

**CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION
ACT (CHIPRA)
QUALITY DEMONSTRATION GRANT
FINAL OPERATIONAL PLAN
and FIRST PROGRESS REPORT
MAINE ~ VERMONT**

January 14, 2010

Division of Quality, Evaluation, and Health Outcomes

Family and Children's Health Programs Group

Center for Medicaid, CHIP, and Survey and Certification

Centers for Medicare & Medicaid Services

Table A

Project Description

Table A describes in detail the Improving Health Outcomes for Children (IHOC) project as a whole, how Maine and Vermont intend to address each category selected in our application, how the work performed under each category will complement the efforts undertaken in other categories, and how activities conducted across all categories will contribute to the overall improvement of children’s health care under Medicaid and CHIP, and how the operational plan has changed since the grant application was submitted.

Information Requested	Grantee Response
<p>Provide a succinct description of the proposed project.</p>	<p>Maine and Vermont’s CHIPRA Quality Demonstration Grant “Improving Health Outcomes for Children” (IHOC) will enhance the quality of care delivered to children in their states and inform best practices for the nation, particularly rural areas. Building on existing health quality infrastructures, MaineCare and the Department of Vermont Health Access (Maine and Vermont’s Medicaid/CHIP agencies) propose activities under Grant Categories A (Maine only), B, C and E (Vermont only) to collect and report on the use of evidence-based child health quality measures; expand HIT to improve the flow of child health data; enhance payment reform; support and evaluate pediatric-focused medical home models and promote a collaborative learning environment that can be a national model for other states.</p> <p>For Category A, Maine proposes to enhance the state’s current quality performance measurement and incentive payment systems to include the core child health quality indicators and other identified measures, with the goal of reducing unnecessary variation in pediatric care, aligning payment and financial incentives with pediatric quality measures, and improving the health of low-income and other children in Maine. To achieve this, CHIPRA quality measures and strategies for incentivizing child health quality will be integrated into risk-based managed care contracts that are expected to be in place in January 2012. The MaineCare program currently operates on a fee-for-service basis, and pays qualifying primary care providers a small fee to manage MaineCare members’ care through the Primary Care Case Management program. MaineCare is in the process of developing an RFP for release in the Spring 2011 for Medicaid managed care plans to manage the MaineCare program beginning in 2012. The state is currently planning for this transition, developing quality standards, measures and payment incentives for the managed care plans to be included in the RFP and eventually in the managed care contracts. The proposed quality incentive payments for plans, while still being vetted, include several CHIPRA measures, primarily those that are NCQA HEDIS measures. A final set of measures and payment incentives for MaineCare managed care plans is expected to be released in February 2011. Managed care plans will also be required to participate in all existing MaineCare quality initiatives including both ME’s Improving Health Outcomes for Children (IHOC) CHIPRA grant and the Maine Patient Centered Medical Home (PCMH) Pilot. The Maine PCMH Pilot was formed prior to the CHIPRA Demonstration Grant when several organizations in Maine came together to develop a Maine Patient Centered Medical Home Pilot. The PCMH Pilot is partnering with IHOC and has already agreed to include many CHIPRA measures in its outcome and process measures for</p>

	<p>the pediatric medical home practices.</p> <p>In Category B, both states propose to enhance their HIT infrastructures to improve the flow and use of child health quality information—Vermont by expanding the <i>Vermont Blueprint for Health</i> HIT infrastructure to support guideline-based care and performance measurement in pediatric populations and Maine by automating EPSDT data collection and sharing comprehensive health assessments with health care providers and case managers of children in foster care. For Category C, Maine and Vermont will assess and support pediatric practices in operating as patient-centered medical homes in their respective states. Maine will also pilot learning initiatives in the Pediatric PCMH Pilot sites and other pediatric practice settings including the implementation of the current pediatric care guidelines—the <i>Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents</i>, Third Edition. They will also increase provider education on child health outcomes. Finally, under Grant Category E, Vermont will build upon its leadership role as convener of the National Improvement Partnership Network to increase the number of participating states (particularly non-Demonstration states), expanding the reach of CMS’s child health improvement efforts. As part of its sustainability plan, Maine will be one of the states working with Vermont to establish a child health Improvement Partnership program.</p> <p>The proposed activities capitalize on each state’s unique strengths in ways that support shared learning, and increase opportunities for actualizing the objectives. Maine’s expertise in Medicaid quality measurement and pay-for-performance, including recent experience developing patient-centered medical homes that involve both pediatric and family practices, will inform Vermont efforts to extend their state health reform initiative, the <i>Vermont Blueprint for Health</i>, to children. Similarly, Maine’s plans to adopt <i>Bright Futures</i> practice standards, increase provider participation in quality improvement activities and create a child health Improvement Partnership will benefit from Vermont’s role in developing the <i>Bright Futures</i> guidelines and toolkit, and its leadership in promoting and sustaining quality Improvement Partnerships in Vermont and nationally.</p>
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<p>What are the principal objectives of the demonstration, including expected outcomes and products?</p>	<p>Maine’s principal objectives for Category A are to:</p> <ul style="list-style-type: none"> • Engage stakeholders—including pediatric healthcare providers, professional organizations, health systems, child and family advocates, public and private payers, and quality improvement organizations—for the purpose of providing feedback on the development, implementation and use of pediatric measures for quality improvement throughout the demonstration. • Collect and evaluate the CHIPRA initial core measures and additional pediatric quality measures identified by stakeholders. Report results to payers, providers, consumers and CMS, and identify barriers and solutions to implementation. Quality measures will be available that can be used for payment incentives by payers, for quality improvement activities by practices, and for assisting consumers in selecting quality providers. Maine will use a phased-in approach to collect and report the CHIPRA measures. In 2011, Maine will add approximately 14 claims-based CHIPRA measures to its existing MaineCare utilization review and payment incentive reports to providers, and modify its annual patient experience of care survey to meet the CHIPRA measure requirement. Beginning in 2011 and continuing into 2012, the second phase will focus on collecting and reporting measures drawn from data sources that currently do not identify Medicaid patients and will need to be linked to Medicaid eligibility data, including measures from immunization registries, birth certificate registries, and hospital discharge data. Using all of these data sources, Maine will be able to report on approximately 22 CHIPRA measures. The final phase, to begin in 2013, will use data from a new automated EPSDT registry system developed through activities in Category B of the demonstration (see below), to collect and report on process of care measures. Reporting of the available CHIPRA measures will occur at least annually beginning in 2012. • Refine MaineCare’s pay-for-performance program under its new managed care system to provide greater incentive for child health quality improvement. Maine is in the planning phase for its move to managed care expected to begin in 2012. During the planning stage, which is expected to end in the spring of 2011 with the release of the managed care RFP, the state is defining quality standards for plans as well as performance measurement requirements and incentive payments that will include CHIPRA measures. Quality standards will include a requirement that MaineCare managed care plans participate in existing MaineCare quality initiatives including both the IHOC CHIPRA demonstration grant and the Maine PCMH Pilot incentive payments. The list of performance measures and payment incentives for managed care including many CHIPRA measures will be completed in February 2011 for inclusion in the RFP. They will also be included in the final contracts with selected plans expected to commence in 2012. • Align pediatric quality measures selected by the demonstration with quality measurement activities of other payers, professional organizations, and with MaineCare payment incentives. By maximizing the overlap of measures required by different payers, the demonstration will minimize the administrative burden of collection for providers and facilitate broad adoption of the measures across the State. • Beginning in 2012, with input from the pediatric and mental health community, identify and review the feasibility of collecting evidence-based child behavioral health measures, building on the National
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	<p>Outcomes Measures supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).</p> <ul style="list-style-type: none"> • For Category B, Maine’s principal objectives are to : • Design, develop and implement HIT linkages and systems within the Maine Department of Health and Human Services and with pediatric practices and health systems to collect and report EPSDT/Bright Futures preventive measures and other clinical data from the clinical record. Maine will pilot HIT linkages and systems with the four pediatric practices participating in the PCMH Pilot project. Each pediatric practice belongs to a different health system in Maine, and are located in different regions in the state. Expansion to additional practices serving children will occur as we obtain success and negotiate specifics to move forward. • Design, implement and evaluate an electronic health assessment for children in Maine’s foster care system. <p>Vermont’s principal objectives are to:</p> <ul style="list-style-type: none"> • Expand (build) the <i>Vermont Blueprint for Health</i> central registry (DocSite)) to include data elements and performance measures for the 4 areas of pediatric care for which guidelines exist (i.e. preventive services, asthma, ADHD, obesity) in order to support guideline-based care, performance measurement, population management, and coordination with community-based services for the pediatric population. Development of the central registry will include expanding its flexible web-based reporting platform to drive improvements in care delivery and guide state health reform. • Support use of DocSite in pediatric and family practices participating in the Blueprint by deploying up to 2 pediatric practice facilitators to work with practice teams on effective use of the central registry. • Support interface development for guideline-based data elements between DocSite and commercial EHRs to support data feeds for pediatric providers participating in the Blueprint who use an EHR. Interfaces will be developed for the EHR products being used by pediatric/family practices joining the Blueprint. The full list of products currently in use or that will be used by participating pediatric/family practices is unknown at this time. In terms of which products practices may purchase, the Vermont Information Technology Leaders (VITL) has established a preferred EHR vendor listing for Vermont practices. This designation indicates that the vendor 1) meets all interoperability specifications of the Vermont Health Information Exchange (HIE); 2) includes in the product’s base price all interfaces necessary for practices to connect to the exchange; and 3) agrees to discounted prices for practices in the state and to standard contracts. VITL’s preferred EHR vendors include Allscripts™; Fletcher Allen Health Care’s (Burlington, VT) PRISM (Patient Record and Information Systems Management), which is based on technology from Epic Systems Corporation; athenahealth; and PrimeSuite 2008 (a Greenway Medical Technologies, Inc. product). Practices have the option of purchasing a product from the list of preferred vendors, though it is not a requirement for participation in the Blueprint.
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Following a similar process that the Blueprint has employed to date, Blueprint leadership, VITL, DocSite, and UVM/VCHIP will approach the development of interfaces on a case-by-case (that is, practice-by-practice) basis, as the scope and complexity of this work is highly variable across vendors and products. Under CHIPRA, UVM/VCHIP pediatric clinical faculty will provide clinical interpretation of data fields in a given EHR in use to determine which fields require modification, or which new fields must be created, so that data fields in the EHR map onto those in the DocSite central registry that are used to calculate performance measures. Based on these assessments, clinical faculty will provide a set of recommendations to the Blueprint indicating modifications (i.e. changes to existing data fields or the development of new fields) that would need to be made to the EHR to enable data feeds to the DocSite central registry. The Blueprint will then work with VITL, DocSite, the practice, and/or the practice's EHR vendor to modify the EHR product, where feasible.

For **Category C**, Maine's principal objectives are to:

- Implement the Bright Futures Resource Toolkit with Maine child health providers and assess the impact on the provision of EPSDT services in Maine.
- Develop and implement "Learning Community" activities with the PCMH Pilot and other practices to enhance practice-level capacity for child health quality improvement and to evaluate the impact on quality.
- Build a child health quality improvement partnership in Maine that will be sustained after the grant ends.

Vermont's principal objectives are to:

- Extend the *Blueprint for Health* integrated health model (or "Advanced Primary Care Practice (APCP) model") in Vermont's pediatric population by deploying up to 2 NCQA scorers to conduct NCQA assessments in pediatric/family practices joining the Blueprint and by deploying pediatric practice facilitators (up to 2, as stated above) to work with practice teams on quality improvement.
- Design and conduct a pediatric-specific evaluation to assess impact of the APCP model on care delivery, health status, and healthcare costs.

Maine and Vermont will also jointly design and implement a comparative cross-site evaluation of the implementation and impact of Maine and Vermont's child health quality improvement strategies using the pediatric PCMH/APCP model.

Under **Category E**, Vermont's principal objectives are to:

- Continue to support the national network of 15 Improvement Partnership states (National Improvement Partnership Network, or NIPN) through the provision of technical assistance.
- Assist an additional 20 states in development of a sustainable state Improvement Partnership to focus on the priorities of this demonstration, particularly those not receiving Federal funding under the grant and smaller, rural states. Specifically, Vermont will provide technical assistance to 5 states per year for years 2 through 5 of the demonstration grant. Among the states that will receive technical assistance to build a child health Improvement Partnership is the state of Maine. This will increase the number of states with an existing or

	<p>developing Improvement Partnership program specifically targeted at quality for children to 35 total states. Evaluate the implementation, efficiency, and impact of the Improvement Partnership model and national network.</p>
<p>Explain the role of each State participating in the demonstration (if the project involves multiple States).</p>	<p>As partners, Maine and Vermont will consult, collaborate, and share information throughout the grant period, thereby benefiting from each state's experiences, and expertise.</p> <p>For example:</p> <ol style="list-style-type: none"> 1. While Vermont will not be implementing the core measures, through regular cross-state meetings and communication with Maine, Vermont will keep abreast of Maine's experience and assess meaningfulness of the measures among Blueprint constituents (e.g., providers, state government, Vermont legislature) and the feasibility of collecting some measures under the Blueprint. Through its partnership with Maine and by following the experience in other states, Vermont hopes to assess the utility and value of these performance measures across Medicaid/CHIP fee-for-service and managed care delivery systems and to benchmark with other states, regional and national rates. 2. Both Maine and Vermont are in the process of defining and automating <i>Bright Futures</i> measures. Communication, consultation and sharing of information across states will occur regularly through identified point persons in each state. 3. Both Maine and Vermont are promoting the use of HIT to include child health measures. Each state has unique health data systems and health policies that impact the development of HIT capacity. Maine and Vermont will capitalize on each state's unique proficiencies in ways that support shared learning, and increase opportunities for actualizing the objectives. Both states will communicate and share best practices on the automation of Bright Futures in different but parallel HIT systems. <p>Maine and Vermont intend to use the IHOC Executive Committee meetings to share common issues and problems encountered around child health quality measurement and pediatric improvement both for the specific activities of this grant and to align pediatric initiatives currently taking place or that arise over the course of the grant across the two states.</p> <p>Maine and Vermont are also jointly developing a cross-state comparative evaluation plan of the implementation and impact of ME and VT's child health quality improvement strategies, using the pediatric PCMH model. The evaluation team will use a team approach to develop and implement the evaluation plan.</p> <p>Another example of collaboration with distinct roles pertains to Category E: Create a Model Targeting Health Care, Delivery, Coordination, Quality, or Access. Vermont plans to expand the National Improvement Partnership Network (NIPN) as part of Category E. Maine is one of the states intending to develop an Improvement Partnership and will benefit from Vermont's expertise in this area.</p>
<p>Briefly summarize the activities planned</p>	

<p>for each grant category to be addressed by the demonstration. See reference materials in Appendices 1-5.</p>	
<ul style="list-style-type: none"> • Category A (Performance Measures) 	<p>Maine will use Category A funds to enhance the state’s current quality performance measurement and incentive payment systems by developing and implementing a set of pediatric quality measures that includes the core child health quality indicators under development by CMS and Agency for Healthcare Research and Quality (AHRQ), and additional measures identified by IHOC stakeholders. As many of the draft core measures require clinical data versus claims, this work will be integrally tied to work proposed under Category B to automate EPSDT <i>Bright Futures</i> reporting and data warehousing. As described in Category C, core and other measures will be integrated into metrics used by the pediatric practices participating in the Maine PCMH Pilot, to inform their quality improvement and practice transformation efforts. Maine envisions that by expanding the list of measures collected, aligning them with federal standards, and facilitating their use by MaineCare and other payers, providers, and consumers, it will reduce unnecessary variation in pediatric care and improve the health of low-income and other children in Maine.</p> <p>By working collaboratively with existing quality initiatives in both the public and private sectors we seek to incorporate these quality measures (once collection has proven to be feasible) to inform quality improvement of pediatric care across all payers. Our goals are that, by the end of the five-year demonstration, MaineCare and other payers will include more child-related evidence-based quality measures in their payment methods, there will be timely and actionable quality performance feedback to medical providers serving children to inform practice-level quality improvement, and transparency and consumer choice will be increased by making these quality measures publicly available through the MaineCare program, the Department of Health & Human Services web-based reporting platform, and other statewide quality improvement efforts. Through our partnership with Vermont, we will inform Vermont’s and national efforts to replicate the adoption of the core measures in states that are both currently using quality metrics for payment and states that have not yet developed such systems. By Years 4 and 5, Vermont will review Maine's work in collecting and reporting on the initial core measures set and determine the feasibility and utility of collecting the data necessary to capture some core measures through the <i>Blueprint for Health</i> central registry (DocSite).</p> <p>In addition to aligning the clinical quality measures (CQMs) across IHOC and the Maine PCMH Pilot with the CMS EHR Incentive program’s “meaningful use” measures, we also have agreement from key stakeholders that we need to identify a common system for collecting these CQMs from providers, ideally capturing them directly from certified EHR systems so that the data collection is embedded in existing provider workflows. While we have not fully identified this data collection system as yet, we anticipate that IHOC quality data will be collected through Maine’s designated health information exchange and managed through an integrated system for multiple purposes, including those of our IHOC development activities, MaineCare’s management of meaningful use, and statewide collection and management of quality data. Through our work in Maine IHOC and the related PCMH Pilot, we plan to continue these discussions and anticipate identifying a viable system for this data collection within the next 12-18 months.</p>

	<p>We look forward to working with the Centers for Excellence sites in identifying behavioral health measures that Maine may pilot collection of within selected providers.</p>
<ul style="list-style-type: none"> • Category B (Health Information Technology) 	<p>Maine and Vermont propose to advance a shared mission to expand the use of the states' health information technology (HIT) and health information exchange (HIE) capacity and resources to promote child health quality improvement and the health of their children. Both Maine and Vermont are working toward a vision of a fully implemented HIT system that provides evidence-based, real-time data on quality measures to clinicians, state agencies, social service providers, and policy makers so that prevention and treatment resources are efficiently deployed in ways that produce measurable improvement in child health and well-being. Each state will tailor its approach to its unique environment with Maine using a phased-in approach to work towards a fully implemented HIT system. Both states envision sharing with other states, particularly those with substantial rural populations, their experience and lessons learned about the challenges and best practices of HIT/HIE development and deployment for child health care quality improvement. To this end, Maine and Vermont each propose objectives to enhance their HIT infrastructures in ways that complement current and proposed HIT initiatives (e.g., ARRA HIT grants) and that will improve the flow and use of child health quality information. In Vermont, this involves expanding the current state HIT infrastructure to support the expansion of the <i>Blueprint for Health</i> to pediatric populations. Maine will augment its HIT systems to document children's use of preventive services, and increase early identification and treatment of developmental issues. Additionally, Maine will pilot the automation of a comprehensive health assessment for children in foster care, and track outcomes with the goal of expanding for all children in foster care and other high-risk populations.</p> <p>The Maine HIT/HIE planning efforts have included detailed surveys of Maine's hospital and physician community.</p> <p>The Maine IHOC initiative is focusing its initial health care delivery system improvement efforts on the four pediatric practices in Maine's PCMH Pilot. Baseline information is available on those practices sites including information on their current HIT status – i.e. we know that all four sites have fully implemented EHRs, 2 using GE Healthcare Centricity, and the others using AllScripts/Touchworks and EPIC Systems EpicCare. None have yet demonstrated meaningful use within the CMS EHR Incentive Program, but three sites are part of larger health systems (Eastern Maine, Maine General, and Maine Health) and one is a federally qualified health center. The health systems are all actively working with the Maine Regional Extension Center to demonstrate meaningful use, and expect to do so by the end of CY 2011. Later this year, we will additionally be working with additional primary care practices as part of our efforts to improve EPSDT screening through use of AAP Bright Futures. More detailed analysis and development of the necessary capacity for <i>Bright Futures</i> data collection from those EMR's building off data collected in the state's HIT survey will be performed early in 2011.</p> <p>In Vermont the Blueprint for Health will be expanding into every Hospital Service Area (HSA) with at least two practice sites by July 2011, and will include any willing practice by October 2013. Practice participation in the Blueprint is voluntary. Assignment of a practice facilitator and NCQA assessments are coordinated in each local HSA with Blueprint staff. As a result specific practices had not been targeted for a pilot. The Blueprint has</p>

established protocols with the State of Vermont's Regional Extension Center (REC) to ensure coordination of practice by practice planning for EHR adoption, including using the clinical data repository (DocSite) if no EHR is planned. Meaningful use is a targeted consideration in all these efforts.

Maine's 5 Indian tribal health systems are being targeted as part of Maine's overall HIT/HIE planning and they are active participants, and represented, on the state HIT Steering Committee. Maine Care includes the Health Directors from the 5 tribal health systems in all MaineCare stakeholder groups. We will follow up with them to ensure their participation with IHOC and request their participation on the IHOC State Coordinating.

Vermont has no federally recognized Indian tribes.

Maine's HIT/HIE development efforts are tightly coordinated with its IHOC grant-funded activities. MaineCare's Deputy Medical Director serves on the IHOC project and as chief liaison between Maine's Medicaid Agency and its HIT/HIE planning and implementation effort, the overall state HIT/HIE coordination effort, and HealthInfoNet, which serves both as Maine's single Regional Extension Center and governor-designated statewide health information exchange. Maine's Office of the State Coordinator for HIT is an active member of the IHOC Statewide Coordinating Committee and the IHOC HIT Subcommittee and also works closely with IHOC to ensure coordination, non-duplication, and synergy with all HIT/HIE efforts in Maine.

Currently the State of Maine has a Strategic and Operational Plan for HIE that has been approved by the Office of the National Coordinator for HIT. Within it the State of Maine includes the current adoption of HIT by all providers – Acute, Ambulatory, and others including Indian Health Services. The state has a relatively high adoption rate of EMR. EMR penetration in Maine includes:

- 71% of Large hospitals
- 62% of medium hospitals
- 58% of small hospitals
- 74% of FQHCs
- 100% of Indian Health Centers
- 50% of ambulatory primary care practices

The State Medicaid Health Plan has been drafted with feedback from the Office of the State Coordinator for HIT and HealthInfoNet. The CHIPRA activities for Maine will be included in the upcoming HIE planning activities discussed above to assure that there is synergy and funds are being allocated appropriately.

The IHOC is also leveraging the statewide HIE – HealthInfoNet – to support its efforts. HealthInfoNet is currently exchanging data with 15 of Maine's 39 hospitals, and a number of ambulatory practices. In 2011, HealthInfoNet is connecting fourteen additional hospitals and a number of ambulatory practices to support the exchange of clinical summary records and other critical health information such as medication and laboratory results. The IHOC will leverage the interfaces developed by HealthInfoNet with target practices to expand the data set exchanged by the HIE to include EPSDT data. This way funds can be maximized to develop a solution

	<p>that meets immediate pilot interests but also statewide deployment and sustainability.</p> <p>Vermont's Medicaid EHR Incentive Program (EHRIP) is currently being planned in the context of our SMHP (State Medicaid HIT Plan). Development of the EHRIP is taking into consideration the Blueprint for Health expansion including the CHIPRA efforts focused on pediatric practices. The REC is actively involved in the development of the SMHP, the EHRIP, and activities with Blueprint for Health.</p>
<ul style="list-style-type: none"> • Category C (Provider-Based Models) 	<p>Through expansions of their PCMH models in this demonstration, Maine and Vermont will advance their shared mission to act as catalysts for practice and health system transformation to high-quality, well-coordinated, and financially sustainable health systems. Vermont will extend the patient-centered medical home and practice facilitation components of the <i>Blueprint for Health Advanced Primary Care Practice model (APCP)</i> to the pediatric population. Maine will work with the four pediatric practices in its PCMH Pilot as well as other high-MaineCare volume pediatric practices in the state to provide pediatric-specific learning initiatives to create network for quality improvement, disseminate pediatric practice standards and foster collaborative learning and practice transformation around child health quality improvement goals. Both states will also evaluate the impact of PCMH implementation in the pediatric population.</p>
<ul style="list-style-type: none"> • Category D (Pediatric Electronic Health Record) 	<p>Not selected by this grantee.</p>
<ul style="list-style-type: none"> • Category E (CMS Priorities) 	<p>Vermont proposes to pursue Category E to assist an additional 20 states (preferably non-CHIPRA Demonstration states and rural states, and in particular Maine as the lead on this grant) in developing a sustainable state Improvement Partnership (IP) to focus on the priorities of this demonstration and to evaluate the IP model as a replicable, sustainable vehicle to effect measureable improvements in the quality of children's healthcare. An Improvement Partnership is defined as a durable state or regional collaborative of public and private partners from across the healthcare system that uses the science of quality improvement and a systems approach to improve healthcare infrastructure and practice. This Category is intended to serve all states. The proposed IP model and national network of IP states, the National Improvement Partnership Network (NIPN), are designed to support within and cross-state collaboration, respectively; accelerate translation of evidence-based strategies to children's healthcare delivery; and provide an innovative approach to test, share, and learn about strategies to reduce redundancies and costs in the Medicaid program while improving access and quality of health care for children. Vermont's experience to date with IPs indicates that states with an IP program will have improved delivery, access, and quality healthcare outcomes for children and families.</p>
<p>How will the activities associated with these categories be integrated?</p>	<p>The activities under Category A, B and C in Maine and B, C, and E in Vermont are closely integrated in that they all are contributing toward both states' overall goal of improving pediatric clinical practice in different settings that serve children.</p> <p>Maine conceptualizes the grant categories as component strategies for achieving practice improvement statewide to improve children's health. For example, work proposed under Category A is shown under the strategies of standardizing pediatric quality measures and making these measures available to providers and the public. Together these strategies are expected to raise awareness about the variability in quality of care statewide, provide baseline expectations, and help inform areas to prioritize for quality improvement and learning session</p>

