Report to the Joint Fiscal Committee:

A Plan to Implement Electronic Health Records for Nine of the State's Designated Agency System

Required Under: Act 72 of 2019 Sec C.100
Submitted Jointly by: Vermont Care Partners & Vermont Agency of Human Services
Prepared by: Vermont Care Partners

In 2019, the legislature appropriate funding for the implementation of an electronic health record system for the State's Designated Agency System. In order for the funds to be used, the Joint Fiscal Committee must approve a plan prepared by Vermont Care Partners and the Agency of Human Services.

Sec. C.100 FISCAL YEAR 2019 ONE-TIME APPROPRIATIONS

(10) To the Agency of Human Services: $1,500,000 to fund grants for the development of an electronic medical/health records system for the State's Designated Agency system.

(A) Vermont Care Partners and the Agency of Human Services shall present a plan for review and approval by the Joint Fiscal Committee at its July 2019 meeting. The plan shall summarize the development and implementation of the system and demonstrate that this project will support the goals set forth in the statewide Health Information Technology (HIT) Plan (defined in 18 V.S.A. § 9351) and meet, at a minimum, the connectivity requirements set forth in the statewide HIT plan and the requirements of the Centers for Medicaid Services (CMS). The plan shall support current payment reform initiatives and include the projected project timeline and total budget including the allocation of this appropriation. No funds shall be released prior to review and approval by the Joint Fiscal Committee.

The following document contains the plan for the Joint Fiscal Committee's consideration.

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1.0 Financial and Go-Live Summary

FINANCIAL AND GO-LIVE SUMMARY FOR NINE DESIGNATED AGENCIES IMPLEMENTING EHRS FROM TWO VENDORS

AGENCY	Current Annual*	Estimated implementation Cost**	***New Annual Cost	Approximate Delta in Annual Cost	Projected Go-Live
CSAC	$ 88,575.00	$ 295,000.00	$ 170,200.00	$ 81,625.00	11/12019
HC	$ 57,355.00	$ 290,675.00	$ 372,517.00	$ 315,162.00	9/3/2019
HCRS	$ 101,351.00	$ 364,675.00	$ 200,000.00	$ 98,649.00	9/3/2019
RMHS	$ 53,723.00	$ 204,425.00	$ 185,750.00	$ 132,027.00	9/3/2019
LCMHS	$ 237,075.35	$ 775,295.00	$ 241,261.98	$ 4,186.63	Summer 2020
UCS	$ 72,637.00	$ 801,826.00	$ 141,417.00	$ 68,780.00	Spring 2020
WCMHS	$ 196,355.00	$ 743,284.00	$ 242,268.00	$ 45,913.00	Summer 2020
NCSS	$ 165,288.60	$ 831,826.00	$ 372,514.69	$ 207,226.09	Spring 2020
NKHS****	$ 85,000.00	$ 285,000.00	$ 334,000.00	$ 249,000.00	N/A
Total	$1,057,360	$4,592,006	$ 2,259,928.67	$ 1,120,943.72	

* **Current annual does not include** the initial build including hardware and software. Nor does it include the ongoing expense of maintenance, upgrades in hardware and software, upgrades to product etc. A few agencies will be maintaining their existing product for a period of time for data retention and historically archiving purposes.

****Estimated implementation** incudes vendor costs and external project management. It does not include loss of productivity, staff time, internal project management etc.

*****Does not include** CPI every year for Credible. No increase for 5 years for Netsmart.

VCP proposed formula for distribution of funds: Given that each agency had to make the decision to upgrade their EHR and it was an equally difficult financial decision for all, we recommend that the funds are allocated equally amongst the 9 agencies.

******Estimated

2.0 Project Justification

VCP is a statewide network of 16 of the State's designated, community-based agencies providing a comprehensive array of services and supports to people living with mental health conditions, substance use disorders, and intellectual and developmental disabilities. The network has approximately 32,000 clients and serves nearly 50,000 Vermonters.

In late 2016, nine of the comprehensive designated agencies came together to discuss the need to move to a new electronic health record (EHR). The rationale for the move included the following:

1) 7 agencies were on a legacy platform on a trajectory for potential sun-setting
2) 1 agency had an EHR from a vendor was going out of business

3) 1 agency with a platform that was not working well for them and that was about to be revamped
4) Legacy EHRs were not keeping pace with new requirements.
5) There were large staffing requirements to provide 'scaffolding' to support the EHRs
6) Reporting was costly and inefficient (clinical; billing; financial; administrative)

VCP and the nine agencies saw this as an opportune time to coordinate their efforts to update their aging systems to more modern systems enabling them to participate in an integrated delivery system with value-based payment methodologies. The decision was made to do so in a coordinated manner that would leverage experience and expertise, and improve overall efficiency.

Rather than have each agency write and post a RFP on their own, VCP hired a project manager to assist with the development of a comprehensive Request for Proposal (RFP) and selection process for the nine agencies. This took place in January 2017, and was supported by a grant from the Health and Human Services Health Resources and Services Administration (HRSA). VCP and its network agencies wrote and posted a RFP that was centered on the future of an integrated health delivery system and value-based payment methodologies. It was also centered on the ability for vendors to develop a unified solution. VCP received 16 responses. After a formalized vetting process, each of five selected vendors was brought in for a two-day vetting process that included content experts from all participating agencies and VCP staff. VCP hired outside consultants to be a part of the vetting process to provide additional subject matter expertise and oversight. Annmarie Curley of Newgrange IT Consulting and Jed Batchelder an independent health care IT consultant worked with VCP and the agencies to fully vet the vendors and worked with VITL to ensure that the vendors met the VHIE connectivity requirements

Over time and with significant additional vetting and further site visits, the pool was narrowed down to two vendors – one of which was able to implement a unified solution. The two vendors met the selection criteria (inclusive of price, meaningful use certification, clinical ease of use, mobile solutions, etc.) and the goals of going beyond a traditional EHR to enable participation in an integrated value-based health delivery system. While we originally had the lofty goal of a unified EHR for all nine agencies, in the end, agencies had to choose the vendor that was right for them. They had to consider everything from their agency specific fiduciary responsibility to the interoperability needs in their community to acceptance and ease of use by their staff. Agencies selected the vendors that best met the needs of their agency resulting in two products (Credible and Netsmart's My Avatar) across the nine agencies. VCP considers this process to have been a great success.

The two EHRs are not being custom built for the agencies. They are high quality off the shelf solutions that are being configured for the specific agencies. Credible is a behavioral health EHR that enables everything from scheduling and billing to mobile reporting and integrated care for all the populations served at the agencies. Netsmart is a company offering an EHR solution specifically designed for human services communities including behavioral health, substance

use and developmental disabilities. They are focused on integrated value-based care which also includes scheduling, billing, and a mobile solution. More information can be found at: https://www.credibleinc.com/ and https://www.ntst.com/.

It is extremely important to VCP and to the nine agencies that the new EHRs align with the State of Vermont's Health Information Exchange goals. VCP's Simone Rueschemeyer co-chaired the State's SIM Health Data Infrastructure Workgroup, is currently a representative of the State's Health Information Exchange (HIE) Steering Committee and was part of the development of the last two Vermont's Health Information Exchange Strategic Plans. The State's Strategic Plan can be found at: https://healthdata.vermont.gov/sites/healthdata/files/HIE%20Strategic%20Plan.pdf.

The HIE's Plan's primary goals are as follows:

1. **Create One Health Record for Every Person - Support optimal care delivery and coordination by ensuring access to complete and accurate health records.**

If the State eventually wants everyone to have a complete health record, we need all care settings to have the ability to capture health data in a standard way, through an EHR. This effort provides a link to an essential care setting that has been fundamentally left out of traditional health records and health information exchange. The technology within the new EHRs will allow the agencies to keep pace with the physical health data systems. In addition, the new EHRs are necessary to position the agencies to connect to the HIE when a privacy solution that complies with federal law is implemented. (See Technical Approach for more information about health information exchange).

2. **Improve Health Care Operations - Enrich health care operations through data collection and analysis to support quality improvement and reporting.**

The new EHRs will help improve data quality while reducing administrative burden via better user interface which can reduce errors, and redundant data entry. They will streamline treatment activity through better scheduling and service data capture and move data capture to point of service delivery via remote system access. The new, standardized EHRs will also link to the VCP data repository which in the future we hope will support improved panel/population health management i.e., using data to assess care outcomes and test health management solutions.

3. **Use Data to Enable Investment and Policy Decisions - Bolster the health system's ability to learn and improve by using accurate, comprehensive data to guide investment of time, labor and capital, and inform policy making and program development.**

Modern EHRs will allow more and higher quality data to be collected through improved user interface (UI). In addition, they will continue to transmit data to the VCN Data Repository which will allow for statewide and more advanced analytics supporting the state and legislature in

using real data sets to understand the impacts of funded health services. Using data to inform clinical decision will allow for better coordinated, efficient, and effective service delivery structures.

