vendor community to address these issues. (A related risk factor identified as "Failure of EHR and HIE vendors to deliver promised interoperability capacities" was identified in the previous HIT plan).

#### **Staff hiring and turnover (7/3)**

The timing of funding approvals relative to the implementation of activities has meant in most cases that the State is behind in staffing for approved positions. We are currently mitigating this by pursuing the hiring activities as quickly as possible following the necessary State processes for moving funded positions into identified vacancies that are supported in the State budget. (A related risk factor identified as "Critical state or VITL staff turnover" was identified in the previous HIT plan).

#### **Perceived difficulty in receiving CMS incentive slows momentum (6/6)**

This was an identified risk in the previous HIT plan and bears inclusion here as well. The meaningful use incentives are a major driver in providers' interest in adopting EHRs and exchanging information. As practices assess the meaningful use targets, it is important that the State and the REC assist them in developing explicit strategies to achieve their goals so that perceptions will be trumped by doable action plans. Tying the value of HIT to the State's clinical transformation agenda will help to remind practices that their efforts are about more than the incentives and that the value of an improved delivery system will be enduring. One of our purposes in participating in the Meaningful Use Acceleration Challenge is to promote a closer working relationship between the EHRIP and VITL in collaboration for education and outreach about the Meaningful Use stages we are about to recognize for incentive payments.

## 6. Tracking Program Progress

Appendix B (referred to as Appendix C in ONC-HIE-PIN-002) – “Tracking Program Progress” is attached and reports on progress with the key priority areas of HIE.

### Attachments:

Appendix A: Changes to HIE Strategy

Appendix B: Tracking Program Progress

Appendix C: Privacy and Security Framework Templates

Diagram 1: Vermont HIT Enterprise Architecture

Diagram 2: Schematic View of Health Information Exchange eco-system

Diagram 3: A representation of the role of DVHA’s Division of Health Reform

Diagram 4: A representation of the relationships of AHS Programs and Operations, Departments and Divisions

## APPENDIX A - Changes to HIE Strategy

Domain/Sections	Short Description of Approved Portion of SOP that Grantee is Proposing to Change (include page numbers)	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
<b><i>Include in First and Subsequent SOP Updates</i></b>				
Overall HIE Strategy including Phasing	No significant changes in overall strategy; some timing changes.			
Governance	No significant changes in HIE governance. Stakeholder groups continue as previously identified, though there are occasional changes in the composition as additional organizations are represented.			
Technology	As previously planned, VITL has implemented a new HIE Platform from Medicity, which included a DIRECT component. The only change in Technology is represented by the plan to adopt a DIRECT solution from a different vendor.	Add DIRECT functionality to the VHIE from a different vendor.	The new vendor can provide the necessary functionality in a more simple technical architecture.	There are no changes to the budget. An internet-based vendor will host secure messaging using DIRECT.

Financial	No changes in plans related to Vermont's HIT Fund or to Section 3013 funding plans. We anticipate a CMS HITECH fair share contribution, pending a funding request approval.	A pending IAPD submitted to CMS includes a request for Federal Financial Participation in the Vermont HIE.	State Medicaid Director's Letter of May 18, 2011 addresses the use of administrative funds to support HIE as part of the Medicaid EHR Incentive program. Costs must be allocated across participants to assure a fair share determination.	Vermont has requested \$4,507,358 as a calculated fair share for this FFP, which qualifies for 90% participation. The time frame associated with these funds includes FFY 2012 and 2013. (This request was approved May 4, 2012).
Business Operations	No changes in business operations are proposed.			
Legal/Policy	Vermont has updated its privacy and security policy.  Act 48 establishes the Green Mountain Care Board which is focused on payment and payer reform with no direct impact on the HIE but is a significant change in the State's health care reform landscape.	A new privacy and security consent policy is being implemented.  Act 48 has additional specific requirements for a State HIT Plan. We intend to have a single plan which will address ONC SOP requirements while addressing these additional Act 48 requirements.	Legal review of previous consent policy found it to be inadequate.  A single plan will avoid confusion in our day-to-day referencing of 'the plan'.	There are no budget implications. HIE platform technology will support administration of the consent policy.  The Act 48 requirements do not change what information we need to support the development of an HIT Plan (effort), just what is included in the document.
Strategies for e-Prescribing	No significant changes in strategy.			
Strategies for Structured Lab Results Exchange	No significant changes in strategy.			
Strategies for Care Summary Exchange	No significant changes in strategy.			