	<p>topic selection proposed under Category C. Likewise, many of the measures require clinical data not currently available. Thus automating the collection of this data is necessary to produce the measures themselves. The hope is to reduce unnecessary administrative burden and duplicate entry thereby freeing up time available for clinical care. Finally, we plan on piloting the automation of EPSDT and learning activities in both in official PCMH Pilot sites and in other practices working toward medical homes, in order to compare the impact of these projects at different stages of medical home readiness.</p> <p>In Vermont, the inclusion of Bright Futures and other pediatric care guidelines (i.e., asthma, ADHD, and obesity) in the DocSite central registry under Category B will enable pediatric and family practices participating in the Blueprint to track their progress on performance measures over time. Once operational, Blueprint pediatric practice facilitators (Category C) will produce performance reports in DocSite to: 1) assess practices' improvements over time; 2) compare performance across practices within a given hospital service area and across Vermont; and 3) identify areas of focus for quality improvement (QI) activities within each practice. Moreover, a feedback loop will exist between Vermont's Category B and C work so that not only will data coming from DocSite be used to drive QI in practices, but data needs identified in QI efforts (e.g. PDSA cycles) may necessitate addition or modification of data elements and performance measures in DocSite over time. "Separate" activities within a given category will also be integrated. More specifically, pediatric practice facilitators will work with NCQA scorers and use the results of NCQA assessments to help practices improve their level of medical home-ness (Category C). In Category E, Vermont will draw from UVM/VCHIP's experience supporting practices in NCQA recognition, as well as its extensive history of conducting QI in practices, and more recently administering Maintenance of Certification (MOC)-approved QI projects, to help inform the National Improvement Partnership Network's strategic priorities.</p>
<p>What are the expected benefits of integrating these activities in the manner described?</p>	<p>Some of the benefits of integrating the activities are described above in terms of maximizing resources and strategies to achieve the ultimate goal of pediatric practice improvement. In Maine an added benefit of integrating the various activities is that it addresses concerns by providers that this is a separate MaineCare initiative that is occurring on a parallel track with other quality initiatives in which providers are participating in the state. Developing automated data collection, standardizing quality measures, and practice improvement together and aligning these activities with initiatives across health systems in the state will facilitate provider participation. In Vermont, CHIPRA demonstration grant categories align closely with the key components of the Blueprint, allowing Vermont the opportunity to build off of its existing, multi-pronged health reform framework and more rapidly expand the initiative statewide. By building off existing quality structures and working to integrate the project with existing information technology projects currently underway, both Maine and Vermont will provide a more seamless set of resources to providers to support the delivery of quality care while maximizing availability of funds.</p>
<p>In what general ways has the operational plan changed from the original version submitted with the grantee's application?</p>	<p>While we have added more details to the operational plan and accommodated some changes in the environment in both states, the basic components of the original plan have not changed substantially. Both states still intend to implement work in each of the categories for which they originally applied. The specifics of the plans, however, have been modified somewhat to accommodate for policy changes in both states that have occurred since the application was submitted.</p>

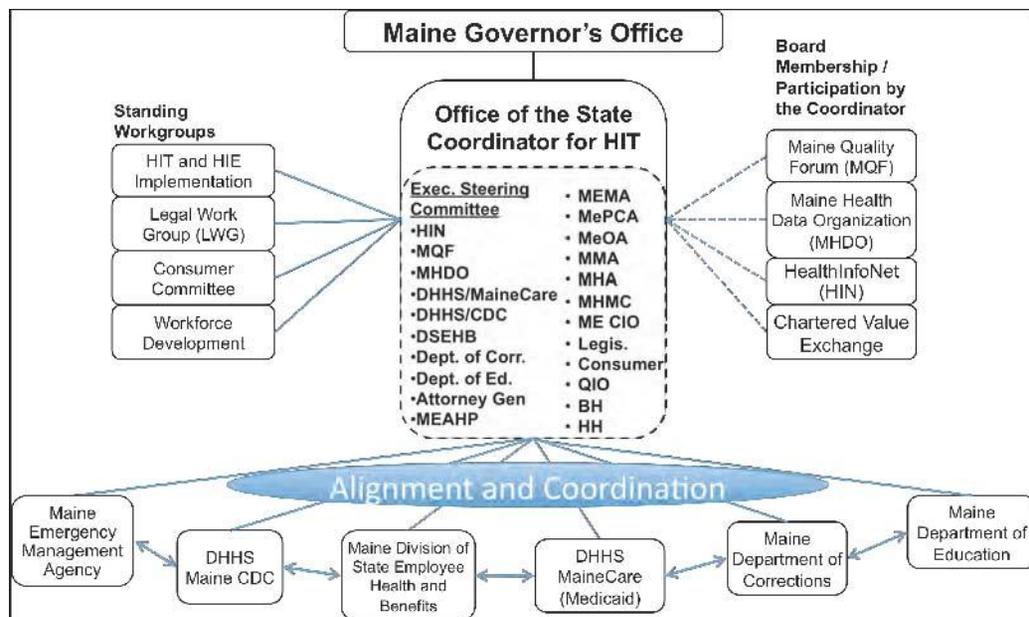
	<p>For example, the 2010 legislative session in Vermont marked major changes to the state’s health reform initiative, the <i>Vermont Blueprint for Health</i>. Vermont Act 128 of 2010 amends previous legislation, defining the <i>Blueprint for Health</i> as a “program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting maintenance, prevention, and care coordination and management.” This change effectively expands the Blueprint Integrated Pilot covering approximately 10% of the state’s population to all Vermont residents. Key benchmarks articulated in the new legislation include:</p> <ul style="list-style-type: none"> - By January 1, 2011, health insurers are required to participate in the <i>Blueprint for Health</i> as a condition of doing business in the state; - By July 1, 2011 the Blueprint must include at least two primary care practices in each of Vermont’s 13 hospital service areas (HSAs); and - By October 1, 2013, expansions must include all willing primary care practices statewide. <p>Originally intended to pilot the Blueprint in the state’s pediatric population, Vermont’s CHIPRA demonstration funding will be used to support the initiative’s expansion to pediatric and family practices serving children statewide. Tasks identified in Tables D and E of this Final Operational Plan reflect the same work that was proposed in the original grant application with slight variances. More specifically, Vermont’s original Objective 1 in Category C, to work with the Blueprint to adapt the Blueprint financial impact model to the pediatric population, and to negotiate multi-payer payment reform to support pediatric patient-centered medical homes and expansion of community health teams to support children’s services, has been accomplished in part through the work of the Blueprint for Health leadership and the Vermont House Health Care Committee. As defined above, multi-payer payment reforms are in effect statewide January 1, 2011. Moreover, the Blueprint financial impact model has been fully constructed to assess care delivery and costs for all Vermont residents and is currently being populated by the state’s multi-payer claims database, VHCURES. With the deletion of this objective, Vermont’s Category C activities have broadened to include an additional piece of the Blueprint expansion, the deployment of practice facilitators to support patient-centered medical home implementation and quality improvement in pediatric and family practices. The final variance represented in Tables D and E is that activities have been set against a more aggressive timeline than originally proposed, reflecting the current expansion goals for the Blueprint.</p> <p>In Maine, a major change that has occurred in the state is that the legislature approved a plan to implement risk-based managed care contracts in the MaineCare program. This has operational implications for Maine’s original proposal in that some quality functions currently managed by the Office of MaineCare Services in its Primary Care Case Management program including pay-for-performance incentive payments to providers may be subsumed under the managed care organizations’ responsibilities. Several members of the CHIPRA steering committee are on the planning committees for the managed care transition and will ensure that the MCOs that the state subcontracts with will be required to provide the data and measures required under CHIPRA Category A and any other measures identified through our planning process as being important for pediatric quality improvement. CHIPRA staff and/or members of the Steering Committee will also participate in the Finance and Operations subcommittees to ensure that requirements of managed care contracts include performance incentives for providers, including participants in the state’s PCMH Pilot who will be receiving additional supports under</p>
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	<p>this grant.</p> <p>During the nine month planning period Maine also has modified its stakeholder engagement plan, redefining its subcommittee structure and membership to maximize participation and the use of participants' time. Initially, Maine proposed convening a Pediatric Quality Council, a Measures & Reporting Subcommittee, a Practice Improvement Subcommittee and an annual Child Health Summit. In the process of convening stakeholders, we discovered that many of the stakeholders of the Pediatric Quality Council, the Measures and Reporting Subcommittee and the Practice Improvement Subcommittee were the same people. There is a large overlap in the pediatric healthcare providers and health systems interested in collecting and reporting results on pediatric measures, and those working on integrating health information technology and quality improvement initiatives. Therefore, we combined the Pediatric Quality Council, the Measures & Reporting Subcommittee and the Practice Improvement Subcommittee into one subcommittee: Measures and Practice Improvement (MPI). Since committee time is limited and to ensure provider involvement and engagement in the development of measures and learning initiatives Maine has also contracted with pediatricians to advise and assist CHIPRA project staff in identifying <i>Bright Future</i> measures to be collected, provide recommendations to the MPI Subcommittee, and support the PCMH Pilot in adopting core measures.</p> <p>Also based on feedback from providers, rather than convening an annual Child Health Summit, we now plan to use existing forums, meetings and other opportunities to effectively communicate learning and elicit feedback. We will consider convening a Child Health Summit(s) if existing means are not adequate.</p>
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Table B

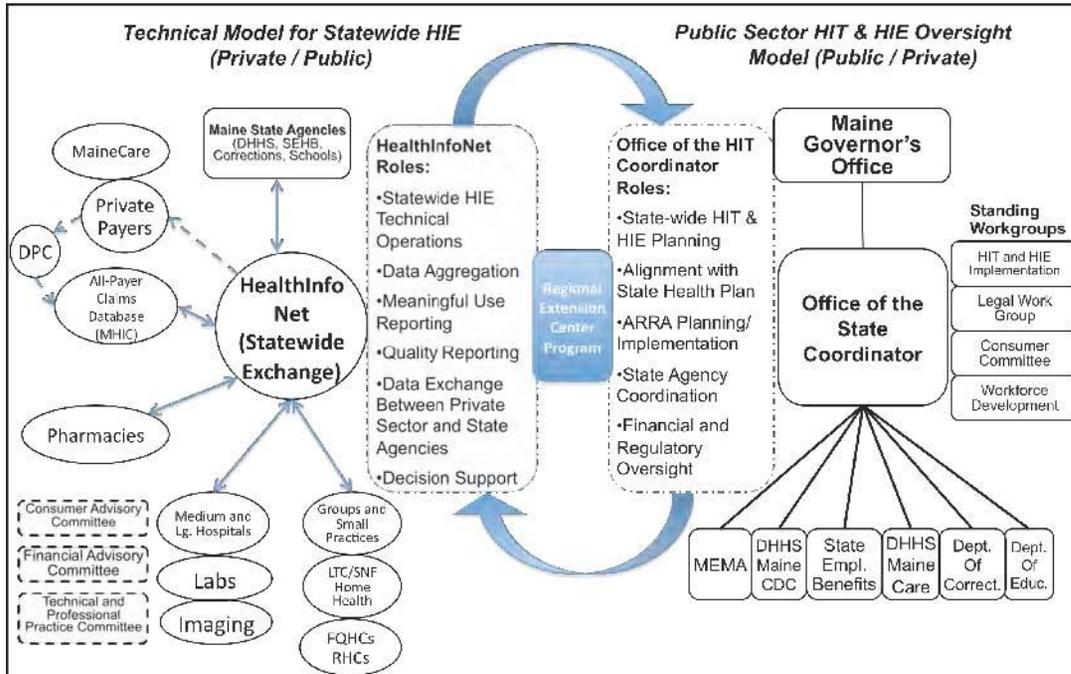
Integration of CHIPRA Quality Demonstration Grant Health Information Technology (HIT) Activity with Other Federal HIT Grants

Maine's Office of the State Coordinator for HIT



Maine's Vision for HIE Governance and Oversight

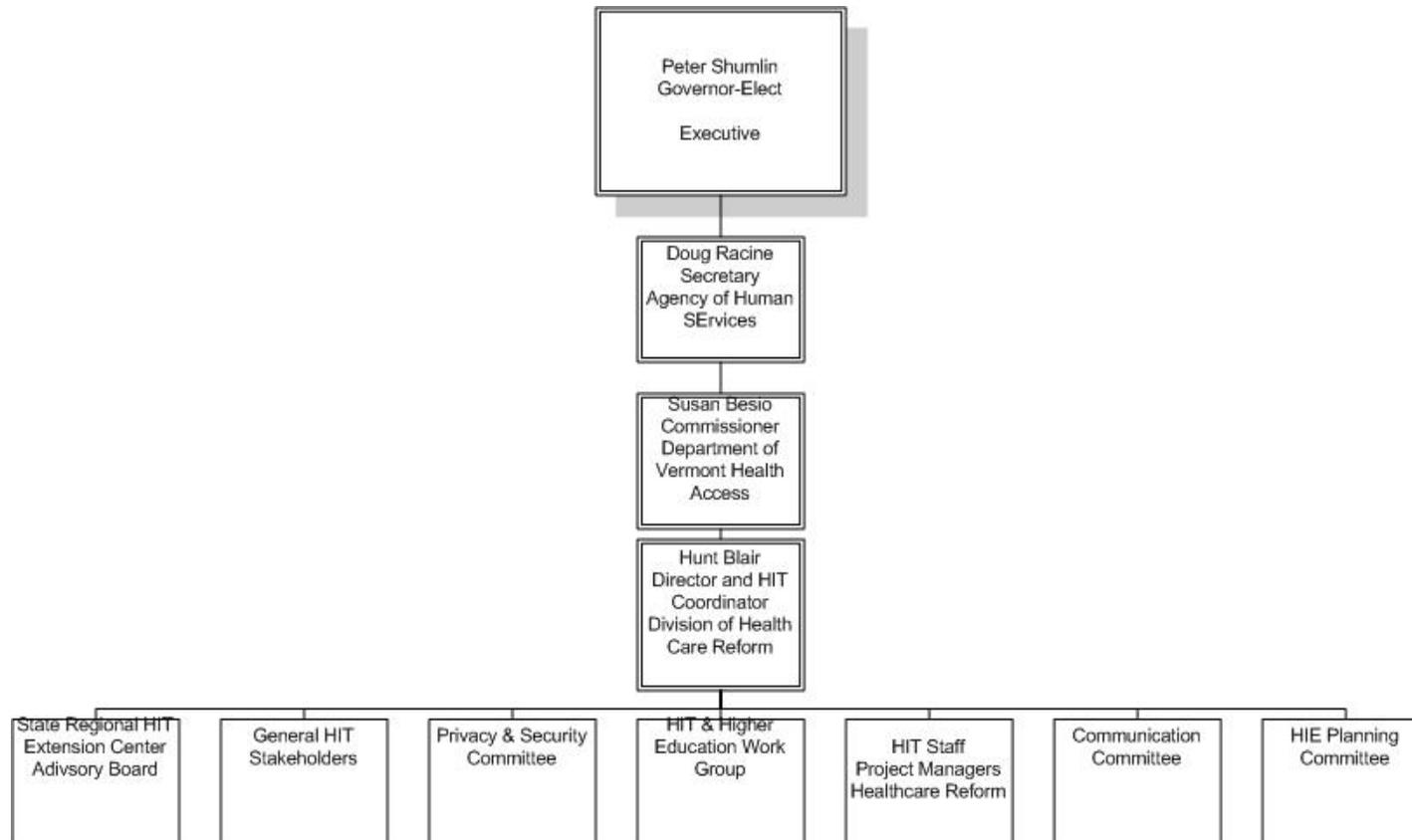
Please refer to Attachment A at the end of this document for more information on Maine's HIT/HIE Governance

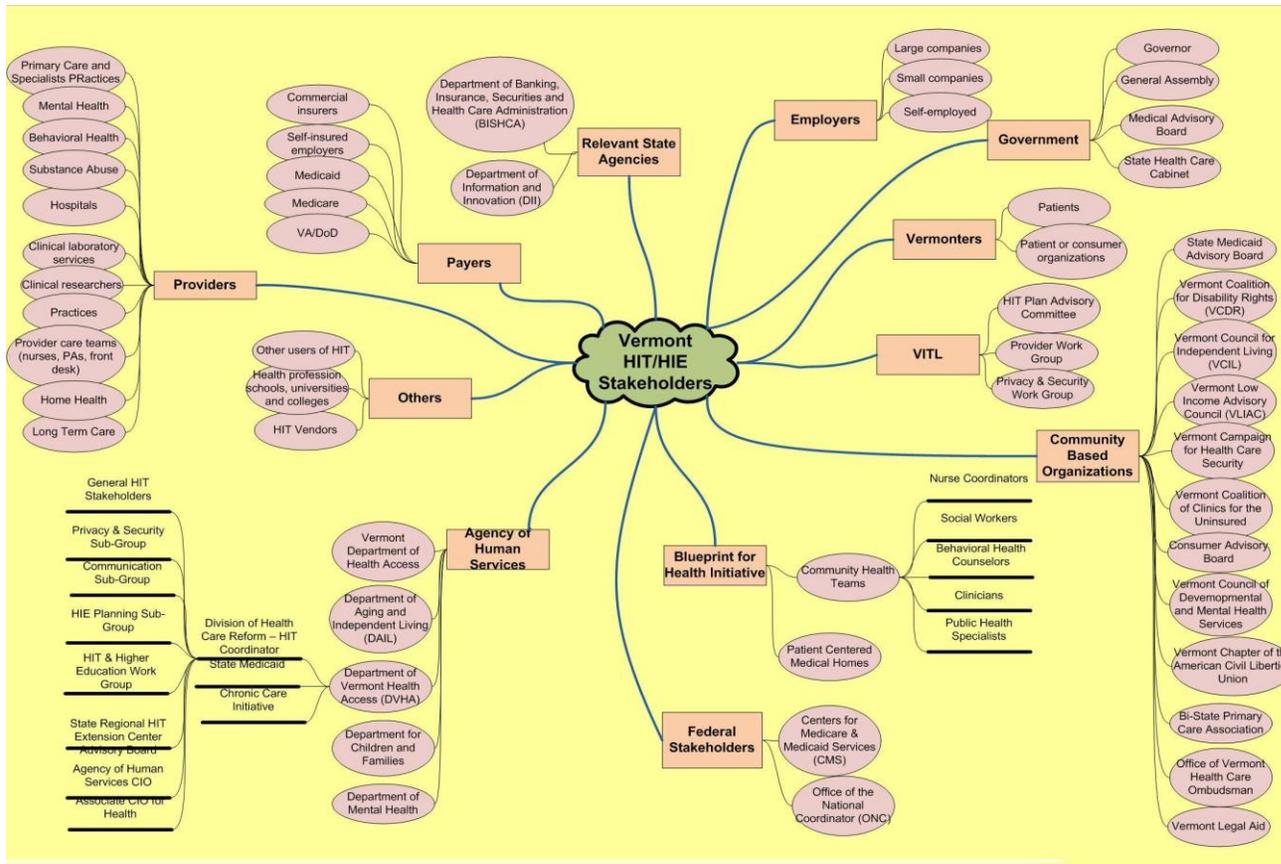


Vermont

Proposed organizational chart and stakeholder diagram below.

Please refer to Attachment A at the end of this document for more information on Vermont's Governance





CMS seeks to avoid duplication of efforts under multiple Federal HIT grant authorities and to promote approaches under which these efforts complement one another. Recognizing this, Maine and Vermont are working to coordinate their IHOC activities with the other HIT initiatives underway in each state. Table B describes the status of HIT activities in each State pertaining to other Federal HIT grants, including provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), and how these activities complement IHOC objectives and will achieve synergy of efforts.

<u>State (specify Lead or Partner)</u>	<u>Grant Authority for Other HIT Federal Grant</u>	<u>Description and Status of HIT Activity Conducted under Other Federal Grant</u>	<u>Areas of Overlap with CHIPRA Quality Demonstration Grant (by Category)</u>	<u>How HIT Activities Will Be Coordinated</u>
Maine	ONC: Health Information Technology/ Exchange	<ol style="list-style-type: none"> 1. Enable the transformation: In adherence to federal guidelines for meaningful use of HIT, by 2015, all providers in Maine will have an EHR pursuant to National Standards and will be sharing appropriate clinical and administrative information through HealthInfoNet, the statewide health information exchange organization, to promote high quality and cost effective healthcare. 2. Security and Privacy: All healthcare information shared and stored electronically will adhere to the most strict privacy, security, and confidentiality requirements as defined by the collaborative work of HIN, the State Government (including the Attorney General) and where possible the guidelines provided through federally supported projects such as the HISPC (discussed above). 3. Patient focused health: By 2015 all people of Maine will have secure electronic access to comprehensive healthcare information and will be assured that if they consent to participate in HIE, their providers will also have comprehensive access to their clinical information to guarantee the most informed decision making at the point of care. 4. Improve the quality of care: By 2015, all providers serving individuals and populations in Maine will achieve federal meaningful use guidelines, improve performance, and support care processes on key health system outcomes measures. 5. Coordination of care: Beginning in 2010 and phased in through 2015, the statewide health information organization, HealthInfoNet, will deploy statewide health information exchange services, connecting all providers, payers, laboratories, imaging centers, pharmacies, public agencies and 	There is potential overlap between provider practices and the HIE vendor that are part of organizations adopting, implementing, and pursuing meaningful use. Project management strategies will need to be coordinated to assure the most efficient linkages to the HIE. There is opportunity for efficiency through coordination. Privacy and security strategies that are being developed complement the CHIPRA plan.	<ol style="list-style-type: none"> 1. Active participation of the HIT Coordinator in CHIPRA management and planning meetings. 2. Updates of CHIPRA activities by a MaineCare representative at monthly HIT Steering Committee meetings. 3. Regular (not less than monthly) meetings between the CHIPRA Program Manager and HIT Coordinator to compare work plan progress.

		<p>other relevant stakeholders. These services will allow for the appropriate, secure, and private exchange of relevant personal health information to the point of care for all Maine people consenting to participate, assuring that their healthcare is coordinated among all primary care and specialty providers.</p> <p>6. <i>Benefit public and population health:</i> HIE activities in Maine will be aligned at every level possible through the Office of the State Coordinator for HIT (OSC) to assure that the data collected, where appropriate, is used to improve population health. As discussed above, statewide HIE services are critical for required disease reporting, biosurveillance, public health tracking (immunization IMPACT etc.), as well as population support functions of the Maine CDC.</p> <p>7. <i>Promote public-private cooperation and collaboration:</i> All health information technology and exchange activities will be developed and overseen through structures that promote cooperation and collaboration among all public and private stakeholders, building upon existing partnerships developed throughout the history of HIE in Maine and in recognition of the specific public sector regulatory, accountability and fiscal functions.</p> <p>8. <i>Promote efficiency and effectiveness of healthcare delivery:</i> Recognizing that HIT and HIE are tools, evaluation metrics will be iteratively developed and promulgated across the healthcare system of Maine to assure that HIT tools are used appropriately to the benefit the people of Maine.</p>		
Maine:	ONC: Regional Extension Center:	Assist providers across the state of Maine with a comprehensive set of technical assistance services and direct support offerings designed to ensure the successful implementation and meaningful use of Electronic Health Records (EHRs) for the purposes of health care quality improvement.	Workflow redesign, EMR implementation, and meaningful use reporting services are likely to be complementary as opposed to overlapping.	Key IHOC Steering Committee members participate on the Regional extension Center steering committee allowing coordination of effort and to address any duplication of effort that might occur.

Maine:	ONC: Bangor Beacon Community Program	To implement and evaluate the impact of a Care Management Model that coordinates care management services from primary care and mental health, and telehomecare services for high risk/high cost chronic disease patients.	There is little likelihood of overlap and duplicative service to be performed in both the Bangor Beacon Community and the IHOC program as the populations of focus tend not to overlap significantly, with the Bangor Beacon focused on chronic diseases.	The HIT Coordinator sits on the Executive Steering Committee of the Bangor Beacon Community and the IHOC Steering Committee and has committed to addressing duplicative efforts should they occur.
Maine:	CDC: improvements to Maine's public health system	Complete an electronic death certificate system; make necessary updates to an electronic birth certificate system; build systems to allow health care providers to more easily transfer information on immunizations to Maine CDC; apply public health performance management principles in Maine CDC and its work; improve capacity for health planning at the state and district level; and make public health data more accessible.	There is no overlap in the work being planned by the MECDC in the immunization registry. Immunization registry IT functions are being modified for statewide infrastructure to support goals of MU and public health. There is no overlap in the scope of work related to updates to the vital record systems, but there may be opportunity to leverage that work. Specifically, members of the IHOC Steering Committee and staff have met with the MECDC to provide input on planned updates to the electronic birth certificate system, exploring the possibility of adding or modifying fields that could serve as a source of data for several of the perinatal CHIPRA quality measures in the new system.	Office of Information Technology, the HIT Coordinator, MECDC, and MaineCare representatives participate in the IHOC Steering Committee where reviews of work are discussed. Additionally there are regular (weekly and bi-weekly) meetings with OIT and the HIT Coordinator organized by the IHOC Project Manager to review plans and work of the various agencies against the work plan.

Maine	HHS: The Telehealth Network Grant Program	The program provides technical assistance to help healthcare organizations, networks and providers implement cost-effective telehealth programs serving rural and medically underserved areas and populations. The program is designed for entities with a successful track record in helping to develop sustainable telehealth programs	There is no direct overlap for funded activities that would be duplicative through the telehealth workgroup or IHOC program.	The HIT Coordinator and members of the IHOC Steering Committee participate in telehealth committees where plans are developed.
Maine	ONC: RECs Support Critical Access and Rural Hospitals	Assist critical access and rural hospitals with their particular needs and challenges. It will build upon the substantial base HHS has already built to provide assistance to health care providers throughout the country as they transition to EHRs. By converting to certified EHR technology, these facilities can qualify for substantial additional incentive payments from Medicare or Medicaid.	There is little overlap in the scope of work other than connections to the HIE and enabling MU through REC assistance with those hospital owned practices that participate with the hospital in an IT system.	The HIT Coordinator participates on the executive committee of both the Maine regional extension Center and the IHOC Statewide Coordinating Committee.
Vermont	ONC: Section 3013 HIE Coop Agreement	Planning and implementation related to state Health Information Exchange.	Supports connectivity of CHIPRA funded development of Blueprint Medical Home sites to state HIE.	Vermont's State HIT Coordinator is also the Director of the Division of Health Care Reform at DVHA and also has responsibility for development of State Medicaid HIT Plan and coordination with the expansion of Blueprint Medical Homes and all HIT-HIE initiatives. Serves on the IHOC Vermont Coordinating and cross-state Executive Committees.
	CMS: Section 4201 HIT PAPP / IAPP	Supports administration and oversight of Medicaid provider incentive program, adoption of EHR technology and HIE.	Supports provider adoption, implementation and meaningful use of HIT.	Vermont's State HIT Coordinator is also the Director of the Division of Health Care Reform at DVHA and also has responsibility for development of State

				Medicaid HIT Plan and coordination with the expansion of Blueprint Medical Homes and all HIT-HIE initiatives. Serves on the IHOC Vermont Coordinating and cross-state Executive Committees.
	HRSA: Health Center Controlled Network grant (to Bi-State Primary Care Assoc.)	Expansion of Vermont FQHC network to / integration with the HIE and Blueprint initiatives.	Complementary, aligned approach to expansion of Blueprint Medical Homes and statewide HIE connectivity, practice facilitators, and implementation of clinical registry.	Vermont's State HIT Coordinator is also the Director of the Division of Health Care Reform at DVHA and also has responsibility for development of State Medicaid HIT Plan and coordination with the expansion of Blueprint Medical Homes and all HIT-HIE initiatives. Serves on the IHOC Vermont Coordinating and cross-state Executive Committees.