A Core Piece of Business

Having an EHR is foundational to the business of each designated agency and as such, the vendor chosen was the decision of each of the agencies. This initiative is not only an EHR implementation for each agency but also a business and care delivery transformation resting on the foundation of IT platforms. It is our belief that the new EHRs will provide a transformative platform that will:

- Enable operational efficiencies
    - A modern EHR which has an easier to use and understand interface will reduce data entry errors which will mean less internal auditing and re-work. This modernization will also reduce the administrative burden by making workflows, data entry and recovery easier, and shorten training time for staff.

- Support the shift to value-based payment
    - The chosen EHR platforms will allow designated agencies to capture information digitally, and track additional aspects of client care beyond the current fee for service data points. Having the ability to capture clinical outcomes and highlight client progress, will be not only invaluable but necessary as we move to value-based payment.

- Develop capabilities to further participate in population health initiatives
    - A state of the art system will enable agencies to define, track, and report out on additional data elements in concert with other members of the health care community to expand work in the area of population health.

- Enhance capabilities to work as part of a greater integrated care delivery system in VT
    - A contemporary EHR for these agencies will come closer to providing similar tools that the medical community already has in place. Better analytic capabilities will allow enhanced alignment of operational goals among care partners. Greater alignment of clinical goals within the health care system will increase care coordination realize efficiencies, and improve outcomes.

- Enable enhanced quality improvement and care delivery
    - Better capture of more digital information will allow more sophisticated analysis and planning around quality of care for specific cohorts as well as individuals. Data driven planning will allow for more targeted allocation of resources to improve client experience and outcomes.

- Lead the agencies in the correct direction to meet the HIT goals

- The antiquated EHRs currently in use by the agencies are a barrier to achieving the HIT goals. Newer systems can more easily be configured and updated to track information and activities that are aligned with HIT goals.

3.0 Clarity of Purpose

The purpose of this initiative is to replace aging and/or disappearing legacy EHRs with state of the art EHRs that can able the nine agencies to participate in an integrated delivery system with value-based payment methodologies.

Current agency legacy EHRs are no longer supporting our vision, nor are they sophisticated enough to move us to be fully data driven or participate in an integrated delivery system. In addition, some of the legacy EHRs are sun-setting and will no longer be supported by the vendor. Moving toward outcome-driven payments, analyzing data and outcomes to improve care at the point of service, and focusing on improving the health of our population, all require data. Collecting that data as close to the source as possible increases data integrity and usability. Upgrading to more sophisticated systems will move the agencies further down this path.

This is an EHR implementation for each agency. It is not a health information exchange though the vendors chosen have the capabilities to enable the sharing of information and the exchange of data. (See Technical Approach). None of the agencies met the Certificate of Need (CON) threshold. That stated, VCP came to agreement with the Department of Mental Health that they would keep DMH appraised of the process and of any potential barriers to realizing full implementation.

4.0 Implementation

Each agency is already in the process of undertaking this project. Some have go-live dates as soon as September 3, 2019. They each have robust implementation plans that have been designed in collaboration with their vendors. Each agency has engaged their organization at multiple levels in all parts of the process and each agency has had implementation teams formalized since the beginning of the vetting process.

Implementation Plans

It is important to point out that this is not one implementation for nine agencies. Each of the nine agencies are implementing their EHRs within their agencies at different times but with similar implementation plans by vendor. Below is a chart of the agencies, the vendor, and estimated go-live date. The Netsmart agencies will be implementing consecutively with 2-3 weeks in between each one.

AGENCY	VENDOR	ESTIMATED GO-LIVE DATE
Counseling Service of Addison County	Credible	11/1/2019

Health Care and Rehabilitation Services	Credible	9/3/2019
Howard Center	Credible	9/3/2019
Lamoille County Mental Health Services	Netsmart's MyAvatar	Summer 2020
Northeast Kingdom Mental Health Services	Undecided – Will decide by 12/31/2019	N/A
Northwestern Counseling & Support Services	Netsmart's MyAvatar	Spring 2020
Rutland Mental Health Services	Credible	9/3/2019
United Counseling Service	Netsmart's MyAvatar	Spring 2020
Washington County Mental Health Services	Netsmart's MyAvatar	Summer 2020

Attachment A: Implementation Plan Summaries, includes varying summaries of the implementation plans. The Credible agencies each have robust implementation plans designed in concert with their vendor (Credible considers the full implementation plans to be proprietary). The four agencies moving forward with Netsmart's MyAvatar have a joint implementation plan.

5.0 Project Leadership and Management

Included with the Implementation Plan Summaries are summaries of the Project Implementation Teams. Each agency has empowered their leader and team to successfully implement the EHRs. The four agencies that are moving onto Netsmart's MyAvatar are implementing a unified system and have hired a consulting firm to provide them with the specific services mentioned above. The remaining agencies will be relying on their vendor, Credible, and their own internal resources to move to their new platforms. They are meeting weekly to develop aligned processes.

VCP's Role in Implementation Post Vendor Selection and Standardization

Deployment of new systems requires numerous workflow changes, review and adaptation of policies and procedures, harmonization of code sets training and more. VCP is a collaboration of 16 of the State's 18 designated and specialized service agencies. VCP's role in the implementation of the EHRs is primarily supportive and consultative. VCP is also taking a leadership role to assure that the EHRs are standardized and aligned to the extent possible.

VCP's HIT Director will be working with the vendors to develop the necessary feeds to the data repository and to ensure uninterrupted functioning of the repository.

Integration of Legacy Systems into New EHRs
In an effort to maintain the highest quality data and decrease the chances of corrupting the new systems' data, only relevant client data will be migrated from the current systems to the new systems at the time of conversion. Agencies will employ various methods of retaining access to historical data, including maintaining existing systems for historical purposes and/or putting data onto new servers which will need to be purchased as the old ones are at use end.

6.0 Financial Considerations

The new EHRs use a subscription-based model and as such there is no on premise or on-site hardware dedicated to the EHRs. Staff will access the EHRs using remote connectivity through typical end point devices. E.G. PCs, laptops etc.

VCP and the agencies underwent a robust negotiation process with the vendors which resulted in each agency having a specific contract with their vendor that they felt was financially sound. Each of the nine agencies determined internally how they would fund the EHRs while VCP worked with the State to determine if there was a possibility to support implementation through the use of one-time funds. VCP presented to CMS as well as to the various departments within AHS.

Again, none of the agencies met the CON threshold that would trigger the agencies to provide the State with detailed information on the financial considerations.

It is important to note, that this is the first step to fully participate in a state-wide integrated delivery system. The overarching steps include:

1) EHR go-live and post-go live/ agency
2) Connectivity to the VCN data repository
3) Interoperability with other providers which will also depend on the other providers' IT systems capabilities to be interoperable.
4) Connectivity to the VHIE (assuming solution to 42CFR Part2)

Initial EHR Build and Funding
An upfront capital infusion was necessary for the agencies moving to new EHRs and they are extremely appreciative. The appropriation funding will be used as one-time funds to support implementation costs for work already completed and/or future work, depending on the agency and their vendor contract. It will not be used to support ongoing costs.

As has been the case for previous EHRs, the ongoing cost is part of doing business. The initial funding has been budgeted in various ways by each agency. An EHR is not an optional part of a DA any more than an office building is and will be covered as part of doing business. The

agencies expect the new EHRs to manage costs going forward through enhanced automation, as well as increasing staff productivity.

VCP represents the needs of the designated and specialized service agencies on the HIE Steering Committee – the group that is responsible for driving more efficient and effective statewide data exchange strategy. It is VCP's goal therefore that the needs of these agencies will be represented in the public investment strategy recognizing that proposals to drawdown federal funds have not been successful to date.

Funding of Ongoing Maintenance and Upgrades
Our options are hosted solutions that are subscription base. This means that the initial cost is much lower than these kinds of purchases have been historically. While the ongoing costs are higher than what we have now, they reduce the need for onsite equipment, reduce systems risk and increase systems resiliency. Additionally, it represents modern system sustainability by converting traditional large upfront and less predictable capital expenditures to a steady stream of operationalized costs reflecting a long range total cost of ownership and vendor partnership. The subscription model also includes some ongoing maintenance.

The network agencies exist in large part to provide the services that the State is mandated to provide. They are primarily Medicaid funded (85%) and are capped. As such, there is little to no opportunity to cost shift to other revenue sources. As they must for other utilities, agencies have no choice but to budget for the ongoing costs. As new requirements are designed by the State of Vermont, whether for reporting or for health information exchange, agencies will need to make those changes within their EHRs at an additional cost. This is true for all agencies – not only the ones that are moving to new EHRs in the coming year. For example, should the State and VITL come up with a consent management platform and process that is compliant with federal law and request that the designated and specialized service agencies connect to the VHIE, interfaces will need to be developed which would be a cost not currently factored into the initial build.