<b><i>The Core Documents Are Required As Part Of First SOP Update. Changes Should be Indicated in Subsequent SOP Update</i></b>				
Sustainability	In the approved Vermont SOP, Sustainability is addressed in Section 2 (Sustainability Plan), pages 6-8).	VITL annual report: <ol style="list-style-type: none"> <li>1. EHR Adoption</li> <li>2. Interfaces</li> <li>3. DIRECT</li> <li>4. Added Services (ACO services)</li> </ol>	The VITL annual report was published 1/15/2013 and identifies the 4 tactics for creating sustainability.	The development of a more detailed sustainability plan is included in current budget projections.
Privacy and Security Framework	In the approved Vermont SOP, Privacy and Security Framework is addressed in Section 4 (Privacy and Security Framework), page 20, and in the SOP's Appendix C and D, pages 33 – 41.	<ol style="list-style-type: none"> <li>1. Consent policy approved</li> <li>2. VITL primary agent for implementation, with DHR</li> <li>3. Implementation plan in place</li> <li>4. Funded through DVHA grant agreement</li> </ol>	This topic was covered in the approved SOP. The only change is the initiation of implementation – 2 <sup>nd</sup> quarter of 2013.	There are no budget implications for ONC. The State is addressing the additional cost of implementation.
Evaluation Plan	In the approved Vermont SOP, the Evaluation Plan is covered in Section 3 (Evaluation Plan), pages 8-19. A Table provides a summary of our evaluation plans across 6 topics.	<ol style="list-style-type: none"> <li>1. We are behind schedule</li> <li>2. Resource recently hired to assist with this effort – skilled in web-based research techniques</li> <li>3. Sequence of evaluations will remain as documented in the approved SOP. Milestone dates have been revised.</li> </ol>	Time constraints; availability of resources.	There are no budget implications for ONC. The State is addressing the additional cost of implementation.

## APPENDIX B Tracking Program Progress

See Appendix B in *ONC-HIE-PIN-002* for measure definitions and sources

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of April 2012	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
<b>1. % of pharmacies participating in e-prescribing</b>  (VT: 145 licensed pharmacies operating in the state per NCPDP)	93%  (According to the Surescripts state profile for 2011 which are the latest statistics)	96%	94%	97%		
<b>2. % of labs sending electronic lab results to providers in a structured format<sup>4</sup></b>  (VT: 14 hospital and 2 commercial labs, using HL7/2.5)	50%	63%	55.44% (Vermont HIE results indicate 13 of 16 labs are doing this, or 81.25%.)	81%		

<p><b>3. % of labs sending electronic lab results to providers using LOINC</b></p>	<p>0%</p> <p>VITL does not maintain a common order and results catalog, so this is not tracked. Hospitals are advised to send LOINC in OBX 3.4 for future reporting purposes.</p>	<p>6%</p> <p>VITL will provide support to hospitals to map their lab catalog to LOINC, and add the LOINC as the secondary id.</p>	<p>0%</p>	<p>25%</p>		
<p><b>4. % of hospitals sharing electronic care summaries with unaffiliated hospitals and providers</b></p> <p><b>(Note:</b> Hospitals are sending discharge summaries and radiology reports, not CCDs. VITL has not surveyed hospitals as to the affiliation of the destinations. A survey will need to be conducted to determine this.</p>	<p>0%</p>	<p>7%</p> <p>VITL will provide support to hospitals to generate CCDs. A plan will be developed to achieve this goal.</p>	<p>28.84%</p>	<p>57%</p>		

<sup>4</sup> **Structured format:** Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text).

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of April, 2012	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
<p>5. % of ambulatory providers electronically sharing care summaries with other providers</p> <p>(VT: 893 PPCPs participating in the REC program)</p>	41.2%	50%	50.46%	70%		95%
<p>6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC and SNOMED.</p> <p>%</p>	<p>0%</p> <p>Planning mode for electronic laboratory report data. Dependent on labs filtering for reportable lab results.</p>	<p>TBD</p> <p>VITL will develop a plan with Public Health for reportable labs.</p>	0%	<p>100%</p> <p>(Once activated in a 2013 project our sole Public Health agency will account for this result.</p>		100%

<p><b>7. Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code.</b></p> <p><b>Yes/no or %</b></p>	0%	TBD	100% (VT has one registry, operated by the State. We are now in production with a limited number of practices, with immunization messages via the HIE)	100%		100%
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<p><b>8. Public Health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide).</b></p> <p><b>(VT has a single Public Health Agency – Vermont Department of Health.</b></p>	0%	0% TBD VITL will develop a plan with Public Health for syndromic surveillance hospital data.	0%	0% (Plan for 2013 is to introduce Electronic Lab Reporting for Public Health, with a goal of 50% of labs participating. Syndromic Surveillance will follow in 2014.		100%
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<b>9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1.</b>	0%	0% TBD VITL will develop a plan with Public Health for syndromic surveillance ambulatory data.	0%	0% We will do a syndromic surveillance program in 2014.		100%
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## Appendix C. Templates for Guiding Statewide Privacy and Security Frameworks

-This appears as Appendix A in ONC-HIE-PIN-003

### Template 1

#### HIE Architecture Model: Point-to-Point Directed Exchange

Domain	Description of approach and where domain is addressed in policies and practices	Description of how stakeholders and the public are made aware of the approach, policies, and practices	Description of gap area and process and timeline for addressing (if needed, use additional documents to describe and insert reference here)
<b>Required to address</b>			
Openness and Transparency	Comment: Vermont has just initiated Point-to-Point Directed Exchange for testing. While we don't expect the privacy and security approach to differ, we do anticipate there may be some refinements to address specific issues associated with directed exchange. This comment applies to the entire Template 1 discussion. This Template will be addressed in a future revision to the SOP.		
Collection, Use and Disclosure Limitation			
Safeguards			
Accountability			
<b>Optional to address</b>			
Individual Access			
Correction			
Individual Choice			
Data Quality and Integrity			

## Template 2

**HIE Architecture Model: Data Aggregation (HIE entities that store, assemble or aggregate individually identifiable health information, whether centrally or in a federated model)**