Table C

Elements of CHIPRA Quality Demonstration Grants that Advance CMS Priorities

In developing and testing systems of high-quality care for children, Maine and Vermont are including activities that will promote improved service delivery in areas of shared interest, with the aim of producing best practices that can serve as models for other States. CMS has requested that, to the extent possible, grantees align their efforts with specific goals related to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services, obesity screening and treatment, oral health, and behavioral health. Table C describes how IHOC activities in Maine and Vermont will advance CMS’s goals in these areas.

CMS Priority	Grantee/Partner State	Description of Initiative	How Initiative Will Be Integrated into Demonstration	Expected Outcome(s)
EPSDT Service	Maine	<ol style="list-style-type: none"> 1. Automate Bright Futures 2. Improve Implementation of Bright Futures 3. Track EPSDT/Bright Futures Measures 	<p>Automate Bright Futures-connect databases that collect data relevant to EPSDT screenings; implement Bright Futures toolkit and do training around screenings for development, autism, maternal depression, etc; Work with the state EPSDT Committee to educate providers about EPSDT services.</p> <p>Members of the state EPSDT committee have identified several preventive health measures that they would like tracked by primary care providers including hearing, vision, obesity, and dental. These measures are being incorporated into the clinical quality measures for the pediatric practices in the Maine PCMH Pilot and will be</p>	<ul style="list-style-type: none"> • Improve rate of EPSDT screenings in the state of Maine over the next 4 years If we can improve reporting and capture clinical care already being performed by integrating the HIT efforts, the rates may show an initial increase on their own. In order to see a steady improvement of rates over time, we will need to do education with the physicians, practices, and work with families. In addition, to the extent that managed care contracts include financial incentives for EPSDT/BF screens this is also likely to improve screening rates by providers. • Increased provider awareness about EPSDT requirements • Increased screening for

	Vermont		clinical Microsystems methodology to provide ongoing coaching and support to practice teams for improvements in office processes and care delivery. It is anticipated that weekly meetings will be held for the first 10 weeks that practice facilitators work with practice team members; after this initial period, meetings will occur once per month.	Bright Futures and collect on performance measures through the DocSite registry.
Obesity	Maine	Track BMI%	Track BMI with Bright Futures encounter forms and create electronic system to track nutrition and physical activity counseling; consider working with Let's Go (Maine Medical Center/MaineHealth's Child Obesity Prevention Program) and the 5-2-1-0 initiative in Maine on training around obesity with providers. Maine Medical Center/Let's Go has a NICHQ/HRSA grant on obesity where they are hoping to run an IHI style learning collaborative over the next 18 months with 50 groups nationally, recruiting some groups in Maine. We are hoping to work with them to spread their efforts although we do not expect to be leading them at this time. The Maine Youth Overweight Collaborative is over 3 years old in the state and has done extensive work with the practices.	<ul style="list-style-type: none"> • Collect BMI and assess number of children with MaineCare who are overweight/obese • Increase screening and counseling for nutrition and physical activity • Identify community and medical resources to help families work on issues around obesity.
	Vermont	Obesity is a focus in both children's preventive services and Vermont's chronic care initiative. UVM/VCHIP, with support from DVHA and the Vermont Department of Health, has conducted a quality improvement project with six primary care practices to improve body mass index (BMI) measurement and intervention. In another collaborative project between DVHA, UVM/VCHIP, Vermont	Obesity performance measures	<ul style="list-style-type: none"> • Pediatric and family practices participating in the Blueprint will receive support to implement the obesity guidelines and collect on obesity performance measures (including the HEDIS measure) through the DocSite registry.

		<p>Department of Health, Department of Banking, Insurance, Securities and Health Care Administration (VT's regulatory agency), BlueCross/ BlueShield, MVP, and CIGNA, 34 pediatric and family medicine practices improved BMI measurement for teen age youth. Methods used in these successful efforts could be expanded to the additional pediatric and family practices signing onto the Blueprint.</p>	<p>will be built into the DocSite central registry. Additionally, pediatric practice facilitators will provide support to practices to implement the obesity guidelines in Vermont.</p>	
Oral Health	Maine	<p>Report on CHIPRA measures and CMS 416 around oral health.</p>	<p>Will track oral health measures; create awareness around EPSDT dental measures; coordinate efforts on improving dental care in state with From the First Tooth Program and Maine Oral Health Program. The First Tooth Program located in MaineHealth has funding from the Harry and Sadie Davis Foundation to do practice improvement around dental care and fluoride varnish. They do site visits, have a physician champion, and provide training throughout the state. The Maine Kids Oral Health Partnership also provides leadership on pediatric dental issues and training around fluoride varnish. We would hope to spread the word about these programs with the practices, but do not expect to be doing the actual practice improvement work in this area since</p>	<ul style="list-style-type: none"> • Increase oral health risk assessment screening • Track number of children who have identified a dental home and work to increase available services • Increase fluoride varnish application for children receiving dental services • Improve collaboration between the medical and dental communities.

	Vermont	<p>Oral health is an integral part of the implementation of Bright Futures and will therefore be included in the implementation of the guidelines in Vermont. It is a particular focus for pediatricians and family physicians for young children birth through age 3. Additionally, an oral health risk assessment tool has been developed and tested nationally and will be available for use by pediatric and family practitioners.</p>	<p>established groups already exist.</p> <p>The Bright Futures performance measure “oral health risk assessment was conducted by 12 months” will be built into the DocSite registry. Additionally, pediatric practice facilitators will provide support to practices to implement the Bright Futures standards, inclusive of oral health.</p>	<ul style="list-style-type: none"> • Pediatric and family practices participating in the Blueprint will receive support to implement the oral health guidelines and collect on oral health performance measures through the DocSite registry.
Behavioral Health	Maine	<ol style="list-style-type: none"> 1. Automation of Foster Care Health Assessment 2. Look at feasibility of behavioral health measures 	<p>Part B: Automating Foster Care Comprehensive Health Assessment; Part C: Considering practice improvement initiatives around integrating behavioral health in primary care in years 3-5.</p>	<ul style="list-style-type: none"> • Increase primary care provider’s understanding of the foster care system and behavioral health needs of these children. • Increase access to records of children in foster care to families and providers • Improve patient’s access to behavioral health services in their PCMH • Create closer collaboration between medical and behavioral health communities by involving experts from both communities in the selection and piloting of behavioral health measures in primary care practices as part of the demonstration.

	Vermont	Behavioral health/ mental health screening is part of the Bright Futures guidelines for school age children and adolescents. Additionally, maternal depression screen is the <i>Bright Futures</i> standard for children less than 6 months of age.	The Bright Futures performance measures for behavioral/mental health will be built into the DocSite central registry.	<p>In addition, behavioral health may be the focus of one of the learning collaboratives once measures have been collected to see where performance needs improvement. We plan to convene primary care and mental health experts to help build collaborative efforts in these areas.</p> <ul style="list-style-type: none"> • Pediatric and family practices participating in the Blueprint will receive support to implement the behavioral/ mental health and maternal depression screen and collect on the associated performance measures through the DocSite registry.
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Table D

Grant Implementation Milestones – Master Timeline

The implementation plan described in Tables D and E serves as a detailed road map for the full lifespan of the IHOC grant and describes the individual tasks needed to conduct the demonstration from February 22, 2010 (notice of award) through April 21, 2015 (final report due). This plan describes, in sequence, the key milestones overall and for each category that will be necessary to implement the demonstration. Among the milestones included is submission of the deliverables required by CMS and listed in Appendix 9.

Please note that each task listed in Table D has subtasks or interim steps listed in Table E. We have noted the corresponding subtask for each task in the remarks section below.

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-1.0	Task 1: Develop organizational structure for demonstration grant	Feb-10	Dec-10	Governance, staffing, and management structure and delineation of roles and responsibilities for the grant will be agreed upon by both states.	IHOC EC	Maine-based Project Director and Project Assistant hired. VT Project Manager position posted. Cooperative agreement between MaineCare and USM-Muskie School signed. Subcontract with State of VT signed. UVM subcontract still under review. IHOC EC, ME SCC, and VT SCC were all convened during planning period. For more detail, please refer to subtasks 1-1.1 through 1-1.5 in Table E
1-6.0	Task 6: Complete CHIPRA Grantee Deliverables for CMS (includes SF-269 expenditure reports, SF-424a annual budget presentations, progress reports, and Final Report)	Feb-10	Apr-15	CMS receives timely information needed to monitor the progress and expenditures of the grant.	OMS, MSPS, VCHIP, DVHA	Expenditure report for 6-month period ending 8/22/2010 completed. For more detail, please refer to subtasks 1-6.1 through 1-6.25 in Table E

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-8.0	Vermont Task 8: Expand the <i>Vermont Blueprint for Health</i> central registry (DocSite) to support guideline-based care, performance measurement, population management, and coordination with community-based services for the pediatric population	Mar-10	Feb-15	DocSite central registry includes data elements and performance measures to support quality care for the pediatric population	Blueprint/DVHA, VCHIP	<p>DocSite is the vendor for the <i>Vermont Blueprint for Health</i> central registry.</p> <p>For more detail, please refer to subtasks B-8.1 through B-8.8 in Table E</p>
C-1.0	Maine Task 1: Identify the measures to focus practice improvement efforts, and invite pediatric practices in the PCMH Pilot to test.	Jun-10	Mar-11	Cross-listing of CHIPRA, Bright Futures, and meaningful use measures. Final list of pediatric measures for practice improvement. Awaiting final CHIPRA measures specifications	MPI, MSPS, ME CDC, OMS, MPI, QC	<p>PCMH Pilot pediatric practices are not required to collect CHIPRA measures as part of the PCMH Pilot; however, they are active participants in the CHIPRA MPI Subcommittee and are collaborators. All 4 PCMH pediatric pilot sites will participate in IHOC. The Maine PCMH Pilot preexisted CHIPRA in the state- they are 1.5 years into a 3 year pilot so they are already working on a set of pediatric quality measures for their EMR collection ahead of many of the national deadlines for CHIPRA.</p> <p>We hope to align as many measures as possible and expect when national pediatric quality measures set is finalized that the PCMH may have to adjust over time to new measures.</p> <p>For more detail, please refer to subtask C-1.1 in Table E</p>

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-3.0	Task 3: Finalize Final Operational plan (FOP)	Jun-10	Nov-10	Final Operational Plan completed in compliance with grant requirements	IHOC EC	Completed. Reviewed draft plans with ME SCC and with IHOC Exec Committee prior to submission. For more detail, please refer to subtasks 1-3.1 through 1-3.3 in Table E
1-2.0	Task 2: Finalize evaluation plan and implement plan throughout the grant period	Jun-10	Feb-11	Evaluation plan completed and included in Final Operational Plan delivered to CMS	MSPS, VCHIP	Logic/Conceptual Models developed by ME & VT, reviewed and revised by ME SCC and MPI, and submitted to national evaluators. For more detail, please refer to subtasks 1-2.1 through 1-2.5 in Table E
A-4.0	Maine Task 4: Identify barriers and explore solutions to implementation process	Jun-10	Jan-13	Barriers to implementation of Core Measures identified with possible solutions	MSPS, OMS, ME CDC	Impact of Managed Care implementation unknown at this time. For more detail, please refer to subtasks A-4.1 through A-4.2 in Table E
A-2.0	Maine Task 2: Identify data sources for collecting the CHIPRA core measures	Jul-10	Jun-11	Sources and collection strategy will be identified for each measure.	MSPS, OMS, ME CDC, MPI	Completed CHIPRA Baseline Measures Report in August 2010. Identified status (currently available or to be developed) and source (claims, discharge data, immunization registry, etc.) for the initial core measures. Report will be updated once final core measures are released. For more detail, please refer to subtasks A-2.1 through A-2.3 in Table E

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
A-3.0	Maine Task 3: Collect & review CHIPRA, CMS - 416(EPSDT), and other identified measures	Jul-10	Jan-13	CHIPRA and other identified measures are constructed and available for reporting.	OMS, MSPS	<p>Specifications for 13 of 14 claims-based initial core measures have been reviewed and programmed. Waiting for release of final core measure specifications to begin work on remaining measures.</p> <p>For more detail, please refer to subtasks A-3.1 through A-3.11 in Table E</p>
A-1.0	Maine Task 1: Engage and convene Measures and Practice Improvement (MPI) Subcommittee (including pediatricians, family physicians, pediatric nurse practitioners, physicians assistants, and pediatric healthcare professional organizations) and the State Coordinating Committee (including child & family advocates, public & private payer, QI, health systems	Jul-10	Feb-15	Stakeholders participate in the MPI and provide feedback throughout process of measure implementation.	MECDC, OMS, MSPS	<p>Maine SCC and the MPI Subcommittee have both met several times since 7/10. Outreach efforts were successful, and membership includes representatives from targeted organizations.</p> <p>Lesson learned: minimize number of committees to increase participation and reduce stakeholder burnout as membership often overlaps.</p> <p>For more detail, please refer to subtasks A-1.1 through A-1.2 in Table E</p>
C-2.0	Maine Task 2: Implement the Bright Futures Toolkit with child health providers and assess impact on EPSDT services in Maine	Sep-10	Jan-13	Increased use of evidence-based EPSDT tools and improved quality of pediatric primary care	MPI, MSPS, ME CDC, OMS, QC	<p>About 50% of pediatric groups have EMRs; there is no national EMR that has Bright Futures already fully incorporated into programming so many EMRs are doing local changes but need to be aware of copyright issues so this is challenging and time consuming for practices. Currently Bright Futures forms are paper based. Several of the screening forms for</p>

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
						developmental delay (PEDs, ASQ) will cost practices additional money. For more detail, please refer to subtasks C-2.1 through C-2.8 in Table E
A-5.0	Maine Task 5: Align MaineCare payment/ financial incentives with pediatric quality measures	Sep-10	Dec-14	Financial incentives for pediatric measures are aligned.	MPI, SCC, ME CDC, OMS, MSPS	For more detail, please refer to subtasks A-5.1 through A-5.4 in Table E
B-2.0	Maine Task 2: Design, implement & evaluate an electronic health assessment supporting children in Maine's foster care system	Sep-10	Dec-14	Electronic health data system for foster children developed and tested.	OIT, ME CDC, OMS, MSPS MPI, SCC	Review of other State's foster care health data systems completed. The review assisted the workgroup in assessing feasibility of their plan, and considering what data systems Maine might include and who should have access. Staff has also followed up with states to gather specific measures for consideration in Maine's system For more detail, please refer to subtasks B-2.1 through B-2.9 in Table E
C-3.0	Maine Task 3: Develop a Pediatric Improvement Partnership that supports learning communities and quality improvement initiatives (links to Task 1-4.0 and VT Task E-1.0)	Sep-10	Jan-15	Alignment and integration of QI initiatives assist and support pediatric providers to improve quality of care for targeted conditions	QC, MPI, MSPS, ME CDC, OMS, UVM/VCHIP	For more detail, please refer to subtasks C-3.1 through C-3.7 in Table E

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-4.0	Task 4: Create a Pediatric Improvement Partnership (IP) in Maine	Sep-10	Feb-15	Grant activities are aligned with and integrated into existing pediatric quality improvement efforts.	UVM/VCHIP, ME CDC, OMS, MSPS	Completed Maine Pediatric Quality Improvement Inventory (directory of Maine-based organizations and data systems related to pediatric QI). Outreach to QI initiative representatives underway. For more detail, please refer to subtasks 1-4.1 through 1-4.2 in Table E
1-5.0	Task 5: Develop and implement a sustainability plan beyond the CHIPRA Demonstration Grant	Sep-10	Feb-15	Infrastructure supporting pediatric quality improvement in place so improvement will be ongoing beyond the CHIPRA grant period.	IHOC EC	For more detail, please refer to subtasks 1-5.1 through 1-5.4 in Table E
B-1.0	Maine Task 1: Collaborate & coordinate with Health Systems & FQHC's to determine interface specifications in order for them to participate in the automation & exchange of EPSDT data (<i>Bright Futures</i>)	Sep-10	Feb-15	Health systems and FQHC's participate in the development and automation of the EPSDT data system	HIN, MPI, OIT, ME CDC, OMS, MSPS	For more detail, please refer to subtasks B-1.1 through B-1.5 in Table E
B-3.0	Maine Task 3: Identify barriers and explore solutions to implementing an electronic health data system supporting children in Maine's foster care system	Nov-10	Feb-15	Barriers to implementation of foster care data system identified with possible solutions	OCFS,OIT, ME CDC, OMS, MSPS,	For more detail, please refer to subtask B-3.1 in Table E

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-9.0	Vermont Task 9: Support utilization of DocSite in pediatric and family practices participating in the Blueprint	Nov-10	Feb-15	DocSite registry is used by pediatric practice facilitators, pediatric/family practice teams and community health team members to support quality care in the pediatric population	Blueprint/DVHA, VCHIP	For more detail, please refer to subtasks B-9.1 through B-9.2 in Table E
B-4.0	Maine Task 4: Determine if we will develop architecture for an interim EPSDT data entry system with capacity to identify payers (for practices who do not have electronic health record system or do not have capacity to capture required measures) and proceed accordingly	Dec-10	Oct-11	Method of capturing Bright Futures data available to practices without EHR's.	OIT, OMS, ME CDC, MSPS, MPI	<p>HIT stakeholders and ME Steering Committee reviewed a proposal to develop architecture for an interim EPSDT data entry system with capacity to identify payers (for practices who do not have electronic health record systems or do not have capacity to capture required measures).</p> <p>HIT stakeholders determined a EPSDT data entry system is already in place and developing an additional means would only serve to create yet another means of manual data entry.</p> <p>The decision was made to focus on developing EHR linkages and practices instead of this task.</p> <p>For more detail, please refer to subtasks B-4.1 through B-4.4 in Table E</p>

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-5.0	Vermont Task 5: Extend the <i>Blueprint for Health</i> integrated health model (or "Advanced Primary Care Practice (APCP) model") in Vermont's pediatric population	Dec-10	Feb-13	Pediatric and family practices serving children in Vermont operate as APCPs and receive payment reforms	Blueprint/DVHA, VCHIP	Blueprint APCP model is comprised of five key components: 1) medical homes; 2) community health teams; 3) payment reforms; 4) HIT; and 5) an evaluation infrastructure. CHIPRA Category C activities focus primarily on the medical home and evaluation infrastructure components. For more detail, please refer to subtasks C-5.1 through C-5.8 in Table E
B-5.0	Maine Task 5: Evaluate Bright Futures implementation	Jan-11	Jun-13	Report documenting lessons learned and results from Maine's implementation experience	MSPS, ME CDC, ME OMS, OIT, HIN	This task was intended to evaluate the interim data entry system for Bright Futures. Since that interim system will not be piloted, this task is eliminated. For more detail, please refer to subtasks B-5.1 through B-5.2 in Table E
C-6.0	Vermont Task 6.: Design and conduct pediatric-specific evaluation to assess impact of the APCP model on care delivery, health status, and healthcare costs	Jan-11	Aug-14	Evaluation report(s) describing the impact of the Blueprint health reforms on identified process and outcome measures in the pediatric population	VCHIP, Blueprint/DVHA	For more detail, please refer to subtasks C-6.1 through C-6.8 in Table E
A-6.0	Maine Task 6: Report results of core CHIPRA measures to payers, providers and consumers	Jan-11	Feb-15	Children's health care quality measures will be available to payers, providers & consumers	OMS, MSPS, ME CDC	For more detail, please refer to subtasks A-6.1 through A-6.6 in Table E
A-7.0	Maine Task 7: Align pediatric measures with meaningful use, and other payers, professional	Jan-11	Feb-15	Payers, professional organizations and specialty groups align pediatric measures.	MPI, SCC, ME CDC, OMS, MSPS	Many providers have reported that a key barrier to collection of measures is that measures required by different payers and government agencies are

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	organizations and specialty groups					not aligned. Not possible for them to collect and/or focus on improving so many different measures. For more detail, please refer to subtasks A-7.1 through A-7.3 in Table E
E-1.0	Vermont Task 1: Assist an additional 20 states in development of a sustainable state Improvement Partnership to focus on the priorities of this demonstration, particularly those not receiving Federal funding under the grant and smaller, rural states	Jan-11	Feb-15	20 additional states develop a sustainable Improvement Partnership	VCHIP, Vermont state partners (DVHA, Vermont Department of Health)	For more detail, please refer to subtasks E-1.1 through E-1.7 in Table E
E-2.0	Vermont Task 2: Continue to support the national network of Improvement Partnership states (National Improvement Partnership Network, or NIPN) through the provision of technical assistance	Jan-11	Feb-15	Operational and sustainable national network which facilitates technical assistance across member states	VCHIP, Vermont state partners (DVHA, Vermont Department of Health)	For more detail, please refer to subtasks E-2.1 through E-2.4 in Table E
E-3.0	Vermont Task 3: Evaluate the implementation, efficiency, and impact of the Improvement Partnership model and national network	Jan-11	Feb-15	Evaluation report(s) describing the Improvement Partnerships/ national network and their impact on healthcare quality	VCHIP, NIPN Evaluation Committee	For more detail, please refer to subtasks E-3.1 through E-3.11 in Table E

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-7.0	(Joint) ME/VT Task 7: Design and implement a comparative cross-state evaluation of the implementation and impact of ME and VT's child health quality improvement strategies using the pediatric PCMH model to complement and inform the national evaluation	Feb-11	Feb-15	Cross State Evaluation	MSPS, UVM/VCHIP	For more detail, please refer to subtasks C-7.1 through C-7.3 in Table E
B-10.0	Vermont Task 10: Utilize and expand DocSite flexible web-based reporting platform to drive improvements in care delivery and guide state health reform	Jun-11	Feb-15	Performance reports on pediatric and family practices participating in the Blueprint	VCHIP, Blueprint/DHVA, DocSite	For more detail, please refer to subtasks B-10.1 through B-10.2 in Table E
B-11.0	Vermont Task 11: Support interface development for guideline-based data elements between DocSite and commercial EHRs for pediatric providers participating in the Blueprint who use an EHR	Sep-11	Feb-15	Mapped data elements between the DocSite central registry and commercial EHR(s)	VCHIP, Blueprint/DVHA, VITL, DocSite	For more detail, please refer to subtask B-11.1 in Table E

Table D

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-6.0	Maine Task 6: Design and implement an integrated electronic data system for Bright Futures (EPSDT in Maine) that links practices' EHR systems to DHHS, pilot with PCMH Pilot pediatric practices and then stage roll out in practices that have a high volume of MaineCare (Medicaid) patients	Jan-12	Oct-14	Integrated electronic Bright Futures data system developed and tested.	HIN, OIT, ME CDC, OMS, MSPS MPI	We intend to pilot this task with the pediatric practices participating in the PCMH Pilot and then expand. To additional practices. For more detail, please refer to subtasks B-6.1 through B-6.2 in Table E
C-4.0	Maine Task 4: Support and expand the evaluation of the PCMH Pilot to focus on pediatric practices and children's health outcomes (Evaluation)	Jan-12	Jan-15	Increased knowledge and use of evidence-based practices. Learning from PCMH Pilots is shared with other pediatric providers.	QC, ME CDC, OMS, MSPS,	For more detail, please refer to subtask C-4.1 in Table E
A-8.0	Maine Task 8: Identify and test new behavioral health measures	Jun-12	Jun-14	Lessons learned from testing of behavior health measures documented.	ME CDC, OMS, MSPS, OCFS	For more detail, please refer to subtasks A-8.1 through A-8.5 in Table E
B-7.0	Maine Task 7: Identify barriers & explore solutions to implementation	Oct-12	Feb-15	Barriers to implementation of BF data system identified with possible solutions	OIT, HIN, PCMH, MPI, ME CDC, OMS, MSPS	For more detail, please refer to subtask B-7.1 in Table E

Table D

* List tasks in sequential order

** Include successes, barriers, delays, lessons learned) for any tasks that have been completed

Table E
Grant Implementation Milestones – by Category (as appropriate)

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-0.0	Organizational Structure	Feb-10	Nov-10			
1-1.0	Task 1: Develop organizational structure for demonstration grant	Feb-10	Dec-10	Governance, staffing, and management structure and delineation of roles and responsibilities for the grant will be agreed upon by both states.	IHOC EC	Maine-based Project Director and Project Assistant hired. VT Project Manager position posted. Cooperative agreement between MaineCare and USM-Muskie School signed. Subcontract with State of VT signed. UVM subcontract still under review. IHOC EC, ME SCC, and VT SCC were all convened during planning period. For more detail, please refer to subtasks 1-1.1 through 1-1.5 in Table E
1-1.1	Finalize cooperative agreement between MaineCare, and University of Southern Maine, Muskie School	Mar-10	May-10	Finalized cooperative agreement between MaineCare and USM, Muskie School	OMS, MSPS	Completed
1-1.2	Develop job descriptions, search committee, and hire personnel for new staff positions	Mar-10	Dec-10	Project Director, ME and VT Managers, and Project Assistant staff will be hired	OMS, MSPS, ME CDC, VCHIP, DVHA	Project Director hired in 7/2010. Project Assistant hired in 9/2010. UVM/VCHIP Manager hired. ME Project Manager position on hold initially to determine priorities, now in process of interviewing candidates. DVHA Project Manager position posted.