7.0 Technical Approach, Reporting, Interoperability

Both of the selected software companies have many installations nationwide and are leaders in the field of Mental Health Electronic Health Records systems. They both have proven track records of success. One of them, Netsmart also has experience in Vermont and is currently in use at one SSA and one DA. Both are meaningful use certified.

State Reporting
The nine agencies are partnering with vendors who provide a constellation of solutions centered around the EHRs. These new systems, using current technology and designs, can be more easily configured to meet the current reporting specifications, and be agile enough to accommodate improvements in the reporting. The short-term goal is to transition to a data-centered EHR and move away from document-centered systems. This will also increase our

ability to data mine on the care we deliver today and increase the transparency and accountability for care provision.

The new systems are required to be compatible with older systems such as the State of Vermont's Monthly Service Reports (MSR) in order to remain compliant. As a result, they will continue to meet State of Vermont reporting requirements. Newer systems will be more readily able to adapt to changes being made by the State of Vermont and other stakeholders. That stated, changes in future reporting requirements will require financial resources to make changes which should be considered as we all try to balance the use of limited resources in the provision of services and supports to the people we serve.

Connectivity to the Vermont Health Information Exchange (VHIE)

The role of the Health Information Exchange in Vermont is to aggregate health information and make it exchangeable across health care providers. The largest constraint for connection of the designated agencies to the VHIE today is the federal regulation 42CFR Part 2 which protects the privacy of substance use disorder patient records by prohibiting unauthorized disclosures of the records except in limited circumstances. VCP and its agencies fully support the concept of sharing information that falls under the jurisdiction of 42CFR Part 2, with other members of the treatment community as long as that information is collected, stored, managed and shared in a way that allows the individual being served control over their information consistent with the intent and requirements of the law.

As stated in the Vermont HIE Plan, "currently, the VHIE cannot manage SUD data apart from other medical data and many EHR systems cannot separate sensitive data types when sharing with the VHIE; therefore, records containing SUD treatment information cannot be shared. This challenge will remain so long as sharing requirements are limited by laws or regulations and as long as consent processes remain onerous to clinical staff." While this solution is not available today, VCP understands that VITL is working to meet this need in the relatively near future. As such, VCP agencies are building opt-in solutions to be ready and able to plug into a state-wide data sharing solution for clinically sensitive data types when it is available. VCP's plan is to have as much clean high quality data in digital form as possible, so that when there is a solution to manage 42CFR Part 2 within the VHIE, agencies will be ready to implement connectivity and data sharing in an expedited manner. Legacy EHRs were either cost prohibitive in their ability to produce CCDs, ADTs, etc., or did not have the capabilities to produce them at all. The two new vendors are meaningful use certified and as such can transfer data electronically. They both have HL7 capability and can transfer ADTs, CCDs, etc. VCP worked with VITL during the onset of the EHR vetting process, has participated on workgroups with VITL to focus on consent management, and will continue to work with VITL and the agencies to develop the interfaces when a solution is built. This will be an additional cost to the agencies.

Interoperability

There are multiple facets to interoperability, and this initiative is a big step forward for our system of care in all of them. The EHRs selected through the vetting process will improve the network's ability to transfer clients between agencies when necessary and appropriate. Fewer

systems also mean it will be easier for staff to move between agencies with minimal retraining. In addition, more consistent language and documentation will streamline compliance and auditing. Similarly, the chosen EHRs will allow more consistent workflows across agencies as well as configurations such as: coding, cost centers, program codes, service codes etc. all of which will drive toward better coordination, both administrative and clinical. Best practices can be more easily replicated within a standardized and aligned EHR network. Agencies have and will continue to have the ability to transfer data when a client transfers to another agency. This was never meant to be a health information exchange between the designated agencies in large part due to the fact that agencies don't typically share clients. They are deploying new EHRs that are replacing legacy EHRs.

The two vendors are meaningful use certified and as such have the capability to transfer information electronically. It is important to note that interoperability is not only impacted by the capabilities of the vendors the agencies have chosen but also the capabilities of the receiving/sending EHRs of other providers.

Integration of Clinically Sensitive Data into General Health Records
Integrating agency records requires a robust consent model. Without a model within the general health record, or VHIE, it is impossible to develop a plan to integrate with general health records. That stated, we remain committed to the improvement of health information technology and exchange in Vermont as demonstrated by our years of involvement and committed on the HIE Steering Committee and the State Innovation Model Health Data Infrastructure Workgroup.

Interoperability with community-based partners is essential. The scope and range of activities and services required for the delivery of care in a community setting are beyond the data collection scope of out-of-the-box EHR's today. While our short-term goal is to transition to a data-centered EHRs and move away from document-centered systems, the long term goal envisions systems that can more fully integrate with other health systems and care models to right-size care, stabilize costs, and optimize outcomes. Moving into a data management model and away from document-centered records, will increase accountability.

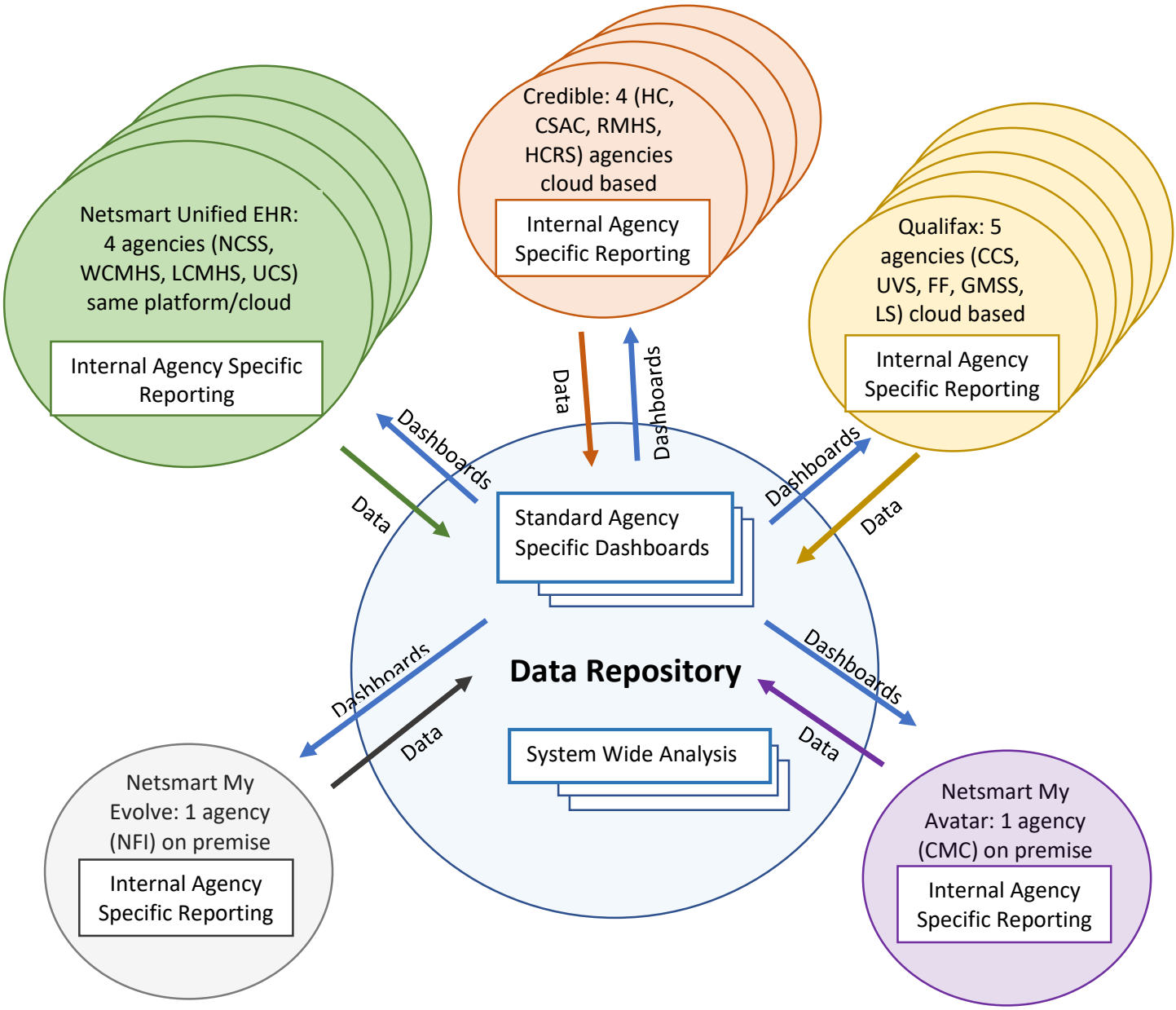
Ability to Capture Data on Services Provided that Do Not Result in a Claim
The capture of services that do not result in a claim (non-billable services such as care inquiry calls, training, disaster and post-vention services etc.) will be driven by the agency workflows, and data collection requirements other than claims generation. The new systems will be configured to allow this kind of data to be captured. The decision process for which non-billable activities will be collected and when and how, would typically be part of work flow development. This could be driven by a number of factors including data reporting and analytics requirements.