Domain	Description of approach and where domain is addressed in policies and practices	Description of how stakeholders and the public are made aware of the approach, policies, and practices	Description of gap area and process and timeline for addressing (if needed, use additional documents to describe and insert reference here)
<b>Required to address</b>			
Openness and Transparency	<p>Under Vermont law, individuals are implied to have a full right of access to their protected health information in that a failure of a licensed health care provider to make PHI available upon the patient's written request is grounds for discipline under the health care providers licensure laws. See 26 VSA § 1354(a)(10) and 3 VSA § 129a(a)(8). The Hospital Bill of Rights, 18 VSA §§ 1853(3),(4) and (9), requires that a patient has the right to obtain from the physician coordinating his or her care, complete and current information concerning the diagnosis, treatment and any known prognosis in terms the patient can reasonably be expected to understand. The patient has the right to receive information necessary to give informed consent for any procedure or treatment and the right to know the identity and professional status of individuals providing services. The Nursing Home Residents Bill of Rights, 33 VSA § 7301(c), also requires that a resident be fully informed of his or her medical condition and given an opportunity to participate in the planning of medical treatment. Although neither statute requires patient notice regarding the electronic exchange of protected health care information, the provision of such notice is within the spirit of each law. Additionally, both statutes require hospital patient or nursing home resident consent for the disclosure of such information outside of those individuals involved with the individual's treatment within the relevant facility. See 18 VSA § 1853(7) and 33 VSA § 7103(H). See also Vermont consent law discussion set forth in Individual Choice Principle below.</p>	<ol style="list-style-type: none"> <li>1. State HIT Coordinator has established a privacy and security stakeholder group who meet regularly to discuss all related issues.</li> <li>2. Meeting minutes and decisions are documented and communicated to a large stakeholder list, and are also published on the HIT website.</li> <li>3. A revised stakeholder engagement model is currently under development and will include broader communications and a more interactive website.</li> </ol>	<p>A revised privacy and security policy has been developed with the privacy and security stakeholder group. This policy has now been approved by both the Agency of Administration and by the Green Mountain Care Board, as required by Vermont statute. A copy of the approved policy is attached.. This policy fully addresses the domain of Openness and Transparency as specified in ONC-HIE-PIN-003.</p>

<p>Collection, Use and Disclosure Limitation</p>	<p>Under Vermont law, the scope of disclosure of protected health information will be governed by the scope of the patient consent permitting such disclosure, since patient consent, as described in the discussion of the Individual Choice Principle above, is largely required for any disclosure of protected health information beyond the treating health care provider. However, there are also a number of disclosures which Vermont law requires a health care provider to make without patient consent. These include, among others, disclosure of treatment of firearm wounds, 13 VSA § 4012, certain instances of cancer or communicable disease, 18 VSA § 151-157, § 1001-1007, § 1041 and § 1093, child and vulnerable adult abuse, 33 VSA § 4913 and § 6903, lead poisoning of children under age 6, 18 VSA § 1755(d) and immunizations 18 VSA § 1129. Nothing in Vermont law would prohibit these required disclosures from being made electronically through an exchange, if the health care provider and the exchange agreed to do so.</p>	<ol style="list-style-type: none"> <li>1. State HIT Coordinator has established a privacy and security stakeholder group who meet regularly to discuss all related issues.</li> <li>2. Meeting minutes and decisions are documented and communicated to a large stakeholder list, and are also published on the HIT website.</li> <li>3. A revised stakeholder engagement model is currently under development and will include broader communications and a more interactive website.</li> <li>4.</li> </ol>	<p>A revised privacy and security policy has been developed with the privacy and security stakeholder group. This policy has now been approved by both the Agency of Administration and by the Green Mountain Care Board, as required by Vermont statute. A copy of the approved policy is attached. This policy fully addresses the domain of Openness and Transparency as specified in ONC-HIE-PIN-003.</p>
<p>Safeguards</p>	<p>Vermont's Health Information Technology law provides that any standards and protocols developed by VITL require that protected health information be secure and traceable by an electronic audit trail, 18 VSA § 9351(e), (formerly 22 VSA § 903(f)).</p>	<p>See above.</p>	<p>VITL (the State's HIE) meets the guidance for encryption and for authentication and authorization. While VITL has conducted an assessment of risks and vulnerabilities, this has not been done with the "State HIE Security Checklist". Although use of this checklist is not required, we will conduct an assessment utilizing the recommended checklist before the next SOP annual update. VITL does use NIST 800-63 version 1.0.2 as a guide – VITL achieves assurance level 3 by requiring each provider organization's system to install a digital certificate in order to connect to the HIE.</p>