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
1-1.3	Sign subcontracts with the State of Vermont and UVM	Apr-10	Dec-10	Signed subcontracts with the State of Vermont (DVHA) and UVM	MSPS, VCHIP, DVHA	State of VT subcontract signed 8/10. UVM subcontract still under review due to differing policies & procedures between institutions. UVM subcontract signed 11/10.
1-1.4	Convene <i>Improving Health Outcomes for Children</i> Executive Committee (IHOC EC), establish membership and convene State Coordinating Committees, and subcommittees, during 9 month planning phase for implementation period	Jun-10	Nov-10	IHOC EC , State Coordinating Committees in ME and VT, and subcommittees convened during the planning period	IHOC EC	IHOC EC convened June, Sept. & Nov. during the planning period. ME & VT SCC convened 3 & 2 times respectively, during the planning process. ME MPI Subcommittee convened July, Aug, Sept. & Oct during the planning period. VT Blueprint/HIT Subcommittee convened 3 times during the planning process.
1-1.5	Establish and define relationship with EPSDT Advisory Council, which includes consumer advocates and a broad range of stakeholders	Sep-10	Nov-10	EPSDT Advisory Council will have an identified role and relationship with the CHIPRA IHOC project	OMS, ME CDC, MSPS	Met with EPSDT Advisory Council and they will join ME's SCC.
1-2.0	Task 2: Finalize evaluation plan and implement plan throughout the grant period	Jun-10	Feb-11	Evaluation plan completed and included in Final Operational Plan delivered to CMS	MSPS, VCHIP	Logic/Conceptual Models developed by ME & VT, reviewed and revised by ME SCC and MPI, and submitted to national evaluators. For more detail, please refer to subtasks 1-2.1 through 1-2.5 in

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
						Table E
1-2.1	Develop conceptual/logic models for grant activities in Maine and Vermont	Jun-10	Sep-10	Logic models completed and sent to national evaluators	MSPS,VCHIP	Logic/Conceptual Models developed by ME & VT and submitted to national evaluators.
1-2.2	Coordinate with national evaluators to ensure no duplication of effort	Sep-10	Jan-11	Meetings convened with national evaluators to review evaluation plans.	MSPS,VCHIP	
1-2.3	Develop initial evaluation plan addressing state-specific questions	Sep-10	Jan-11	Draft evaluation plan produced	MSPS,VCHIP	Including a Cross-State Evaluation Plan
1-2.4	Meet with subcommittees, Steering committee and SCC to share conceptual models, evaluation plan questions and proposed metrics	Jun-10	Jan-11	Meetings held with State Steering Committee and SCC and evaluation plan modified as necessary.	MSPS,VCHIP	ME shared Concept Models with ME SCC & MPI. Revised based on feedback.
1-2.5	Finalize evaluation plan	Oct-10	Feb-11	Evaluation plan submitted to CMS	MSPS,VCHIP	
1-3.0	Task 3: Finalize Final Operational plan (FOP)	Jun-10	Nov-10	Final Operational Plan completed in compliance with grant requirements	IHOC EC	Completed. Reviewed draft plans with ME SCC and with IHOC Exec Committee prior to submission. For more detail, please refer to subtasks 1-3.1 through 1-3.3 in

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
						Table E
1-3.1	Define cross-state process for developing and approving the final OP through IHOC Exec Committee	Jun-10	Sep-10	Cross-state process for developing, drafting, reviewing and revising the FOP defined	IHOC EC	Completed: With input from Stakeholders, Project Director, Project Managers & Project Staff draft; review by ME & VT Steering Committees and IHOC EC.
1-3.2	Convene stakeholder subcommittees, state coordinating committees and IHOC Exec Committee to review and finalize draft operational plans	Jul-10	Nov-10	FOP will have been reviewed by and include input and feedback from stakeholder subcommittees, state coordinating committees and the IHOC EC.	IHOC EC	Completed. Reviewed draft plans with ME SCC on 10/27/2010 and with IHOC Exec Committee on 11/10/2010.
1-3.3	Attain CMS approval of Final Operations Plan	Nov-10	Dec-10	CMS approval of FOP	IHOC EC	
1-4.0	Task 4: Create a Pediatric Improvement Partnership (IP) in Maine	Sep-10	Feb-15	Grant activities are aligned with and integrated into existing pediatric quality improvement efforts.	UVM/VCHIP, ME CDC, OMS, MSPS	Completed Maine Pediatric Quality Improvement Inventory (directory of Maine-based organizations and data systems related to pediatric QI). Outreach to QI initiative representatives underway. For more detail, please refer to subtasks 1-4.1 through 1-4.2 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-4.1	Conduct detailed, statewide inventory of existing and planned healthcare quality initiatives with a pediatric component in Maine to avoid duplication, ensure coordination, and learn from best practices already in place	Jun-10	Sep-10	Maine Pediatric Quality Improvement Inventory produced Understand past and existing quality improvement efforts within the state and how they can dove-tail with the IHOC effort.	MSPS	IHOC project staff and stakeholders had started working on this inventory earlier than was previously reported. Completed. Produced Maine Pediatric Quality Improvement Inventory outlining Maine-based organizations with pediatric QI focus, advocacy organizations, pediatric QI initiatives, and data systems.
1-4.2	Engage QI initiative representatives to participate in a coordinated effort to align the QI initiatives, including those identified in the inventory and Quality Counts, the Maine Health Management Coalition and the Maine Quality Forum	Sep-10	Feb-15	Invite members of different QI initiatives to participate in the MSCC and MPI committees. Get input on how to build successful quality improvement initiatives and how to create a sustainable effort beyond grant period.	ME CDC, OMS, MSPS	Outreach to QI initiative representatives to continue throughout grant period.
1-5.0	Task 5: Develop and implement a sustainability plan beyond the CHIPRA Demonstration Grant	Sep-10	Feb-15	Infrastructure supporting pediatric quality improvement in place so improvement will be ongoing beyond the CHIPRA grant period.	IHOC EC	For more detail, please refer to subtasks 1-5.1 through 1-5.4 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-5.1	Brief Maine’s Governor -elect & leadership team, including the Maine DHHS Commissioner, on the IHOC Project	Jan-11	Dec-11	Maine’s new Governor, leadership team will be briefed on the (CHIPRA) IHOC project	OSC-HIT, OMS, ME CDC	
1-5.2	Create a Maine IHOC Website	Jun-11	Dec-12	Maine IHOC website	OMS, OIT	
1-5.3	Incorporate IHOC measures, reporting, and incentives into Maine’s Managed Care RFP and Plan	Sep-10	Apr-11	Maine’s RFP for Managed Care Organizations will include requirements for MCO’s to participate in CHIPRA IHOC and Patient-centered medical home pilots, CHIPRA/IHOC quality measures included in list that plans report to the state and those that will have payment incentives for quality improvement.	OMS, ME CDC, MSPS	In process
1-5.4	Pursue and obtain funding to sustain IHOC activities beyond the CHIPRA grant period	Jan-13	Feb-15	Additional funding will be obtained to sustain IHOC activities beyond the CHIPRA grant period	IHOC EC	
1-6.0	Task 6: Complete CHIPRA Grantee Deliverables for CMS (includes SF-269 expenditure reports, SF-424a annual budget presentations, progress reports, and Final Report)	Feb-10	Apr-15	CMS receives timely information needed to monitor the progress and expenditures of the grant.	OMS, MSPS, VCHIP, DVHA	Expenditure report for 6-month period ending 8/22/2010 completed. For more detail, please refer to subtasks 1-6.1 through 1-6.25 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-6.1	Submit SF-269 expenditure report, along with any additional detail required by CMS	Sep-10	Sep-10	SF-269 expenditure report submitted to CMS	OMS, MSPS	Completed: For the 6-month period ending 8/22/2010
1-6.2	Submit Final Operational Plan covering categories A,B,C, and E. Include first progress report	Feb-10	Nov-10	FOP and first progress report submitted to CMS	OMS, MSPS, VCHIP, DVHA	
1-6.3	Submit SF-424a annual budget presentation and narrative	Dec-10	Jan-11	SF-424a annual budget and narrative submitted to CMS	OMS, MSPS, VCHIP, DVHA	For Grant Year 2, which begins on 2/22/2011
1-6.4	Submit SF-269 expenditure report, along with any additional detail required by CMS	Mar-11	Mar-11	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS,MSPS	For the 6-month period ending 2/22/2011
1-6.5	Attend CMS-sponsored grantee conference in Washington, DC or Baltimore, MD area	Apr-11	Apr-11	Attendance by grantee project director at a minimum, at CMS sponsored grantee conference in spring of 2011	MSPS, OMS, VCHIP,DVHA	Spring 2011 (Date TBD). At a minimum, grantee project director must attend.
1-6.6	Submit web-based progress report	Jul-11	Aug-11	Web-based progress report submitted to CMS	OMS, MSPS	For period: 1/1/2011 - 6/30/2011
1-6.7	Submit SF-269 expenditure report, along with any additional detail required by CMS	Sep-11	Sep-11	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 8/22/2011

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-6.8	Submit SF-424a annual budget presentation and narrative	Dec-11	Jan-12	SF-424a annual budget and presentation narrative submitted to CMS	OMS, MSPS, VCHIP, DVHA	For Grant Year 3, which begins on Feb 22, 2012
1-6.9	Submit web-based progress report	Jan-12	Feb-12	Web- based progress report submitted to CMS	OMS, MSPS, VCHIP, DVHA	For period: 7/1/2011 - 12/31/2011
1-6.10	Submit SF-269 expenditure report, along with any additional detail required by CMS	Mar-12	Mar-12	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 2/22/2012
1-6.11	Submit web-based progress report	Jul-12	Aug-12	Web-based progress reports submitted to CMS	OMS, MSPS, VCHIP, DVHA	For the period: 1/1/2012 - 6/30/2012
1-6.12	Submit SF-269 expenditure report, along with any additional detail required by CMS	Sep-12	Sep-12	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS, VCHIP, DVHA	For the 6-month period ending 8/22/2012
1-6.13	Submit SF-424a annual budget presentation and narrative	Dec-12	Jan-13	SF-424a annual budget and narrative submitted to CMS	OMS, MSPS, VCHIP, DVHA	For Grant Year 4, which begins on Feb 22, 2013
1-6.14	Submit web-based progress report	Jan-13	Feb-13	Web-based progress reports submitted to CMS	MSPS, OMS, VCHIP, DVHA	For period: 7/1/2012 - 12/31/2012
1-6.15	Submit Standard Form 269, along with any additional detail required by CMS	Mar-13	Mar-13	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 2/22/2013
1-6.16	Attend CMS-sponsored grantee conference in	Apr-13	Apr-13	Attendance by project director at a minimum, at CMS sponsored grantee conference in summer of	MSPS, OMS, VCHIP, DVHA	Spring 2013 (Date TBD). At a minimum, grantee project director must attend.

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
	Washington, DC or Baltimore, MD area			2011		
1-6.17	Submit web-based progress report	Jul-13	Aug-13	Web-based progress reports submitted to CMS	MSPS, OMS, VCHIP, DVHA	For the period: 1/1/2013 - 6/30/2013
1-6.18	Submit Standard Form 269, along with any additional detail required by CMS	Sep-13	Sep-13	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 8/22/2013
1-6.19	Submit SF-424a annual budget presentation and narrative	Dec-13	Jan-14	SF-424a annual budget and narrative submitted to CMS	OMS, MSPS, VCHIP, DVHA	For Grant Year 5, which begins on Feb 22, 2014
1-6.20	Submit web-based progress report	Jan-14	Feb-14	Web-based progress reports submitted to CMS	MSPS, OMS, VCHIP, DVHA	For the period: 7/1/2013 - 12/31/2013
1-6.21	Submit Standard Form 269, along with any additional detail required by CMS	Mar-14	Mar-14	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 2/22/2014
1-6.22	Submit web-based progress report	Jul-14	Aug-14	Web-based progress reports submitted to CMS	MSPS, OMS, VCHIP, DVHA	For the period: 1/1/2014 - 6/30/2014
1-6.23	Submit SF-269 expenditure report, along with any additional detail required by CMS	Sep-14	Sep-14	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 8/22/2014
1-6.24	Submit SF-269 expenditure report, along with any additional detail required by CMS	Mar-15	Mar-15	SF-269 expenditure report and any additional detail required by CMS, submitted to CMS	OMS, MSPS	For the 6-month period ending 2/21/2015

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
1-6.25	Submit Final Report	Feb-15	Apr-15	Final Report submitted to CMS	OMS, MSPS, VCHIP, DVHA	Format and content to be decided after consulting with the national Evaluation Contractor
A-0.0	Category A: Collecting & Reporting Quality Measures	Jul-10	Feb-15			Our estimated dates are based on the February 2011 expected release date provided by CMS. Based on this comment we have modified some task end dates (A 3.9 and A 4.1) to accommodate a March release, if the release date is much later, other end dates may need to be modified accordingly.
A-1.0	Maine Task 1: Engage and convene Measures and Practice Improvement (MPI) Subcommittee (including pediatricians, family physicians, pediatric nurse practitioners, physicians assistants, and pediatric healthcare professional organizations) and the State Coordinating Committee (including child & family advocates, public & private payer, QL, health	Jul-10	Feb-15	Stakeholders participate in the MPI and provide feedback throughout process of measure implementation.	MECDC, OMS, MSPS	<p>Maine SCC and the MPI Subcommittee have both met several times since 7/10. Outreach efforts were successful, and membership includes representatives from targeted organizations.</p> <p>Lesson learned: minimize number of committees to increase participation and reduce stakeholder burnout as membership often overlaps.</p> <p>For more detail, please refer to subtasks A-1.1 through A-1.2 in Table E</p>

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	systems					
A-1.1	Inform pediatric medical providers about collection & reporting of core measures through Grand Rounds and electronic communication	Jul-10	Feb-15	Stakeholders and local experts are engaged in the collection and reporting process.	MECDC, OMS, MSPS	Ongoing throughout grant period
A-1.2	Elicit input & feedback from stakeholders on how measures are helpful for practice improvement in improving health outcomes	Jul-10	Feb-15	Collected measures are used by and support pediatric practice improvement efforts in Maine.	MPI, SCC, ME CDC, OMS, MSPS	Focus of the first several MPI Subcommittee meetings was on presenting and getting feedback on the draft CHIPRA core measures and additional measures recommended by the Maine AAP Quality Improvement Subcommittee. Feedback will be sought throughout grant period.
A-2.0	Maine Task 2: Identify data sources for collecting the CHIPRA core measures	Jul-10	Jun-11	Sources and collection strategy will be identified for each measure.	MSPS, OMS, ME CDC, MPI	Completed CHIPRA Baseline Measures Report in August 2010. Identified status (currently available or to be developed) and source (claims, discharge data, immunization registry, etc.) for the initial core measures. Report will be updated once final core measures are released. For more detail, please refer to subtasks A-2.1 through A-2.3 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
A-2.1	Develop a plan for collecting claims and experience of care measures and reporting, to include in the managed care contracts	Sep-10	Jun-11	Written plan identifying core measures and/or data that Managed Care Organizations (MCOs) will provide to OMS. Plan will be used to develop language for the managed care contracts.	MSPS, OMS	MaineCare is in the process of converting from a fee-for-service delivery system to a capitated managed care system. Measurement activities will need to take into account this transition.
A-2.2	Identify measures that need to be collected through the automated EPSDT data system (Category B)	Aug-10	Jun-11	List of measures and specifications that will be collected through the automated registry system (to be developed under Category B) provided to IT staff to ensure inclusion in new system.	MSPS, ME CDC, OMS	
A-2.3	Identify any measures with unknown source	Jul-10	Jun-11	Measures with unknown or unfeasible data sources will be documented and brought to the MPI subcommittee and SCC for follow-up and resolution (see A-4.2).	MSPS, MECDC, OMS	
A-3.0	Maine Task 3: Collect & review CHIPRA, CMS - 416(EPSDT), and other identified measures	Jul-10	Jan-13	CHIPRA and other identified measures are constructed and available for reporting.	OMS, MSPS	Specifications for 13 of 14 claims-based initial core measures have been reviewed and programmed. Waiting for release of final core measure specifications to begin work on remaining measures. For more detail, please refer to subtasks A-3.1 through A-3.11 in Table E
A-3.1	Review NCQA/HEDIS specifications for claims-based measures; verify	Aug-10	Jun-11	Fields needed to construct claims-based CHIPRA measures are available in MaineCare claims.	MSPS, OMS	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	needed fields are available in MMDSS and identify & trouble shoot potential issues					
A-3.2	Develop & implement methodology to extract claims-based measures, test & revise methodology, if needed	Sep-10	Jun-11	Programs that extract claims-based CHIPRA measures from MaineCare claims database completed and tested for potential problems.	MSPS, OMS	
A-3.3	In response to feedback from the MPI subcommittee, update & review collection method	Jan-11	Jan-13	Feedback from users of measures ensures that collection process and/or construction methods do not omit important data, improving accuracy and utility of measures on an ongoing basis.	MSPS, OMS	
A-3.4	For hospital-based measures (catheter-associated infection rates), review data currently available in MHDO hospital discharge database	Jul-10	Mar-12	Existing data sources leveraged to produce hospital-based measures.	MSPS, OMS, ME CDC	
A-3.5	Request query of hospital databases to produce age and payer specific hospital-based CHIPRA measures	Sep-10	Mar-12	Data needed to construct hospital-based CHIPRA measures available for reporting.	MSPS, OMS, ME CDC	
A-3.6	Incorporate infection-rate results into CHIPRA core	Jan-11	Mar-12	Infection-rate results included in CHIPRA reports (as defined in reporting plan developed under	MSPS, OMS, ME CDC	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	measures summary report			A-6.2).		
A-3.7	Convene workgroup with representatives from Maine CDC ORDVS (vital statistics data and IMMPACT2 registry) and MaineCare OIAS (MaineCare eligibility data) to determine most feasible means of producing vital statistics and immunization data	Feb-11	Mar-12	Feasible method of collecting data needed to construct CHIPRA measures from vital statistics and immunization registry data identified and documented.	MSPS, OMS, ME CDC	
A-3.8	Develop and implement a plan to collect immunization and vital statistics-based measures	Feb-11	Mar-12	CHIPRA measures based on immunization and vital statistics data are collected and available for reporting.	OMS, ME CDC, MSPS	
A-3.9	Revise questionnaire for annual survey of children enrolled in MaineCare to include CAHPS 4.0 items	Nov-10	Apr-11	Revised questionnaire for annual survey of children enrolled in MaineCare.	MSPS, OMS, ME CDC, MPI	The end date of this subtask was revised to allow time to verify specifications from the final core measures, scheduled to be released in Feb 2011.
A-3.10	Collect experience of care measures from 2011 MaineCare survey after coordinating efforts with the Maine Health Care Management	Apr-11	Aug-11	CHIPRA experience of care measures collected and are available for reporting. Alignment with MHMC efforts allows for comparisons between children enrolled in MaineCare versus privately insured children.	MSPS, OMS, ME CDC, MPI	Current process of collecting experience of care information through a state-wide survey may not be feasible in managed care environment. Collection of this measure may need to occur through contracting process with managed care entities.

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	Coalition					
A-3.11	Engage family advocates and members in determining how the patient experience of care measures are helpful	Sep-12	Mar-13	Summary report of value of experience of care measures to families and children produced from meetings and focus groups.	SCC, MSPS, OMS, ME CDC	
A-4.0	Maine Task 4: Identify barriers and explore solutions to implementation process	Jun-10	Jan-13	Barriers to implementation of Core Measures identified with possible solutions	MSPS, OMS, ME CDC	Impact of Managed Care implementation unknown at this time. For more detail, please refer to subtasks A-4.1 through A-4.2 in Table E
A-4.1	Evaluate, identify & report which CHIPRA Core Measures can be collected from existing claims or other clinical data, and which ones cannot be collected through current processes	Jun-10	Apr-11	Report documenting status of each CHIPRA core measure (currently available or to be developed) and source (claims, discharge data, immunization registry, etc.)	MSPS, OMS, ME CDC,	Completed CHIPRA Baseline Measures Report in August 2010 based on draft measures. Report will be updated once final core measures are released. (End date revised to allow time for review of final measures).

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
A-4.2	Identify challenges to collecting any measure and brainstorm potential solutions	Jul-10	Jan-13	Discussion of barriers will be a standing item on all MPI subcommittee, steering committee, and SCC meeting agendas. Summary report of barriers identified in meetings and focus groups.	SCC, MSPS, OMS, ME CDC, MPI	
A-5.0	Maine Task 5: Align MaineCare payment/ financial incentives with pediatric quality measures	Sep-10	Dec-14	Financial incentives for pediatric measures are aligned.	MPI, SCC, ME CDC, OMS, MSPS	For more detail, please refer to subtasks A-5.1 through A-5.4 in Table E
A-5.1	Determine initial reporting requirements to be recommended in Managed Care contracts	Sep-10	Feb-11	Written plan identifying CHIPRA and other measures that Managed Care Organizations (MCOs) will provide to OMS. Plan will be used to develop language for the managed care contracts.	OMS, MSPS, ME CDC, Managed Care Quality Work Group	
A-5.2	Determine pay-for-performance incentives to be included in Managed Care contracts	Dec-10	Jan-11	Written plan identifying CHIPRA and other measures and methodology for performance incentives for Managed Care Organizations (MCOs); this plan will be used to develop language for the managed care contracts.	OMS, MSPS, ME CDC, Managed Care Quality Work Group	
A-5.3	Conduct provider baseline and subsequent survey, or focus groups, of MaineCare providers on the use of reporting measures and (future) quality improvement efforts	Jan-11	Dec-11	Baseline report on the use of quality measures by Maine pediatric providers and “readiness” for quality improvement.	MSPS, OMS, ME CDC	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
	(Evaluation)					
A-5.4	Evaluate impact of pay-for-performance incentives over time (Evaluation)	Oct-13	Dec-14	Data analyzed and report produced summarizing changes in CHIPRA measures with financial incentives over time.	MSPS, OMS	
A-6.0	Maine Task 6: Report results of core CHIPRA measures to payers, providers and consumers	Jan-11	Feb-15	Children's health care quality measures will be available to payers, providers & consumers	OMS, MSPS, ME CDC	For more detail, please refer to subtasks A-6.1 through A-6.6 in Table E
A-6.1	Identify and analyze reporting options for each measure	Jan-11	Feb-15	Written documentation of reporting options for each CHIPRA measure	OMS, MSPS, ME CDC, MPI	
A-6.2	Define at what level of detail and frequency data should be provided to providers, consumers and payers, and for what purpose	Jan-11	Dec-11	Meeting minutes and written plan detailing schedule for reporting of each CHIPRA measure, including level of reporting (e.g. statewide, by provider), and recipient (providers, payers or consumers).	OMS, MSPS, ME CDC, SCC, MPI, EPSDT Advisory Group	
A-6.3	Integrate reporting into the DHHS web-based reporting platform	Jan-11	Feb-15	Selected CHIPRA measures will be available to the public online.	ME CDC, DHHS Commissioners Office , OMS, MSPS	
A-6.4	Produce measures for EPSDT/ <i>Bright Futures</i> registry and integrate into reports	Jun-12	Dec-12	CHIPRA measures drawn from the automated EPSDT system (developed under Category B) integrated into ongoing reporting.	OMS, MSPS	Revised dates for this subtask to align with the planned implementation of the automated EPSDT system (see task B-1)
A-6.5	Report results on a periodic basis, obtain feedback, and incorporate feedback	Sep-11	Feb-15	Pediatric quality measure reports produced according to the plan developed under A-6.2. Reports improved over time through	OMS, MSPS, ME CDC	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	into reporting.			stakeholder feedback.		
A-6.6	Explore and leverage complementary DHHS efforts, enabling practices and health systems to track their own data over time	Jan-11	Feb-15	Email, meeting minutes, and other documentation of efforts to collaborate and share learning across organizations engaged in measuring pediatric quality improvement.	OMS, MSPS, ME CDC, MPI, OIT	
A-7.0	Maine Task 7: Align pediatric measures with meaningful use, and other payers, professional organizations and specialty groups	Jan-11	Feb-15	Payers, professional organizations and specialty groups align pediatric measures.	MPI, SCC, ME CDC, OMS, MSPS	Many providers have reported that a key barrier to collection of measures is that measures required by different payers and government agencies are not aligned. Not possible for them to collect and/or focus on improving so many different measures. For more detail, please refer to subtasks A-7.1 through A-7.3 in Table E
A-7.1	Engage stakeholders including providers, families, payers (Maine Health Management Coalition), ME Quality Forum and pediatric practices in the PCMH pilot in identifying how to make reporting "Meaningful"	Jan-11	Jun-11	Meeting minutes and written tables comparing pediatric quality measures currently collected or under consideration by Maine-based organizations.	OMS, MSPS, ME CDC, SCC,	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
A-7.2	Explore and develop a plan to integrate and align reporting of measures with Maine Kids Count, Pathways to Excellence, and other pediatric quality reporting efforts.	Jan-11	Feb-15	Meeting minutes and written plan for alignment of pediatric quality measure reporting for Maine providers (including but not limited to CHIPRA measures). By minimizing provider burden, the number of providers who report measures will be increased.	OMS, MSPS, ME CDC, MPI, OIT	
A-7.3	Select a group of providers to pilot meaningful reporting utilizing well child visit data and immunization data	Jan-11	Dec-11	Report on results of focus group with pilot participants, highlighting perceived usefulness of reports and how they can be made more useful.	OMS, MSPS, MPI	Invite pediatric practices of the PCMH Pilot to participate.
A-8.0	Maine Task 8: Identify and test new behavioral health measures	Jun-12	Jun-14	Lessons learned from testing of behavior health measures documented.	ME CDC, OMS, MSPS, OCFS	For more detail, please refer to subtasks A-8.1 through A-8.5 in Table E
A-8.1	Conduct environmental scan of child behavioral health measures currently in use in Maine (e.g. performance reports from behavioral health administrators, CAFAS tool, Bright Futures)	Jun-12	Dec-12	Written documentation of behavioral measures currently used in Maine.	MSPS, OCFS, ME CDC	
A-8.2	Review evidence-based behavioral health measures from literature, federal agencies and other	Jun-12	Dec-12	Written summary of evidence for and national use of behavioral health measures to inform what behavioral health measures ME might pilot. Will consult with	MSPS, OCFS, ME CDC	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	states			related Centers of Excellence.		
A-8.3	Convene child MH experts to identify and recommend behavioral health measures to be included as part of the standard set for pediatric providers	Jan-13	Feb-13	Meeting minutes and list of recommended behavioral health measures to incorporate into a standard set for pediatric providers in Maine.	MSPS, OCFS, ME CDC	
A-8.4	Develop plan to test the implementation of selected behavioral health measures, possibly through pilot practices; consult with AHRQ Pediatric Quality Measures Coordinating Center regarding the proposed measures and testing plan	Jan-12	Jan-13	Written plan for implementing behavioral health measures in Maine pediatric practices on a pilot basis, including a plan for evaluating the implementation process and outcomes.	MSPS, OCFS, ME CDC	
A-8.5	Implementation of behavioral health measures on a pilot basis	Feb-13	Jun-14	Evaluation report examining perceived facilitators/barriers to implementation and outcomes.	MSPS, OCFS, ME CDC	
B-0.0	Category B: Promote the Use of HIT in Children's Health Care Delivery	Feb-10	Feb-15		IHOC-EC	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-1.0	Maine Task 1: Collaborate & coordinate with Health Systems & FQHC's to determine interface specifications in order for them to participate in the automation & exchange of EPSDT data (<i>Bright Futures</i>)	Sept-10	Feb-15	Health systems and FQHC's participate in the development and automation of the EPSDT data system	HIN, MPI, OIT, ME CDC, OMS, MSPS	For more detail, please refer to subtasks B-1.1 through B-1.5 in Table E
B-1.1	As Is Assessment: Identify work flow processes of how providers currently use and submit EPSDT data to the Office of MaineCare Services	Sep-10	Feb-11	EPSDT (Bright Futures) “ As Is” Assessment Report describing the current business and IT processes used by providers to submit EPSDT data to OMS	OIT, ME CDC, OMS, MSPS	
B-1.2	Engage IT representative of FQHC's, and Maine pediatric healthcare systems to coordinate the automation and exchange of EPSDT data	Jan-11	Feb-15	IT representatives from FQHC's, and Maine's pediatric healthcare systems will participate in the coordination and automation and exchange of EPSDT data	OIT, MPI, HIN, OMS, ME CDC, MSPS	
B-1.3	Assess feasibility of integrating data with health & social	Dec-10	Feb-11	Written analysis of feasibility of integrating EPSDT data with health & social services data	HIT, MPI, SCC	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	services data (e.g. WIC, school based health centers)					
B-1.4	Identify prioritize, standardize and define measures to be automated; map them to meaningful use standards; determine additional measures to collect, and coordinate with Pathways to Excellence (MHMC) and other professional associations	Sep-10	Feb-11	List of measures to automate will be defined, standardized and prioritized	ME CDC, OMS, MPI, MSPS,	
B-1.5	Assess, develop and implement a plan to address linkage needs between state databases, HIE, and health systems/ FQHC's	Sep-11	Jun-12	A written plan to address linkage needs between state databases, HIE, health systems and FQHC's will be developed and implemented with approval by the HIT subcommittee	HIE, OIT, ME CDC, OMS, MSPS MPI	
B-2.0	Maine Task 2: Design, implement & evaluate an electronic health assessment supporting children in Maine's foster care system	Sep-10	Dec-14	Electronic health data system for foster children developed and tested.	OIT, ME CDC, OMS, MSPS MPI, SCC	Review of other State's foster care health data systems completed. The review assisted the workgroup in assessing feasibility of their plan, and considering what data systems Maine might include and who should have access. Staff has also followed up with states to gather specific measures for consideration in Maine's system

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
						For more detail, please refer to subtasks B-2.1 through B-2.9 in Table E
B-2.1	Identify States automating health care data for foster care children to inform design of a system in Maine	Sep-10	Nov-10	Written report indicating other states designs for automating health care data for children in foster care	ME CDC, OMS, MSPS	Completed. States or localities highlighted in the report included Cook County, IL HealthWorks; Texas Foster Care Health Passport; San Diego County, and Washington DC.
B-2.2	Analyze existing foster care children's utilization, costs, and quality of care outcomes relative to non-foster care kids; and those who have received a non-automated comprehensive health assessment and who have not, to inform what data to automate (Evaluation)	Nov-10	Mar-11	Data analysis of claims data and summary report completed and presented to Foster Care Workgroup.	ME CDC, OMS, MSPS	
B-2.3	Convene workgroup to identify & prioritize the data elements to be included the system	Sep-10	Jun-11	List of data elements will be identified and prioritized	OIT, ME CDC, OMS, MSPS, OCFS,	Multiple public & private stakeholders interested in participating.