8.0 Alignment with the Full VCP Network

What the VCP agencies are doing is unique. All 16 agencies will work within a streamlined network of four platforms with three vendors (Netsmart, Credible, and Qualifax). Though they are on different platforms, they have come together to focus on standardization and data quality. Last summer and fall, 10 groups came together with representation from the agencies to standardize 50 documents. These draft standardized documents were then vetted through each agency and approved by the EHR Steering Committee comprised of representation from 10 of the designated agencies. This type of consolidation and standardization is unique for the industry. It will not only increase efficiency for data collection, reporting and analysis, but will also help to streamline our work with the State of Vermont and other stakeholders.

All EHRs within the network roll data up to the VCP statewide clinical repository. The new EHRs will enable the repository to expand as they will improve the breadth and accuracy of data through the interface. This will then enable VCP to further align data points to improve the dashboards being created and used. The implementation of the EHRs will also allow for agencies to become better aligned improving our network's ability to set and achieve goals for value demonstration and quality improvement among other areas.

16 agencies, three vendors, one repository.
*Data are submitted separately to the repository from 16 agencies.
** 9 agencies moving to a new platform (NKHS undecided)



The Role of the Data Repository and Accompanying Analytics Services

The VCN Data repository is built to collect information from all of the network agencies and provide data analysis, in the form of interactive dashboards.

Our primary goals are:

- Develop a standardized system for collecting data and performing reporting and analytics for network agencies, to improve care quality, document value, and support the health care triple aim.
- Gain efficiency by having a single point of contact for data requests related to our network's data that resides in the repository.
- Support coordination and collaboration among our network agencies.

The role of the data repository will not change significantly as a result of the EHR replacements. The repository will continue to provide dashboards and analytics for the agencies as well as aggregated system wide data, for specific reporting purposes. Due to the persistent nature of the repository interface specification, the information flowing from the agencies, will be contiguous in spite of the change in systems. Additionally, the repository data will be available for long term trends that span agency systems.

9.0 Attachment A: Implementation Plan Summaries

Health Care & Rehabilitation Services (HCRS)
Electronic Health Record Implementation Summary

The HCRS Implementation has been divided into four separate phases. Through the Partnership with Credible, a Milestone sign-off will be completed at the end of each phase to ensure the Implementation is on schedule.

Phase 1: Credible Tour / Data Gathering. This Milestone began January 1, 2019 and was completed by February 22, 2019.

Purpose: During the Credible Tour / Data Gathering phase, Credible staff came to HCRS and gave our Project team and Super Users a tour of the Credible software utilizing Credible best practice workflows and to gather all the needed data to configure our Credible solution. During the Credible Tour / Data Gathering phase, HCRS was expected to:

1. Define the HCRS's Project Team.
2. Hold internal meetings to define/re-define expectations regarding staff buy-in, change management, project management, and business practice changes consistent with implementing an EHR.
3. Provide all requested data to Credible. This includes information related to: revenue recognition practices, chart of accounts, client demographic information, defining programs, teams, payers, prescriber information, to name a few.
4. Participate in a two (2) day on-site Credible Tour with Credible's Implementation and Learning and Development Team, as well as complete additional trainings in Credible's Learning Management System.
5. Participate in a one and a half (1.5) to two (2) day on-site with Credible's Implementation Team to further understand the basic Credible concepts, make decisions regarding the configuration of the Agency's Credible domain, identify and make decisions regarding State Reporting configuration (if applicable), and provide/clarify all remaining data needed for configuration.

Phase 2: Configuration. February 22, 2019 to July 12, 2019

Purpose: During the Configuration phase, Credible's Implementation Manager, Configuration Analyst, and Billing Specialist will be actively reviewing the data provided by HCRS's Project Team and completing the configuration of our Credible domain. During the Configuration phase, HCRS's Project Team completed the following:

1. Attend remote calls through Go-To-Meeting with the Implementation Manager to review progress and learn more about Credible features and functionality.
2. HCRS will be introduced to and make decisions about utilizing Credible features and functionality. When necessary, HCRS will provide needed information to allow Credible to complete configuration. As Credible best practice of state-specific forms are reviewed, HCRS will also provide input on minor changes needed for these forms.

3. Attend remote calls, as requested, by the Credible Billing Specialist or Configuration Analyst for the purpose of clarifying questions related to the data provided in Data Gathering.
4. Receive weekly updates on the status of configuration.
5. Attend a 1-2 hour call at the end of the Configuration phase to review the configuration and Milestone.

Phase 3: Testing and Training. July 15, 2019 to September 3, 2019

Purpose: During the Testing and Training phase, Credible and HCRS project team will work together to validate the accuracy of configuration, and make any final edits to configuration needed prior to GoLive. Testing also includes payer testing of 90% of the Partner's revenue sources or top 10 payers. During the Testing and Training phase, HCRS's Project Team can expect to:

1. Attend regularly scheduled calls through Go-To-Meeting with the Credible Implementation Manager to review accuracy of clinical and administrative areas of the configuration.
2. Attend regularly scheduled calls through Go-To-Meeting with Credible Billing Specialist to review accuracy of billing configuration.
3. Receive training on how to enter services into the domain.
4. HCRS will practice entering test services into the domain for purposes of workflow, form and payer testing.
5. Credible Billing Specialists will work with members of the HCRS Project Team to learn how to resolve Red Xs, run pre-billing checks, and generate a batch.
6. Payer testing will be completed: HCRS with the support of the Credible Billing Specialist will complete File Acceptance and live payer testing.
7. HCRS staff will work with the Credible State Reporting Team to submit test submission of State Reports.
8. HCRS staff will complete end-user training.
9. Final data imports are completed to enter all client demographic and needed clinical data.
10. HCRS Project Team is introduced to Credible Partner Services, who will provide ongoing support throughout the contract with Credible.

Phase 4: GoLive September 3, 2019 to October 19, 2019

Purpose: HCRS is set to GoLive with Credible on 9/3/2019. During the Post GoLive Support phase, Credible's Implementation Manager, Configuration Analyst, and Billing Specialist will continue to work with HCRS's Project Team to ensure a successful transition to the utilization of Credible. During the Post GoLive Support phase, HCRS's Project Team can expect to:

1. Complete a weekly Post GoLive checklist form in the Partnership domain. The Post GoLive checklist will assist HCRS to identify workflow or configuration issues before they become large problems or staff bad habits. The Credible Implementation Manager, Configuration Analyst, or Billing Specialist will be available to assist HCRS with a resolution of identified concerns.

2. Complete a daily 15-minute Touch Point with a member of the Credible Implementation team for at least the first two (2) weeks following GoLive. The daily Touch Point is a brief call to check on progress, troubleshoot any issues/concerns, or answer questions.
3. Complete a Pre-Billing/Batching Training Call with the Credible Billing Specialist. This call will walk HCRS's billing staff through Credible's best practice workflow for pre-billing checks and batching files using HCRS's actual production data. The goal of this call is to ensure the successful batch submission of production files to HCRS's payers.
4. Complete a Posting Training Call with the Credible Billing Specialist. This call will walk HCRS's billing staff through Credible's best practice workflow for manually and electronically posting claims, as well as how to address splitting revenue on a remit between Credible and HCRS's legacy software.
5. Complete 1-3 Month End Closing Calls with the Credible Billing Specialist. These calls will walk HCRS staff through Credible' s best practice workflow for closing the month, resolving any transactional mapping issues, and generating the first AR export batch.
6. During this phase, HCRS is expected to enter Task Tickets for any concerns/questions and a Credible Services Coordinator and/or Billing Specialist will address concerns via the Task Ticketing System.

Project Team Configuration:

IT Director – Project Manager
Chief Operations Officer
Administrative Service Manager
Billing Manager
CYF Division Director
CYF School Area Manger
Adult Division Director
DS Assistant Director
Residential Services Area Manager
Nurse Manager

Governance Structure:

The EHR Development Team reports directly to the Senior Leadership Team. The Development Team is responsible to ensure efficiencies in design for the larger HCRS staff. The Senior Leadership reviews and approves all decisions recommended by the project team.