Accountability	Vermont's Health Information Technology law provides that any standards and protocols developed by VITL require that protected health information be secure and traceable by an electronic audit trail, 18 VSA § 9351(e), (formerly 22 VSA § 903(f)). Vermont's mental health information provisions, 18 VSA § 7103(c), provides that any person violating its prohibitions against releasing protected health information relating to mental health services without consent, may be fined not more than \$2,000 or imprisoned for not more than one year, or both. Outside of this specific provision, accountability for maintaining the confidentiality of protected health information under Vermont law largely falls under the State's licensure provisions for specific types of health care providers and facilities and not as a private right of action under state law. In the event that an individual has a complaint relating to the use or disclosure of his or her protected health information, a professional grievance against the health care provider or facility responsible may be submitted for review by the licensing authority.	See above.	VITL will utilize functionality in the Medicity HIE software platform to manage consent and to ensure that a current instance of consent supports the sharing of IIHI. Practices are already in effect at VITL to support any necessary notifications to individuals of privacy violations and security breaches.
Individual Access	See Openness and Transparency discussion above.	See above.	A revised privacy and security policy has been developed with the privacy and security stakeholder group. This policy has now been approved by both the Agency of Administration and by the Green Mountain Care Board, as required by Vermont statute. A copy of the approved policy is attached.. This policy fully addresses the domain of Openness and Transparency as specified in ONC-HIE-PIN-003.
Correction	There is no specific Applicable State Law addressing this domain. Vermont accepts the applicable federal law as sufficient.	See above.	See response to the Data Quality and Integrity domain below.

Individual Choice	Vermont law is stricter than the HIPAA Privacy Rule in that it requires individual consent for a health care provider to make disclosures of information gathered and maintained for the purpose of the health care provider's treatment of the patient. The patient privilege statute, 12 VSA § 1612, prohibits physicians, chiropractors, dentists, nurses, mental health providers (and by implication the organizations who maintain their records) from disclosing protected health information without the patient's consent ("waiver") or an express requirement of law. The Hospital Patient Bill of Rights, 18 VSA § 1852(7), and the Nursing Home Resident Bill of Rights, 18 VSA § 1852(7), also require individual patient or resident consent prior to the disclosure of protected health information beyond those providing care at the relevant facility. Under the mental health care provisions, 18 VSA § 7103(a), no disclosure may be made of the protected health information relating to an individual or to the individual's identity without the individual's written consent. Similarly, no protected health information which includes the results of genetic testing or the fact that an individual has been tested shall be disclosed without the written consent of the individual, 18 VSA § 9332(e). Drug test results subject to Vermont's drug testing law set forth in 21 VSA § 516(a) and (b) may not be disclosed except as provided in the statute or with the written consent of the individual.	See above.	A revised privacy and security policy has been developed with the privacy and security stakeholder group. This policy has now been approved by both the Agency of Administration and by the Green Mountain Care Board, as required by Vermont statute. A copy of the approved policy is attached.. This policy fully addresses the domain of Openness and Transparency as specified in ONC-HIE-PIN-003.
Data Quality and Integrity	There is no specific Applicable State Law addressing this domain. Vermont accepts the applicable federal law as sufficient.	See above.	A review of current processes and practices related to detection, prevention, and mitigation of unauthorized changes to, or deletions of, individually identifiable health information will be undertaken prior to the next annual SOP update. That update will also include a description of our patient matching approach and the accuracy threshold achieved.

## Appendix D. Policy on Patient Consent for Provider Access to Patient Health Information Through the VHIE

## Policy on Patient Consent for Provider Access to VHIE

### Section 1 - Definitions

(a) “Consent” or “Written Consent” shall mean an individual’s act of giving written permission to a Participating Health Care Provider in the Vermont Health Information Exchange (“VHIE” or “Exchange”) to permit access to the individual’s protected health information (“PHI”) on the Exchange to the Participating Health Care Provider involved in the treatment of the individual. Consent shall be evidenced by a signature provided in writing or other legally recognized tangible medium that is retrievable in a perceivable form. Consent may be provided by an individual’s legal representative as authorized by law.

(b) “De-identified” shall mean that all identifying information related to an individual as set forth in the HIPAA Privacy and Security Rule<sup>1</sup> are removed from the protected health information.

(c) “Health Care Operations” shall mean activities of a Participating Health Care Provider providing treatment to an individual relating to quality assessment and improvement, evaluations relating to the competence of treating providers or necessary administrative and management activities<sup>2</sup>.

(d) A “Legal Representative” under Vermont law may be a legal guardian, a parent of an unemancipated minor or an agent once an advance directive becomes effective.

(e) A “Medical Emergency” is a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention<sup>3</sup>. The term “Medical Emergency” specifically is intended to include an “Emergency Medical Condition” which is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of medical attention could reasonably be expected to result in (1) placing the health of the individual in serious jeopardy or (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part<sup>4</sup>.

(f) A “Participating Health Care Provider” shall mean a health care provider, including a physician practice and any health care organization,<sup>5</sup> that has executed an effective VHIE Data Services and Participation Agreement with Vermont Information Technology Leaders, Inc. (“VITL”). The term “Participating Health Care Provider” shall include all the individual providers and authorized staff employed or otherwise legally associated with the entity or organization.

(g) “Protected Health Information” (“PHI”) shall mean “individually identifiable health information” in any form or medium about the past, present or future physical or mental health or condition of an individual as such terms are defined in the HIPAA Privacy and Security Rule<sup>6</sup>.

(h) “Revoke” or “Revocation” of Consent shall mean an individual’s statement of intent to terminate the permission given to a Participating Health Care Provider to access the individual’s Protected Health Information on the Exchange. Revocation of Consent shall be evidenced by a signature provided in writing or other legally recognized tangible medium that is retrievable in a

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<sup>1</sup> 45 CFR § 164.514(b).

<sup>2</sup> 45 CFR §164.501.

<sup>3</sup> 42 CFR 2.15.

