



Annual Progress Report

As required by 18 V.S.A. § 9352 (e)

Submitted January 17, 2012

Our Vision: A transformed health care system where health information is secure and readily available when people need it, positioning Vermont as a national example of high quality, cost effective care.

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January 17, 2012

Secretary of Administration
Commissioner of Information and Innovation
Commissioner of Banking, Insurance, Securities & Health Care Administration
Commissioner of Vermont Health Access
Secretary of Human Services
Commissioner of Health
Commissioner of Mental Health
Commissioner of Disabilities, Aging, and Independent Living
Senate Committee on Health and Welfare
House Committee on Health Care

Dear Legislators and Administration Officials:

Enclosed please find the Vermont Information Technology Leaders, Inc. (VITL) Annual Progress Report describing our activities for calendar year 2011.

The year 2011 was important for Health Information Technology nationally and here in Vermont. VITL has been supporting primary care practices deploy and use electronic health records (EHR) as the Regional Extension Center for Vermont and has made a major upgrade to its Health Information Exchange to more effectively support the state's health reform programs.

VITL has enrolled 832 of the 991 primary care providers in the state in its EHR support program. This is the highest percentage of eligible primary care providers of any Regional Extension Center nationally. We see this as a reflection of the Vermont provider community's commitment to health care reform and their recognition of the important supporting role of Health IT. There are currently 569 primary care providers live on EHR's.

In 2011, VITL made a transition of its major technology partner for Health Information Exchange services. VITL contracted with Medicity, one of the most experienced companies in the field, to be the hub of the Vermont exchange. This transition, which was completed in late October, will permit much more rapid deployment of information exchange services going forward.

VITL continues to work with the Vermont Blueprint for Health to ensure that the infrastructure is in place to support the Blueprint's statewide rollout as required by Act 128 and in support of the state's ambitious health reform initiatives. Interfaces enable physicians to send data to the Blueprint Registry, which is used

by community health teams to support patient care. VITL will continue its development efforts in 2012 to insure that all hospital service areas are able to participate in the Blueprint program.

VITL launched an electronic prescribing initiative in the fall of 2009 with a federal grant secured by U.S. Senator Patrick Leahy. Support was provided to providers and to pharmacies to enable e-prescribing. Increased use of electronic prescribing will improve patient safety and the quality of care and will position participating practices to take additional steps toward a full EHR under the CMS EHR incentive program.

VITL board members and advisors continued to contribute to VITL's success working on governance and finance issues, as well as guiding the organization's expanded responsibilities. We would like to thank them for their support and willingness to share their expertise. VITL also thanks the General Assembly and the Administration for its support. We look forward to continued collaboration in 2012.

Respectfully submitted,

A handwritten signature in black ink that reads "Don George". The signature is written in a cursive style with a large, prominent "D" and "G".

Don George

Chair, VITL Board

A handwritten signature in black ink that reads "David Cochran". The signature is written in a cursive style with a large, prominent "D" and "C".

David Cochran, MD

VITL President and CEO

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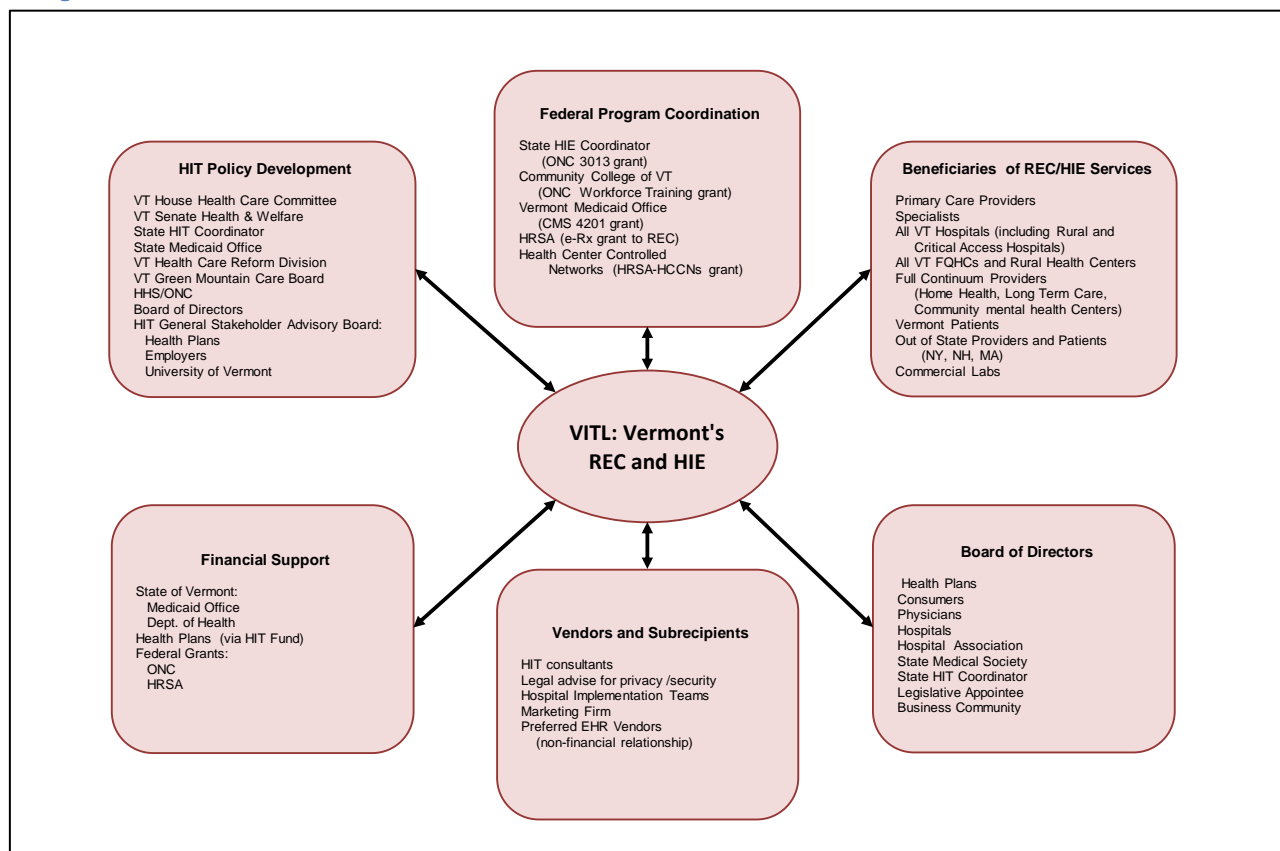
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1. Introduction

Vermont Information Technology Leaders, Inc. (VITL) is a 501(c) (3) non-profit organization, which functions as a public-private partnership. VITL was incorporated in Vermont on July 22, 2005, and is funded by both the state and federal governments through grants. VITL is a multi-stakeholder organization formed by a broad base of health care providers, payers, employers, consumers, and state agencies. These constituencies are represented by volunteers who serve on VITL’s board of directors, its two board-level advisory committees, and other stakeholder advisory groups. Members of VITL’s Board of Directors are listed in Appendix E.

VITL is a component of Vermont’s overall health reform initiative. VITL’s vision is to support health reform programs, such as the Blueprint for Health, to transform the care that Vermonters receive. By statute, VITL is designated in the Vermont Health Information Technology Plan to operate the exclusive statewide health information exchange network. VITL’s primary objectives are to facilitate the adoption of certified Electronic Health Record (EHR) technology, improve the quality and efficiency of patient care through clinical transformation in physician offices, control health care costs, and foster health information exchange (HIE) among health care provider organizations. VITL, under a grant from the Department of Vermont Health Access (DVHA) provides data services to support the Blueprint for Health Initiative and other public health programs.

Figure 1: VITL Stakeholders

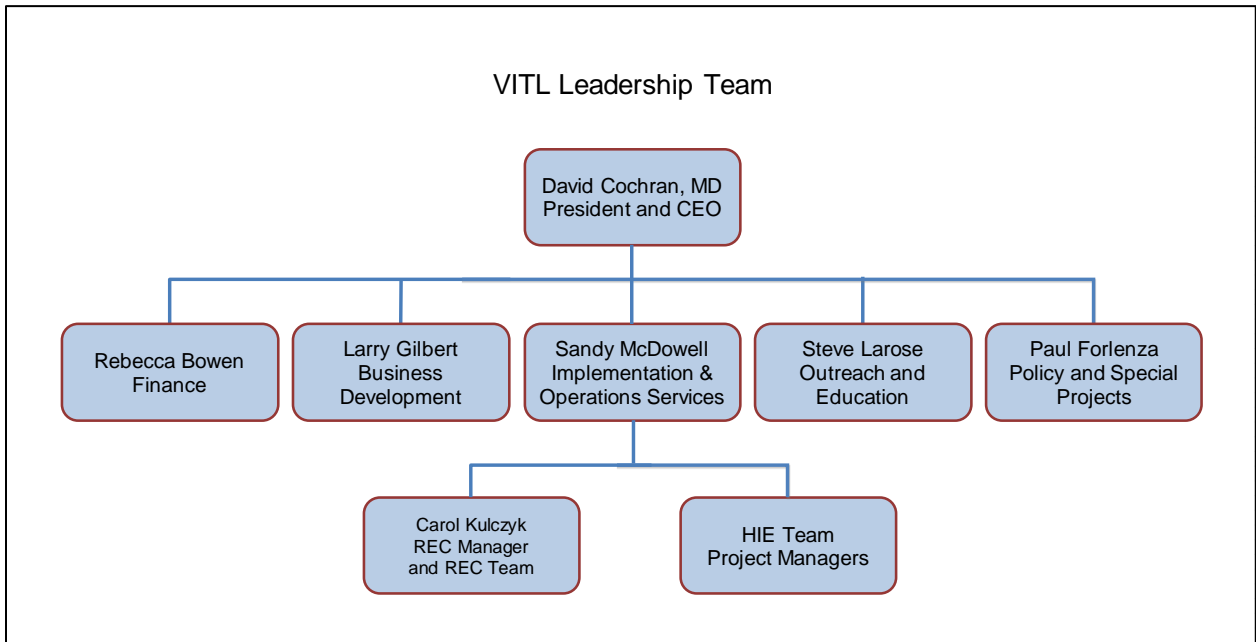


VITL is the recipient of a cooperative grant from the Federal Office of the National Coordinator for Health Information Technology (ONC) to be the Regional Extension Center (REC) for Vermont. In

that role, VITL helps eligible primary care providers implement certified Electronic Health Records (EHR) technology and achieve meaningful use of the technology. ONC operates within the Federal Department of Health and Human Services (HHS).