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-2.4	As Is Assessment: Identify business & IT processes used in the current foster care health assessment system	Sep-10	Dec-10	“As Is” Assessment Report describing the current business and IT processes used for foster care health assessment	OCFS,OIT, ME CDC, OMS, MSPS, HIT	OIT actively in process with OCFS, and private providers.
B-2.5	Engage and convene family members, advocates, and foster care children to ADVISE the project	Sep-10	Feb-15	Children in foster care, their birth parents, and foster parents will meet with IHOC staff to provide input, feedback and advice on an electronic health assessment for children in foster care	ME CDC, OMS, MSPS, , OCFS	Representatives from foster parent, birth parent and youth in foster care advocacy groups will be contacted to coordinate the best way to engage these key stakeholders.
B-2.6	Identify, define & develop architecture of secure, HIT Health Assessment that sends healthcare data--including 72 hour evaluation upon entry into care--to providers when there is a transition of care	Jan-13	Jan-14	Development of architecture of a secure HIT Health Assessment that has capacity to send healthcare data to providers	OCFS,OIT, ME CDC, OMS, MSPS, HIT	
B-2.7	Pilot with a small group of child health care providers	Jan-14	Apr-14	Pilot of a secure HIT Health Assessment that sends healthcare data to providers when there is a transition of care	OCFS,OIT, ME CDC, OMS, MSPS, HIT	
B-2.8	Evaluate how automated availability of information to pilot providers (care managers and caregivers) affects delivery of care	Jun-14	Dec-14	Report produced summarizing findings from data analysis and qualitative interviews.	MSPS,	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	(qualitative interviews, data analysis)					
B-2.9	Explore expanding to all primary care providers that care for foster children	Dec-14	Feb-15	Foster Care Work Group will review evaluation report, successes, and barriers and determine if expansion is recommended	OCFS,OIT, ME CDC, OMS, MSPS, HIT	
B-3.0	Maine Task 3: Identify barriers and explore solutions to implementing an electronic health data system supporting children in Maine's foster care system	Nov-10	Feb-15	Barriers to implementation of foster care data system identified with possible solutions	OCFS,OIT, ME CDC, OMS, MSPS,	For more detail, please refer to subtask B-3.1 in Table E
B-3.1	Identify barriers and explore solutions	Nov-10	Feb-15	Meeting minutes of subcommittee will include standing item of barriers encountered. Final evaluation report of pilot will include summary of barriers to foster care automation and solutions.	OCFS,OIT, ME CDC, OMS, MSPS, HIT	
B-4.0	Maine Task 4: Determine if we will develop architecture for an interim EPSDT data entry system with capacity to identify payers (for practices who do not have	Dec-10	Oct-11	Practices without EHR's will have a method of reporting Bright Future data to the state.	OIT, OMS, ME CDC, MSPS, MPI	HIT stakeholders and ME Steering Committee reviewed a proposal to develop architecture for an interim EPSDT data entry system with capacity to identify payers (for practices who do not have electronic health record systems or do not have capacity to capture required measures).

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
	electronic health record system or do not have capacity to capture required measures) and proceed accordingly					<p>HIT stakeholders determined a EPSDT data entry system is already in place and developing an additional means would only serve to create yet another means of manual data entry.</p> <p>The decision was made to focus on developing EHR linkages and practices instead of this task.</p> <p>For more detail, please refer to subtasks B-4.1 through B-4.4 in Table E</p>
B-4.1	Convene HIT stakeholders and determine if developing an interim data entry system for providers who do not have EHR's is a priority, as we work towards an automated EPSDT/Bright Futures system that links to EHR's.	Dec-10	Jan-11	Minutes will reflect stakeholders priorities	OIT, ME CDC, OMS, MSPS MPI, Health Systems, QC	HIT Stakeholders met, reviewed a proposal to develop an interim data entry system for providers who do not have EHRs and determined the priority is focusing on linkages to EHR's.
B-4.2	Pilot connectivity between practices/ WIC programs/ school-based health centers/, health systems, and state registry for measure collection	Jan-12	Jul-12	If a interim data entry system were a priority, the connectivity between the State registry and practices, health care systems, WIC and school-based health systems would be piloted	OIT, ME CDC, OMS, MSPS MPI	Although Stakeholders determined the task is not a priority, this subtask is addressed in B-1.3 and B-1.5

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
B-4.3	Identify barriers and possible solutions to participating and utilizing a registry system, identify lessons learned to inform the implementation of the automation of Bright Futures	Jan-12	Jul-12	Barriers identified included increased manual data entry by providers.	OIT, ME CDC, OMS, MSPS MPI,	As a result of increased burden, Stakeholders determined the interim TASK would not be pursued
B-4.4	Re-pilot and implement interim electronic data entry system on a broader scale	Sep-12	Feb-14	Interim electronic data entry system.	OIT, ME CDC, OMS, MSPS MPI,	Stakeholders determined an interim data entry system would not be piloted
B-5.0	Maine Task 5: Evaluate Bright Futures implementation	Jan-11	June-13	Report documenting lessons learned and results from Maine's implementation experience	MSPS, ME CDC, ME OMS, OIT, HIN	This task was intended to evaluate the interim data entry system for Bright Futures. Since that interim system will not be piloted, this task is eliminated. For more detail, please refer to subtasks B-5.1 through B-5.2 in Table E
B-5.1	Develop process evaluation of provider data for generation of MaineCare/other state reports	Jan-11	Sep-12	Plan for evaluating the interim data system completed.	MSPS	Task eliminated. Stakeholders determined an interim data entry system would not be piloted

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-5.2	Evaluate how reports are being used through focus groups & interviews (Evaluation)	Mar-12	Jun-13	Report summarizing results of focus groups and interviews.	MSPS, ME CDC, ME OMS, HIT	Task eliminated. Stakeholders determined an interim data entry system would not be piloted.
B-6.0	Maine Task 6: Design and implement an integrated electronic data system for Bright Futures (EPSDT in Maine) that links practices' EHR systems to DHHS, pilot with PCMH Pilot pediatric practices and then stage roll out in practices that have a high volume of MaineCare (Medicaid) patients	Jan-12	Oct-14	Integrated electronic Bright Futures data system developed and tested.	HIN, OIT, ME CDC, OMS, MSPS MPI	For more detail, please refer to subtasks B-6.1 through B-6.2 in Table E
B-6.1	Identify and design a central repository that is in alignment with state information systems	Jan-12	Jan-14	Design of a central repository that is aligned with state information systems	OIT, ME CDC, OMS, MSPS	
B-6.2	Re-assess EHR capacity and data exchange infrastructure to determine next steps	Jan-14	Oct-14	A work plan detailing EHR and data exchange next steps	HIE, OIT, ME CDC, OMS, MSPS MPI	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-7.0	Maine Task 7: Identify barriers & explore solutions to implementation	Oct-12	Feb-15	Barriers to implementation of BF data system identified with possible solutions	OIT, HIN, PCMH, MPI, ME CDC, OMS, MSPS	For more detail, please refer to subtask B-7.1 in Table E
B-7.1	Prioritize & implement possible solutions	Oct-12	Feb-15	Discussion of barriers/solutions included as standing item on all HIT subcommittee, steering committee, and SCC meeting agendas. Summary report on barriers and solutions identified in meetings and focus groups.	HIT, PCMH, MPI, ME CDC, OMS, MSPS	
B-8.0	Vermont Task 8: Expand the <i>Vermont Blueprint for Health</i> central registry (DocSite) to support guideline-based care, performance measurement, population management, and coordination with community-based services for the pediatric population	Mar-10	Feb-15	DocSite central registry includes data elements and performance measures to support quality care for the pediatric population	Blueprint/DVH A, VCHIP	DocSite is the vendor for the <i>Vermont Blueprint for Health</i> central registry. For more detail, please refer to subtasks B-8.1 through B-8.8 in Table E

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-8.1	Determine guideline-based child health topics to be incorporated initially into the DocSite registry (e.g. preventive services); determine phased schedule for incorporation of additional topics for which guidelines exist (e.g. asthma, ADHD, obesity) in collaboration with the Blueprint and pediatric stakeholders	Mar-10	Jan-11	List of initial topics and timeline for inclusion of additional topics	UVM/VCHIP; Blueprint/DVHA , AAP-VT, VT Department of Health	This task will include review of adult topics already in DocSite and determination of whether they can be used, as is or with modifications, for pediatric visits.
B-8.2	Select and/or develop core pediatric performance measures for preventive services (i.e., Bright Futures) for inclusion in the DocSite registry in collaboration with the Blueprint and pediatric stakeholders	Dec-10	Feb-11	List of core pediatric performance measures for Bright Futures	UVM/VCHIP; Blueprint/DVHA , AAP-VT, VT Department of Health	Core pediatric performance measures will be used for practice-level comparative performance tracking (e.g. practice performance over time, individual practice to all participating practices in its HSA, individual practice to all participating practices in Vermont) and to drive quality improvement activities.

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-8.3	Select and/or develop core pediatric performance measures for asthma, ADHD, and obesity for inclusion in the DocSite registry in collaboration with the Blueprint and pediatric stakeholders	Dec-10	Dec-11	List of core pediatric performance measures for asthma, ADHD, and obesity	UVM/VCHIP; Blueprint/DVHA , AAP-VT, VT Department of Health	Core pediatric performance measures will be used for practice-level comparative performance tracking (e.g. practice performance over time, individual practice to all participating practices in its HSA, individual practice to all participating practices in Vermont) and to drive quality improvement activities.
B-8.4	Provide consultation to DocSite team for development of visit planners in the registry consistent with the Bright Futures guidelines; incorporate other Bright Futures clinical assessment questionnaires (e.g. pre-visit questionnaire) and screening tools as appropriate to support the delivery of guideline-based care	Mar-10	May-11	Emails, meeting minutes, notes from phone communications between clinical advisor(s) and DocSite	UVM/VCHIP; DocSite, Blueprint/DVHA	<p>Formats of clinical assessment tools outside of the visit planner to be determined (e.g. check boxes indicating a tool was used; printable forms; or printable forms that also allow for data entry)</p> <p>Provider use of the tools is optional, though pediatric practice facilitators will both encourage their use and provide coaching on effective use in the effort to support the provision of high quality care to children. Additional payment will not be tied to use of the forms/tools.</p>

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
B-8.5	Provide consultation to DocSite team for development of visit planners in the registry consistent with the asthma, ADHD, and obesity guidelines; incorporate other clinical assessment tools as appropriate to support the delivery of guideline-based care	Jun-11	Jan-13	Emails, meeting minutes, notes from phone communications between clinical advisor(s) and DocSite	UVM/VCHIP; DocSite, Blueprint/DVHA	Formats of clinical assessment tools outside of the visit planner to be determined (e.g. check boxes indicating a tool was used; printable forms; or printable forms that also allow for data entry)
B-8.6	Provide consultation to DocSite team for development of data elements needed to be captured in the DocSite registry (or transmitted to the registry by EHRs) in order to enable calculation of the core pediatric performance measures	Mar-10	Jan-13	Emails, meeting minutes, notes from phone communications between clinical advisor(s) and DocSite	UVM/VCHIP; DocSite, Blueprint/DVHA	
B-8.7	Conduct clinical and technical review of Bright Futures and other guideline-based visit planners, questionnaires, screening tools, etc. in DocSite prior to	Jan-11	Jun-13	Clinical notes, minutes from clinical consult meetings	UVM/VCHIP; Select clinical content experts	

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
	going live					
B-8.8	Review Maine's work in collecting/reporting on the initial core measures set and determine feasibility and utility in collecting the data necessary to capture some core measures through the DocSite registry	Mar-13	Feb-15	Emails, meeting minutes, notes from phone communications between Maine and Vermont project staff	UVM/VCHIP; Blueprint/DVHA	As a learning health system, Blueprint measures are continuously evolving. Plans are also underway to incorporate other AHRQ-based measures into the DocSite central registry.
B-9.0	Vermont Task 9: Support utilization of DocSite in pediatric and family practices participating in the Blueprint	Nov-10	Feb-15	DocSite registry is used by pediatric practice facilitators, pediatric/family practice teams and community health team members to support quality care in the pediatric population	Blueprint/DVHA, VCHIP	For more detail, please refer to subtasks B-9.1 through B-9.2 in Table E
B-9.1	Pediatric practice facilitators to participate in initial and on-going trainings and receive individualized, on-going support from DocSite on use of the central registry and how practice facilitators can assist practice team members (e.g. provider, care	Nov-10	Feb-15	Training notes and materials	UVM/VCHIP pediatric practice facilitators; DocSite, Blueprint/DVHA	Trainings will be conducted by the Blueprint for Health and DocSite staff and are subsidized by the Blueprint. UVM/VCHIP pediatric practice facilitators will participate in the trainings.

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Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	coordinator, etc.) and community health team members in its use					
B-9.2	Pediatric practice facilitators to provide direct, individualized, and on-going coaching and support to practice teams and community health teams on use of the DocSite registry, including but not limited to: a) using the registry to track patient data and practice performance; b) using visit planners to drive guideline-based care; c) generating outreach reports to aid in care coordination; and d) generating comparative performance reports to track practices' progress on the core performance indicators and to guide on-going quality improvement	Dec-10	Feb-15	Emails, meeting minutes, notes from phone communications between pediatric practice facilitators and practice teams; documented recommendations for practices; documented strategies for working successfully with practice teams	UVM/VCHIP pediatric practice facilitators; DocSite, Blueprint/DVHA	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-10.0	Vermont Task 10: Utilize and expand DocSite flexible web-based reporting platform to drive improvements in care delivery and guide state health reform	Jun-11	Feb-15	Performance reports on pediatric and family practices participating in the Blueprint	VCHIP, Blueprint/DHV A, DocSite	For more detail, please refer to subtasks B-10.1 through B-10.2 in Table E
B-10.1	Pediatric practice facilitators to work with practice teams and community health teams participating in the Blueprint to determine reports and reporting formats that best support patient outreach, care coordination, and quality improvement	Jun-11	Feb-15	Sample reports; documented communications between pediatric practice facilitators and practice teams/community health team members	UVM/VCHIP pediatric practice facilitators; DocSite, Blueprint/DVHA	
B-10.2	Provide clinical consultation to the Blueprint/DocSite to conduct on-going refinements of Bright Futures, asthma, ADHD, and obesity performance measures, forms, and reports in DocSite for increased functionality and usability	Nov-11	Feb-15	Emails, meeting minutes, notes from phone communications between clinical advisor(s) and DocSite	UVM/VCHIP; Blueprint/DVHA , DocSite	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
B-11.0	Vermont Task 11: Support interface development for guideline-based data elements between DocSite and commercial EHRs for pediatric providers participating in the Blueprint who use an EHR	Sep-11	Feb-15	Mapped data elements between the DocSite central registry and commercial EHR(s)	VCHIP, Blueprint/DVH A, VITL, DocSite	For more detail, please refer to subtask B-11.1 in Table E
B-11.1	Review and provide clinical recommendations on VITL/DocSite-generated mapping of commercial EHR(s) and DocSite registry data elements	Sep-11	Feb-15	Emails, meeting minutes, notes from phone communications between clinical advisor(s), Blueprint/DVHA, VITL, and DocSite	UVM/VCHIP; Blueprint/DVHA , VITL, DocSite	VITL: Vermont Information Technology Leaders is an independent not-for-profit entity established in Vermont statute to build and maintain a statewide Health Information Exchange (HIE) network and to support expanded use of Electronic Medical Records (EMRs) in the state. VITL is also the state's Regional Extension Center (REC).
C-0.0	Category C: Evaluate Provider-Based Models Which Improve the Delivery of Children's Health Care	Jun-10	Feb-15			

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-1.0	Maine Task 1: Identify the measures to focus practice improvement efforts, and invite pediatric practices in the PCMH Pilot to test.	Jun-10	Mar-11	Cross-listing of CHIPRA, Bright Futures, and meaningful use measures. Final list of pediatric measures for practice improvement. Awaiting final CHIPRA measures specifications	MPI, MSPS, ME CDC, OMS, MPI, QC	<p>PCMH Pilot pediatric practices are not required to collect CHIPRA measures as part of the PCMH Pilot; however, they are active participants in the CHIPRA MPI Subcommittee and are collaborators. Yes- all 4 PCMH pediatric pilot sites will participate in IHOC. The Maine PCMH Pilot preexisted CHIPRA in the state- they are 1.5 years into a 3 year pilot so they are already working on a set of pediatric quality measures for their EMR collection ahead of many of the national deadlines for CHIPRA. We hope to align as many measures as possible and expect when national pediatric quality measures set is finalized that the PCMH may have to adjust over time to new measures.</p> <p>For more detail, please refer to subtask C-1.1 in Table E</p>
C-1.1	Pediatric practices in the PCMH Pilot will integrate the identified measures into PCMH pilot	Aug-10	Sep-11	At least 75% of EMR based pediatric measures in CHIPRA set will be incorporated into PCMH	MPI, MSPS, ME CDC, OMS	Timelines for PCMH Pilot and CHIPRA IHOC projects are not matching up since PCMH is 1.5 years underway and CHIPRA core measures won't be finalized until Feb 2011. Will need to work with pediatric PCMH groups to adjust measures over time.

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-2.0	Maine Task 2: Implement the Bright Futures Toolkit with child health providers and assess impact on EPSDT services in Maine	Sep-10	Jan-13	Increased use of evidence-based EPSDT tools and improved quality of pediatric primary care	MPI, MSPS, ME CDC, OMS, QC	<p>About 50% of pediatric groups have EMRs; there is no national EMR that has Bright Futures already fully incorporated into programming so many EMRs are doing local changes but need to be aware of copyright issues so this is challenging and time consuming for practices. Currently Bright Futures forms are paper based. Several of the screening forms for developmental delay (PEDs, ASQ) will cost practices additional money.</p> <p>For more detail, please refer to subtasks C-2.1 through C-2.8 in Table E</p>
C-2.1	Outreach to pediatric providers about IHOC, Bright Futures Toolkit and practice improvement initiative	Dec-10	Jun-11	Improved awareness of new Bright Futures 3 curriculum and resources. More standardized patient handouts for anticipatory guidance.	MSPS, ME CDC, OMS,	
C-2.2	Engage the Maine Dental Association in the IHOC project to implement the CHIPRA oral health preventive and treatment measures in order that we may improve child oral health outcomes in Maine.	Dec-10	June 11	Broader collaboration of medical and dental partners in the state contributing to improved access to oral screening and fluoride varnish for children in primary care offices.	MSPS, ME CDC, OMS, QC	Several oral health initiatives are already underway in the state- we hope to spread what they are doing across the states and to the PCMH sites if not already involved in the work.

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-2.3	Engage health systems in Maine to create buy-in and participation	Nov-10	Jun-11	Collaboration among the health care systems and IHOC to spread practice improvement efforts, maximize local expertise in the state, and spread best practices from larger population areas to rural sites	MSPS, ME CDC, OMS,	
C-2.4	Implement Bright Futures program statewide	Apr-11	Jan-13	Increase EPSDT screening rates	MSPS, ME CDC, OMS, QC	
C-2.5	Monitor changes in provider participation in EPSDT screening and reporting to MaineCare	Dec-10	Feb-15	Increase provider participation in EPSDT screening and reporting to MaineCare- capture those using EMR and avoid double-entry.	OMS, ME CDEC. MSPS	
C-2.6	Provide training and/or technical assistance (such as a learning sessions or academic detailing)	Mar-11	Sep-12	Develop different ways to train adult learners about Bright Futures and improve quality care.	QC, ME CDC, OMS, MSPS, UVM (Shaw, Duncan)	
C-2.7	Coordinate with HIT about the automation of Bright Futures measures and train providers on new system	Jan-13	Jan-14	Work with providers around HIT to increase provider buy-in and reduce frustration with new technology	OIT, OMS, ME CDC, MSPS, QC	
C-2.8	Recruit pediatric practices and pilot automated Bright Futures system and measures with selected practices.	Oct-13	Jun-14	Pilot HIT automation and trouble shoot technology	OIT, OMS, ME CDC, MSPS, QC	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
C-3.0	Maine Task 3: Develop a Pediatric Improvement Partnership that supports learning communities and quality improvement initiatives (links to Task 1-4.0 and VT Task E-1.0)	Sep-10	Jan-15	Alignment and integration of QI initiatives assist and support pediatric providers to improve quality of care for targeted conditions	QC, MPI, MSPS, ME CDC, OMS, UVM/VCHIP	For more detail, please refer to subtasks C-3.1 through C-3.7 in Table E
C-3.1	Contact all and track all professional organizations and groups running QI initiatives to find out work plans, goals, timelines to align QI efforts	Sep-10	May-11	Create timeline of current practice improvement efforts to help coordinate efforts and not overwhelm practices with activities	QC, MSPS, ME CDC, OMS	In the next year, the state has been awarded several grants to improve developmental screening and obesity including the Maine Developmental Disability Council's Maine's ASD Systems Development Project (MeASD) for developmental and autism screening and the Maine Medical Center's Let's Go NIHCQ/HRSA grant. Plan to coordinate these efforts with IHOC to maximize both financial and human resources.
C-3.2	Identify and determine high volume MaineCare practices to target for practice improvement efforts	Sep-10	Feb-11	List of practices to target to quality improvement efforts	OMS, MSPS, ME CDC	Initial list has been formulated although a final list has not been agreed on by the Maine steering committee yet. The initial list of 50 high volume practices in the state being considered include practices across the state and with varying levels of HIT sophistication. If the national evaluators have a specific

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
						sampling strategy we will use this in targeting practice selection, although the voluntary nature of participation could affect which practices ultimately participate.
C-3.3	Survey pediatric providers about readiness for practice transformation and QI work, do focused interviews with 10-15 practices (Evaluation)	Feb-11	May-11	Report summarizing survey findings completed. Identify areas that practices will need assistance before starting QI work- readiness for change, help with NCQA standards, areas they need to do practice improvement around	MSPS, ME CDC, OMS	
C-3.4	Conduct an environmental scan to determine potential areas for learning initiatives such as asthma, obesity, dental health, etc.	Oct-10	Feb-11	Emails, phone calls, meetings with people and groups doing practice improvement. See if we can spread the efforts of other groups who are already being funded around CMS priority areas rather than starting a new initiative.	MSPS, ME CDC, OMS, QC, MPI	
C-3.5	Explore and determine with input from PCMH practices which learning initiatives to focus on once Bright Futures training is under way	Oct-10	Jun-11	Prioritize learning initiatives based on practice needs	MSPS, ME CDC, OMS, QC, MPI	Several PCMH groups have already done work around asthma, obesity, and developmental screening
C-3.6	Identify one area for focused pediatric quality improvement and conduct a learning initiative with ongoing technical support	Jan-13	Dec-13	Focused pediatric learning initiative over 6-9 months	MSPS, ME CDC, OMS, QC, MPI	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-3.7	Identify learnings from QI initiative, explore if feasible to provide a behavioral health learning initiative, and if so implement	Sep-14	Jan-15	Identify best practices and spread ideas; determine best was to do QI work both locally and statewide	MSPS, ME CDC, OMS, QC, MPI	
C-4.0	Maine Task 4: Support and expand the evaluation of the PCMH Pilot to focus on pediatric practices and children's health outcomes (Evaluation)	Jan-12	Jan-15	Increased knowledge and use of evidence-based practices. Learning from PCMH Pilots is shared with other pediatric providers.	QC, ME CDC, OMS, MSPS,	For more detail, please refer to subtask C-4.1 in Table E
C-4.1	Explore & possibly implement organizing a learning collaborative around behavioral health measures or other topic	Jan-14	Jan-15	Understand needs around behavioral health in PCMH practices	QC, ME CDC, OMS, MSPS, MPI	
C-5.0	Vermont Task 5: Extend the <i>Blueprint for Health integrated health model</i> (or "Advanced Primary Care Practice (APCP) model") in Vermont's pediatric population	Dec-10	Feb-13	Pediatric and family practices serving children in Vermont operate as APCPs and receive payment reforms	Blueprint/DVH A, VCHIP	Blueprint APCP model is comprised of five key components: 1) medical homes; 2) community health teams; 3) payment reforms; 4) HIT; and 5) an evaluation infrastructure. CHIPRA Category C activities focus primarily on the medical home and evaluation infrastructure components. For more detail, please refer to

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
						subtasks C-5.1 through C-5.8 in Table E
C-5.1	Conduct outreach to pediatric and family practices on the Blueprint for Health expansion and benefits for the pediatric community	Dec-10	Nov-11	Provider community is familiar with Blueprint and benefits of participation	UVM/VCHIP; AAP-VT, VT Department of Health, Blueprint/DVHA	
C-5.2	Conduct National Committee for Quality Assurance (NCQA) Physician Practice Connections - Patient Centered Medical Home (PPC-PCMH) assessment in 2-3 pediatric practices in Year 1	Dec-10	Feb-11	2-3 completed assessment surveys	UVM/VCHIP; Blueprint/DVHA	UVM/VCHIP NCQA scorer has been hired, trained, and is ready to deploy in Dec 2010.
C-5.3	In collaboration with pediatric leadership, conduct learning opportunities around NCQA PPC-PCMH recognition, customized to the particular needs of pediatric and family	Mar-11	Jun-13	Training presentations and materials	UVM/VCHIP; AAP-VT, VT Department of Health, Blueprint/DVHA	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
	practices interested in joining the Blueprint					
C-5.4	Hire, train, and deploy up to 1 (new) FTE NCQA scorer to conduct initial NCQA PPC-PCMH scoring in pediatric and family practices joining the Blueprint	Feb-11	Feb-12	Completed assessment surveys for pediatric/family practices joining the Blueprint	UVM/VCHIP; Blueprint/DVHA	Vermont 2010 legislation requires that at least 2 NCQA PPC-PCMH assessments are conducted in primary care practices in each of the state's 13 HSAs by Jul 2011
C-5.5	Expand NCQA scorer capacity up to 2 FTE to conduct initial and follow-up (as appropriate) NCQA PPC-PCMH scoring in pediatric and family practices joining the Blueprint	Feb-12	Feb-15	Completed initial and follow-up assessment surveys for pediatric/family practices folded into the Blueprint	UVM/VCHIP; Blueprint/DVHA	Vermont 2010 legislation requires that all willing practices must be incorporated into the Blueprint (i.e. practices must have undergone an NCQA PPC-PCMH assessment) by Oct 2013 (Year 4 of the CHIPRA demonstration).