<sup>4</sup> 42 U.S.C. § 1395dd(e)(1); 42 C.F.R. § 489.24(b).

<sup>5</sup> As defined in 18 VSA § 9402(6).

<sup>6</sup> 45 CFR §160.103.

perceivable form, unless it pertains to access to information from a Participating Health Care Provider identified as a federal substance abuse treatment program, and in such case, oral revocation is sufficient. Revocation of Consent may be provided by an individual's legal representative as authorized by law.

(i) "Treatment" shall mean the provision, coordination, or management of health care and related services by one or more health care providers.

## Section 2 - Introduction

Participating Health Care Providers shall contract with the Vermont Information Technology Leaders, Inc. ("VITL") to make the PHI of its patients available to the Exchange under the terms of a VHIE Data Services and Participation Agreement in order that VITL is authorized by law to act as a Business Associate ("BA") and a Qualified Service Organization ("QSO") of the Participating Health Care Provider pursuant to federal law.

## Section 3 - Policy

### (a) Consent for Provider Access

Participating Health Care Providers shall only access Protected Health Information on the Exchange for individuals for whom they have a current Written Consent for such access on record. The policy does not apply where the PHI is being accessed from the Participating Health Care Provider's own electronic health record or the PHI is directed to a Participating Health Care Provider from another Participating Health Care Provider in a manner consistent with the federal HIPAA privacy regulations and Vermont law.

### (b) Patient Education Materials

Participating Health Care Providers shall direct individuals to educational information developed and made available to them by VITL regarding the Exchange and its use by Participating Health Care Providers, and shall refer individuals to VITL for additional information. This information shall advise individuals of the ability of Participating Health Care Providers to access their PHI for treatment. It shall advise them of the content of the information on the Exchange accessible to Participating Health Care Providers. It also shall advise them that their information can be available to Participating Health Care Providers providing treatment in an emergency and that de-identified information may be used for research, quality improvement and public health purposes. Upon request, the individual shall also be provided a Notice of Privacy Practices by the Participating Health Care Providers.

### (c) Consent Procedure for Provider Access

Participating Health Care Providers shall seek Written Consent from patients for their access to the individual's PHI on the Exchange using a Consent form which includes the statements required by VITL for the Exchange. VITL shall establish a mechanism for Participating Health Care Providers to confirm that an individual has consented to the Participating Health Care Provider's access to the individual's PHI on the Exchange. It is the obligation of the Participating Health Care Provider to maintain a record of the individual's Consent.

### (d) Form of Consent

(1) An individual's Consent for Participating Health Care Provider's access to his or her PHI on the Exchange (1) shall be dated with the name, address, and birth date of the individual, (2) shall be

effective indefinitely so long as the individual receives care from the Participating Health Care Provider unless the form used specifies an expiration date or Consent is revoked and (3) shall include statements substantially similar to the following:

- (A) I give my consent to [Name of Participating Health Care Provider] to access and use or disclose my protected health information, including mental health, and substance abuse treatment information, on the Exchange for my treatment, for payment for my treatment and for health care operations consistent with the federal HIPAA privacy regulations and Vermont law.
- (B) My consent includes the re-disclosure of protected health information received from a drug or alcohol treatment program for my treatment.
- (C) I have been referred to VITL for information regarding the Exchange and am aware that I can request information regarding the privacy practices of my Participating Health Care Provider as described in its Notice of Privacy Practices.
- (D) I understand I do not have to give my consent in order to receive treatment from [Name of Participating Health Care Provider].
- (E) This consent is subject to my revocation (termination) at any time except to the extent that my protected health information obtained from the Exchange has already been accessed by Participating Health Care Provider and included in its medical record.
- (F) If not previously revoked, or otherwise stated, my consent will terminate when [Participating Health Care Provider] receives notice that I will no longer be a patient.

(2) Consent may be given by an Individual's legal Representative as authorized by law.

(e) Individual Access to PHI on Exchange

An individual shall be provided the right of access to his or her PHI available on the Exchange through his or her Participating Health Care Provider or through VITL.

(f) Access by Treating Participating Health Care Providers Only

All Participating Health Care Providers on the Exchange shall have policies and procedures (1) to ensure that PHI from another Participating Health Care Provider is accessed on the Exchange only when it has received an individual's Consent or the PHI is directed to the Participating Health Care Provider from another Participating Health Care Provider and (2) to ensure that only those involved in the diagnosis or treatment of an individual, payment for that treatment or necessary health care operations may access the individual's PHI on the Exchange. Participating Health Care Providers and VITL shall comply with all applicable federal and state laws .

(g) Emergency Access to PHI on Exchange

A Participating Health Care Provider may access the PHI of an individual on the Exchange without the individual's Consent for use in the treatment of the individual for a Medical Emergency when the Participating Health Care Provider is unable to obtain the individual's Consent due to the individual's Emergency Medical Condition. Participating Health Care Providers accessing PHI for a Medical Emergency must notify the individual or the individual's legal representative of such access as soon after such access as is reasonably possible and must obtain Written Consent for further access to PHI of that individual on the Exchange after the Medical Emergency has ended. If PHI from a Participating Health Care Provider, who is identified on the Exchange as a federal substance abuse treatment program, is accessed for a Medical Emergency over the Exchange, this Participating Health Care Provider will be notified that PHI has been accessed for a Medical Emergency. This notification shall be in writing and will include: the name of the medical personnel to whom disclosure was made and their affiliation with any health care facility, the name of the individual

making the disclosure, the date and time of the disclosure, and the nature of the emergency.