Counseling Service of Addison County (CSAC)
Electronic Health Record Implementation Summary

The CSAC Implementation has been divided into four separate phases. Through the Partnership with Credible, a Milestone sign-off will be completed at the end of each phase to ensure the Implementation is on schedule.

Phase 1: Credible Tour / Data Gathering. This Milestone began February 29, 2019 and was completed by March 29, 2019.

Purpose: During the Credible Tour / Data Gathering phase, Credible staff came to the Counseling Service of Addison County (CSAC) and gave our Project team and Super Users a tour of the Credible software utilizing Credible best practice workflows and to gather all the needed data to configure your Credible solution. During the Credible Tour / Data Gathering phase, CSAC was expected to:

1. Define the CSAC's Project Team.
2. Hold internal meetings to define/re-define expectations regarding Staff Buy- In, Change Management, Project Management, and Business Practice changes consistent with implementing an EHR.
3. Provide all requested data to Credible. This includes information related to: Revenue Recognition practices, Chart of Accounts, Client Demographic information, defining Programs, Teams, Payers, Prescriber Information, to name a few.
4. Participate in a two (2) day on-site Credible Tour with Credible's Implementation and Learning and Development team, as well as complete additional trainings in Credible's Learning Management System.
5. Participate in a one and a half (1.5) to two (2) day on-site with Credible's Implementation team to further understand the basic Credible concepts, make decisions regarding the configuration of the Agency's Credible domain, identify and make decisions regarding State Reporting configuration (if applicable), and provide/clarify all remaining data needed for configuration.

Goal: At the end of the Credible Tour / Data Gathering phase, CSAC was asked to sign the Data Gathering Milestone. This Milestone sign-off indicates that both CSAC and Credible have all the data needed to complete the configuration of the domain. CSAC did sign off on this Milestone being completed.

Phase 2: Configuration. This Milestone began in early March of 2019 and we are continuing to work on the configuration details. The goal for completing the Configuration Phase is by September 13, 2019.

Purpose: During the Configuration phase, Credible's Implementation Manager, Configuration Analyst, and Billing Specialist will be actively reviewing the data provided by CSAC's project team and completing the configuration of your Credible Domain. During the Configuration phase, CSAC's project team can expect to:

1. Attend remote calls through Go-To-Meeting with the Implementation Manager to review progress and learn more about Credible features and functionality.
2. You will be introduced to and make decisions about utilizing Credible features and functionality. When necessary, CSAC will provide needed information to allow Credible to complete configuration. As Credible Best Practice or State-Specific forms are reviewed CSAC will also provide input on minor changes needed to these forms.
3. Attend remote calls, as requested, by the Credible Billing Specialist or Configuration Analyst for the purpose of clarifying questions related to the data provided in Data Gathering.
4. Receive weekly updates on the status of configuration.

5. Attend a 1-2 hour call at the end of the Configuration phase to review the configuration and Milestone.

Goal: At the completion of the Configuration phase, CSAC's Domain will be completed based on the data provided in the Credible Tour / Data Gathering phase. CSAC will be asked to sign the Configuration Milestone indicating that configuration is completed. **CSAC expects to attain the September 13, 2019 Configuration completion date goal.**

Phase 3: Testing and Training. We expect this Milestone to begin by early August 2019. The goal to complete the Testing and Training Phase is by October 31, 2019.

Purpose: During the Testing and Training phase, Credible and CSAC project team will work together to validate the accuracy of configuration, and make any final edits to configuration needed prior to GoLive. Testing also includes Payer Testing of 90% of the Partner's Revenue Sources or top 10 Payers. During the Testing and Training phase, CSAC's project teams can expect to:

1. Attend regularly scheduled calls through Go-To-Meeting with the Credible Implementation Manager to review accuracy of clinical and administrative areas of the configuration.
2. Attend regularly scheduled calls through Go-To-Meeting with Credible Billing Specialist to review accuracy of billing configuration.
3. Receive training on how to enter services into the domain.
4. CSAC will practice entering test services into the domain for purposes of Workflow, Form and Payer testing.
5. Credible Billing Specialists will work with members of the CSAC project team to learn how to resolve Red Xs, run Pre-Billing Checks, and Generate a Batch.
6. Payer Testing will be completed: CSAC with the support of the Credible Billing Specialist will complete File Acceptance and Live Payer Testing.
7. CSAC staff will work with the Credible State Reporting team to submit test submission of State Reports.
8. CSAC staff will complete End User training.
9. Final data imports are completed to enter all Client demographic and needed clinical data.
10. CSAC Project Team is introduced to Credible Partner Services, who will provided ongoing support throughout the contract with Credible.

Goal: At the completion of the Testing and Training phase, CSAC and Credible will have confirmed the accuracy of the configuration completed, successfully passed Live Payer Testing for 90% of Revenue or Top 10 Payers, and CSAC staff will have completed End User training. CSAC will be asked to sign the Payer Testing Milestone indicating the successfully completion of Payer Testing, and the GoLive Readiness Milestone indicating the configuration has been validated and the domain is ready for production use. **CSAC expects to attain the October 31, 2019 Testing and Training completion date goal.**

Phase 4: Post GoLive Support

Purpose: CSAC anticipates being Live on Credible as of November 1, 2019. Meaning that CSAC would be actively using the Credible software. During the Post GoLive Support phase, Credible's Implementation Manager, Configuration Analyst, and Billing Specialist will continue to work with CSAC's project team to ensure a successful transition to the utilization of Credible. During the Post GoLive Support phase, CSAC's project teams can expect to:

1. Complete a weekly Post GoLive checklist form in the Partnership domain. The Post GoLive checklist will assist CSAC identify workflow or configuration issues before they become large problems or staff bad habits. The Credible Implementation Manager, Configuration Analyst, or Billing Specialist will be available to assist CSAC with a resolution of identified concerns.

2. Complete a daily 15-minute Touch Point with a member of the Credible Implementation team for at least the first 2 weeks following GoLive. The daily Touch Point is a brief call to check on progress, troubleshoot any issues/concerns, or answer questions.
3. Complete a Pre-Billing/Batching Training Call with the Credible Billing Specialist. This call will walk CSAC's Billing staff through Credible's Best Practice workflow for Pre-Billing checks and batching files using CSAC's actual production data. The goal of this call is to ensure the successful batch submission of production files to CSAC's Payers.
4. Complete a Posting Training Call with the Credible Billing Specialist. This call will walk CSAC's Billing staff through Credible's Best Practice workflow for manually and electronically posting claims, as well as how to address splitting revenue on a remit between Credible and CSAC's legacy software.
5. Complete 1-3 Month End Closing Calls with the Credible Billing Specialist. These calls will walk CSAC staff through Credible's Best Practice workflow for closing the month, resolving any transactional mapping issues, and generating the first AR Export Batch.
6. During this Phase, CSAC is expected to enter Task Tickets for any concerns/questions and a Credible Services Coordinator and/or Billing Specialist will address concerns via the Task Ticketing System.

Goal: To provide a smooth transition from Implementation to ongoing Credible Partner Support and to ensure successful billing from GoLive. CSAC will be asked to sign the Post GoLive Milestone indicating that training and completion of 1st month end close and payment posting. **CSAC expects to attain the Post GoLive Milestone by early December 2019.**

SUMMARY OF CSAC IMPLEMENTATION TEAM

CSAC has a nine-person internal Project Implementation Team that includes three co-project managers (CFO, Billing/records Manager and IT manager), with the CFO as the lead Project Manager. The team includes 4 administrators and 5 program staff representing each clinical area of CSAC. The team is empowered to make decisions regarding the implementation of the EHR based upon feedback from CSAC's "Super Users" and Subject Matter Experts". There are 36 "Super Users" and "Subject Matter Experts" who represent all specific areas of CSAC's operations. Generally, these individuals are involved with the project implementation by attending meetings and trainings and providing direct feedback to the implementation team regarding workflows and decisions. The 10 Super Users and the Project Implementation Team will be the main resource in training CSAC staff to the CSAC specific workflows within the EHR in preparing to go Live and afterward. The 26 Subject Matter Experts are more of a reference for the Implementation Team on the workflows and other components during implementation and then will also be an additional level of support to assist staff as needed as CSAC prepares to go Live and after go Live.

Credible has an Implementation Manager guiding/facilitating CSAC through the various steps/phases of the CSAC implementation.

UEMRVT

Unity. Vision. Vermont.