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-5.6	Hire, train, and deploy .5 FTE practice facilitator to work with 2-3 pediatric practices in Year 1 for on-going quality improvement	Dec-10	Feb-11	Emails, meeting minutes, notes from phone communications between pediatric practice facilitators and practice teams; documented recommendations for practices; documented strategies for working successfully with practice teams	UVM/VCHIP; Blueprint/DVHA	Trainings will be conducted by the Blueprint for Health and DocSite staff and are subsidized by the Blueprint. UVM/VCHIP pediatric practice facilitators will participate in the trainings. Practice facilitators consult to practice teams to: improve preventive and chronic care delivery, particularly around Bright Futures, asthma, ADHD, and obesity, as appropriate; improve access and office efficiency; increase effectiveness of interdisciplinary teams; increase innovative use of HIT systems and data; and increase emphasis on patient-centered care. It is estimated that 1 practice facilitator can work with 9-15 practices at a time.
C-5.7	Expand practice facilitator capacity to 1 FTE to work with pediatric and family practices serving children for on-going quality improvement	Feb-11	Feb-12	Emails, meeting minutes, notes from phone communications between pediatric practice facilitators and practice teams; documented recommendations for practices; documented strategies for working successfully with practice teams	UVM/VCHIP; Blueprint/DVHA	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
C-5.8	Expand practice facilitator capacity up to 2 FTE to work with pediatric and family practices serving children for on-going quality improvement	Feb-12	Feb-15	Emails, meeting minutes, notes from phone communications between pediatric practice facilitators and practice teams; documented recommendations for practices; documented strategies for working successfully with practice teams	UVM/VCHIP; Blueprint/DVHA	
C-6.0	Vermont Task 6.: Design and conduct pediatric-specific evaluation to assess impact of the APCP model on care delivery, health status, and healthcare costs	Jan-11	Aug-14	Evaluation report(s) describing the impact of the Blueprint health reforms on identified process and outcome measures in the pediatric population	VCHIP, Blueprint/DVHA	For more detail, please refer to subtasks C-6.1 through C-6.8 in Table E
C-6.1	Develop mixed methods evaluation plan including a) qualitative assessment of PCMH implementation and practice transformation, and b) quantitative, pre-post longitudinal analyses of patient- and practice-level quality outcomes using medical record reviews, patient and practice surveys, etc.	Jan-11	Feb-11	Evaluation Plan	UVM/VCHIP; Blueprint/DVHA	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
C-6.2	Identify/engage intervention and comparison practices for inclusion in the longitudinal outcomes evaluation	Jan-11	Apr-11	Identified intervention and comparison practices	UVM/VCHIP; Blueprint/DVHA	
C-6.3	Design data collection tools	Jan-11	Feb-11	Data collection tools	UVM/VCHIP; Blueprint/DVHA	
C-6.4	Obtain University of Vermont (UVM) Institutional Review Board (IRB) approval for all materials	Mar-11	Mar-11	UVM IRB approval	UVM/VCHIP	
C-6.5	Conduct data collection including medical record review, interviews, focus groups, systems survey, etc.	Apr-11	Feb-13	Databases of qualitative and quantitative data	UVM/VCHIP; Blueprint/DVHA	
C-6.6	Analyze data	Oct-11	Aug-13	Coded qualitative data summarized by major and sub-themes; graphs, tables, and (possible) statistical output of analysis on quantitative data	UVM/VCHIP; Blueprint/DVHA	
C-6.7	Produce interim and final reports	Apr-12	Aug-13	Interim and final reports	UVM/VCHIP; Blueprint/DVHA	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-6.8	Work with the Biomedical Informatics Unit at UVM to identify research and evaluation questions for the Blueprint expansion to pediatrics that could be answered by the advanced analytics platform (currently under development) which will contain all-payer claims, clinical, and DocSite data	Jan-11	Aug-14	Research and evaluation questions of interest to pediatric stakeholders	UVM/VCHIP, UVM Biomedical Informatics; Blueprint/DVHA	
C-7.0	(Joint) ME/VT Task 7: Design and implement a comparative cross-state evaluation of the implementation and impact of ME and VT's child health quality improvement strategies using the pediatric PCMH model to complement and inform the national evaluation	Feb-11	Feb-15	Cross State Evaluation	MSPS, UVM/VCHIP	For more detail, please refer to subtasks C-7.1 through C-7.3 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
C-7.1	Design a comparative, cross-state evaluation, including questions, measures, and methods. Identify where state-specific measurement activities will generate comparable data to answer cross-state evaluation questions and where additional data collection may be required	Feb-11	Jun-11	Evaluation plan with specific metrics identified.		
C-7.2	Implement cross-state comparative evaluation	Jul-11	Jun-14	Collect data on comparable metrics identified across states		
C-7.3	Analyze data; produce interim and final reports	Jul-14	Feb-15	Final evaluation report comparing methods of each respective state and different outcomes.		
E-0.0	Category E: Create a model targeting healthcare delivery, coordination, quality or access	Jun-10	Feb-15			
E-1.0	Vermont Task 1: Assist an additional 20 states in development of a sustainable state Improvement Partnership to focus on the priorities of	Jan-11	Feb-15	20 additional states develop a sustainable Improvement Partnership	VCHIP, Vermont state partners (DVHA, Vermont Department of Health)	For more detail, please refer to subtasks E-1.1 through E-1.7 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
	this demonstration, particularly those not receiving Federal funding under the grant and smaller, rural states					
E-1.1	Determine objective set of standards to define an Improvement Partnership	Jan-11	Feb-11	Objective criteria for becoming an Improvement Partnership	UVM/VCHIP; NIPN Steering Committee	
E-1.2	Conduct systematic technical assistance needs assessment across existing IPs	Mar-11	Aug-11	Technical assistance needs assessment report	UVM/VCHIP; NIPN Steering Committee	NIPN Steering Committee may be asked to provide input into methodology for the technical assistance needs assessment.
E-1.3	Develop technical assistance tools and resources to assist states in initiating and sustaining an IP program	Nov-11	Dec-14	Tools/resources to support Improvement Partnership programs	UVM/VCHIP; NIPN Steering Committee, network member states	NIPN Steering Committee and network member states to review and provided feedback on developed resources as appropriate.
E-1.4	Initiate and maintain a robust online technical assistance resource center for developing/sustaining IP programs	Jan-11	Feb-15	Established SharePoint site available to network members	UVM/VCHIP; NIPN Steering Committee, network member states	SharePoint site allows all member states to post resources for use by the network. Previously identified as E-2.5; now moved to this task.

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
E-1.5	Recruit states for development of an IP program	Jan-11	Aug-14	List of interested states	UVM/VCHIP; Vermont state partners (DVHA, Department of Health)	<p>To date, UVM/VCHIP leadership have initiated conversations with states around development of an IP through multiple venues, including but not limited to: speaking engagements related to Bright Futures work; AAP networks; presentations at national conferences, e.g., Association of Maternal and Child Health Programs (AMCHP), Pediatric Academic Society (PAS), and the like. UVM/VCHIP will continue using these strategies to recruit states under the CHIPRA grant.</p> <p>Previously identified as E-2.6; now moved to this task.</p>
E-1.6	Conduct initial site visit in interested states, convening key partners from across the healthcare system to discuss the model and benefits of establishing an IP program	Mar-11	Mar-15	Site visit report with recommendations	UVM/VCHIP; Vermont state partners (DVHA, Department of Health)	<p>UVM/VCHIP leadership have had initial conversations with interested individuals in the following states: AL, DE, IA, IN, MD, ME, MO, NE, NH, and SC. Typically 2 representatives from Vermont conduct a site visit. Past visits have included a combination of UVM/VCHIP faculty and VT state employees.</p> <p>Previously identified as E-2.7; now moved to this task.</p>

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
E-1.7	Conduct on-going, individualized coaching to developing IPs as needed	Mar-11	Feb-15	Emails, notes from phone communications between UVM/VCHIP faculty/staff and state partners and IP states	UVM/VCHIP; Vermont state partners (DVHA, Department of Health)	VCHIP provides direct, one-on-one TA to states. NIPN provides a forum for UVM/VCHIP, as well as other IP member states receiving CHIPRA funding (i.e. NM, OR, UT, and WV), to share activities and learnings under the grant to network members, based on the interests of the group. One topic related to ME/VT's CHIPRA grant that has been an area of discussion for the network to date includes the role of Improvement Partnerships in assisting pediatric/family practices in achieving NCQA medical home recognition. UVM/VCHIP has been playing this role in the Vermont Blueprint for Health's work with the adult population, and will continue in the initiative's expansion to pediatrics, providing additional opportunities for learning about NCQA medical home recognition in child-serving practices. As ME/VT's grant work gets underway, project staff will have the opportunity to share learnings around other areas of grant implementation, including the automation of Bright Futures, supporting provider implementation of Bright Futures and other clinical guidelines, and supporting pediatric/family practices in their use of EHRs.

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
						Other areas of intersection between NIPN and CHIPRA grant activities will be explored throughout the course of the grant. Previously identified as E-2.8; now moved to this task.
E-2.0	Vermont Task 2: Continue to support the national network of Improvement Partnership states (National Improvement Partnership Network, or NIPN) through the provision of technical assistance	Jan-11	Feb-15	Operational and sustainable national network which facilitates technical assistance across member states	VCHIP, Vermont state partners (DVHA, Vermont Department of Health)	For more detail, please refer to subtasks E-2.1 through E-2.4 in Table E
E-2.1	Develop a five-year strategic plan for the network	Jan-11	Jun-11	Five-year strategic plan	UVM/VCHIP; NIPN Steering Committee and network members; National Advisory Committee	Convene NIPN Steering and National Advisory Committees to identify/recommend practice-level, state policy, and federal/national priority areas for the network and to direct continued development of the national IP model toward alignment with CHIPRA priorities

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
E-2.2	Conduct monthly network conference calls and plan and conduct annual in-person meetings to facilitate learning across member states	Jan-11	Feb-15	Conference call minutes; annual meeting presentations and materials	UVM/VCHIP; NIPN Steering Committee, network member states	VCHIP serves as convener and primary technical assistance (TA) provider though TA is also multi-directional between and across member states. Content of annual in-person meetings is customized to fit the current need of member states. Past meetings have addressed state/federal policy, IP program operations, and practice-level quality improvement topics.
E-2.3	Convene content-specific subgroups (Maintenance of Certification or MOC; NCQA), continuing to develop the network's role in areas that align with members' expertise	Jan-11	Feb-15	Conference call minutes, planning documents	UVM/VCHIP; NIPN Steering Committee, network member states	
E-2.4	Conduct on-going, individualized coaching to existing IPs as needed	Jan-11	Feb-15	Emails, notes from phone communications between UVM/VCHIP faculty/staff and state partners and IP states	UVM/VCHIP; Vermont state partners (DVHA, Department of Health)	VCHIP provides direct, one-on-one TA to states
E-3.0	Vermont Task 3: Evaluate the implementation, efficiency, and impact of the Improvement Partnership model and national network	Jan-11	Feb-15	Evaluation report(s) describing the Improvement Partnerships/ national network and their impact on healthcare quality	VCHIP, NIPN Evaluation Committee	For more detail, please refer to subtasks E-3.1 through E-3.11 in Table E

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/ Organization/ Staff	Remarks
E-3.1	Design evaluation, including questions, measures and methods in collaboration with stakeholders and with guidance from the NIPN Evaluation Committee	Jan-11	Feb-11	Evaluation Plan	UVM/VCHIP; NIPN Steering and Evaluation Committees	
E-3.2	Design data collection tools	Jan-11	Feb-11	Data collection tools	UVM/VCHIP; NIPN Evaluation Committee	
E-3.3	Review CHIPRA national evaluation design for Category E to ensure no duplication of efforts	Jan-11	Jan-11	Possible edits to evaluation plan	UVM/VCHIP	Mathematica has indicated that states' Category E projects will not be included in the national evaluation but has expressed interest in being kept abreast of developments in Vermont's local evaluation under this category. Vermont looks forward to sharing its work in this area with Mathematica and CMS.
E-3.4	Finalize evaluation design and data collection tools	Feb-11	Feb-11	Finalized evaluation plan and data collection tools	UVM/VCHIP; NIPN Evaluation Committee	
E-3.5	Obtain University of Vermont (UVM) Institutional Review Board (IRB) approval	Mar-11	Mar-11	UVM IRB approval	UVM/VCHIP	
E-3.6	Collect and enter data	Apr-11	Feb-13	Databases of qualitative and quantitative data	UVM/VCHIP	

Table E

Task	Task Description	Start Date	End Date	Outcome/Products	Responsible State/Organization/Staff	Remarks
E-3.7	Analyze data	Oct-11	Aug-13	Coded qualitative data summarized by major and sub-themes; graphs, tables, and (possible) statistical output of analysis on quantitative data	UVM/VCHIP; NIPN Evaluation Committee	
E-3.8	Use evaluation data to make improvements to technical assistance provision throughout grant years	Apr-12	Feb-15	Modified technical assistance resources, tools, and products	UVM/VCHIP; NIPN Steering Committee	
E-3.9	Write reports, papers and presentations	Apr-12	Aug-13	Reports, papers, presentations	UVM/VCHIP; NIPN Steering Committee, network member states	
E-3.10	Share and discuss findings	Sep-13	Feb-15	Emails, meeting minutes, conference notes, etc.	UVM/VCHIP; NIPN Steering Committee, network member states	
E-3.11	Use findings to refine the model and network	Feb-14	Feb-15	List of recommendations for modifying the model and making changes to NIPN based on evaluation findings; modified tools and reference documents	UVM/VCHIP; NIPN Steering Committee, network member states	

Table F

Management Plan

The management plan indicates how the overall project will be managed, including a plan for communication among task leaders and across the States of Maine and Vermont. Table F provides a detailed listing of the States, organizations (e.g., State agencies, contractors), and individuals involved in managing this demonstration, and what their roles are.

State	Agency/Contractor Organization	Key Staff	Role
Grantee: Maine			Organizational Structure:
	Maine DHHS including: OMS, ME CDC,OIT, & OSC-HIT, MSPS AAP, Maine Chapter Maine Parent Federation Quality Counts Vermont’s DVHA UVM VCHIP AAP, Vermont Chapter Child & Family Advocate TBD	Co-Chairs: Rod Prior Steve Maier	IHOC Executive Committee meets 2x/yr during implementation and serves as the primary oversight committee: <ul style="list-style-type: none"> • Provide expert guidance to grant activities; ensure consistency of activities with national and federal policy and initiatives • Ensure visibility of the demonstration within Maine and Vermont, regionally and nationally • Ensure stakeholder representation and buy-in in both states • Ensure communication, coordination and integration between Maine and Vermont • Ensure communication, coordination and integration with other child healthcare quality and related child health and wellness efforts within and across states • Provide final approval of a cross-state 5-year Operational Plan to include an evaluation plan • Serve as a resource to CMS and its technical assistance and evaluation contractors for the demonstration • Other roles as appropriate to support planning, implementation and evaluation of the demonstration, project goals and CMS objectives

State	Agency/Contractor Organization	Key Staff	Role
Maine Vermont	OMS ME CDC MSPS UVM DVHA	<p>Chairs: Brenda McCormick (ME) Steve Maier (VT) Judy Shaw (VT)</p> <p>Co-Chairs: Rod Prior (ME) Steve Meister (ME) Steve Maier (VT) Judy Shaw (VT)</p>	<p>The Steering Committees serve as the committees responsible for planning, implementation and oversight of the IHOC grant activities in each state:</p> <ul style="list-style-type: none"> • Establish all processes to achieve grant objectives • Oversee day-to-day activities to meet milestones and tasks of the grant • Review all draft project documents (planning, implementation, evaluation and reporting) • Execute daily/weekly project decision-making for objectives <p>The State Coordinating Committee will meet quarterly during the implementation phase and serve as the primary state-wide, broad-based stakeholder committee providing critical integration & input into IHOC grant activities:</p> <ul style="list-style-type: none"> • Provide feedback and direction to specific grant planning and implementation. • Ensure visibility of the demonstration within each state. • Engage stakeholders. • Ensure communication, coordination, and integration with other child healthcare quality and related child health and wellness efforts in the state • Review drafts and provide feedback of a state-specific 5-year Operational Plan for recommendation to the IHOC Executive Committee, to include an implementation plan and an evaluation plan • Other roles as appropriate to support implementation and evaluation of the demonstration, project goals, and CMS objectives

State	Agency/Contractor Organization	Key Staff	Role
Maine Vermont	MSPS UVM DVHA	Joanie Klayman ME Project Manager (TBD) Marie D'Amico Russell Frank	<p>CHIPRA Project Director oversees ME and VT CHIPRA operational plan. Project Managers from DVHA, VCHIP and ME:</p> <ul style="list-style-type: none"> • Provides the day-to-day oversight of CHIPRA grant implementation plan • Ensures Subcommittees convened and • Provides status updates to CHIPRA Project Director, Steering Committees monthly, State Coordinating Committees quarterly, and IHOC E.C. biannually, with ad hoc communication taking place as needed throughout the grant period.
Maine	MSPS	Joanie Klayman	<p>Sub-Recipient and Subcontractor development, management and oversight in Maine is provided by the Project Director for:</p> <ul style="list-style-type: none"> • Quality Counts • HealthInfoNet • Clinical Consultants • State of Vermont • University of Vermont
Vermont	UVM	Judith Shaw Paula Duncan Marie D'Amico	<p>Sub-Recipient and Subcontractor development, management and oversight for UVM/VCHIP includes:</p> <ul style="list-style-type: none"> • Clinical Consultants TBN • Johnson Group Consulting, Inc. • AcademyHealth (Lisa Simpson) • Category E Evaluation Committee Independent Consultants
Maine Vermont	USM UVM	Kim Fox Melissa Phillips	<p>Evaluation Plan: Maine and Vermont leads develop and implement:</p> <ul style="list-style-type: none"> • A process and outcome evaluation • A cross state evaluation on the PCMH Pilot

State	Agency/Contractor Organization	Key Staff	Role
Maine Vermont	MSPS DVHA UVM	Joanie Klayman Russell Frank Marie D'Amico	<ul style="list-style-type: none"> Collaborate with the national evaluation team <p>Sustainability Plan: IHOC Executive Committee provides oversight of the development and implementation of sustainability plan. Project Director and UVM/DVHA/ME Project Managers</p> <ul style="list-style-type: none"> Coordinate, communicate & monitor efforts
Maine			Category A: Collecting, Reporting & Aligning Measures:
	MSPS	Nath Anderson	<p>MSPS staff analyst manages the collection and reporting of CHIPRA core measures and additional measures and coordinates efforts with MPI, Quality Counts, coding specialists and reports to multiple stakeholders including:</p> <ul style="list-style-type: none"> ME Steering Committee MPI Subcommittee MSCC EPSDT Advisory Work Group ME CDC OMC
Maine			Category B: Promote the Use of HIT in Children's Health Care Delivery:
	OIT MSPS	Greg Schueman ME Project Manager	<p>Design and implementation of an integrated electronic data system for Bright Futures (EPSDT in Maine) that links to practices' EHR systems: The design and implementation of an integrated electronic data system is managed by the DHHS Office of Information Technology (OIT) Project Manager. OIT Project Manager</p>

State	Agency/Contractor Organization	Key Staff	Role
Maine	ME CDC MSPS	Dr. Stephen Meister ME Project Manager	<ul style="list-style-type: none"> • Provides coordinates and collaborates with Health Information Exchange vendor / REC vender, (which are the same vendor), HealthInfoNet • Ensures close collaboration and communication with the Maine Project Manager and provides status updates to multiple stakeholders <p>ME Project Manager staffs the HIT Subcommittee</p> <p>Design and develop an electronic Health Assessment supporting Maine’s children in foster care: The Chair of the Foster Care Work Group:</p> <ul style="list-style-type: none"> • Convenes work group members • Assists the work group in prioritizing health assessment data and workflow processes for electronic health assessment <p>ME Project Manager staffs the Foster Care Work Group.</p>
	OIT	Greg Schueman	<p>The OIT Project Manager:</p> <ul style="list-style-type: none"> • Develops the electronic processes for the flow of health data • Provides status updates to stakeholders
	DHHS Commissioner OIT MSPS OMS	Jim Leonard Greg Schueman Joanie Klayman or designee Dr. Rod Prior	<p>The Maine Office of State Coordinator of Health Information collaborates and meets regularly with CHIPRA Project Director, OIT Project Manager and other project staff and :</p> <ul style="list-style-type: none"> • Reviews State HIT progress • Impact on CHIPRA Implementation Plan and Time line <p>Project Staff attend monthly STATE HIT Update Sessions.</p>

State	Agency/Contractor Organization	Key Staff	Role
Maine	Quality Counts	Dr. Lisa Letourneau Dr. Amy Belisle	<p>Quality Counts will develop and implement quality improvement initiatives and learning activities such as learning sessions, academic detailing, learning collaborative sessions, web-based learning for the pediatric providers in Maine including:</p> <ul style="list-style-type: none"> • Training providers on Bright Futures • Work with the Maine Steering Committee and the MPI to prioritize additional learning activities. • Work with VCHIP & ME stakeholders on formerly establishing a Improvement Partnership in Maine • Participate in the MPI Subcommittee, the State Coordinating Committee, and the IHOC E.C Committee. • Provide project updates to the ME Project Manager, Project Director, Maine Steering Committee, the HIT Subcommittee, the Maine State Coordinating Committee, and IHOC EC Committee with ad hoc communication as needed throughout the grant period
Vermont	UVM DVHA	Russell Frank Judith Shaw Paula Duncan Marie D'Amico Craig Jones Lisa Dulsky-Watkins Hunt Blair Victoria Loner, DVHA Deputy Director	<p>Expansion of Blueprint for Health Advanced Primary Care Practice (APCP) activities: DVHA and UVM/VCHIP IHOC project leadership</p> <ul style="list-style-type: none"> • Collaborate with Blueprint for Health Director and Associate Director and the Director of the Healthcare Reform Division to ensure alignment of CHIPRA with the Blueprint for Health statewide expansion (inclusive of HIT infrastructure expansions).
	DVHA	Craig Jones Lisa Dulsky-Watkins	<p>Blueprint for Health Director and Associate Director are responsible for expansion of the Blueprint APCP statewide. VCHIP NCQA scorers and pediatric practice facilitators:</p> <ul style="list-style-type: none"> • Staff a portion of the expansion efforts to pediatric and family practices (the remaining staffing needs are met through non-CHIPRA funding sources, including State funds).
	UVM	Paula Duncan Caitlin Patterson (VCHIP NCQA Scorer) VCHIP NCQA Scorer TBN	

Monitoring Plan

The progress and success of this demonstration will be monitored using the framework of goals, objectives, strategies, and activities articulated in the final Operational Plan for the demonstration developed in the initial nine-month planning phase. With regard to project administration and implementation, we will utilize the implementation plan presented at the top of this Section to monitor project administration and implementation. Progress and challenges will be measured and reported on a monthly and quarterly basis for each of the Categories for Maine and Vermont as well as for cross-state activities. The implementation plan, additional work products, plans and meeting minutes will be posted on SharePoint for cross state review.

Table G

Technical Assistance

Maine and Vermont have objectives and tasks in their operational plans that will require the expert advice and implementation assistance of several key external partners. To the extent that these needs and potential partners have been identified, this information is presented in Table G. While we do not anticipate these needs overlapping with areas of technical assistance that CMS will provide to all grantees, we recognize that should this occur we would need to adjust our TA plans and contracts accordingly.

Grantee	Entity Providing TA Procured by Grantee/ Key Personnel	State(s) Receiving TA Procured by Grantee	Area(s) in Which TA Procured by State Will Be Provided	Additional TA from CMS Needed by Grantee
Maine	Pediatric clinical consultants	Maine	<ul style="list-style-type: none"> • Selection and implementation of additional measures to collect and report • Linkages and outreach to pediatric health providers and health systems 	The grantee would appreciate technical assistance regarding incorporating supplemental measures (not in the initial core set) into the demonstration. Maine will work with SAMHSA to identify possible behavioral health measures.
Maine	Quality Counts	Maine	Practice Improvement Initiatives	
Maine	HealthInfoNet	Maine	Health Information Exchange	
Maine	Approximately 10 independent physician advisors	Vermont	Conduct clinical and technical review of guideline-based data elements in the <i>Vermont Blueprint for Health</i> central registry (DocSite) for clinical accuracy and feasibility of implementation	
Maine	4-7 independent expert consultants (confirmed: Klein-Walker, D.; Mangione-Smith, R.; Kogan, M.; Lasker, R.)	Vermont	Serve in an advisory capacity to the design and implementation of Vermont's Category E evaluation	
Maine	Kay Johnson, President of Johnson Group Consulting, Inc., of Hinesburg, VT	Vermont	Develop technical assistance materials to support building and sustaining an Improvement Partnership program in states	

Maine	Lisa Simpson, incoming President and CEO, AcademyHealth	Vermont	Serve in an advisory capacity to UVM/VCHIP on strategic direction and policy implications for the National Improvement Partnership Network (NIPN).	
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Evaluation Activities

Provide the information requested below:

Grantee: Maine and Vermont

Does the grantee plan to conduct any independent evaluation activities?