(h) Audit of Consents

VITL shall periodically audit the Consent records of Participating Health Care Providers according to VITL's Policy on Auditing and Monitoring. Failure to obtain or maintain patient consent shall result in sanctions under the VHIE Data Services and Participation Agreement. VITL shall review all instances of emergency access to PHI on the Exchange.

(i) Request for Audit Report

An individual may request an Audit Report of access to his or her PHI on the Exchange by contacting VITL's Privacy Officer. VITL shall provide the requested Audit Report as soon as reasonably possible and within 30 calendar days.

(j) Revocation

An individual who has granted Consent to permit his or her PHI to be accessed on the Exchange for treatment, for payment for treatment, and Health Care Operations by a Participating Health Care Provider shall be entitled to revoke such consent. After receiving notice of an individual's Revocation of Consent, a Participating Health Care Provider shall not access the Exchange to seek the individual's PHI. VITL shall establish a mechanism for Participating Health Care Providers to confirm that an individual has revoked consent for the Participating Health Care Provider's access to the individual's PHI on the Exchange. It is the obligation of the Participating Health Care Provider to maintain a record of the individual's Revocation.

(k) Re-disclosure Prohibition Notice for Substance Abuse Treatment Program PHI

The Exchange shall provide notification substantially similar to the following statement to Participating Health Care Providers who access PHI from a federal substance abuse treatment program on the Exchange:

- The information that has been disclosed to you includes records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