Unified Electronic Medical Record Project of Vermont

Designated Agency Consortia

Clara Martin Center (CMC)
Lamoille County Mental Health Services (LCMHS)
Northwest Counseling and Support Services (NCSS)
United Counseling Services (UCS)
Washington County Mental Health Services (WCMHS)

INITIATIVE UPDATE
FOR
VERMONT JOINT FISCAL COMMITTEE

Authored by:
Sean Thomson
Solution Delivery Manager

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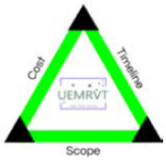
• REVISION HISTORY

Version Table		
Version Number	Date	Notes
201907232354	7/24/2019	Initial Published Draft
201907241451	7/24/2019	Minor revisions

Executive Summary

Project Status



Vision

- UEMRVT has a Unified Vision, Governance, and Technological Enforcement to bring about the Digital Transformation of the UEMRVT Agencies, moving from Documents to Data.
- The UEMRVT Consortia wishes to foster stronger partnerships with our key stakeholders
- The UEMRVT Consortia plans to align with population health, risk bearance, and whole-person care for stronger community health outcomes across Vermont.

Tenets

- Business Transformation
  - UEMRVT not an IT Project, this is a Business Transformation Project
- Practice Standardization
  - The project will result in practice standardization improving data integrity and comparability
- Data not Documents (and the "**One Truth**" model)
  - It also results in an almost purely data-based workflow ("**paperless**" or "**paper on demand**")
  - This includes a focus on a "one-truth" data model, aka "Single Source of Truth" (SSOT).

Strategic Differentiators

Solution	Approach
• Interoperability ○ Current Vendor Integrations between Behavioral Health Partners and Physical Health Networks using a National Secure Health Information Exchange Architecture • Population Health Integration Readiness • Master Patient Index	• Practice Standardization • Economies of Scale and Resource • Long Term Sustainability • Digital Enforcement of System and Standardization Integrity

Timeline

Phase 0 - Discovery and Initialization		March 2019 - November 2019
Phase 1 - Configuration and Pre-Launch Prep	Solution Validation 1: September 2019 Solution Validation 2: December 2019	May 2019 - February 2019
Phase 2 - Localization	User Acceptance Testing, End User Training, Conversion Validation, Legacy System Continuity Planning	January 2020 - June 2020
Phase 3 - Go-Live	**NCSS** - 3/9/2020 **UCS** - 4/20/2020 **LCMHS** - 5/18/2020 **WCMHS** - 6/22/2018	March 2020 - June 2020
Phase 4 - Post Launch and Support Transition		March 2020 through July 2020
Phase 5 - Continuous Improvement		July 2020 and ongoing

Business Drivers

The primary marketplace challenges attributed to the legacy technologies and subsequent operational difficulties, mostly managed through work-arounds and labor-intensive practices, were as follows:

Legacy interfaces created user difficulties and poor experiences for clinicians resulting in negative impacts on data integrity.

The lack of patient/client portals hindered improvements to client experiences and communication modernization.

The lack of interoperability from the community health systems to physical health providers, and vice versa, created barriers to integrated care models.

The lack of advanced analytical toolsets and data-driven workflows limited the opportunities for informed-design transformation of care models.

Disparate and decentralized systems locked the agencies into inefficient support models without economies of resource or scale.

In an effort to address those challenges and beyond, four (4) of the designated agencies completed the procurement phase of the UEMR initiative and emerged together as a unified consortia within the next phase of the project, affectionately known as UEMRVT (Unified Electronic Medical Records system of Vermont). This next phases plans to implement a fabric of digital solutions for the EMR, advanced analytics, data sharing, and improved clinician and client user experiences. Those four agencies, with support by a fifth agency possessing platform expertise (Clara Martin Center), are committed to the original mission with renewed enthusiasm and operational support for practice standardization and improved care and collaboration across the Vermont healthcare landscape.

The proposed digital solution fabric, will also address vision alignment challenges. By partnering the UEMRVT consortia (UEMRVT-C) with a vendor who provides a constellation of solutions orbiting around the EMR, the short term goal is to transition from the document-centered systems used today to a data-focused EMR. This short range goal will also increase UEMRVT-C's ability to data mine on the care delivered today and therefore increase the transparency and accountability for care provision. The long term goal is to have 100% of services documented within a data-driven, integrated system. The scope and range of activities and services required for the delivery of care in a community setting are beyond the data collection scope of out-of-the-box EMR's. However, once this solution is realized, models of care with comprehensive and inclusionary services can be developed to integrate with the physical health systems and care models in order to right-size care, stabilize costs, and optimize outcomes.

As healthcare evolves it requires, indeed, craves data. Data-driven systems meet this directive by collecting data as few times as possible and as close to the source as possible therefore increasing data integrity and useability. Patient Portals for continuous client feedback, secured data exchanges and integrations to reduce redundancy and create single data entry-points for providers, are all necessary to the success of outcomes-based care and the value-based payment systems to fuel it.

All that said, the center-point of the entire project, is a transformation toward care collaboration across all health providers in Vermont, especially for a client bases that represents a high-needs population. This is achieved by moving beyond data exchange and into data integration. The EMR alone is not the answer; it's the solution fabric that allows the

data in the designated agency UEMRVT systems to move into the right place at the right time in other EMR's and data systems throughout the Vermont Healthcare landscape of providers and vice versa. This will also allow for redundant data entry to be minimized in order to increase the usefulness and effectiveness of care coordination tools.

Arriving through the procurement phase of the project and beginning discovery and implementation, the UEMRVT Consortia has tremendous evidence to support an assertion that it has chosen a vendor-partner, Netsmart Technologies, to deliver this solution fabric to achieve the unified Vision and Mission of the UEMRVT Consortia.

• Vision

Vision

To achieve a technology-based business transformation in order to pivot the participating agencies into a strategic role within the Vermont healthcare landscape.

Mission

To achieve this vision, the mission is to deliver a **unified** and **standardized** electronic medical record system across all four (or more) participating agencies that:

1. Improves the internal operations of the agencies,
2. Fosters a new era of data integration with UEMRVT-C's mainstream healthcare partners and data driven care,
3. While using the project as a platform for stronger partnerships with key stakeholders, such as the State of Vermont.

Goals and Objectives

The goals, in order to achieve the mission will be to:

1. Replace the legacy electronic medical record systems
2. Standardize practice management across the agencies, including workflows, business practices, coding, and data collection methods, wherever possible
3. Migrate as much viable data and record artifacts as possible without damaging the integrity of the highly governed data within the new system
4. Develop advanced reporting and analytics
5. Forge the cornerstones of population health, including care data and a Master Patient Index
6. Erect the beginnings of integrated care through healthcare information exchange with mental health and, potentially, substance use disorder data with other care partners, including but not limited to hospitals, FQHC's, primary care, and other community health partners.

Definition of Success

The UEMRVT shared instance of the Netsmart myAvatar Electronic Medical Record system, CareConnect, Order Entry, eMAR, Patient Portal, and CarePathways, PsychNote, Clinician POV, and KPI Tools implemented in all four (4) consortia agencies and operating in a standardized fashion such that all client-side functions and maintenance of the system can be conducted by a geographically separated but centrally managed configuration team and such that all functionality changes within the system affecting the core instance/version and/or data standardization and integrity are also centrally governed.

Complex Initiative Streams

The UEMRVT project is a complex initiative with two major project streams; (1) Practice Standardization; and (2) EMR Implementation. In order for the UEMRVT Agencies to coexist in a sustainable way within a shared instance of the myAvatar platform while preserving economies of scale and resources, the business practices of the four agencies will be adapted for optimized system performance and automation while preserving that which is strategically and culturally important to Vermont's Designated Agency System and its partners.

A known impact of the Practice Standardization stream is a lengthened overall project timeline. This risk is actively managed by the internal and vendor project teams and the project deliverables are being adapted to the Kanban Agile Project Methodology employed to make this successful.

● Strategic Differentiators

The UEMRVT Project contains several strategic differentiators focused to deliver the project with the established and complex Vision and Mission.