VITL collaborates with the Deputy Director of Healthcare Reform and state HIT coordinator to ensure that the state’s HIT policy objectives are articulated and achieved. The efforts of VITL are coordinated with other state and federal initiatives, including the National Health Information Network (NHIN), the national eHealth Initiative, and the Vermont Blueprint for Health. VITL's work helps to facilitate communication among Vermont's health information technology community and creates the foundation for future health information technology collaboration.

Figure 2: VITL’s Leadership Team



2. Federal Health Care Reform and Vermont

The Federal Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 seeks to improve American health care delivery and patient care through an unprecedented investment in health information technology. HITECH directed the Centers for Medicare and Medicaid Services (CMS) to implement Medicare and Medicaid EHR Incentive Programs. These programs provide incentive payments to eligible professionals and hospitals including critical access hospitals (CAHs) as they adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology. To receive incentives, providers must meet the requirements of the CMS Final Rule on Meaningful Use of Certified EHR technology published July 2010. These requirements are summarized in Appendix A.

2.1. HITECH Provisions

Four Vermont organizations are participating in the HITECH initiatives to help build the foundation for every American to benefit from an electronic health record:

- Community College of Vermont
- State of Vermont
- Vermont Rural Health Alliance
- VITL

During 2010, ONC entered into cooperative agreements with these Vermont organizations and others across the country to implement the goals of HITECH. The funds to the Vermont organizations totals \$13.6m. Additionally, the Department of Vermont Health Access (DVHA) receives additional funds from CMS to administer the Medicaid EHR Incentive Program.

The following table details federal cooperative agreements and grants Vermont organizations have received to implement Health Information technology (HIT):

Figure 3: Vermont participation in HITECH

HITECH Provisions	Awards	Vermont Participation
State Health Information Exchange Cooperative Agreement Program supports States to establish health information exchanges (HIEs)	ONC awarded \$548 million to 56 states and territories	State of Vermont was awarded \$5.03m to expand the Vermont Health Information Exchange (VHIE). VITL, under a grant from DHVA, is performing the work.
Health Information Technology Extension Program funds Regional Extension Centers (RECs) to offer technical assistance, guidance and best practices to accelerate health care providers' efforts to adopt EHR technology	ONC awarded \$677 million to 62 non-profits to support a nationwide system of RECs that covers every geographic region of the United States.	VITL's award is currently \$5.4m to support 845 primary care providers. This is a four-year grant with a biennial evaluation in January 2012.
Regional Extension Center Support to Rural and Critical Access Hospitals provides funds to assist CAH/RHs adopt EHRs.	ONC awarded \$20 million in additional funding to 46 RECs.	VITL will receive up to \$162k in supplemental funds to support Rural and Critical Access Hospitals to evaluate their HIPAA security risks.
Community College Consortia to Educate Health Information Technology Professionals Program seeks to rapidly create health IT education and training programs at Community Colleges or expand existing programs.	ONC awarded \$36m to five regional groups of more than 70 community colleges in all 50 states.	Community College of Vermont (CCV) received \$580k to train 225 students in 3 roles: Practice Workflow and Information Management Redesign Specialist, Implementation Support Specialist, and Technical/Software Support Staff

<p>HRSA grant to assist Health Center Controlled Networks implement HIT projects</p>	<p>HRSA awarded \$83.9m in Recovery Act Funds to expand use of health information technology.</p>	<p>The Vermont Rural Health Alliance, a program of Bi-State Primary Care Association was awarded a HRSA grant for \$2.2m to implement a HIT Project for all VT FQHCs. Details of VITL’s contract for \$825k with Bi-State are in Section 10.</p>
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2.2. CMS Meaningful Use of Certified EHR Technology

The CMS Medicare and Medicaid EHR Incentive Programs provide financial incentives to eligible professionals and hospitals for the meaningful use of certified EHR technology. By using EHR technology, providers will reap benefits beyond financial incentives—such as reduction in errors, availability of records, alerts, clinical decision support, and e-prescribing/refill automation. The term “meaningful use” is defined by CMS in their Final Rule published July 2010. Please see the appendices for details about these programs:

- Meaningful use measures are described in Appendix A
- Eligible professionals and eligible hospitals are defined in Appendix B
- Differences between the Medicare and Medicaid Incentive Programs are outlined in Appendix C

3. Vermont Public Policy Governing VITL and HIT

Three statutes specify the public policy for governing VITL and deploying and funding HIT in Vermont.

3.1. Governance and HIT Plan

18 V.S.A. § 9351 and § 9352 prescribes the Secretary of Administration HIT responsibilities and the state government appointments to the VITL Board of Directors. The statute:

- Assigns the responsibility for developing a statewide HIT plan to the Secretary of Administration
- Requires that the plan include:
 - the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients.
 - standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in Vermont.
- Specifies that the Governor and the General Assembly will each appoint one representative to the VITL Board of Directors.
- Designates VITL to operate the exclusive statewide health information exchange network for Vermont.

The relevant statutory language is in Appendix D.

3.2. Blueprint and Connectivity to the Vermont HIE

Act 128 of 2010 (An act relating to health care financing and universal access to health care in Vermont) leverages the resources provided by the HITECH Act of 2009. The Act includes initiatives to accelerate the expansion of the Blueprint for Health, including a requirement that the Blueprint expand to at least two primary care practices in each hospital service area by July 2011 and to all primary care practices who wish to participate by October 2013.

Act 128 also required hospitals to participate in the Blueprint for Health by creating and maintaining connectivity to the state's health information exchange network by July 1, 2011. However, hospitals were not required to create a level of connectivity that the state's exchange was not supporting. The Director of Health Care Reform established criteria for hospitals connecting to the Vermont Health Information Exchange (VHIE). VITL provides data services to the Blueprint Registry under a grant with the Department of Vermont Health Access (DVHA).

3.3. HIT Reinvestment Fee (8 V.S.A. § 4089k)

During the 2009 legislative session, the Governor and General Assembly agreed to establish a fund to finance HIT projects. The fund finances many of the Blueprint and VITL's HIT projects. Fund details are in section 4.1.1

4.0 VITL Sources and Uses of Funds

In calendar year 2011, VITL incurred expenditures of \$5.595 million. VITL received \$5.508 million from State and Federal sources, plus \$110,197 in other revenues.

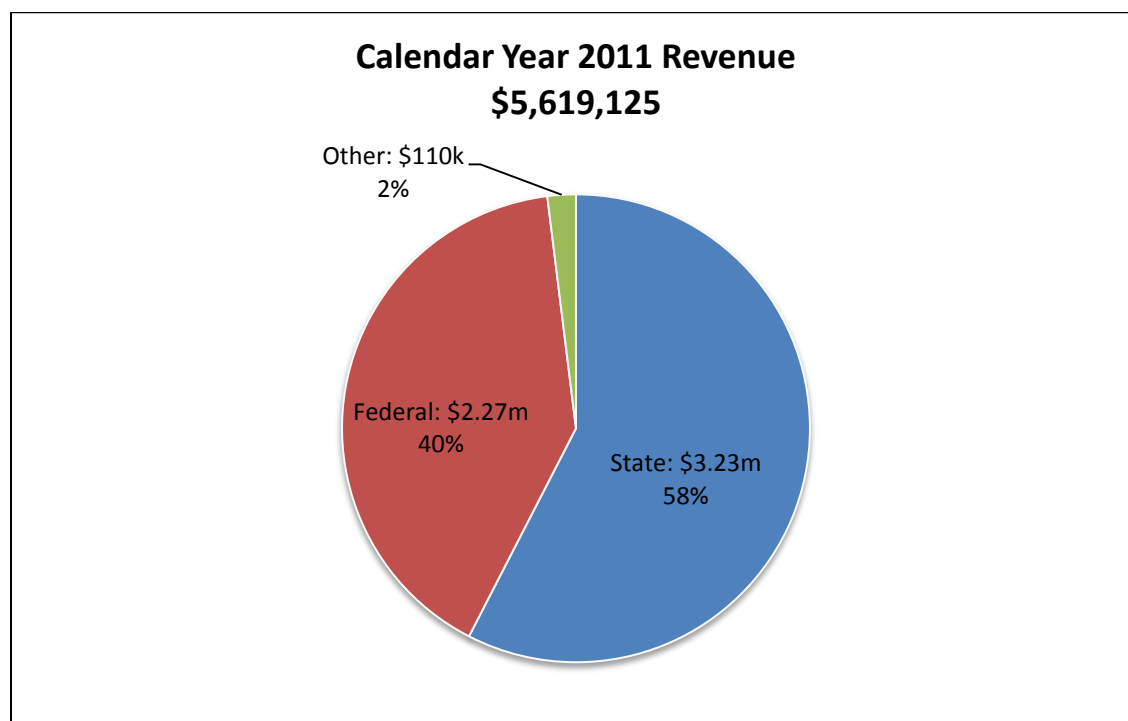
4.1 VITL Sources of Funds

VITL's primary sources of funding come from:

- A grant with the State of Vermont (SOV)
- A cooperative agreement with ONC
- A grant from the Federal Health Resources and Services Administration (HRSA)

VITL also had contracts with health care organizations to deliver HIT services.