Diagram 2

Schematic View of Health Information Exchange eco-system

*This is not a data flow diagram – it is for illustration & discussion purposes*

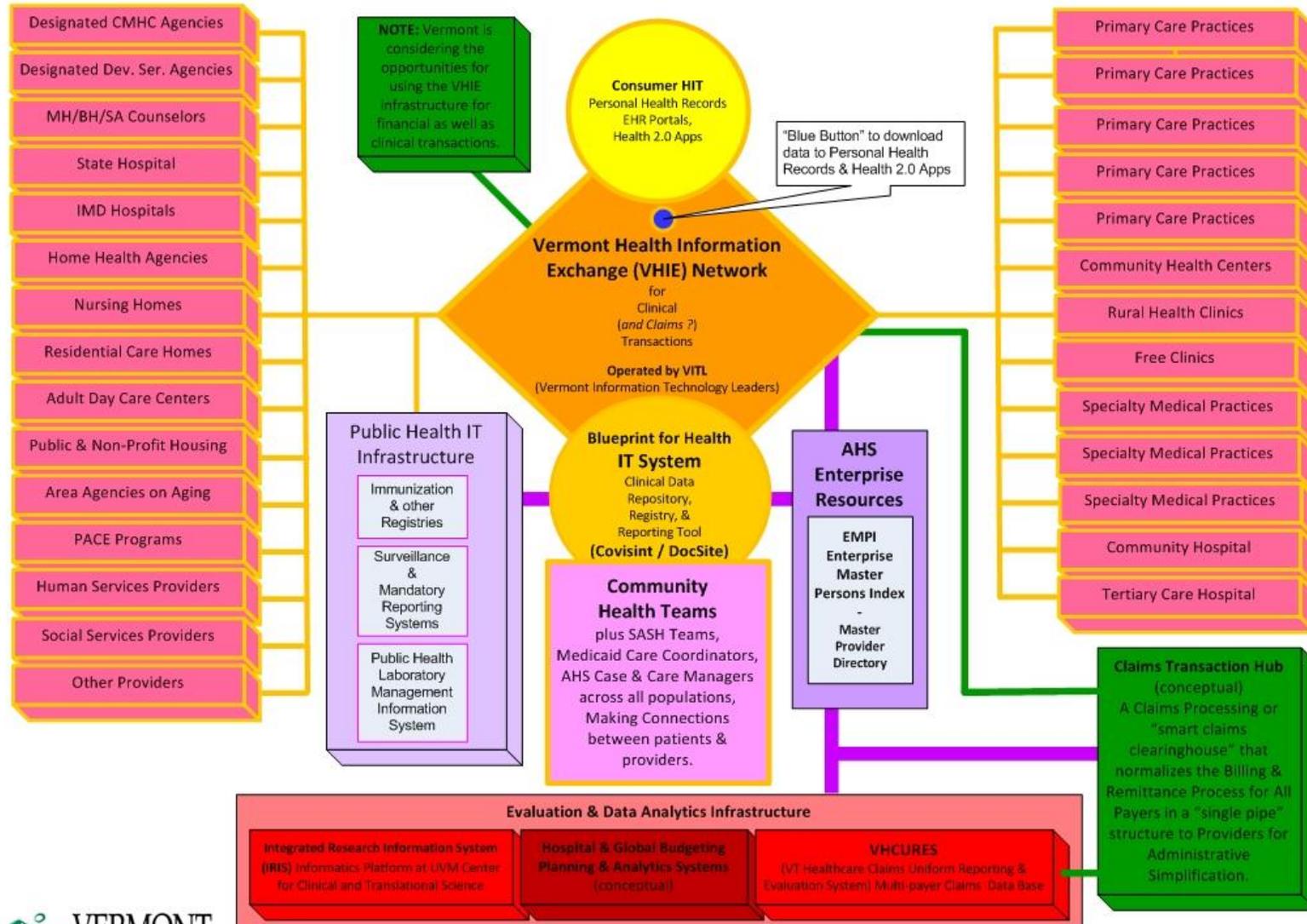


Diagram 3

A representation of the role of DVHA's Division of Health Reform

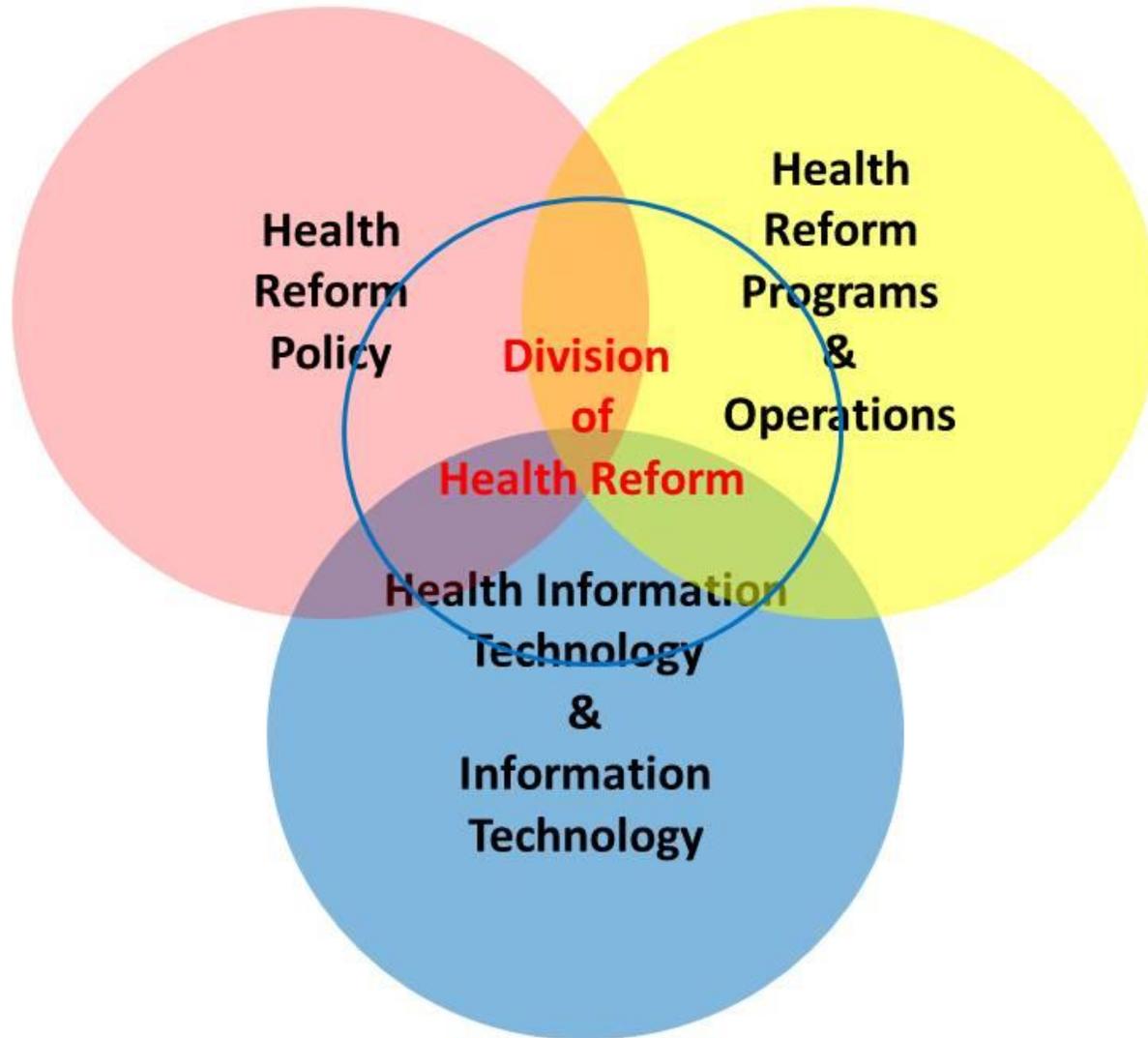
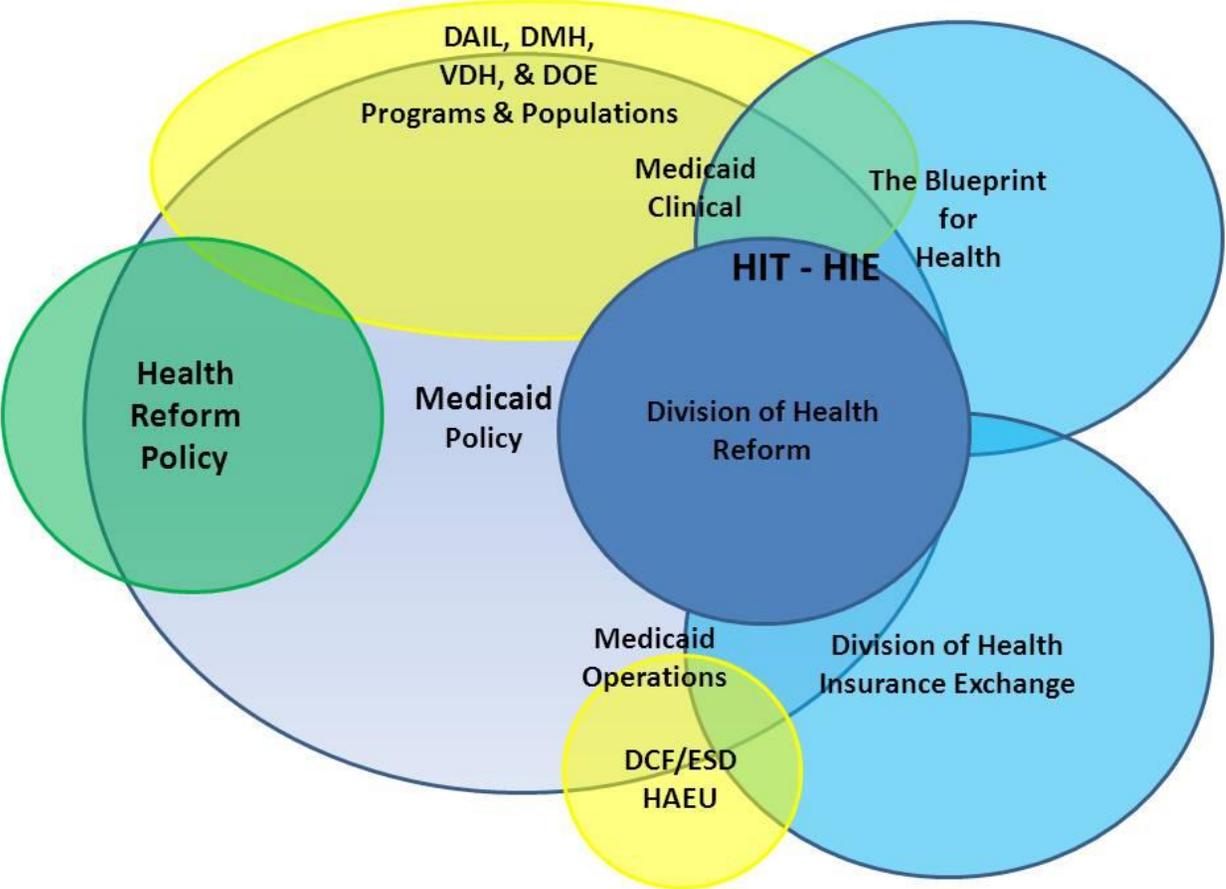