SOLUTION STRENGTHS		Netsmart's myAvatar
Mobile	Mobility Solutions and Apps	✓
Interoperability	National Secure Health Information Exchange Architecture	✓
	Active Integrations between Behavioral Health Partners and Physical Health and/or Hospital Networks	✓
	Federated Query capability into healthcare network systems	✓
Interoperability Options	Web Services	✓
	APIs	✓
	Direct Messages with CCD's	✓
	FIHR	✓
Integrated Health	Integrated Health Modules for providing physical health care in community and behavioral health settings	✓
Analytics	Advanced analytics engines to analyze internal and external comparative data	✓
Population Health	Integration with and Provision of Population Health Toolsets	✓
MPI	**Master Patient Index. An MPI is critical for population health and integrated health tools for unique and unified identification of person-centric records. An integrated MPI for the UEMRVT system will allow the participating agencies to more easily analyze population cohorts alongside the State of Vermont and other Health Care Partners.**	✓

VENDOR STRENGTHS		Netsmart
Vision	Company Vision for Short Term Solutions and Long Range Planning	✓
Partnership	Nationally positioned to monitor and influence the state of care records	✓
	Strategically and technologically positioned to provide solutions for future challenges	✓
	Staffing and Expertise to assist in the development of best practices with solution-based integration	✓
	Nationally positioned and partnered with other critical path electronic health care initiatives	✓
Proof of Value in Solutions	Active Integrations between Behavioral Health Partners and Physical Health and/or Hospital Networks	✓
	Successful health network-based implementations	✓

Additionally, the UEMRVT consortia identified a collective strength, beyond economies of scale, by working together in a unified approach. The benefits outweighed the

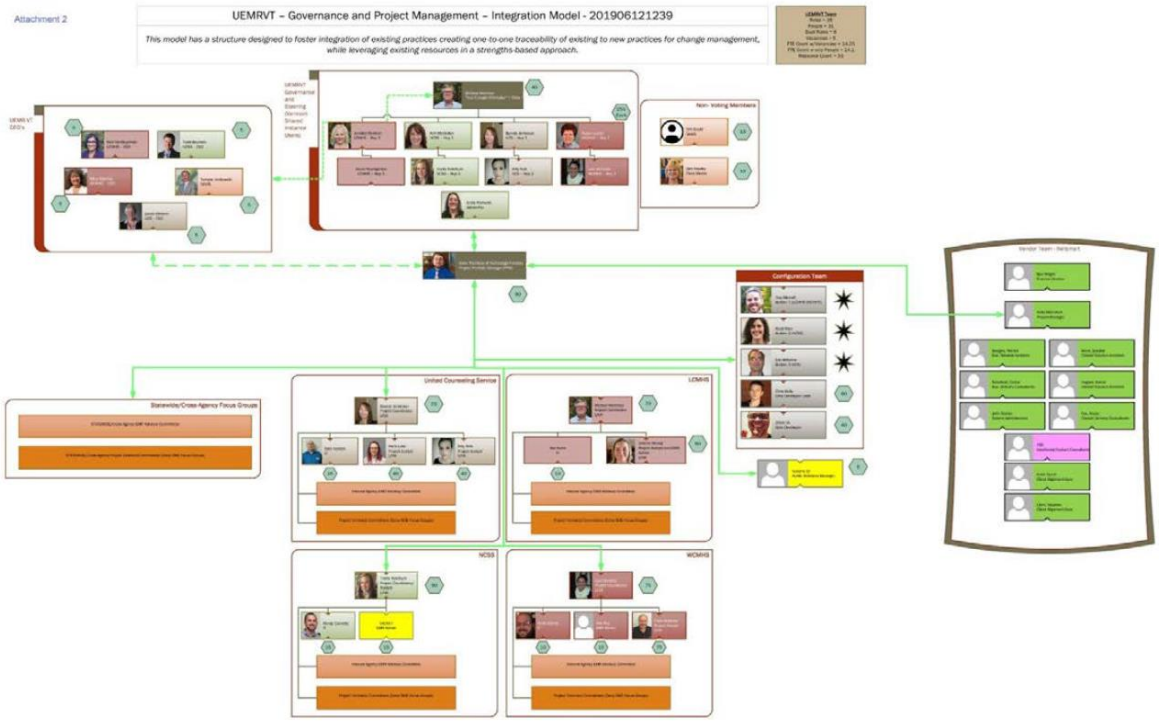
UNIFIED VS INDIVIDUAL IMPLEMENTATION		Unified	Individual
Human Resources	Economies of resources to be found in shared EMR administration	✓	
System Resources	Potential to share source code, templates, reports, configuration files	✓	
Standardization	Practice Standardization platform	✓	
	Forcing function for standardization and unification	✓	
MPI	Master Patient Index to support Master Patient records for, sharing clients across DA's for client-centered specialist or best practice care	✓	
	MPI to support the foundation for population health	✓	
	MPI to support advanced care management	✓	
Purchasing Power	Purchasing power as a larger group	✓	
Strategic Stance	Together the group is a larger customer to improve strategic positioning within the customer base and improve solution priorities for Vermont within vendor roadmaps.	✓	
Autonomy	Complete autonomy from partner agencies resulting in an increase in individual agency operational agility		✓

Unified Solution, Governance, and Digital Enforcement

Finally, in order to protect the investment in the unification and shared platform and to optimize both future results and sustainability, the UEMRVT solution will have digital enforcement through database architecture and a corresponding Governance Structure.

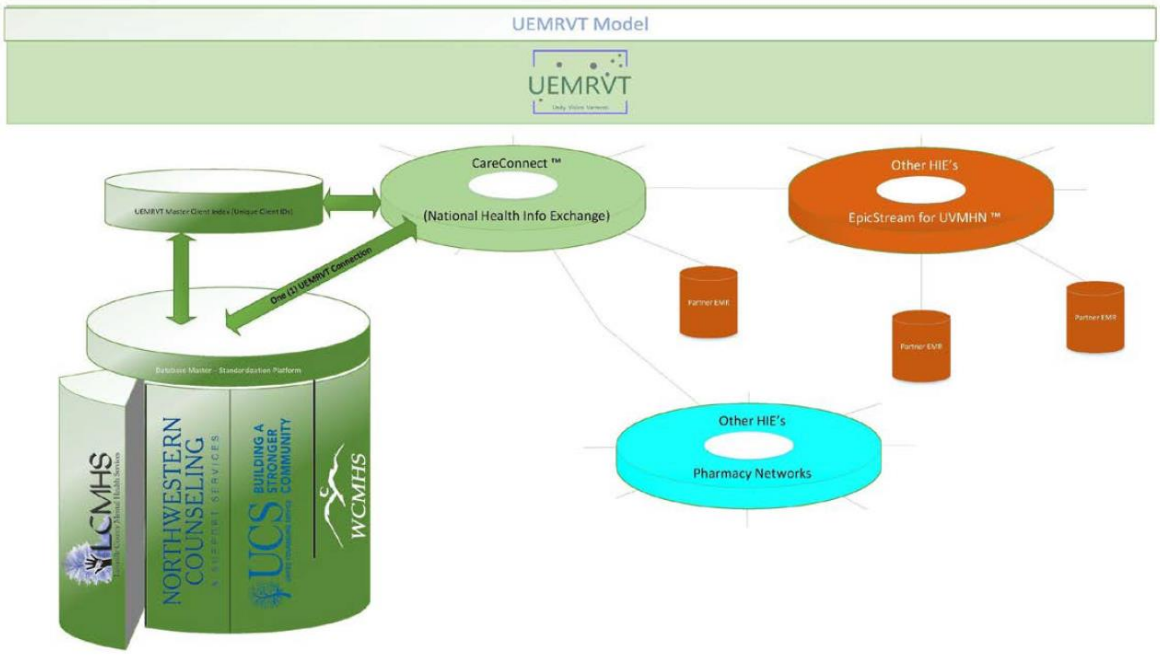
A strong, ratified, and documented Governance structure is key in complex projects. Established bylaws, roles, and responsibility, alongside a cohesive and collegial project team are the hallmarks of UEMRVT success.

Org Chart



Database Architecture

The database model allows for the necessary flexibility to support differing efforts across the UEMRVT agencies while enforcing and maintaining standardization where appropriate. This will maximize the interoperability of the resulting system.



Summary Project Plan

Fostering Practice Standardization

One Truth Model

This concept has several connotations and is sometimes known as the SSOT (single source of truth) model. For our project it has two specific goals.

The first goal is "Digital First" and is intended to foster cohesion in a large and geographically spread team. By keeping all project materials fully electronic and by employing modern digital conference room technology, a team member attending meetings via web conference or completing assignments remotely can participate as fully and comprehensively in project efforts as if they were sitting down the hall. Digital First methods remove distance as a barrier to effective teams.

The second goal is "Single/Authority Sourcing." This method fosters the creation of complex project libraries and tools that consolidate all sources of material, regulations, templates, best practices, etc, and allow for not only their analysis and comparison, but conflict identification and solution engineering. This component will be critical in the practice standardization stream.

Additional Components of the Project Plan

- Toolset Management including Project and Team Sites
- Artifacts Management including Unified Libraries and Lexicons
- Governance Plan with Roles and Responsibilities
- Meeting Plan
- Project Change Order Plan
- Agency Change Management Plan
- Unified Project Schedule with Phase Management and Work Breakdown Structure
- Risk and Issues Response Plan
- Communication Plan
- Training and Sustainability Plan

Project Phases and Associated Timeline

This project schedule was co-developed with Netsmart and integrated both the Practice Standardization and the EMR Implementation project streams.