Figure 4: VITL Revenue CY2011



4.1.1. State of Vermont Grants

- Department of Vermont Health Access Grant (DVHA)

Starting in 2009, the Division of Health Reform in the Department of Vermont Health Access entered into a grant agreement with VITL for HIE services. The SOV grant is funded by Federal Funds and the HIT Fund. The HIT Fund is an assessment of .0199 of 1% of all health care claims paid by commercial Vermont insurers, or a fee determined by BISHCA based upon the insurer's market share. Vermont statute specifies that HIT funds are to be used for the advancement of health care information technology programs and initiatives as outlined in the Vermont Health Information Technology Plan including:

- *A program to provide electronic health information systems and practice management systems for primary care practitioners in Vermont;*
- *Financial support for VITL to build and operate the health information exchange network;*
- *Implementation of the Blueprint for Health information technology initiatives and the advanced medical home project; and*
- *Consulting services for installation, integration, and clinical process re- engineering relating to the utilization of healthcare information technology such as electronic medical record.*

In February 2010, ONC awarded the State Health Information Exchange ("HIE") Cooperative Agreement to the State of Vermont. Since then, VITL has served as the primary subcontractor for this program.

In calendar year 2011, VITL posted Revenue of \$2,274,380 in grant funds from the State of Vermont for support of Regional Extension Center (REC) services and Health Information Exchange (HIE) development and implementation.

- Vermont Blueprint for Health (DVHA)

Beginning in 2011, the VITL contract for connectivity services to the Blueprint project was merged with the DVHA-VITL Grant. VITL posted Revenue of \$127,167 for Blueprint services.

- Vermont Matching Funds for the REC (3012) Cooperative Agreement

VITL's Regional Extension Center ("REC") cooperative agreement with ONC provides for 90% of REC expenses. By Federal Statute, the other ten percent must come from non-federal sources. The State of Vermont provides a 10% match.

In calendar year 2011, VITL posted Revenue of \$191,541 from the State of Vermont for support of the Regional Extension Center program. The REC program is described in section 5.

4.1.2 Federal Funding

- Office of the National Coordinator Regional Extension Center Program (REC)

In calendar year 2011, VITL posted Revenue of \$2,274,380 in Federal Funds for the Regional Extension Center program. These federal funds reimbursed VITL for 90% of the expenditures for REC services. The funds are not available for general unrelated expenses.

- Health Resources and Services Administration (HRSA) Grant for e-Prescribing Program

VITL received two consecutive HRSA grants dating back to September 2008. The most recent HRSA grant ended on August 31, 2011, and was not available for renewal. In calendar year 2011, VITL posted Revenue of \$504,043 in Federal Funds for the HRSA grant. The funds were used to promote e-prescribing in Vermont. This incentive program is described in section 9

4.1.3 Other Sources of Funds

- Bi-State Primary Health Care Association FQHC HIT Program

VITL is a sub-contractor to Bi-State Primary Care Association to implement the Federally Qualified Health Center HIT program funded by a HRSA grant. In calendar year 2011, VITL posted Revenue of \$185,107 for this program.

- VITL Contracts with Independent Providers

VITL provides consulting services to healthcare providers that do not fall under the State HIE Grant or the Federal REC Cooperative Agreement. These services are provided on a fee-for-service basis with an individual scope of work developed between VITL and the provider. In calendar year 2011, VITL received \$45,186 in independent contracts.

- VITL Annual Summit

VITL holds a one-day Annual Summit featuring nationally known speakers and separate seminars. In calendar year 2011, VITL received \$42,936 in Summit revenue.

Figure 5: State and Federal Funding FY2010-2014

State and Federal Funding FY2010-2014					
Timeline	Audit FY 2010	Audit FY2011	Budget FY 2012	Projected FY 2013	Projected FY 2014
State of Vermont:					
REC Match	\$36,505	\$186,519	\$270,417	\$132,646	\$71,883
HIE Grant (includes federal funds)	\$2,856,704	\$1,798,734	\$5,133,317	\$3,078,516	\$2,903,942
Blueprint for Health	\$105,000	\$321,167	\$0		
Federal Grants:					
ONC Regional Extension Center	\$365,052	\$1,678,672	\$2,433,750	\$1,193,818	\$318,483
HRSA	\$325,225	\$103,470	\$438,818	\$0	\$0
HRSA - Bi-State	\$0	\$153,999	\$531,452	\$211,242	\$84,621
Total Revenue	\$3,688,486	\$4,242,561	\$8,807,754	\$4,616,222	\$3,378,929

4.2 VITL Uses of Funds

VITL uses its funds to finance Regional Extension Center (REC) and Health information Exchange (HIE) programs and support general operations.

Figure 6: VITL Expenses CY2011



4.2.1 Regional Extension Center (REC) Expenses

VITL incurs direct expenses for providing project management and assistance to primary care providers as they implement certified EHR technology and achieve meaningful use as defined by CMS. Most of the funds for these services come from the REC Cooperative Agreement and the State of Vermont DVHA grant. In calendar year 2011, VITL incurred expenses of \$1,427,380 million for REC services.

4.2.2 Health Information Exchange (HIE) Expenses

VITL provides Health Information Exchange development and implementation services to providers covered by the DVHA-Blueprint grant, as well as to individual contracted providers. In calendar year 2011, VITL incurred expenses of \$2,634,270 million for HIE-related services.

4.2.3 General & Administrative Expenses

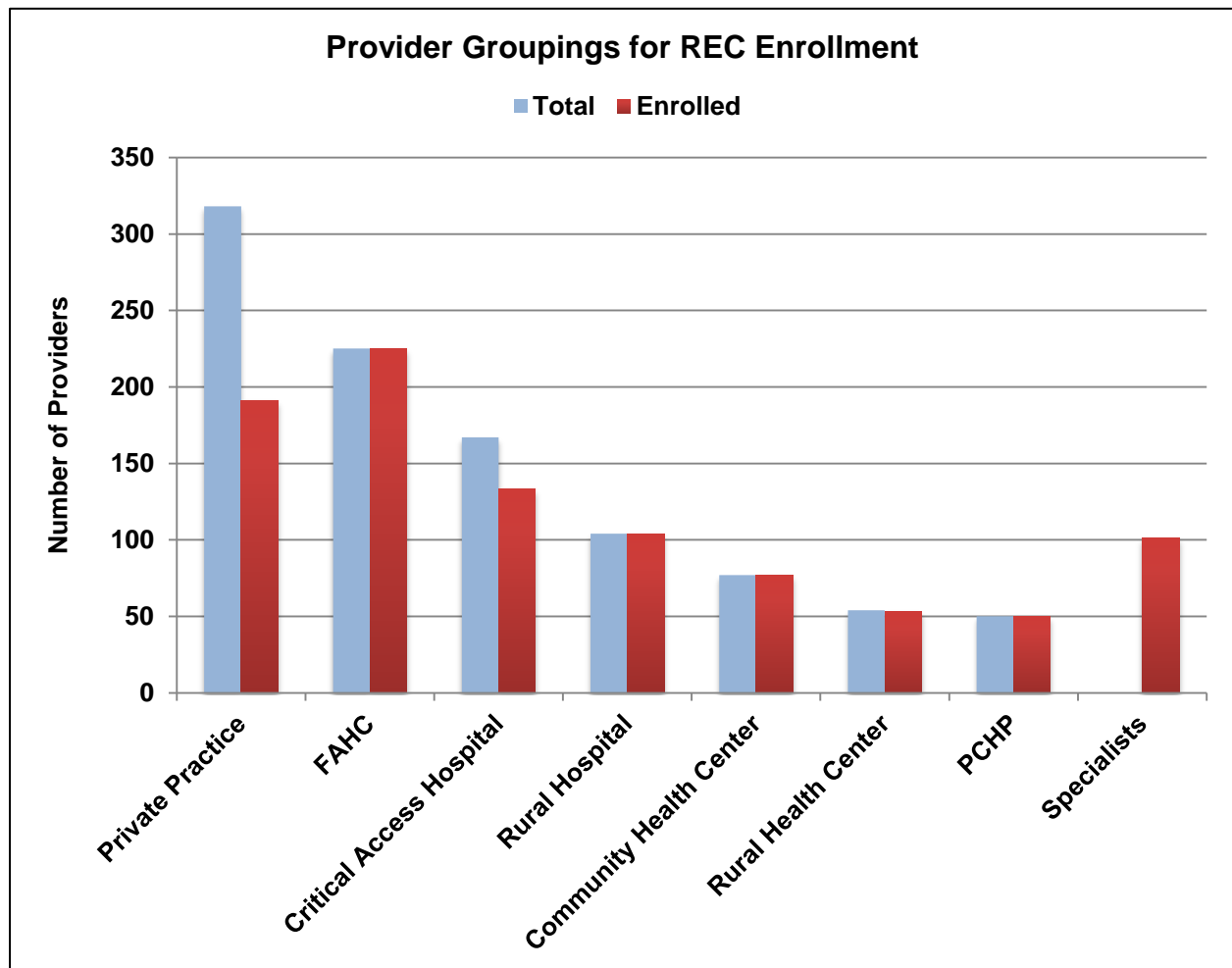
VITL incurs core expenses that are not directly associated with REC or HIE-related services. These expenses include liability insurance, operations overhead, capital equipment, and salary and benefits. In calendar year 2011, VITL incurred \$1,533,128 million in administrative expenses.

5. Regional Extension Center (REC)

In early 2010, ONC entered into cooperative agreements with 62 organizations to provide direct assistance to 100,000 primary care providers across the country. Each organization is required to operate a Regional Extension Center (REC), whose primary purpose is to assist primary care providers achieve meaningful use of certified EHR technology as specified in the CMS Final Rule published in July 2010.

As the Regional Extension Center for Vermont, VITL is expected to assist 845 primary care providers.

Figure 7: Vermont Provider Groupings for REC Enrollment



VITL provides the following services to engage and assist Vermont providers:

- Outreach and Education
- EHR Implementation assistance
- Workflow redesign
- Support for achieving meaningful use

5.1. Outreach and Education

In 2011, VITL continued its efforts to reach out to health care practitioners and the public to educate them about VITL's programs and services, as well as the benefits of EHRs and health information exchange.

During the year, VITL exhibited at several conferences for health care professionals, including the Blueprint for Health Annual Conference, the Vermont Association for Hospitals and Health Systems Annual Conference, the quarterly meetings of the Vermont chapter of the Medical Group Management Association, and the VITL Summit. VITL staff conducted six webinars to answer questions about EHRs and meaningful use.