Yes No

What is the status of these planned activities?

The Muskie School of Public Service (MSPS) and the University of Vermont (UVM) have worked with their respective state partners to develop logic models to describe each state’s activities and to identify short-term, mid-term, and long-term goals of the project. From these logic models, each state will develop an evaluation plan for measuring progress toward program goals. Maine’s approach is primarily formative and will be designed to assist the state in conducting environmental scans, collecting baseline information and qualitative feedback from practices and consumers in advance of and during implementation to inform system design, and tracking and monitoring measures over time to assess program impact. Maine has two logic models. The first logic model reflects Maine’s goals and strategies for supporting practice improvement for providers serving all MaineCare children in the state. The second logic model is focused on the work that they are doing to improve medical management and care coordination for foster care children. Both logic models are attached.

UVM has also developed a logic model for the Blueprint for Health initiative as a whole, which applies to both the adult and pediatric populations, which they plan to evaluate based on metrics and outcomes defined.

UVM is also currently in the process of designing a local evaluation of the Improvement Partnership model and the National Improvement Partnership Network (Category E). Evaluation questions are being drafted and discussed both internally and with the national evaluator and project stakeholders. A national advisory committee to this evaluation has been formed and has completed its first meeting by teleconference.

Together the states also will define shared metrics to be included in a cross-state evaluation comparing changes in pediatric quality with different approaches. The team intends to coordinate closely with the national evaluators to ensure that there is no duplication with the national evaluation.

Maine's evaluation activities in Category A and B entail process and formative evaluation that will supplement and inform the national evaluation in terms of contributing to the collection of data needed and identification of barriers encountered but that are primarily intended to provide real-time information to inform program design and improvement. These activities will include quantitative and qualitative data collection to monitor program progress and barriers/solutions, analyzing performance on measures over time to identify areas for quality improvement, and gathering information to identify appropriate and meaningful strategies for reporting that will supplement providers' existing systems. For Category C, Maine will expand its evaluation of the patient centered medical home pilot, which began in 2009 to include pediatric practices and measures. As an extension of the broader evaluation of adult PCMH practices, we will be comparing the experience of the Pilot practices with two groups of comparison practices: those that applied but were not accepted for the Pilot (n=24) and a sample of "usual care" adult primary care and pediatric practices (n=66). We provided an overview of our proposed methodology to the National Evaluators in conference calls and await upcoming discussions in January to discuss strategies for coordinating our local evaluation with the national evaluation. These strategies will be addressed in our evaluation plan addendum when the plan of the National Evaluation is more clearly defined.

Vermont's proposed activities under Categories B and C involve assisting in the legislatively mandated expansion of an existing program of the State of Vermont, the Vermont Blueprint for Health, to the pediatric population. This mandate, Act 128, states that "the commissioner of Vermont health access shall expand the Blueprint for Health as described in chapter 13 of Title 18 to at least two primary care practices in every hospital services area by no later than July 1, 2011, and by no later than October 1, 2013, to primary care practices statewide whose owners wish to participate." The Blueprint has devised a list of practices in the state that have expressed interest and are considered ready to join the Blueprint through July 2011 which they are sharing and discussing with partner organizations. Three pediatric practices are currently included on this list.

Given this programmatic framework, in our initial discussions regarding an evaluation design for the expansion of the Blueprint for Health to pediatrics, we discussed the possibility of using a phased time-series design to study changes in clinical processes and possibly child health outcomes. In this design, baseline chart review data would be collected on a random sample of children (with conditions of interest as well as well children to look at preventive services) in the initial three pediatric practices joining the Blueprint as well as three practices as similar to the initial three as possible who had not yet been chosen to join the Blueprint. One of the difficulties identified with this approach would be that the three practices chosen as comparison practices may be chosen by the Blueprint to join the initiative within varying timeframes, before post data collection was set to occur. Discussions will continue with UVM/VCHIP and Muskie evaluation staff, Blueprint leadership, and the National Evaluator to determine appropriate comparison

practices that meet the needs and requirements of both the legislative goals of the Blueprint and the National Evaluation of the CHIPRA grant. The outcome of these discussions will be described in the evaluation plan addendum to this Final Operational Plan.

In terms of an evaluation design to examine change in medical homeness, the Blueprint has used the NCQA PPC-PCMH survey, administered by a UVM/VCHIP evaluation team, to score practices in order to determine the multi-insurer per member per month (PMPM) enhanced payment. This process is considered the entry point into the Blueprint program and will be continued as the program expands statewide (including to pediatric practices). The survey may be repeated annually in participating practices by VCHIP in order to track improvements in medical homeness over time and to compare scores to clinical health and process outcomes (collected annually).

We will continue to collaborate and coordinate with the National Evaluator on all of these activities in order to provide all required data to the national evaluation.

FIRST PROGRESS REPORT

Tables H1 – H5

The following tables, H1 – H5, represent the progress report for Maine and Vermont’s IHOC activities that occurred between February 22, 2010 and November 22, 2010. These tables identify major milestones that have been achieved as well as their outcomes. In addition, we note changes in task completion dates, barriers to completion, and lessons learned while preparing for implementation.

H1: Overall Grant Implementation

Task	Task 1-1: Develop organizational structure for demonstration grant	Task 1-2: Finalize Evaluation Plan	Task 1-3: Finalize Operational Plan
*Numbers indicate cross-reference to tasks on Tables D and E			
Description	-Establish membership and convene State Coordinating Committees, Subcommittees & Pediatric Council	-Develop initial evaluation plan -Coordinate with national evaluators -Define process & outcomes measures	-Create internal processes for FOP approval through IHOC Executive Committee -Convene subcommittees and Pediatric Council -Conduct detailed inventories of existing and planned healthcare quality initiatives -Awaiting Exit Conference & CMS approval
Start Date	March 2010	March 2010	March 2010
Target Completion Date	June 2010	Sep 2010	Nov 2010
Actual Completion Date	Anticipated Dec 2010	Anticipated Feb 2011	Nov 2010
Reasons for Variance in Completion Date	Most subtasks completed: IHOC Executive Committee and Maine and Vermont State Coordinating Committees convened; Cooperative Agreement between ME DHHS and USM signed, Subcontract with State of Vermont signed. Subtasks outstanding include hiring Maine Project Manager, DVHA Project	National evaluation plan will not be completed January 2011. To ensure coordination with the national evaluation plan, local evaluation plan will be finalized by Feb 2011, per CMS guidance.	N/A

	Manager, Finalization of Subcontract between Maine and UVM, and final determination of project management software.		
Outcome	Governance, staffing management structure, and roles	Logic Models completed in Maine and Vermont. Evaluation teams have met internally and with the national evaluators to coordinate work.	Internal approval processes developed Subcommittees convened Pediatric Council membership redistributed to other committees -Inventory of quality initiatives in the state completed -FOP submitted
Barriers Encountered/ State Response	Differing institutional business and financial policies, procedures, and practices between state universities required significant negotiation by all parties. Each institution sought consultation from legal, financial and project staff. Multiple meetings were held with key individuals to clarify and resolve issues. Recruitment and hiring is often dependent on contract status and therefore must wait until contracts signed.	N/A	N/A
Lessons Learned	Subcontracting process is complex and may require significant project, legal and financial resource to negotiate terms.	N/A	N/A
Technical Assistance Needs	N/A	N/A	N/A
Remarks	Pediatric Council has been absorbed into other committees. Contract with UVM is under final review and will be submitted for signatures as soon as accepted	ME and VT evaluation team are currently defining process & outcome measures to be used for monitoring, formative evaluation. Plan to coordinate efforts with national evaluator to ensure no duplication of effort	Awaiting Exit Conference & CMS approval
Task	Task 1-4: Create a Pediatric	Task 1-5: Develop and	Task 1-6:

	Improvement Partnership (IP) in Maine	implement a sustainability plan beyond the CHIPRA Grant period	Complete Grantee Deliverables
*Numbers indicate cross-reference to tasks on Tables D and E			
Description	<ul style="list-style-type: none"> -Detailed inventory of pediatric QI initiatives -Engage QI initiative representatives to participate in a coordinated, and aligned pediatric QI effort -Identify child health practices with a high volume of children with MaineCare 	<ul style="list-style-type: none"> -Brief Me's Governor-elect & leadership team on CHIPRA -create IHOC website -Incorporate CHIPRA measures into Managed Care RFP & Contracts - Pursue funding 	<ul style="list-style-type: none"> -Expenditures, --budgets, -progress reports and -final report submitted
Start Date	Sep 2010	Sep 2010	Feb 2010
Target Completion Date	Feb 2015	Feb 2015	Feb 2015
Actual Completion Date	Started	Started	Started
Reasons for Variance in Completion Date		-N/A	N/A
Outcome	<ul style="list-style-type: none"> -Inventory of QI initiatives completed -QI representatives approached and will continue to explore and engage representatives Identified child health practices with a high volume of children with MaineCare 	CHIPRA Project Staff are on Managed Care Work Groups	<ul style="list-style-type: none"> 9/2010 expenditure report submitted to CMS -11/2010 FOP submitted
Barriers Encountered/ State Response	We need to find a neutral location in state for child health improvement partnership; many groups are interested but not all have infrastructure or some have infrastructure but not widespread provider buy-in. We need to be inclusive of QI initiatives statewide.		

Lessons Learned			
Technical Assistance Needs	We are obtaining technical assistance from our partners in Vermont , Quality Counts, & Pediatric Clinical Consultants		
Remarks	Ongoing work with Vermont to schedule time for consulting in state with stakeholder groups	planning is underway on how to incorporate CHIPRA measures, reporting and pay for performance incentives into Managed Care RFP	

H2: Grant Category A

Task	Task A-1: Engage & Convene MPI Subcommittee & State Coordinating Committee	Task A-2, A-3, A-4. Develop, test and validate the initial core measures	Task 5: Align MaineCare payment/financial incentives with pediatric quality measures
<i>*Numbers indicate cross-reference to tasks on Tables D and E</i>			
Description	<p>-Interview practices on data capacity, provider feedback, for revisions to PCPIP & UR reports -Convene annual summit</p> <p>The original objective has been modified to read: Engage and convene Measures and Practice Improvement (MPI) Subcommittee (including pediatricians, family physicians, pediatric nurse practitioners, physicians assistants, and pediatric healthcare professional organizations) and the State Coordinating Committee (including child & family advocates, public & private payer, QI, health systems</p> <p>- Inform pediatric medical providers about collection & reporting of core measures through Grand Rounds and electronic communication - Elicit input & feedback from stakeholders on how measures are helpful for practice improvement in improving health outcomes</p>	<p>-Review final specifications of core measures and finalize implementation plan -Produce claims based measures and integrate into provider reports -Incorporate survey data & Bright Futures data into MaineCare Reports</p> <p>The original objective as stated above has been modified and expanded relative to the original grant proposal due to the complexity and level of detail necessary to collect and report on the measures. The original objective is now separated into three primary tasks: - Identify data sources for collecting the CHIPRA initial core measures (A-2.0) - Collect and review CHIPRA, CMS 416, and other identified measures (A-3.0) - Identify barriers and explore solutions to implementation barriers (A-4.0)</p>	<p>-Determine initial reporting requirements and pay-for-performance incentives to recommend in Managed Care Contract(s) RFP</p> <p>-Conduct survey(s) on the use of reporting measures</p> <p>-Evaluate impact of pay-for-performance incentives over-time</p>
Start Date	Originally May 2010 revised in FOP to July 2010	July 2010	Sep 2010
Target Completion Date	Originally Oct 2010 revised in FOP to Feb 2015	Jan 2013	Dec 2014
Actual Completion Date	Started	Started	Started

Reasons for Variance in Completion Date	Task is revised and incorporated into new Implementation Plan as a key, on-going activity through-out the grant period.	Task revised and incorporated into new Implementation Plan	N/A
Outcome	<p>Maine SCC and the MPI Subcommittee have both met several times since 7/10. Outreach efforts were successful, and current members include representatives from targeted organizations and stakeholder groups.</p> <p>Focus of the first several MPI Subcommittee meetings was on presenting and getting feedback on the CHIPRA core measures and additional measures recommended by the Maine AAP Quality Improvement Subcommittee. Feedback will be sought throughout grant period.</p> <p>Maine providers required to report on numerous measures, which vary according to payer, quality improvement organization, etc. (e.g. HIT/meaningful use criteria, CHIPRA measures, UDS reporting for FQHC providers, Pathways to Excellence for MHMC providers). A new task is added to align pediatric quality measures as much as possible.</p>	<p>Draft measures available have all been reviewed and implementation plan completed for the FOP.</p> <p>We will contrast, compare and revise implementation plan if necessary, once measures are finalized.</p> <p>The following 8 Draft Measures are currently produced from MaineCare claims data for the PCPIP and UR reports: - Chlamydia, WCVs in first 15 mo, WCVs in 3-6 years, WCV 12-21 years, ED visits, ADHD f/u, Hemoglobin A1C,</p> <p>Access to Primary Care Programming for the extraction of the following Draft Measures from MaineCare claims is complete: - Preventive Dental Services, Pharyngitis, Otitis Media, Received Dental Treatment Services, f/u mental health. (Waiting for final specifications for asthma ED visit measure.)</p>	<p>Several members of the CHIPRA steering committee are on the planning committees for the managed care transition and are working to ensure that the MCOs will be required to provide the data</p> <p>- CHIPRA staff and/or members of the Steering Committee will also participate in the Finance and Operations subcommittees to ensure that requirements of managed care contracts include performance incentives for providers, including participants in the state's PCMH Pilot</p>
Barriers Encountered/ State Response	<p>Providers have limited time to attend meetings. Project is maximizing participation by using conference call option and by scheduling meetings during lunch hour.</p> <p>Annual pediatric summit proposed in the original proposal has been</p>	<p>We anticipate needing to code and extract some measures from claims, and determine what is necessary to access payer-specific data for some claims that are not currently identified by payer</p>	<p>We will report barriers and state response as we move forward.</p>

	<p>eliminated in favor of ongoing communication with provider community throughout grant period through the MPI, Grand Rounds and electronic communication.</p>	<p>Impact of the implementation of Managed Care on the collection of the Core Measures is not known at this time. For example, production of measures based on claims may need to be shifted to managed care organizations (through contracting), or the development of an encounter data warehouse. State investigating other states experience testing CHIPRA core measures with Medicaid managed care to inform MCO contract requirements/use of encounter data.</p> <p>Claims-based measures may not accurately reflect services provided by FQHC and RHC practices that bill under a bundled payment. FQHCs also indicated differences in measures they are required to report to HRSA and core measures.</p> <p>State is working with the FQHCs in order to improve validity of measures.</p>	
Lessons Learned	<p>Providers involved in SCC and MPI have made strong recommendation to align the pediatric measures required by CHIPRA with those required by QI organizations, health systems, HIT/meaningful use criteria, and other funding or regulatory organizations. Not feasible for providers to collect or provide data on several versions of the same measure</p>	<p>Stakeholder feedback indicates limited time and resources available for measure collection activities. Minimizing impact on practices will be important to successful implementation.</p>	To be determined
Technical Assistance Needs			
Remarks		<p>Final measures have not been posted. Draft measures reviewed.</p>	

H3: Grant Category B

Task	ME Task B-1: Collaborate & coordinate with Health Systems & FQHC's to determine interface specifications in order for them to participate in the automation & exchange of EPSDT data (<i>Bright Futures</i>)	ME Task B-2, B-3: Design, implement & evaluate an electronic health data system for children in ME's foster care system.	ME Task B6: Design Implement & Evaluate an electronic data system for <i>Bright Futures</i> (EPSDT in ME) (originally Task B-1 and revised in new Implementation Plan)	
*Numbers indicate cross-reference to tasks on Tables D and E				
Description	<p>-MPI Subcommittee membership represents health systems & FQHC's and are working to identify prioritize, standardize and define measures to automate:</p> <ul style="list-style-type: none"> - map them to meaningful use standards -determine additional measures to collect - coordinate with Pathways to Excellence (MHMC) and other professional associations <p>-“As Is” Assessment in process to determine how providers currently use & submit EPSDT data to MaineCare</p>	<p>-The original objective as stated above has been modified and expanded to several subtasks relative to the original grant proposal, due to the complexity and level of detail necessary to establish an electronic health assessment for children in foster care.</p> <p>We convened work groups on three occasions to identify & prioritize work flows & data elements</p> <p>An “As Is’ Assessment is underway to determine current work flows.</p> <p>Work group reviewed the implementation plan and provided feedback on the plan described in Tables D and E of this Final Operational Plan.</p>	<p>-The original objective as stated above was listed first relative to the original grant proposal. It has since been modified with different start and end dates, due to the complexity and need to address multiple tasks.</p> <p>For example, the original task indicated an immediate focus on developing a platform for data entry.</p> <p>Since then, we received a recommendation to consider developing an interim electronic EPSDT system, prior to the design and implementation of the automation infrastructure. We are now reviewing this recommendation and have created additional tasks and subtasks accordingly.</p>	<p>Maine’s system of health assessment of children in foster care relies on a system of comprehensive assessment by a small number of pediatric care organizations who have special training and experience in the assessment and treatment of children in foster care. We plan to pilot secure, electronic linkages and connections between authorized users in a health assessment clinic that serves six counties in Maine, and a state electronic data system. In addition to expediting the health assessment process, this will also serve to create an electronic health record in the Office of Family and Child Services. This assessment will be available for health care providers, and guardians as the children leave foster care and/or age</p>

			<p>Another example is associated with the original subtask of identifying a central repository system. We have since learned we need to complete a thorough assessment of current state systems to determine alignment capacity.</p> <p>We also need to determine specific data fields as a preliminary step to building an automated data system.</p> <p>All of the above are now reflected in additional tasks and subtasks on the Implementation Plan.</p>	<p>out of the foster care system. Simultaneously, Maine has privacy laws regarding the release of mental health and HIV data which impact the flow of this information through the Health Information Exchange. A legal work group has been formed and is working to introduce legislation that will amend current state law to allow for an opt-in consent mechanism for the exchange of “high risk” data. If passed this would allow for the exchange of behavioral health and other sensitive information with appropriate consents. If the state legislation does not pass, the state will continue to work with consumer and advocacy interests (including the Civil Liberties Union) to determine a strategy that will allow consent to be given for exchanging information appropriately which may include a requirement of physicians and other practitioners to solicit consent to share information during a patient visit. Currently the HealthInfoNet Consumer Advisory Committee, the Office of the State Coordinator for HIT and the Attorney General are working on strategies to</p>
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				address such a contingency. The IHOC grant will also work with state officials within the Maine DHHS Office of Child and Family Services, the State HIT Coordinator, and members of the Legal work group to develop an alternative means of distributing the foster care health assessments while working towards a solution.
Start Date	Sept 10	Sept 10	Revised date Oct 12	
Target Completion Date	Feb 15	Dec 14	Oct 2014	
Actual Completion Date	Started	Started	N/A	
Reasons for Variance in Completion Date	Subtasks are in process.	Subtask is in process. Multiple tasks and subtasks added to the new implementation plan		
Outcome	Draft measures under review by stakeholders. “As Is” Assessment provides information that informs discussion and decision making.	Work Group convened and identified multiple needs and priorities. Conducted review of similar efforts in other states. Concept paper for baseline study of service use, quality and costs of foster care children with and without comprehensive evaluation approved by the Work Group. Study design parameters established and data analysis is underway.	Several new tasks and subtasks are now included in the Implementation Plan.	.
Barriers Encountered/ State Response	State has several data systems in that currently access different data. Need to assess each systems capacities and limitations in	Multiple data needs identified by different stakeholders, with multiple data sources and systems	We have created a new task to capture barriers and states response to barriers.	.

	<p>relation to the need for a central repository.</p> <p>Need data fields prior to starting to build electronic data system. Purchased Bright Futures Toolkit and license. Specific requirements related to License require a change in licensee and signed statements by Clinical Consultants.</p> <p>-Need for coordination of efforts reinforced especially in light of competing demands on providers.</p> <p>-Multiple EMR's in use state-wide. Plan to engage health systems participation in IHOC HIT Subcommittee</p>	<p>identified.</p> <p>Expense to address multiple data system is higher than anticipated.</p> <p>Also complicated by state and federal laws. Legislative action needed to change state laws regarding the sharing of behavioral health data.</p> <p>Responses:</p> <p>-System design redefined, with a phase –in process.</p> <p>-Communications with State HIT Coordinator about a legal work group addressing behavioral health barriers.</p>		
Lessons Learned	License Terms and Conditions need to be reviewed prior to purchasing the product.	Adding Behavioral health data significantly complicates data exchange.	We will detail the lessons learned when we respond to the newly revised task B6.	
Technical Assistance Needs				
Remarks				

Task	VT Task B-8: Extend the Blueprint & HIT infrastructure to support the Pediatric Blueprint.		DVHA, VCHIP	
*Numbers indicate cross-reference to tasks on Tables D and E				
Description	<ul style="list-style-type: none"> - Convened the Blueprint/HIT Subcommittee and pediatric leadership group (including representatives from the AAP-VT Chapter and the VT Department of Health) to serve in an advisory capacity to the Blueprint rollout to pediatrics and CHIPRA demonstration grant. -Members of both committees have reviewed and provided feedback on the implementation plan described in Tables D and E of this Final Operational Plan. - UVM has provided clinical consultation to the DocSite registry team for inclusion of Bright Futures data elements and performance measures into the registry -Pediatric practice facilitators have attended training sessions conducted by the Blueprint and DocSite staff on use of the DocSite registry and how to support practices in its use. 			
Start Date	03/2010			
Target Completion Date	11/2010			
Actual Completion Date	11/2010			
Reasons for Variance in				

Completion Date				
Outcome	Established advisory committees and finalized five-year implementation plan			
Barriers Encountered/ State Response				
Lessons Learned				
Technical Assistance Needs				
Remarks				

H4: Grant Category C

Task	Maine Task C-1: Identify the measures to focus practice improvement efforts, and invite pediatric practices in the PCMH Pilot, to test.	Maine Task C-2: Implement the <i>Bright Futures Toolkit</i> with child health providers and assess impact on EPSDT services in Maine
*Numbers indicate cross-reference to tasks on Tables D and E		
Description	-Pediatric practices in the PCMH Pilot will integrate the identified measures into PCMH pilot	-Outreach to pediatric providers about IHOC, Bright Futures Toolkit and practice improvement initiative -Engage health systems in Maine to create buy-in and participation. -Outreach and engagement of Dental Association -Implement <i>Bright Futures</i> -Monitor changes in EPSDT reporting -Pilot <i>Bright Futures</i> automation with select practices
Start Date	June 10	Sept 10
Target Completion Date	Dec 10	Jan 13
Actual Completion Date	Started	Started
Reasons for Variance in Completion Date	N/A	N/A
Outcome	-Developed a list of Pediatric Measures including draft of CHIPRA core measures, <i>Bright Futures</i> /EPSDT/requirements to inform automation of measures - Physician consultants have met with 4 PCMH practices about the draft of CHIPRA core measures and other Pediatric quality measures; engaged many times with Quality Counts Exec Director- Dr. Lisa Letourneau about PCMH Pilot	- We have introduced the <i>Bright Futures</i> toolkit to providers on the Measures and Practice Improvement Subcommittee and the 4 PCMH Pilot sites; - We purchased the license for the <i>Bright Futures Toolkit</i> - <i>Increase awareness of CHIPRA Demonstration Grant statewide :</i> -ME CDC Medical Director has given Grand Rounds in Bangor about IHOC, talk at Maine AAP Meeting; MPI group has met to give providers from all residency programs in state info about IHOC; future Grand Rounds being scheduled .