Diagram 4

A representation of the relationships of AHS Programs & Operations, Dept.'s & Divisions



Terry Bequette  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495

Thank you for the submission of the annual update to the State HIE Strategic & Operational Plan.

In reviewing your submission, we have found that the VHIE/ VITL has provided the requested documentation to meet with the requirements outlined in Program Information Notice #ONC-HIE-PIN-002 and #ONC-HIE-PIN-003, and therefore, the updates are approved.

Keep this notice with your records to document that the grantee is in compliance with the programmatic implementation requirement to submit an annual Strategic and Operational Plan annual update.

Please find below our programmatic feedback on your updated SOP. We look forward to discussing in our next bi-weekly call.

### **Highlights**

- DIRECT was successfully moved from pilot and is now available to all providers
- 81% of labs now sending results in structured format
- 96% of Pharmacies participating in e-prescribing
- Link between VHIE and VDH has been established and immunization messages are now flowing from providers through the VHIE to the Immunization Registry. Work is being done to increase utilization.
- Vermont is extending HIE to “full spectrum providers.” Strategies are being developed to fund technical and workflow changes to fully integrate these providers into health information exchange. The recently awarded SIM Grant will also partially focus on the incorporation of full spectrum providers into coordinated care.

### **Feedback**

Sustainability Plan: Vermont is unique in its extensive history of developing HIE well before HITECH funding. The Blueprint is also a uniquely comprehensive state approach that was well established before this grant. This distinctive background, as well as broad political support in the state, ensure VITL a continued and central role in the ongoing development of HIT and HIE capabilities within the state; however, VITL should take steps to develop a more tangible sustainability plan outlining a clearer path for self-sustainment. The plan currently remains amorphous and too reliant upon other state actors to direct policy decisions while assuming the current political status quo remains constant. A clearer, more self-directed plan would increase the ability of VITL to provide robust services in an expanded range of economic and political scenarios.

Privacy and Security Framework: VITL has already established a full complement of policies to address HIE; however has not yet specifically addressed Direct exchange. VITL states that these policies are likely to be identical or similar to those already in place. As such, ONC is not concerned on any grounds of substance, but as a matter of policy, must ask that these policies be officially applied to Direct exchange within a reasonable period of time.

Evaluation Plan: VITL recognizes that a number of milestones/ timeline projections have been delayed. It is important to avoid continual timeline creep, but overall the plan remains solid.

Please proceed to send in your updated strategic and operational plan document with track changes on. The document should reflect the updates that have been approved during this process including the sustainability plans, the evaluation plan, the privacy and security framework and the program progress.

Feel free to reach out to your Project Officer if you have any questions or need additional clarification.

Regards,

Thaddeus Flood

Project Officer