Electronic communication with various stakeholders has been expanded. Updates on VITL and its programs are routinely sent by email to a list of more than 1,500 interested parties. Facebook, Twitter, and YouTube are all utilized for communication and involvement. VITL moved its website (www.vitl.net) in April 2011 to a new content management system, which provides better navigation and enables the expansion of website content, such as the Vermont eHealth blog (<http://www.vitl.net/blog>). In October 2011, the site was modified to include a new section with content for consumers.

While mass communication is important, one-on-one meetings remain an effective outreach and education method. During 2011, VITL's education and outreach staff continued to make visits to physician practices and hospitals, to answer questions, give presentations, distribute literature, and discuss the federal EHR incentive program. Staff also provided specifics on the services VITL as a Regional Extension Center (REC) offers to primary care providers.

By the end of 2011, VITL had signed up 832 Vermont primary care practitioners to assist them with implementing a certified EHR and achieving meaningful use to qualify for the Medicare/Medicaid incentives. Our target (845) represents more than 85% of the total number of primary care practitioners in Vermont. On a percentage basis, VITL has achieved one of the highest market penetration rates in the country.

5.1.1 VITL Annual Summit

The annual VITL Summit continues to be an important mechanism for engaging physicians, practice administrators, hospital executives, and health information technology managers. The 2011 VITL Summit attracted more than 320 providers, administrators and policy makers. Thirty-four EHR technology and HIT vendors displayed their products in the exhibit hall.

John Halamka, MD, CIO for Beth Israel Deaconess Medical Center in Boston, was the keynote speaker. Dr. Halamka is a national leader in the health information technology industry and serves as the co-chair of the Health IT Standards Committee. He provided detailed information about the expectations for stages 2 and 3 of meaningful use. He also discussed the accomplishments and strategic plans for the advanced use of HIT at Beth Israel. Dr. Halamka's keynote address was video recorded and is available on VITL's YouTube channel, <http://www.youtube.com/vitlvt>.

The breakout session topics were Hands-on EHR strategies, Meaningful Use, Getting started with EHRs, Quality improvement and Health information exchange

The sixth VITL Summit will be held on Thursday, September 13, 2012 at the Sheraton in South Burlington, VT.

5.2. EHR Implementation Process

The REC's scope of work includes assisting health care providers implement EHR technology. Since the inception of the REC in February 2010, we have assisted, directly or with partners, more than 500 providers implement EHRs. A team of four Implementation Specialists managed by the Director of Program Implementation does the majority of this work. The REC Team assists providers with the following implementation related activities:

- EHR selection
- Contract review and negotiations
- Budgeting
- Implementation management
- Go-live preparation

Throughout 2011, the VITL REC Team has continued to develop a significant portfolio of tools and resources to assist providers throughout the implementation process. ONC highlighted several VITL tools and shared them with Regional Extension Centers across the country.

5.3. Progress Achieving Meaningful Use

To qualify for Medicare and Medicaid EHR financial incentives, eligible professionals must achieve meaningful use of certified EHR Technology. To do so, the providers must use an EHR certified by an ONC Authorized Testing and Certification Body (ATCB). The eligible professionals must also demonstrate specific levels of EHR use across a range of diagnostic and record-keeping criteria, including:

- ePrescribing
- maintaining patients' medical problems
- maintaining a patient's allergies and medications
- recording patient demographics
- charting changes in vital signs
- generating lists of patients with specific conditions for quality improvement efforts
- reporting quality measures
- sending patient reminders
- supporting clinical decisions

The complete meaningful use measures are described in Appendix B.

5.3.1. Three Stages of Meaningful Use

CMS is developing the meaningful use rules in three stages:

- Stage 1: focuses on capture of structured data in EHRs
- Stage 2: will emphasize robust exchange of health information
- Stage 3: will concentrate on the improvement of health care outcomes.

The Stage 1 final rule was published by CMS in July 2010. In November 2011, the Department of Health and Human Services moved the Stage 2 start date from 2013 to 2014. Stage 3 is still scheduled for 2015.

5.4. VITL Preferred Partner Program

VITL established a Preferred Partner Program in 2009 to ease the vendor selection process for providers. Participation in the program nearly doubled in 2011 ending the year with seven EHR partners, seven technology services partners, and three implementation services partners.

The genesis of the Preferred Partner Program was the observation that physician practices were finding it difficult and time-consuming to select a vendor to supply and support an EHR. There are over 350 certified EHR products. The process of “shopping” for the right EHR technology, the appropriate hardware and support to implement the technology are serious obstacles for practices.

VITL designed the program to allow practices to select vendors with confidence knowing that pricing, service and interoperability have been evaluated by VITL.

Each category of partnership has different requirements:

- EHR partners must offer transparent pricing to Vermont practices, be fully interoperable with the Vermont Health Information Exchange, include eight standard interfaces in the base price of their product and have a strong service program in the state.
- Technology partners must offer discounted pricing for computer hardware, laptops and printers. They must have a strong local support team and the skills to provide full network security services.
- Implementation partners are required to have demonstrated skills in assisting small practices with EHR deployment, have a strong local presence and offer discounted prices.

By the end of 2011, VITL had enrolled 17 vendors in the Preferred Partner Program. More than 50% are Vermont based (identified with an *):

- EHR Partners
 - Allscripts
 - Athenahealth
 - EPIC/PRISM*
 - Greenway
 - McKesson
 - NextGen
 - Sage

- Technology Partners
 - C2*
 - Dominion Tech*
 - Panurgy*
 - Rose Computer Technology*
 - SymQuest*
 - Tech Group*
 - Technology Consultants*

- Implementation partners
 - Concordant
 - MBA Health Group*
 - Technical Services Program of UVM*

VITL continues to review applications from vendors in all categories.

5.5. VITL's participation in ONC's National Consortium

VITL's cooperative agreement with ONC requires sharing our best practices with other RECs and participating in national Community of Practice (CoPs) meetings. VITL is providing leadership for several of the Community of Practice workgroups. Additionally, VITL shares numerous tools and documents we developed including:

- **EHR Contract Recommendations:** This document was developed to help providers review and assess the elements and wording of EHR vendor contracts. Contract negotiation and finalization is an important part of the process of selecting Practice Management and EHR systems for a practice. The terms of the written contract will be the determining factor for the products and services to which the provider will be entitled and will establish expectations for vendor performance over the period of the contract.
- **EHR Hardware and Equipment Recommendations:** This document was developed to provide computer hardware and equipment recommendations for medical practices implementing EHR technology. The recommendations are based on industry best practices and VITL's experience with a multitude of successful EHR implementations and a variety of applications.
- **VITL Data Workbook:** The VITL Data Workbook was created by reviewing the current Health Reform Quality Care initiatives, the Uniform Data System (UDS) and Meaningful Use reporting requirements. The document creates a crosswalk with most of the data elements needed to complete the reporting requirements for these initiatives. It is meant to be used as a guide to build a data collection system and to enable users to create an EHR that can be a powerful tool for improving the quality of patient care and office efficiency.

5.6 Vermont Participation in Medicare EHR Incentives

The Medicare EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals, and CAHs that demonstrate meaningful use of certified EHR technology.

- Eligible professionals at Middlebury Family Health Center and White River Family practice were the first Vermont physicians to achieve meaningful use
- Medicare eligible professionals must begin participation by 2012 to receive the maximum incentive payment of up to \$44,000 over five years
- Beginning in 2015, CMS will decrease Medicare reimbursements for eligible professionals and hospitals that do not successfully demonstrate meaningful use.

With VITL's guidance, physicians at Middlebury Family Health Center and White River Family Practice became the first Vermont primary care providers to meet all of the Medicare meaningful use requirements. Each physician received a first year incentive payment for \$18,000 from CMS. The

physicians will use the federal funds to pay for the EHR technology and to continue making investments in improving patient care.

At the August 12 press conference in Middlebury, Senator Leahy said:

I am delighted that this targeted federal investment has enabled Middlebury Family Health Center to become the first Vermont practice to receive incentive payments from Medicare for using an electronic health record system. Better records mean better patient care and patient safety for Vermonters. With breakthroughs like this, we are beginning to shift to a higher gear in health reform. The federal partnership with Vermont Information Technology Leaders and local physician practices has the potential to benefit every Vermonter.

During the November 14 event to celebrate White River Family Practice’s success, David Cochran, MD, President and CEO of VITL said:

The incentives are there to acknowledge and mitigate what an important but difficult challenge this is. But it is grounded in a firm belief that if we overcome those challenges, use the records meaningfully, tie them to the kinds of programs we have here in the state with the Blueprint for Health and in the country with the National Strategy for Quality Improvement in Health Care, the result will be better care for our patients, a safer health care system, and a more efficient health care system.

The VITL REC worked with 24 physicians in the following practices to achieve meaningful use and qualify for Medicare EHR Incentives:

Figure 8: Vermont Participation in Medicare EHR Incentives

Name of Practice	Town	County
Bennington Family Practice	Bennington	Bennington
Charlotte Family Health Center	Charlotte	Chittenden
Eric Seyferth, MD	Bennington	Bennington
Evergreen Family Health Partners, LLP	Williston	Chittenden
Hogenkamp & Hogenkamp MDs	Rutland	Rutland
Keith Michl, MD, FACP	Manchester Center	Bennington
Middlebury Family Health Center	Middlebury	Addison
White River Family Practice, PC	White River Junction	Windsor

VITL anticipates that the rate of achieving meaningful use in the Medicare program will accelerate in 2012 for both eligible professionals and providers

5.7. Status of Medicaid EHR Incentive participation in Vermont

The Medicaid EHR Incentive Program in Vermont is administered by the Department of Vermont Health Access (DHVA) under a grant from CMS. The program provides incentive payments to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

- DHVA opened enrollment in Vermont’s Medicaid incentive program October 2011.
- Eligible professionals must meet a Medicaid patient volume threshold (30% for most professionals) to qualify for the Medicaid incentives.
- Eligible professionals are eligible to receive up to \$63,750 over any six years through 2021.
- Eligible hospital incentives are based on a number of factors, beginning with a \$2 million base payment multiplied by a transition factor and by the hospital’s Medicaid share.
- There are no payment adjustments under the Medicaid EHR Incentive Program.