<p>Barriers Encountered/ State Response</p>	<p>-Every group has different specifications and requirements that they must meet; measures are all different- different immunizations required, different well child check measures, etc; -CMS priority areas are not fully reflected in CHIPRA measures (hearing/vision). -PCMH Pilot began prior to CHIPRA demonstration grant and the pediatric practices participating in the Pilot are already doing a lot of intensive work on practice transformation. They are interested in CHIPRA demonstration grant; yet don't want to over commit. -Collaborating with physicians is essential. AAP QI Committee is key partner of CHIPRA and has worked on measures along with guidance from Maine CDC, Quality Counts, PCMH Pilot and EPSDT Advisory Committee.</p> <p>Issue identified re: payer-specific, practice-specific measures. Several existing QI initiatives' measures are not payer-specific. State is convening stakeholder group to discuss whether to collect data on all children or MaineCare children alone.</p>	<p>-We have reached out to providers at different health care systems to join MPI Subcommittee. It took significant, targeted outreach from physicians to recruit providers other than pediatricians. -We invited senior leaders of health care systems to join MSCC. It is difficult for them to come to a centralized location. -We will develop a coordinated effort to engage health care executives and go to their locations</p> <p>Paper state encounter forms are different from new <i>Bright Futures</i> format and therefore need to be revised.</p>
<p>Lessons Learned</p>	<p>-CHIPRA Physician Consultants aid the engagement and participation of the practices -Health care systems and practices are interested in meaningful use measures and reimbursement; -Need to make CHIPRA measures relevant to organizations Recommend greater alignment nationally on measures because it is very confusing for practices -Need to coordinate QI efforts so that we don't overwhelm practices and providers with busy clinical practices -</p>	<p>-We need a multifaceted approach, utilizing existing means to reach providers- Grand Rounds, emails; talks at conferences; updates to Maine Academy of Family Practice and Maine Chapter of AAP. -Need to engage senior leaders personally and at their offices- it is unlikely to get them to come to frequent meetings in Augusta -Maintenance of Certification (MOC) provides an incentive for pediatricians to participate in quality improvement initiatives.</p>
<p>Technical Assistance Needs</p>	<p>Pediatric Clinical Consultants and Quality Counts Clinical Consultant</p>	<p>Pediatric Clinical Consultants</p>
<p>Remarks</p>		

Task	Maine Task C-3: Develop a Pediatric Improvement Partnership that supports learning communities and quality improvement initiatives (links to Task 1-4.0 and VT Task E-1.0)	
*Numbers indicate cross-reference to tasks on Tables D and E		
Description	<ul style="list-style-type: none"> -Contact all and track all professional organizations and groups running collaborative to find out work plans, goals, timelines to align QI efforts -Identify & determine practices serving high volumes of children with MaineCare -Determine topics & implement learning initiative(s) identify learning -Determine if feasible to implement behavioral health learning initiative 	
Start Date	Sept 10	
Target Completion Date	Jan 15	
Actual Completion Date	Started	
Reasons for Variance in Completion Date	N/A	
Barriers Encountered/ State Response	<p>-We are talking with different groups about a neutral location for pediatric improvement partnership. Several groups are interested, but they don't all have the infrastructure needed, engagement of senior leaders in organization, or provider buy-in to be successful.</p> <p>We are working with Quality Counts on developing pediatric improvement partnership and have identified the importance of including other QI partners the effort.</p> <p>-Many QI initiatives are struggling financially and looking for financial resources.</p>	
Lessons Learned	<p>-Many groups are interested in developing or being part of an Improvement Partnership.</p> <p>We need to develop infrastructure.</p> <p>Many groups are interested in further funding for projects and are struggling to determine sustainable funding source- several health care organizations have infrastructure, but do not reach all pediatric groups in the state</p>	

	<p>CHIPRA Demonstration Grant may be able to assist in finding ways to bridge health systems to spread change.</p> <p>-Several different QI organizations are doing pilots at same time of the CHIPRA Demonstration Grant and we need to work together so we are not overwhelming practices with different efforts.</p> <p>We will start to build Pediatric Improvement Partnership to try and coordinate efforts as well as inform practices of what QI opportunities are available</p>	
Technical Assistance Needs	Pediatric Clinical consultants, Quality Counts consultant, VCHIP	
Remarks		

H5: Grant Category E

Task	VT Task E-1: Assist 20 states in developing a sustainable state Improvement Partnership by 2015		
*Numbers indicate cross-reference to tasks on Tables D and E			
Description	<p>- UVM has launched a NIPN website housed on the UVM College of Medicine website; UVM has also initiated an online TA resource center available to network members. Resources developed by VT as well as other network states are being uploaded and made available to the full network.</p> <p>- During the planning phase, IHOC project staff at UVM/VCHIP proposed to conduct a systematic technical assistance (TA) needs assessment across existing Improvement Partnership states to inform resource development and key areas for TA provision to new states.</p>		
Start Date	Revised date Jan 11		
Target Completion Date	11/2010		
Actual Completion Date	Not yet complete		
Reasons for Variance in Completion Date	<p>UVM/VCHIP has continued to support the existing National Improvement Partnership Network (NIPN), providing TA to member states through funding from The Commonwealth Fund (grant end 2/28/2011). Under the Commonwealth grant, VCHIP conducted an operations training in July 2010 to address select operations-focused TA needs identified by member states. A more systematic TA needs assessment will be conducted in the implementation phase of the CHIPRA grant.</p>		
Outcome			

Barriers Encountered/ State Response	UVM/VCHIP's goal in moving from Commonwealth funding to CHIPRA to support NIPN was to ensure that IP member states experienced a seamless transition. To accomplish this goal, the UVM/VCHIP team balanced planning under CHIPRA with implementation under Commonwealth funding. We were able to secure a no cost extension on the Commonwealth contract to ensure that all implementation was covered under this funding stream until we received CMS approval of the Final Operational Plan for implementation to occur under CHIPRA. As part of the Category E planning discussions, the TA needs assessment was designated as an implementation activity, and was therefore shifted to occur in the first 6 months of Year 2 of the grant.		
Lessons Learned			
Technical Assistance Needs			
Remarks			

ATTACHMENT A

MAINE HIT/E

Under the Maine Center for Disease Control and Prevention, the Office of the State Coordinator (OSC) for HIT is administered by the State HIE Coordinator and a staff to carry out its activities. In coordination with the members of a statewide steering committee, which includes IHOC representation through both Medicaid and Public Health representation the OSC for HIT is responsible for statewide HIT & HIE planning, aligning the HIT planning efforts with the State Health Plan, ARRA Planning/Implementation, State Agency Coordination on all HIT related efforts, and financial and regulatory oversight of HIT and HIE efforts and initiatives throughout the state. The office is staffed by the State HIT Coordinator and project management and administrative staffing to support all statewide HIE planning efforts.

The OSC for HIT is tasked with the following:

- § Serve as a focal point on HIT and HIE policy and assure coherent, collaborative cross agency state HIT planning
- § Serve as a clearinghouse for all state HIT policy
- § Coordinate efforts across State government agencies (MaineCare, Maine CDC, Department of Education, Division of State Employee Health Benefits, Maine Emergency Management Association, and other appropriate agencies)
- § Align HIT planning efforts with the State Health Plan
- § Coordinate ARRA HIT/HIE planning and implementation, and provide financial and regulatory oversight of HIT and HIE efforts and initiatives throughout the state
- § Develop and disseminate public information about HIT and HIE through partnerships with stakeholders
- § Work collaboratively with HIN, the State's designated health information exchange, or its successor, pursuant to the public-private partnership as outlined in the State HIT Plan

1.1.1 State HIT Coordinator

The State HIT Coordinator is responsible for fostering the secure movement of health information across the state and effectively working within state government, and with public and private sector stakeholders. To assure appropriate collaboration between the OSC, HIN, MQF, and MHDO, the State HIT Coordinator participates on the Board of each of these organizations

The State HIT Coordinator is responsible for the following tasks:

- § Develop Maine’s Strategic and Operational Plan for statewide HIE in alignment with the state’s vision, direction, requirements, and the needs of Maine’s health care stakeholder community
- § Coordinate an integrated approach with the State Medicaid HIT Plan
- § Coordinate an integrated approach with HIN, Maine’s statewide HIE organization and Regional Extension Center (REC)
- § Coordinate HIT activities across State government and the private sector

1.1.2 Health Information Technology Steering Committee (HITSC)

The Health Information Technology Steering Committee (HITSC) advises the Office of the State Coordinator for HIT in developing the vision, goals, and prioritization areas for advancing HIT and HIE across Maine and to develop appropriate governance, oversight, and accountability mechanisms to assure success.

The HITSC consists of twenty-six (26) members, twenty-two (22) of whom are appointed by the Governor. The State HIT coordinator serves as the Chair.

Health Information Technology Steering Committee (HITSC)	
James Leonard, State HIT Coordinator, Chair	David Winslow, Vice President, Finance, Maine Hospital Association
Devore Culver, Chief Executive Office, HealthInfoNet	Kevin Lewis, Chief Executive Director, Maine Primary Care Association
Karynlee Harrington, Executive Director, Dirigo Health Agency	Lisa Letourneau, M.D., MPH, Executive Director, Quality Counts
Alan Prysunka, Executive Director, Maine Health Data Organization	John Edwards, Ph.D., Psychologist and IT Projects Manager, Aroostook Mental Health Center
Tony Marple, Director, Office of MaineCare Services	Nancy Kelleher, State Director, AARP
Steven Sears, M.D., State Epidemiologist, Maine CDC	Katherine Pelletreau, Executive Director, Maine Association of Health Plans
Jim Lopatosky, Associate CIO-Applications, OIT	David Tassoni, Senior Vice President of Operations, athenahealth, Inc.
Melanie Arsenault, Director, Bureau of Employment Services, Maine Department of Labor	Catherine Bruno, FACHE, Vice President and Chief Information Office, Easter Maine Healthcare Systems
Barry Blumenfeld, M.D., Chief Information Officer Maine Health	Tom Hopkins University of Maine System
Paul Klainer, M.D. Internist and Medical Director, Knox County Health Clinic	Dr. Barbara Woodlee, President, Kennebec Valley Community College
Sandy Putnam, RN, MSN, FNP, Nursing Coordinator, Virology Treatment Center, Maine Medical Center	Perry Ciszewski, an individual representing the State’s racial and ethnic minority communities
Julie Shackley, President/CEO, Androscoggin Home Care and Hospice	Philip Saucier, Esquire, an individual with expertise in health law or health policy

The diversity in representation on the HITSC brings together multiple viewpoints from a variety of stakeholder groups to ensure that all perspectives are accounted for in developing the vision and goals of HIT and HIE throughout the State of Maine.

1.1.3 Standing Committee Composition and Responsibilities

Five standing committees will support the OSC to provide a direct venue for other stakeholders to advise and assure that the OSC is representative of the breadth of interests across the state. Each committee will have representatives appointed by the State HIT Coordinator in alignment with the HITSC. The five standing committees and their responsibilities are listed below:

Committee	Committee Responsibilities
HIT and HIE Adoption/Implementation	This committee will work to assure implementation and adoption issues are addressed to promote alignment across HIE Cooperative Agreement activities, the Medicaid and Medicare incentives, the Regional Extension Centers, and other Federal and State projects and initiatives.
Privacy, Security, and Regulatory Committee	This committee will specifically address state and federal laws and regulations that relate to both HIT implementation and electronic sharing of that information with appropriate parties. This committee will work closely with HealthInfoNet and the State Attorney General to rapidly address State law that impedes providers from appropriately sharing health information. Over time it is expected that this committee will take on additional regulatory roles at HIE activities proliferate statewide.
Consumer Committee	This committee, already convened by HealthInfoNet, will now support both the OSC and HealthInfoNet in addressing consumer safety, privacy, and security concerns. Additional members may be added by the OSC if it is determined that the existing structure lack representation or depth. Initially the Consumer Committee will be reviewing reports from the Privacy, Security, and Regulatory Committee and determining a course of action on the issues outlined in that report.
Financial Accountability and Sustainability Planning Committee	This committee's primary responsibility will be to conduct financial and sustainability planning to assure the investments made for HIE result in a viable health information exchange operation in the long-term. The Committee will develop a strategy to gain sustainable financial funding. Consultation to the group will be made available by the Attorney General's legal staff. (This committee will be made up of HIN's Financial Committee members along with other public representatives).
Quality and Systems Improvement Committee	To assure that the HIT and HIE activities of the OSC and HealthInfoNet are aligned and support broad health systems improvement initiatives, this committee will bring together members of Maine's quality and systems improvement groups to assure that HIT tools are being used in a manner that improves the health of all Maine citizens. The OSC will coordinate the work of this committee with that of the REC and will involve members of Maine's Chartered Value Exchange to direct and oversee quality improvement strategies to assist practices in achieving each stage of meaningful use.
Technical and Architectural Committee	This committee will be chaired by the State's Office of Information Technology (OIT) and is currently being formed. The Director and Associate Director of OIT have committed to addressing issues of system compatibility with the various state systems and HIN. A meeting is scheduled for March 9th to begin the process of identifying issues and membership. The committee will also be connecting with and including members of HIN and its technical staff for work on this committee in the future.
Workforce Development Committee	This committee is chaired by associate Director of the Department of Labor and includes the President of a local community college that was the primary applicant of a community college consortia application to ONC. There are also membership requests to the state university system, specifically a campus that is focused on introducing HIT within its college of health sciences at the baccalaureate level. Other members of the sub-committee will include local business, hospital IT, and planners from the Department of Labor. Both the chair and president of the community college are active members of the OSC Steering Committee.

The Standing Committees will address the key issues relevant to HIT and HIE by functioning as work groups to support the OSC and assure that the OSC addresses a variety of interests across the state.

1.2 Statewide Health Information Exchange – HealthInfoNet

HealthInfoNet is the designated Health Information Exchange (HIE) entity for the state of Maine. HIN is an independent, nonprofit 501c(3) organization whose mission is to create an integrated statewide clinical data sharing infrastructure that will provide a secure data sharing network for public and private healthcare stakeholders in Maine.

1.2.1 HealthInfoNet Board Composition

Committee	Committee Responsibilities
State Government	Maine DHHS, Commissioner
	Maine DHHS, Director of MaineCare Services
	Governor's Office of Health Policy and Finance, Director
	Office of the State Coordinator, State HIT Coordinator
Health Care Providers	Small Rural Hospital, President/CEO
	Southern Maine Integrated Delivery Network, CIO
	Rehab/Home Health, President
	Northern Maine Integrated Delivery Network, Executive Vice President
	Family Medical Clinic, President and CMO
	Western Maine Integrated Delivery Network, CMO
Health Plans	Practicing Physician
	Cigna Healthcare, Market Service Leader
Patient/ Consumer Organizations	National Alliance for the Mentally Ill, Executive Director
	State Senator
Healthcare Purchasers/Employers	Private Research Laboratory, COO
	Former State Senator/Businessman
	Large Northern Business, Retired Director
Public Health Agencies	Maine Center for Disease Control and Prevention, Director
	Private/Public Health Consultant
Health Professional Schools/Universities	Not represented at this time
Clinical Researchers	Not represented at this time
Other Users of HIT	IT Venture Investment Company, Director
HIT Vendors	Represented through contractual relationships

The HIN Board provides a knowledgeable group of individuals with HIE expertise to build upon the ongoing HIE experience and efforts of HIN.

1.2.2 HIN Standing Committee Composition and Responsibilities

1.2.2.1 HIN Finance Committee

This committee is comprised of members with experience and expertise in financial matters, chaired by the HIN Treasurer and with the HIN Chief Executive Officer as an ex-officio member. This Committee is responsible for developing the HIN's financial policies, assisting the Chief Executive Officer in developing annual budgets and reviewing HIN's financial statements and for other related duties as may be prescribed by the Board from time to time. This Committee will continue to serve as a HIN standing committee but members of the committee will also serve on the OSC Financial Accountability and Sustainability Planning Committee. It is planned that the new committee will address the budget requirements for the statewide HIE, develop a sustainability plan for long term financing, and coordinate the funding of the HIE with monies awarded to other ARRA programs.

1.2.2.2 Consumer Advisory Committee

The membership of the HIN Consumer Advisory Committee is comprised of citizens, consumer advocates, consumer organizations, legal experts, health educators, privacy officers, public health professionals, and interested parties with experience and expertise in consumer participation and privacy protection in health information technology systems. The Committee is chaired by a member of the HIN Board. The Committee has been responsible for reviewing and advising on all policies and procedures related to the confidentiality of the HIN clinical data and the privacy protection for patients. The Committee has addressed HIPAA, State law requirements as well as other federal and State guidelines and initiatives, and public health data laws. This committee has been instrumental in the development of the opt-out provision for patient participation in HIN. Today, a number of key consumer advocacy organizations represent the interests of their respective constituencies on the HIN Consumer Advisory Committee. These organizations include the Family Planning Association of Maine, Legal Services for the Elderly, Maine Center for Public Health, the Maine Civil Liberties Union, Maine Disability Rights Center, the Maine Health Management Coalition, the Maine Network for Health, the National Alliance For the Mentally Ill and the and the University of New England Health Literacy Center. The OSC and the HITSC identified the need for a Privacy, Security, and Regulatory Oversight Committee that would be responsible for addressing the legal and regulatory issues for the statewide HIE, support the harmonization of state and federal law, draft legislative recommendations as needed and where appropriate develop/recommend regulatory roles for OSC and the Governor's Office in regard to the sustainable business functions to support HIE statewide. The Consumer Committee is a shared function of both OSC and HIN with a focus on advising both the policy and operational areas and working closely with the Privacy, Security, and Regulatory Committee.

1.2.2.3 Technical and Professional Practice Advisory Committee (TPPAC)

The membership of this committee is comprised of Chief Information Officers, Chief Medical Directors, IT experts, and practicing clinicians. All members have experience and expertise in the implementation and use of health information technology, clinical data sets, and/or public health

information systems. Committee members also represent providers and clinical practices with varying degrees of electronic medical record system use including non-users. This Committee serves as the technical advisory body to the HIN Board and works closely with the HIN staff to manage the statewide HIE deployment. It is expected that this committee will remain as a standing committee of the HIN with a working relationship with the OSC Technical Architecture Committee focusing on Public Information Technology interoperability with HIN.

1.3 Coordination between the Office of the State Coordinator, HealthInfoNet, and DHHS

HIT and HIE have similar goals and many efforts for HIT are related to and impact HIE. CMS has provided the state with guidance on the importance of coordinating statewide HIE and HIT efforts. On the federal level, ONC has been coordinating with CMS to ensure that efforts are streamlined and collaborative rather than duplicative. DHHS is working closely with the State HIT Coordinator to ensure the coordination of HIT efforts, specifically the SMHP.

The State HIT Coordinator acts as the conduit to coordinate all HIT/HIE activities throughout the state. The State HIT Coordinator collaborates regularly with the SMHP project manager and team. The State HIT Coordinator attends status meetings and other key project presentations relevant to SMHP efforts. The State HIT Coordinator is also involved in reviewing documentation and project materials. The State HIT Coordinator works closely with HealthInfoNet to coordinate all statewide HIE efforts and facilitates status updates between state-level HIE efforts and SMHP efforts. Coordination through the State HIT Coordinator helps assure that the State Medicaid HIT Plan is consistent with the State-level HIT plan.

DHHS is involved in the state-wide effort by representation on two state-level HIE and HIT committees. The Director of MaineCare Services and the Director of Maine CDC are members of the Health Information Technology Steering Committee (HITSC) and the Commissioner of DHHS, the MaineCare Medical Director, and the Director of Maine CDC are board members on the HealthInfoNet Board. The MaineCare Medical Director also chairs the Technical and Professional Practice Advisory Committee, one of the HIN Standing Committees.

VERMONT

Governance Structure for the Next Five Years for HIT/E Goals and Objectives

Governance Considerations - Five Year View

Vermont is well positioned to implement a good governance structure for the EHR Incentive Program as it evolves. The specific elements needed for EHRIP governance will be a subset of many of the governance elements already in place. Vermont's history with healthcare reform has led to the development of several governance components that have been established before the passage of both the ARRA-HITECH and ACA acts. Even though these specific opportunities were not anticipated in the development of some of these governance components, Vermont is now in a favorable position with respect to governance.

Enabling legislation provides the authorization for governance of healthcare reform in Vermont. It establishes the organizational responsibilities and authorities and also specifies objectives, measurements, and reporting requirements, in addition to providing the necessary funding mechanisms. A lead organization – The Department of Vermont Health Access – is the organizational center of healthcare governance for the state. DVHA takes the lead in negotiating and managing contracts for significant healthcare components, including the HIE, the REC, and a supporting data repository. DVHA, through the Division of Health Care Reform, also takes the project management lead in the major IT activity, including a Core Components project establishing a SOA-based infrastructure, an MMIS replacement project, an eligibility system replacement project, Vermont’s participation in the MAPIR project, and the development of a Provider Directory for Vermont.

It is significant to note that DVHA also serves as the State Medicaid Agency for Vermont. Having the Division of Healthcare Reform embedded in DVHA provides an organizational (and in our case – a co-located) cohesion between existing SMA functions (administrative, business office, data services, oversight, auditing, privacy and security) and the requirements of new programs such as EHRIP. DVHA’s dual roles of Medicaid administration and Healthcare Reform allow for and requires frequent contact, discussion and planning with other healthcare related activities in the State, including the Vermont Department of Health and the State Agency responsible for insurance oversight and the development of Vermont’s Insurance Exchange (BISHCA – Department of Banking, Insurance, Securities & Health Care Administration).

This overview of Healthcare Governance in Vermont is expanded on below. Vermont’s State HIT Plan, recently approved by ONC and CMS, included a complete description of governance as related to the HIE. That description is incorporated into the Section A “As-Is” portion of this document, specifically in items 5 and 7 of that Section. Important to note from that description are these points:

- Vermont has a collaborative Governance Model
 - VITL has a pivotal role in Vermont’s healthcare reform activities, as both HIE operator and our single REC. VITL’s formation was marked by substantial stakeholder involvement, which is still reflected in the composition of VITL’s board representation of government, consumer, and stakeholder interests. Policy coordination and oversight is placed with the state, led by the State Government HIT Coordinator. Vermont’s governance structure reflects and integrates with the federal HIT/E policy structure enacted in the HITECH Act. Vermont’s Act 61 requires the state to produce and annually update a state HIT Plan that mirrors the requirements and process placed on ONC for the federal HIT Plan.
- State HIT Coordinator
 - The State HIT Coordinator is directly accountable to the Governor and the General Assembly and is responsible for coordinating and convening multi-disciplinary input from broad HIT and HIE stakeholders. The Coordinator is also responsible for ensuring alignment and collaboration with ARRA funded programs across state government. The role of the HIT Coordinator is further described in Section A of this document. That description includes a brief discussion of staffing for this effort.
- Accountability and Transparency
 - Accountability, transparency, and engagement with the public is a longstanding Vermont tradition and is codified in Section 8 of Act 61 of 2009, which requires that the state shall consult with and consider the recommendations of a number of specifically identified stakeholders (see Section A for a full listing).

- Public Engagement, Communication, & Outreach
 - Significant outreach occurred in the development of Vermont’s HIE and the establishment of VITL. Broad consumer engagement since then has been limited as attention was focused on the early implementation efforts of the HIE. With new ARRA resources, as well as state and federal health reform initiatives, particularly the statewide expansion activities of the Blueprint for Health, Vermont is now positioned to initiate a major consumer outreach campaign. The outline of such a campaign is described in Section A of this document.
- Financial Sustainability
 - Per 32 V.S.A. chapter 241 § 10301, Vermont collects a fee (2/10ths of 1%) on all health insurance claims that generates annual revenues for the state Health IT Fund which then provides grants to support HIT and HIE. While the Fund sunsets in 2015, it will provide substantial capacity to match federal funds available through both ONC and CMS to provide for the statewide build out of the HIE infrastructure. Further discussion of this topic is in Section A of this document.
- Legal/Policy
 - Privacy and Security – VITL developed a set of six privacy and security policies to govern the operation of the HIE. These policies are consistent with federal and state laws and regulations, and reflect the privacy principles in the HHS Privacy and Security Framework. The State HIT Coordinator is convening a new Privacy & Security Work Group to establish a continuous improvement process for existing policies. Further discussion of this topic is included in Section A of this document. However, for this “To-Be” Section of the document, we note that preliminary issues on the docket for this Work Group over the coming year include:
 1. 42 CFR Part 2 and recent SAMHSA FAQ on same that requires adjustment to current policy related to exchange of alcohol and substance abuse records;
 2. Discussion about exchange of minors’ health information (particularly because of the different approaches our neighboring states have taken);
 3. Restriction on the exchange of information from self-pay encounters (raised by sections of the HITECH Act);
 4. The federal Data Use and Reciprocal Support Agreement (DURSA) for use with the National Health Information Network; and
 5. Closely related to 4, the general subject of interstate HIE and cross-border issues that arise from differing state privacy and security policies and legislation.

Process steps for the Work Group include:

 1. Identifying members through solicitation at the HIT/E Stakeholders monthly meetings, via the HIT Coordinator’s regular e-Updates, and direct outreach to stakeholder groups and interested parties;
 2. Convening the first meeting before year end;
 3. Hiring a State Privacy Specialist;
 4. Conducting monthly meetings;
 5. Making recommendations to the State HIT Coordinator and DVHA Commissioner (as needed based on meeting outcomes, with reporting to the commissioner and Stakeholders via State HIT Coordinator’s e-Updates quarterly);
 6. Developing potential legislation;

7. Introducing legislation, if any;
8. Continuing monthly (or possibly bi-monthly meetings) as needed for at least the next two years.

Planning elements related to Privacy and Security include:

1. Coordinate adoption of privacy and security policies and procedures with all health systems in the state as part of HIE deployment;
 2. Create easily understood material to support opt-in consent procedures required by state law;
 3. Work with neighboring states to facilitate interstate HIE in conformance with state laws;
 4. Create limited service position at DVHA with responsibility for oversight of HIE Privacy & Security policies and staffing of the state Privacy & Security Work Group.
- State Laws – The process to develop HIE Privacy and security policies included a legal review of all applicable state laws. Policies were written to ensure compliance. Because Vermont’s privacy law is more strict than HIPAA, it was determined that Vermont must use an opt-in model for HIE. That model is reflected in the policy on patient consent. At this time, there are no plans to modify state laws. Comments on Vermont’s efforts to work with neighboring states and to remain consistent with federal developments on privacy and security are included in the governance discussion in Section A of this document.
 - Policies and Procedures – As mentioned, VITL’s board of directors has adopted a comprehensive set of six privacy and security policies and agreement, including: 1) Policy on Participating Health Care Provider Policies and Procedures for the VHIE, 2) Policy on Patient Consent to Opt-In to VHIE, 3) Policy on Secondary Use of Identifiable PHI on VHIE, 4) Policy on Information Security, 5) Policy on Privacy and Security Events, and 6) Policy on Auditing and Access Monitoring. The policies are currently in use by hospitals in multiple Vermont hospital service areas as models for HIE among providers in those communities and will be deployed statewide as the VHIE is built out in calendar 2010. A set of model policies and agreements is part of the “implementation toolkit” provided to all practices and institutions working with VITL. These policies, including proposed revisions to the Secondary Use policy (currently open to public comment) are included in Appendix XXXXXXXX.
 - Trust Agreements – From the beginning the Vermont HIE Network has required that business associate agreements and contract terms be signed with each participating organization. In fact, technical work does not begin on an interface or other project until the agreements have been signed by all parties. These agreements spell out in detail how data is to be used between organizations. Our plan is to leverage current agreements to facilitate statewide expansion and work with counterparts in adjoining states to develop agreements in conformance with other state law, policies, and procedures.
 - Oversight of Information Exchange and Enforcement
 - Vermont statute 18 V.S.A. chapter 219 § 9351 (f) requires that Vermont HIT and HIE programs “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.” In the event that providers, individuals, or other entities are not compliant with state and federal policy, the state has the option to pursue enforcement. Act 61, enacted during the 2009 legislative session, provides several compliance mechanisms including:
 - Sec. 5. 18 V.S.A. § 9437 gives the commissioner of Banking, Insurance, Securities, and Health Care Administration the authority to require that the Certificate of Need (CON) application for a large hospital HIT project “conforms with the health information technology plan established under section 903 of Title 22....”;

- Sec. § 9352 authorizes VITL to require that Health Information Technology systems acquired under a VITL grant or loan comply with data standards for interoperability adopted by VITL and the state health information technology plan;
- Sec. § 9352 also authorizes VITL, following federal guidelines and state policies, if enacted, to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont. Without meaningful use certification, providers will not qualify for the Medicaid incentives created in the ARRA/HITECH act.
- The VHIEN privacy and security policies contain a procedure for dealing with individuals and organizations that are not compliant with the policies. Sanctions may include permanent exclusion from participating in the VHIEN. The legal analysis does note that 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 of that provider or facility. The analysis also points out that “The Secretary of the US Department of Health and Human Services also has the authority to impose civil monetary penalties as set forth in 45 CFR §160.404 as amended by HITECH Act § 13410 and which extends enforcement to State Attorneys General.”