Vermont providers are showing a significant interest in the Medicaid EHR Incentive Program as the table below demonstrates.

Figure 9: Status of Vermont Medicaid EHR Incentive Program as of December 31, 2011

Status	Eligible Professionals	Eligible Hospitals
Registered Providers	171	3
Approved for payments	83	1
Payments approved for 4th Quarter 2011	\$3.6m	
Payments expected in 1st Quarter 2012	\$2.2m	

6. ONC Biennial Evaluation of RECs

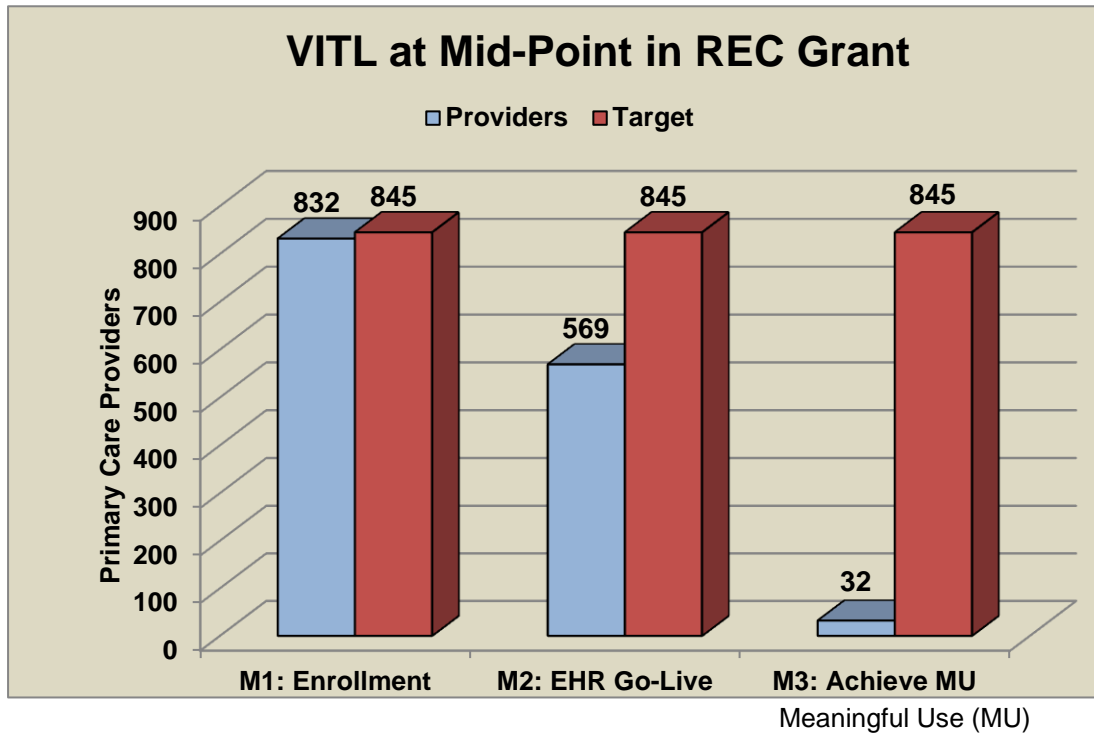
During January 2012, ONC will be conducting a biennial evaluation of all the RECs to determine continued funding for grantees. ONC will review each REC using quantitative and qualitative criteria. The quantitative review is based on three milestones:

- Milestone 1: Enroll providers in the REC program
- Milestone 2: Assist providers to go-live with a certified EHR, e-prescribe and generate quality reports

- Milestone 3: Assist Medicare providers achieve meaningful use and Medicaid providers adopt, implement or upgrade to a certified EHR

At the half way point in the cooperative agreement with ONC, VITL is on target to achieve our goals.

Figure 10: VITL at Mid-Point in Four year ONC REC Cooperative Agreement



The qualitative review will be based on the quality of work RECs have performed in seven areas:

- Direct Assistance to providers
- Support from stakeholders
- Active dissemination of best practices
- Participation in HIEs
- Leverage of other federal programs
- Support for local workforce development
- Timely reporting of finance data

The results of the biennial review are expected to be reported in February.

7. Vermont Health Information Exchange (VHIE)

The Vermont Health Information Exchange program consists of EHR connectivity services and clinical data exchange.

The **EHR connectivity services** provide the mechanism for sending electronic data from hospitals, medical laboratories and other data sources to physician EHRs, and from physician EHRs to other practices, clinical and public health registries. The interfaces and other infrastructure investments are the foundation of the Vermont Health Information Exchange (VHIE).

An **interface** is a software program that reformats data from one system to another. An interface reformats data between an EHR's proprietary clinical data repository and a non-proprietary standard format that can be recognized by other systems. Each category of data (i.e. demographic, lab orders and results, radiology orders and results, clinical summary) requires a separate interface. Many EHR vendors are still developing these interfaces for their EHR products.

Clinical data exchange enables authorized clinicians to aggregate summaries of clinical information from disparate sources for patients who have consented to make their information available. The aggregation of clinical data is performed by a provider portal (targeted for completion during calendar 2012). Within the provider portal, the clinician will see documents (for a consenting patient) that are available from other health care organizations participating in the exchange. The clinician can click on the documents to display them.

Successful clinical data exchange is dependent on many factors including:

- Evolving privacy and security guidance
- A policy for patient consent to view clinical data
- EHR capabilities and HIE standards that are still being developed
- Outreach to Vermonters and providers about the value of exchange

7.1. EHR connectivity services

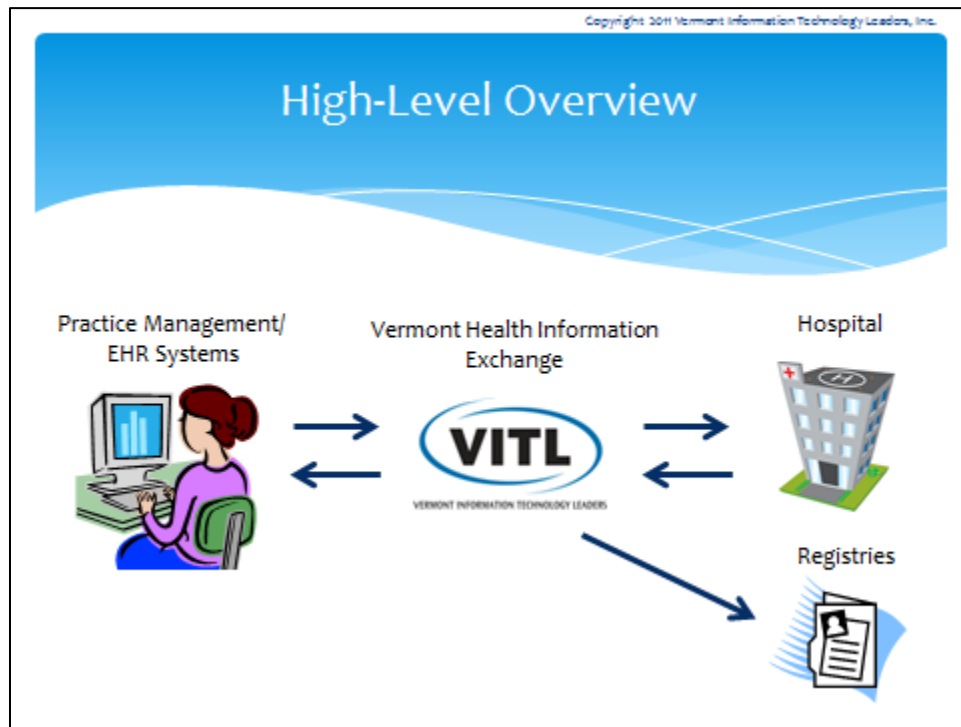
VITL anticipates that the robust clinical data exchange capabilities described below will become operational during calendar year 2012.

When a physician switches from paper medical records to an electronic health records system, one of the first things he or she asks about is the availability of electronic data. There is a large volume of information that may be incorporated into the medical record including:

- Laboratory test results
- Radiology exam reports
- Hospital discharge summaries
- Emergency department visit reports
- Notes from other providers
- Medications
- Allergies
- Problem lists

If this data is not available electronically, the physician office staff must scan paper reports into the EHR or perform manual data entry. This is time consuming, inefficient, and results in less discrete data in the EHR's database. That in turn means the system is not being used to its fullest potential to improve patient care.

Figure 11: High-Level Overview of Vermont Health Information Exchange

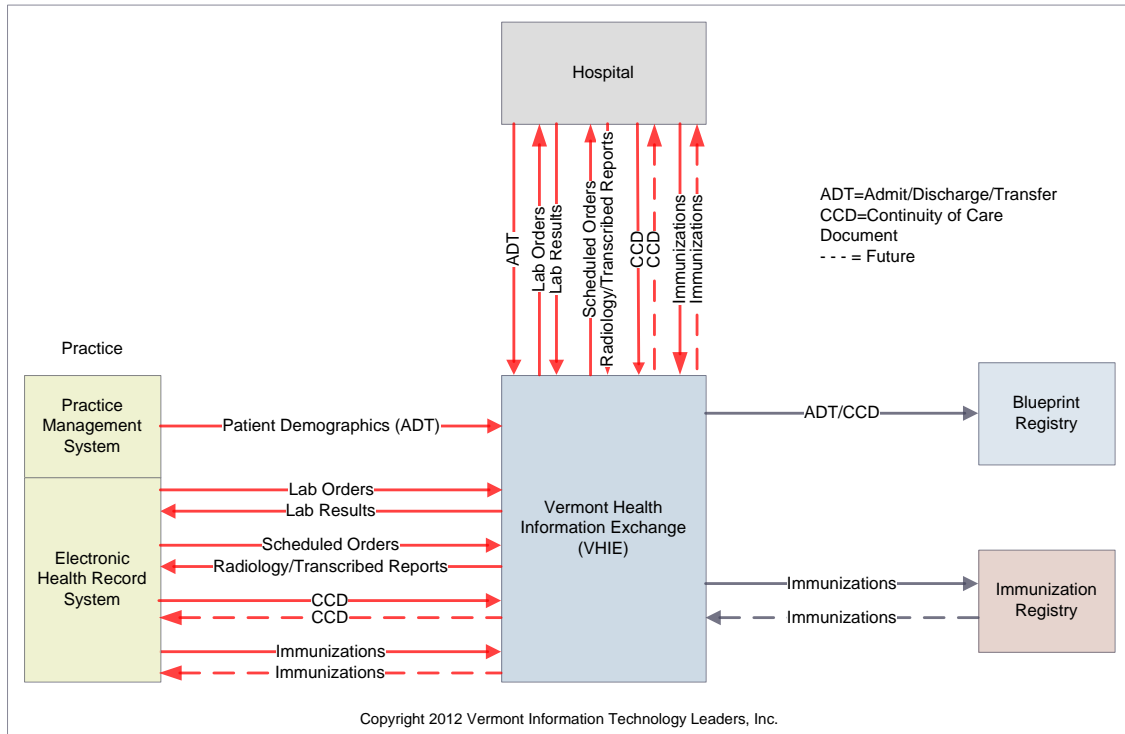


To meet the demand for electronic data, VITL has developed EHR connectivity services that include the following functionality:

- Patient demographic data is sent from the physician practice to the VITL HIE to the Blueprint Registry. This allows the Blueprint community health teams to assist with disease management using a specialized reporting registry.
- Laboratory orders are sent to laboratories electronically rather than by phone or fax. This creates a more readable and timely order.
- Radiology orders are sent to radiology departments electronically, rather than by phone or fax.
- Lab test results and radiology reports are transmitted to the physician's EHR in-box, and matched with the electronic order. The physician reviews the incoming data and then decides whether or not to accept it into the patient's electronic medical record.
- Transcribed reports are transmitted to the physician's EHR in-box. Examples of transcribed reports include an endoscopy report and discharge summary.
- Clinical summaries are sent from the physician practice through the VHIE to the Blueprint Registry. This helps the community health teams assist with management of the appropriate patient population.

- Immunization data is sent from the physician practice to the VHIE. The VHIE assigns the appropriate Immunization Registry identifier, validates the immunization data, and then forwards the correctly identified immunization data to the Vermont Department of Health.

Figure 12: Vermont Health Information Exchange - Connection Details



The EHR connectivity services provide multiple benefits including:

- An audit trail of all electronic transactions is generated.
- Lab and radiology results become available to the physician sooner than faxes or other manual means of report distribution. The result is automatically filed in the EHR if it matches an existing electronic order, improving accuracy and reducing duplicate data entry.
- Receiving transcribed reports electronically enables the report to be included in the patient's electronic medical record, although as unstructured data.
- Clinical summaries are used to provide current clinical patient data to the Blueprint Registry. This enables teams of community providers to proactively engage in patient care management.
- Pediatric and family practices must submit immunization data to the Vermont Department of Health's (VDH) Immunization Registry. VITL is in the process of enabling connectivity from an EHR through the VHIE to VDH. This will eliminate duplicate data entry by the provider, and improve patient identity management at the VDH.

Physicians using VITL's EHR Connectivity Service report that they receive timely results with reduced data entry.

7.2. Privacy and Security Policies

The Division of Health Care Reform in the Department of Vermont Health Access (DVHA) is responsible for coordinating the development of the HIE privacy and security policies. DVHA has adopted the policies previously developed by VITL as the basis for its own policies, but intends to update the policies as part of the state's Health Information Technology Plan. The state HIT Coordinator has been meeting with an advisory group of stakeholders to review proposed updates since December 2010. A revised consent policy is expected to be approved by the Secretary of Administration in 2012.

The state's privacy and security policies are built on a foundation of work originally coordinated by VITL. In April 2008, VITL undertook a six-month process to solicit input from health care providers and consumers regarding development of privacy and security policies for the Vermont Health Information Exchange Network. A set of policies was drafted and circulated for comment. In December 2008, the U.S. Department of Health and Human Services, through its Office of Civil Rights, issued a guidance document to implement the National Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information. VITL's Board, staff and legal counsel analyzed these guidelines in the context of the Health Insurance Portability and Accountability Act (HIPAA), federal and state law, and VITL operations. The analysis informed the development of policies which were adopted by the VITL Board in April 2009.

The initial policies were updated in September 2009 to comply with new privacy and security provisions in the HITECH Act passed by Congress in early 2009. An update of the secondary use policy was adopted in December 2009. This provides a future safeguarded process to use de-identified data from the Vermont Health Information Exchange (VHIE) for quality review purposes with the consent of patients. The latest privacy and security policies can be found at <http://www.vitl.net/health-information-exchange/policies-procedures>.

7.3 Transition to a New HIE Vendor

In early 2011, VITL concluded the review of proposals from several vendors to provide HIE services in Vermont. VITL executed a contract with Medicity in March 2011. The transition to a new HIE vendor included:

- Re-implementation of more than 60 interfaces
- Installation of new infrastructure hardware
- Replacement of the connection to the Blueprint Registry
- Building and moving control to a new master person index (MPI) to tracks patients
- Replacement of a catalog for laboratory orders and results

The transition to Medicity was successfully completed in October 2011. VITL is currently expanding connectivity and interoperability of clinical data throughout Vermont.

Medicity, Inc. was founded in 2000 by an Emergency Department physician, who had a vision of making clinical data more widely available to clinicians at the point of clinical care. The company's focus has been on supporting that vision through development and expansion of its health information exchange capabilities. In early 2011, Medicity was acquired by Aetna Inc., and continues to promote the vision of Medicity's founder with more resources than as a private company. As one of the larger and more mature

health information exchanges, Medicity supports over 125 customers, including leading state health information exchanges in Ohio, Michigan, Colorado, Delaware and Mississippi.

Medicity's provider portal will enable authorized physicians to securely access clinical data that has flowed through the health information exchange. The portal will become available in the later part of calendar 2012. When it is operational, clinical data will be available to authorized providers regardless of their location, while not requiring a practice to have an electronic health record. Access will be controlled by Vermont's policy on a patient's consent to view clinical data, and according to the needs (role) of the provider.

Medicity's experience with installing interfaces will support deployment of clinical connectivity throughout the State consistent with Vermont's objectives and timelines. Medicity has demonstrated that their technology is reliable and scalable. They have established a partnership with VITL that has enabled VITL to participate and lead in Medicity's improved implementation methodology and collaborate on new functionality.

8. Partnership with Vermont State Government

VITL's services are tightly integrated with the state's health reform initiatives. Priority setting for HIE services is made in conjunction with staff at the Division of Health Reform and the Blueprint for Health at DVHA. VITL's initiatives represent a public-private partnership between the state's policy leaders and VITL's implementation teams.

8.1. Department of Vermont Health Access

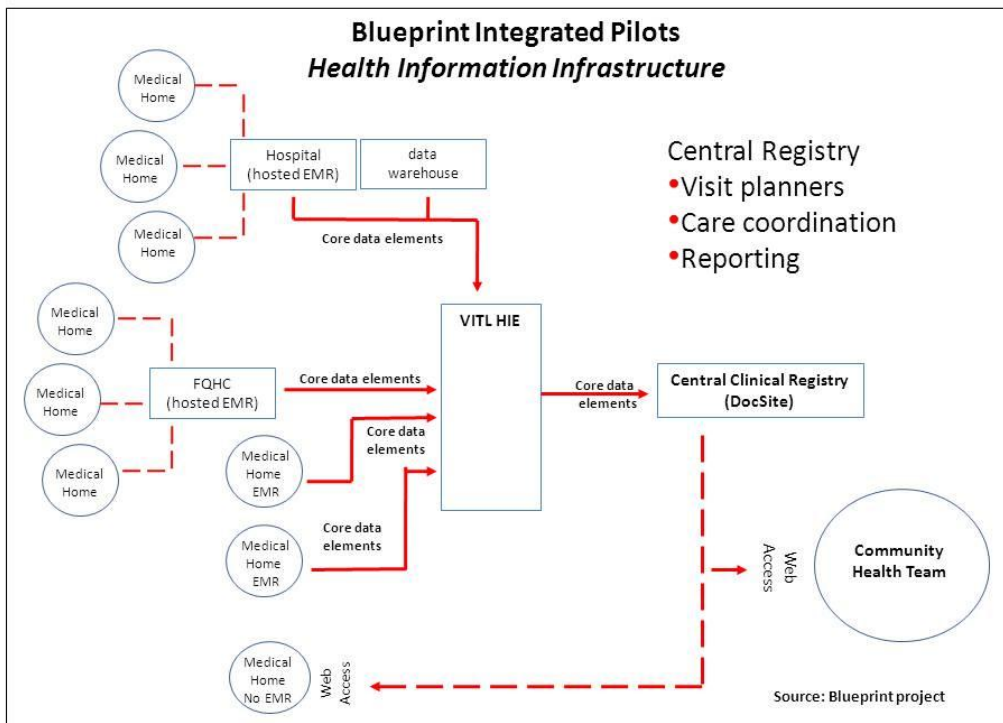
The Division of Health Reform at DVHA is the primary point of connection between VITL and state officials. The Deputy Commissioner in the Division is the state's Health IT Coordinator and ensures the alignment of VITL's efforts with the state's priorities.

DVHA is responsible for administering the Medicaid Meaningful Use Incentive Program for Vermont. VITL provides support to the practices who participate in the Medicaid Meaningful Use program through the Regional Extension Center program. VITL also provides support to the DVHA staff who administers the Medicaid Meaningful Use program.

8.2. Blueprint Registry

Data from sources such as hospital labs and physician EHRs is transmitted via secure interfaces to the Vermont Health Information Exchange (see diagram below). The Vermont Health Information Exchange's Master Person Index (MPI) technology uses demographic information to accurately match various records for the same person. Data is then transmitted to the Blueprint Registry. Clinicians and members of the Blueprint's Community Health Team produce analytical reports from the registry to determine if there are opportunities to improve preventive care or chronic disease management, such as diabetes and hypertension.

Figure 13: HIE Infrastructure to Support Blueprint



At the close of 2011, thirty-nine practices in nine hospital service areas were electronically providing data to the Blueprint Registry:

Figure 14: Hospital Service Areas sending data to Blueprint Registry

Hospital Service Area	Practices sending data to the Blueprint Registry
Barre	13
Bennington	5
Brattleboro	1
Burlington	6
Little Rivers	0
Middlebury	0
Morrisville	1
Newport	1
Randolph	0
Rutland	0
Springfield	0
St. Albans	5
St. Johnsbury	5
White River Junction	2
Totals	39

VITL is planning to connect an additional 51 new practices to the Blueprint Registry by June 30, 2012.

8.3. Immunization Registry

VITL is working with the Vermont Department of Health to develop interfaces that allow physicians to send immunization data from their EHRs to the Vermont Immunization Registry. Submission of both childhood and adult immunization information to the Vermont Department of Health is required by Vermont law and is consistent with the Centers for Disease Control and Prevention recommendations. This electronic transmission will also satisfy a specific requirement for providers seeking meaningful use incentives.

Three practices are prepared to participate in the initial phase of the Immunization Registry project during the first half of calendar 2012, with more practices to follow in the second half of 2012.

The benefits of submitting data to the Vermont Immunization Registry via an interface include:

- Reduced data entry
- Improved data accuracy
- Faster data delivery
- Fulfill data reporting requirements

9. VITL Incentive Programs

During 2010 and 2011, VITL provided financial incentives to providers to implement and use e-prescribing and to accelerate connecting to the Vermont Health Information Exchange (VHIE).

9.1. Electronic Prescribing Incentives

In early 2010, VITL launched the ePrescribe Vermont initiative funded by a HRSA grant to VITL. The program concluded on August 31, 2011. Achievements of the program include:

- Secured a perpetual statewide license from Allscripts for its ePrescribe Deluxe web-based application. VITL offered free use of ePrescribe Deluxe to all Vermont prescribers.
- Educated VITL's outreach staff on how to train physician practice personnel to use ePrescribe Deluxe.
- Conducted a marketing campaign to Vermont licensed prescribers that included a video and recorded demonstration on a DVD and an information packet.
- Enrolled 77 practices in ePrescribe Deluxe, consisting of 201 prescribers who wrote a total of 44,132 electronic prescriptions during 2010 and 84,540 electronic prescriptions during 2011. Offered an incentive of up to \$500 per prescriber for practices with EHRs to adopt and implement the e-prescribing module. Thirty-eight providers added e-prescribing using this incentive.
- Offered an incentive of \$3,500 per independent pharmacy to join Surescripts and begin accepting electronic prescriptions. Eleven independently-owned pharmacies added e-prescribing using this

incentive.

- Contracted with MedMetrics to develop a Vermont Medicaid eprescribing formulary for Allscripts users. The formulary went live on Jan. 13, 2011.

VITL offered an incentive of \$500 per prescriber who attested to using eprescribing for at least 40 percent of prescriptions for non-controlled substances May 1 to July 31, 2011. Ninety-two prescribers received incentive payments.

9.2. Connectivity Incentives

One of the impediments to installing EHR interfaces, at both hospitals and practices, is the cost of each interface. Vendors typically charge a license fee, an implementation fee and an ongoing support fee. Regardless of the size of the organization, these costs must be covered by clinical operations. The installation of an interface at an organization must be weighed against other needs. VITL used several incentive programs to accelerate connectivity and data exchange.

9.2.1. Connectivity Incentives for Pediatric and Family Practices

A Health Resources and Services Administration (HRSA) grant was used to offset costs incurred by pediatric and family medicine practices. VITL identified 32 practices that had an EHR and were potentially eligible to submit immunizations electronically. VITL selected five practices to participate based on the practice's interest and EHR capability. A \$6,200 incentive was provided to each of the practices after they demonstrated generation of production quality immunization messages.

9.2.2. Connectivity Incentives for Critical Access Hospitals

VITL offered \$35,000 incentives to nine Vermont hospitals (one rural hospital and eight critical access hospitals). The incentives were designed to encourage hospitals to install interfaces for results, immunizations, and clinical summaries. Three hospitals worked together with the same vendor to accelerate the development of the interfaces. Each of these hospitals received the full incentive. In early 2012, they will be sending a significant volume of data to the VHIE.

9.2.3. Incentive for Exchanging Data with the Blueprint Registry

Vermont Act 128 requires all Vermont hospitals support the Blueprint for Health by June 30, 2011. VITL provided an incentive to all Vermont hospitals to implement operational patient demographic and laboratory results interfaces. (Due to the transition to Medicity, the deadline was extended to September 30, 2011). The ADT (admission/discharge/transfer) interface populates a statewide master patient index (MPI). The MPI is used to locate a patient's clinical data when consent is given by the patient for clinical data exchange. Practices generally look to a laboratory results interface as a good way to improve efficiency and reduce unnecessary workflow in their practice.

10. Bi-State Primary Care Association / FQHC Project

The Vermont Rural Health Alliance, a program of Bi-State Primary Care Association, was funded by the Health Resources and Services Administration (HRSA) to implement a Health Information Technology

Project on behalf of Vermont's Federally Qualified Health Centers (FQHCs). The objective is to improve the quality of care by ensuring that data in health center electronic health records is structured, reliable, and complete. This objective is facilitated by connecting the EHR systems at each FQHC to Vermont's Health Information Exchange (VHIE). Through the VHIE, the FQHCs can also connect to the Blueprint Registry and Vermont's Immunization Registry.

The project's goal is to enable the health centers to conduct quality improvement activities and ensure their maximum participation in state and federal health care reform opportunities, including a role in the forefront of the statewide expansion of the Vermont Blueprint for Health.

Under a contract with Bi-State, VITL will provide EHR connectivity services to the eight Vermont FQHCs.

- Community Health Center of Rutland Region
- Northern Tier Center for Health
- Springfield Medical Care System
- Northern Counties Health Care
- Community Health Services of the Lamoille Valley
- Community Health Center of Burlington
- Little Rivers Health Care
- Plainfield Health Center

Work is underway with six of the FQHCs. The remaining two, Little Rivers Health Center and Plainfield Health Center, recently signed contracts with their selected vendors to implement a new EHR. VITL will continue to work with all FQHCs after the HRSA contract expires.

11. Status of VITL Projects as of December 31, 2011

VITL uses numerous metrics to measure progress towards specific targets for REC, HIE, Blueprint and Public Health projects. These metrics are represented below.

Figure 15: Status of VITL Projects as of December 31, 2011

Regional Extension Center							
Project	Milestones	Metric	Target	Forecast FY12	Actuals FY10-11	Actuals FY12	Total for Project
Overall EHR Support	Milestone 1: Signed Agreements	# of Primary Care Providers	845	80	797	35	832
	Milestone 2: Functional EHRs			469	260	309	569
	Milestone 3: Meaningful Use			169	4	28	32
Health Information Exchange (HIE)							
Hospital Connectivity	Demographic Data Exchange	# of Hospitals	14	11	2	0	2
	Clinical Data Exchange		14	7	7	0	7
Practice Connectivity	Contributing Data to VHIE ¹	# of Practices		56	33	5	38
	Extracting Data from VHIE ²			90	27	0	27
Blueprint	HIE Services to Blueprint Practices ³	# of Practices	89	56	33	5	38
Public Health	Public Health Services ⁴	# of services	3	0	0	0	0
Notes							
1. Contributing Data: Demographics, clinical summary, immunization data							
2. Extracting Data: Lab results, transcribed or radiology reports							
3. Target for 6/30/12							
4. Public Health Service Examples: Immunization Registry, syndromic data, reportable labs							

12. Conclusion

The last several years have been an exciting time for health care reform in Vermont and the nation. Act 48 of 2011 put Vermont on a path to a transformed health care system. Health IT in the form of Electronic Health Records and Health Information Exchange is part of the foundation that will enable that transformation. Federal HITECH programs and funding allowed VITL and the state accelerate the deployment of that infrastructure. By engaging 85% of the primary care providers in the state and transitioning the health information exchange to a mature and proven platform, VITL has made important strides on the path to a statewide use of Health IT. During 2012, we anticipate seeing broader and better use of technology and the continued transformation of the care delivery environment to one that will deliver better, safer, and more efficient care.

Appendix A: Meaningful Use Measures

Eligible Professional Meaningful Use Table of Contents Core, Menu Set and Clinical Quality Measures	
Eligible Professional Must Achieve 15 of 15 Core Measures	
<ol style="list-style-type: none"> 1 Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. 2 Implement drug-drug and drug-allergy interaction checks. 3 Maintain an up-to-date problem list of current and active diagnoses. 4 Generate and transmit permissible prescriptions electronically (eRx). 5 Maintain active medication list. 6 Maintain active medication allergy list. 7 Record all of the following demographics: Preferred language, Gender, Race, Ethnicity, Date of birth. 8 Record and chart changes in the following vital signs: Height, Weight, Blood pressure, Calculate and Display body mass index (BMI), Plot and display growth charts for children 2–20 years, including BMI. 9 Record smoking status for patients 13 years old or older. 10 Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States. 11 Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule. 12 Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. 13 Provide clinical summaries for patients for each office visit. 14 Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically. 15 Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. 	
Eligible Professional Must Achieve 5 of 10 Menu Set Measures including one public health measure	
<ol style="list-style-type: none"> 1 Implement drug formulary checks. 2 Incorporate clinical lab-test results into EHR as structured data. 3 Generate patient lists by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. 4 Send patient reminders per patient preference for preventive/follow-up care. 5 Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP. 6 Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. 7 The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. 8 The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral. 9 Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. 10 Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. 	

Clinical Quality Measures are on the next page.

Appendix A: Meaningful use Measures (continued)

Eligible Professionals Must Report 3 Core or 3 Alternate Clinical Quality Measures (CQMs)
CMS finalized 44 CQMs for eligible providers, many of which overlap with the CMS Physician Quality Reporting Initiative. Three of the 44 measures are designated "core" and must be reported by all eligible professionals in stage 1. In instances where the denominator for one or more of the core CQMs is zero, the eligible provider is required to report results for up to three alternate core CQMs. In total, eligible providers must report on six CQMs: three core measures (or alternate core measures) and three additional quality measures.
Core CQMs
NQF 0013: Hypertension: Blood Pressure Measurement NQF 0028: Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment; b) Tobacco Cessation Intervention NQF 0421 / PQRI 128: Adult Weight Screening and Follow-up
Alternate Core CQMs
NQF 0024: Weight Assessment and Counseling for Children and Adolescents NQF 0041/PQRI 110: Preventive Care and Screening: Influenza Immunization for Patients >= 50 Years Old NQF 0038: Childhood Immunization Status
Eligible Professionals Must Report 3 of 38 Additional Clinical Quality Measures
The 38 additional clinical quality measures are listed at www.vitl.net/resources .

Appendix B: Eligible Professionals and Hospitals

Eligible Professionals for EHR Incentives

Medicare	Medicaid
<ul style="list-style-type: none"> • Doctors <ul style="list-style-type: none"> – Medicine and Osteopathy – Dental Surgery or Medicine – Doctor of Podiatric Medicine – Doctor of Optometry – Chiropractors 	<ul style="list-style-type: none"> • Doctors and Mid-levels with required Medicaid patient volumes <ul style="list-style-type: none"> – Physicians – Pediatricians – Nurse practitioners – Certified Nurse Midwives – Physician Assistants at FQHC/RHC led by PA – Dentists

Appendix C: Differences between Incentive Programs

What are the differences between the EHR Incentive Programs for Eligible professionals?

Medicare	Medicaid
No patient thresholds	Patient volume thresholds
No mid-levels	Mid-levels included
<ul style="list-style-type: none"> • \$44,000 maximum • 10% HPSA bonus • 75% allowable PFS charges 	<ul style="list-style-type: none"> • \$63,750 maximum
Payments over 5 yrs (2011-2016)	Payments over 6 yrs (2011-2021)
Can not skip a year	Can skip a year
1 st yr must demonstrate Meaningful Use	Adopt, implement or upgrade option for 1st yr
Penalties starting 2015	No penalties

Appendix D: Vermont Statute

Title 18: Health

Chapter 219: HEALTH INFORMATION TECHNOLOGY

§ 9351. Health information technology plan

(a) The secretary of administration or designee shall be responsible for the overall coordination of Vermont's statewide health information technology plan. The secretary or designee shall administer and update the plan, as needed, which shall include the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. The plan shall include standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in Vermont.

(b) The health information technology plan shall:

(1) Support the effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvements;

(2) Educate the general public and health care professionals about the value of an electronic health infrastructure for improving patient care;

(3) ensure the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;

(4) propose strategic investments in equipment and other infrastructure elements that will facilitate the ongoing development of a statewide infrastructure;

(5) Recommend funding mechanisms for the ongoing development and maintenance costs of a statewide health information system, including funding options and an implementation strategy for a loan and grant program;

(6) incorporate the existing health care information technology initiatives to the extent feasible in order to avoid incompatible systems and duplicative efforts;

(7) integrate the information technology components of the Blueprint for Health established in chapter 13 of this title, the agency of human services' enterprise master patient index, and all other Medicaid management information systems being developed by the department of Vermont health access, information technology components of the quality assurance system, the program to capitalize with loans and grants electronic medical record systems in primary care practices, and any other information technology initiatives coordinated by the secretary of administration pursuant to 3 V.S.A. § 2222a; and

(8) Address issues related to data ownership, governance, and confidentiality and security of patient information.

(c) The secretary of administration or designee shall update the plan annually to reflect emerging technologies, the state's changing needs, and such other areas as the secretary or designee deems

appropriate. The secretary or designee shall solicit recommendations from Vermont Information Technology Leaders, Inc. (VITL) and other entities in order to update the health information technology plan pursuant to this section, including applicable standards, protocols, and pilot programs, and may enter into a contract or grant agreement with VITL or other entities to update some or all of the plan. Upon approval by the secretary, the updated plan shall be distributed to the commissioner of information and innovation; the commissioner of banking, insurance, securities, and health care administration; the commissioner of Vermont health access; the secretary of human services; the commissioner of health; the commissioner of mental health; the commissioner of disabilities, aging, and independent living; the senate committee on health and welfare; the house committee on health care; affected parties; and interested stakeholders.

(d) The health information technology plan shall serve as the framework within which the commissioner of banking, insurance, securities, and health care administration reviews certificate of need applications for information technology under section 9440b of this title. In addition, the commissioner of information and innovation shall use the health information technology plan as the basis for independent review of state information technology procurements.

(e) The privacy standards and protocols developed in the statewide health information technology plan shall be no less stringent than applicable federal and state guidelines, including the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments, and the privacy provisions established under Subtitle D of Title XIII of Division A of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, sections 13400 et seq. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail.

(f) Qualified applicants may seek grants to invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information from federal agencies, including the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the U.S. Department of Agriculture, and the Federal Communications Commission. The secretary of administration or designee shall require applicants for grants authorized pursuant to Section 13301 of Title XXX of Division A of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to submit the application for state review pursuant to the process established in federal Executive Order 12372, Intergovernmental Review of Federal Programs. Grant applications shall be consistent with the goals outlined in the strategic plan developed by the Office of the National Coordinator for Health Information Technology and the statewide health information technology plan. (Added 2009, No. 61, § 1; amended 2009, No. 156 (Adj. Sess.), § 1.25; 2011, No. 63, § G.103.)

§ 9352. Vermont information technology leaders

(a) Governance. The general assembly and the governor shall each appoint one representative to the Vermont Information Technology Leaders, Inc. (VITL) board of directors.

(b) Conflict of interest. In carrying out their responsibilities under this section, directors of VITL shall be subject to conflict of interest policies established by the secretary of administration to ensure that deliberations and decisions are fair and equitable.

(c) Health information exchange operation. VITL shall be designated in the health information technology plan pursuant to section 9351 of this title to operate the exclusive statewide health information exchange network for this state. The secretary of administration or designee shall enter into procurement grant agreements with VITL pursuant to section 4089k of Title 8. Nothing in this chapter shall impede local community providers from the exchange of electronic medical data.

(d) Privacy. The standards and protocols implemented by VITL shall be consistent with those adopted by the statewide health information technology plan pursuant to subsection 9351(e) of this title.

(e) Report. No later than January 15 of each year, VITL shall file a report with the secretary of administration; the commissioner of information and innovation; the commissioner of banking, insurance, securities, and health care administration; the commissioner of Vermont health access; the secretary of human services; the commissioner of health; the commissioner of mental health; the commissioner of disabilities, aging, and independent living; the senate committee on health and welfare; and the house committee on health care. The report shall include an assessment of progress in implementing health information technology in Vermont and recommendations for additional funding and legislation required. In addition, VITL shall publish minutes of VITL meetings and any other relevant information on a public website.

(f) Funding authorization. VITL is authorized to seek matching funds to assist with carrying out the purposes of this section. In addition, it may accept any and all donations, gifts, and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any person, firm, foundation, or corporation for any of its purposes and functions under this section and may receive and use the same, subject to the terms, conditions, and regulations governing such donations, gifts, and grants.

(g) Waivers. The secretary of administration or designee, in consultation with VITL, may seek any waivers of federal law, of rule, or of regulation that might assist with implementation of this section.

(h) Loan and grant programs. VITL shall solicit recommendations from the secretary of administration or designee, health insurers, the Vermont Association of Hospitals & Health Systems, Inc., the Vermont Medical Society, Bi-State Primary Care Association, the Council of Developmental and Mental Health Services, the Behavioral Health Network, the Vermont Health Care Association, the Vermont Assembly of Home Health Agencies, other health professional associations, and appropriate departments and agencies of state government, in establishing a financing program, including loans and grants, to provide electronic health records systems to providers, with priority given to Blueprint communities and primary care practices serving low income Vermonters. Health information technology systems acquired under a grant or loan authorized by this section shall comply with data standards for interoperability adopted by VITL and the state health information technology plan. An implementation plan for this loan and grant program shall be incorporated into the state health information technology plan.

(i) Certification of meaningful use. To the extent necessary or required by federal law, VITL shall be authorized to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont.

(j) Scope of activities. VITL and any person who serves as a member, director, officer, or employee of VITL with or without compensation shall not be considered a health care provider as defined in subdivision 9432(8) of this title for purposes of any action taken in good faith pursuant to or in reliance upon provisions of this section relating to VITL's:

(1) Governance;

(2) Electronic exchange of health information and operation of the statewide health information exchange network as long as nothing in such exchange or operation constitutes the practice of medicine pursuant to chapter 23 or 33 of Title 26;

(3) Implementation of privacy provisions;

(4) Funding authority;

(5) Application for waivers of federal law;

(6) Establishment and operation of a financing program providing electronic health records systems to providers; or

(7) Certification of health care providers' meaningful use of health information technology. (Added 2009, No. 61, § 1; amended 2009, No. 67 (Adj. Sess.), § 108; No. 156 (Adj. Sess.), § 1.26; 2011, No. 63, § G.104.)

Appendix E: VITL Board of Directors

Officers

Don George, VITL Board Chair

President and CEO
Blue Cross Blue Shield of Vermont

Judy Higgins, VITL Board Vice Chair

Consultant

Paul Harrington, VITL Board Treasurer

Executive Vice President
Vermont Medical Society

Bea Grause, VITL Board Secretary

President and CEO
Vermont Association of Hospitals and Health Systems

Directors

Hunt Blair

Deputy Commissioner - Division of Health Reform and State HIT Coordinator
State of Vermont

Bruce Bullock, MD

Practicing physician
Rutland, VT

Gertrude M. Hodge

Consumer Advocate

Andrea Lott

CIO, Vice President Information Services
Northeastern Vermont Regional Hospital

Rep. Christopher Pearson (P-Burlington)

Vermont House Health Care Committee

Greg Peters

Lake Champlain Capital Management

Chuck Podesta

Chief Information Officer
Fletcher Allen Health Care