Phase 0 - Discovery and Initialization (March 2019 through November 2019)

This phase is extended as it includes the majority of the Practice Standardization effort and analysis. This includes analysis of and resynchronization with regulatory guides. It also includes modernization of clinical workflows, billing practices, financials, reporting, etc.

Phase 1 - Configuration and Pre-Launch Prep (May 2019 through February 2019)

Using a Kanban Agile project method, coupled with the One Truth model, configuration and requirements gathering begin to overlap early on with improvements made to configuration along the way.

- Solution Validation 1: September 2019
- Solution Validation 2: December 2019

Phase 2 - Localization (January 2020 through June 2020)

This phase will include localized requirements and configuration for specialized programming at each individual agency. Up until this phase the system will have been configured with a unified core build applicable and useable by all UEMRVT agencies. Also this phase will persist for some agencies as other are going live, meaning that Phase 2 and 3 will overlap across the UEMRVT agencies.

- Major Activities in this Phase
  - Final User Acceptance Testing and System Validation
  - End User Training (synchronized with per agency Go Live and supported by a centralized core team)
  - Conversion Validation
  - Legacy System Continuity Planning
    - Migration/Archiving
    - Parallel Operations Plan
    - Transition and Turn Down Plan

Phase 3 - Go-Live (March 2020 through June 2020)

Each Go Live will be successive, starting with NCSS, then UCS, then LCMHS, then WCMHS, separated by several weeks between Go Lives to ensure system performance and functionality.

- NCSS
  - 3/9/2020
- UCS
  - 4/20/2020
- LCMHS
  - 5/18/2020
- WCMHS
  - 6/22/2020

Phase 4 - Post Launch and Support Transition (March 2020 through July 2020)

Each Go Live will inform improvements with high and low priorities. It is within the design of the UEMRVT Project to improve the system between Go Lives with mission critical changes discovered during each Go Live in order to reduce the operational impact on agencies as the project progresses.

Additionally, at this time, a sustainable support methodology will be implemented upon Go Live for each agency. That plan will include self help resource sites, help desk resources, vendor escalation paths, Netsmart Community resources, and learned best practices from agencies already live on the system.

Phase 5 - Continuous Improvement (July 2020 and ongoing)

Inevitably during the project, discoveries for future improvements will be made and "parking lotted" in order to support a timely rollout of the EMR. Through the method outlined during Phase 4, the UEMRVT project intends to prioritize these and begin immediate system improvements as soon as the last agency is live. Additionally, by leveraging the sustainable support model, these improvements will be developed into a systems roadmap that will be synchronized with State and stakeholder requirements in an effort to future-proof the investment made by the UEMRVT agencies.

1.0 Howard Center EHR Implementation Status Summary

July 18, 2019

2.0 Phase 1 – Data Gathering and Project Planning

Started 11/5/2018 – Ended 12/18/2018
Status - Successfully Completed
Activities included: Project scoping, project schedule development, resources assignments and core project team development, environment set up, program review, labs forms, RX forms, employee and client profiles, treatment plans review, data migration planning, client systems review, bed board review, reporting requirements and options review, billing data examples and configuration high level review, data import formats, reports planning, Business Intelligence options, forms planning, reporting planning

3.0 Phase 2 – Configuration and Development

Started – 12/19/2019 – Ended 6/30/2019
Status – Successfully Completed
Activities included: Forms and template development and testing, report development, integration development, client/employee/episode profile configuration, Client portal review and planning, state reporting requirements, data import requirements and testing, staff training for admin and development, external provider set up, treatment plan configuration and development, medical profiles development, eMAR and orders configuration, RX and physician's orders development, security matrix planning and configuration, billing configuration and preparation, bed board training, schedule groups and templates review, development of notifications and triggers, billing workflows development, end user training materials development, project management, device planning, system decommissioning, information forums, signature pads planning, scanning preparation, support structure development, development of testing scenarios, development of additional training facilities and preparation, open clinics support to ensure current EHR close out of open items

4.0 Phase 3 – Test and Train

Started 6/29/19 – Targeted end 9/2/2019
Status – Current phase and on target as of 7/17/19
Activities include(d): Form testing and tuning, state reporting completion and testing, testing and tuning of all configurations based on test scenarios, training finalization, training for support staff and all clinical staff, final data migration, biller payer testing and tuning, final RX set up and testing, preparation and set up of production environment, reporting development and testing, integration development, mobile device distribution, deployment of signature devices, preparation for transition from previous EHR procedures, begin entry of treatment plans and other preparation after production environment readied

5.0 Phase 4 – Go Live and Post Go Live transition start up

Start Target 9/3/2019 Targeted end 11/30/2019 (Go live targeted for 9/3/2019)
Status – Not started
Activities include: Migrate users to new Credible domain, finalize transition from previous EHR including completing any open activity, dual billing procedures (could continue for 6 months in previous EHR), open clinics to support staff transition, super user support within programs and

locations, support for operational processes that have transitioned to new EHR, begin activation of Read Only access in previous EHR, monitor and tune Credible EHR processes/reports/support

Howard Center Implementation Team

6.0 Credible Core Project Team (CCPT)

Name	Title	Role	Organization
Laura Pearce	Director of Information Management and Compliance	Project owner, SME, trainer	Business Operations - IM
Robin Pesci	Health Informatics Manager	Lead HI, SME, trainer	Business Operations - IM
Bob Stetzel	Sr. Director of Information Technology	Lead IT	Business Operations - IT
Alyx Lyons	Project and Portfolio Manager	Project manager	Business Operations - IT
John Fredericks	Information Systems Manager	Lead IT/IS	Business Operations - IT
Ed Giroux	Director, Revenue Cycle	Lead Billing	Business Operations - Finance and Accounting
Liz Brunell	Billing Manager	Billing	Business Operations - Finance and Accounting
Ashleigh Allaire	Sr. Manager	Lead CS participant, trainer, SME, liaison with Client Services teams	Client Services - Long Term Services and Support
Jaime Elliot	Clinical Manager - Outpatient	Lead CS participant, trainer, SME, liaison with Client Services teams	Client Services - Outpatient Services
Betsy Ferry	FCP Program Coordinator	Lead CS participant, trainer, SME, liaison with Client Services teams	Client Services - Home and Community Programs

7.0 Health Informatics Team

Name	Title	Role	Organization
Ed Olszewski	Clinical Informatics Analyst	HI participant, trainer	Business Operations - IM
Judy Emerson	Clinical Informatics Analyst	HI participant, trainer	Business Operations - IM
Dan Ozimek	Technical Training Specialist	Trainer	Business Operations - IM
Bobby Leonard	Health Informatics Systems Auditor	Trainer	Business Operations - IM

8.0 Information Technology Team

Name	Title	Role	Organization
Jim Staples	Application Developer	Developer - reports, integrations, data migration	Business Operations - IT

Bill Post	Sr. Database Administrator and Programmer	Developer - reports, integrations, data migration	Business Operations - IT
Rick Bragg	Sr. Applications Analyst	Developer - reports, integrations, data migration, Application Admin	Business Operations - IT
Emma Owens	Emma Owens	Developer - reports, integrations, data migration, Application Admin	Business Operations - IT

9.0 Training Team

Casey Gates	Team Lead - Developmental Services	Trainer	Client Services - Long Term Services and Support
Lisa Bilowith	Director, Garvin School	Trainer	Client Services - School Programs
Dana Poverman	Director, Medication Assisted Treatment Programs	Trainer	Client Services - Medication Assisted Treatment Programs
Michelle Fane-Cushing	Clinical Director, Outpatient Services	Trainer	Client Services - Outpatient Services
Hanna Wagner	ARCh Program Coordinator	Trainer	Client Services - Access & Intake
Sara Stowell	ARCh Clinical Supervisor	Trainer	Client Services - Access & Intake
Adrianna Benson	Technology Support Analyst	Trainer	Business Operations - IT

Rutland Mental Health Services (RMHS)
Electronic Health Record Implementation Summary

The RMHS Implementation has been divided into four separate phases. Through the Partnership with Credible, a Milestone sign-off will be completed at the end of each phase to ensure the Implementation is on schedule.

Phase 1: Credible Tour / Data Gathering. This Milestone began November 25th, 2018 and was completed by January 18, 2019.

Purpose: During the Credible Tour / Data Gathering phase, Credible staff came to Rutland Mental Health Services, Inc. (RMHS) and gave our Project team and Super Users a tour of the Credible software utilizing Credible best practice workflows and to gather all the needed data to configure your Credible solution. During the Credible Tour / Data Gathering phase, RMHS was expected to:

1. Define the RMHS's Project Team.
2. Hold internal meetings to define/re-define expectations regarding Staff Buy- In, Change Management, Project Management, and Business Practice changes consistent with implementing an EHR.
3. Provide all requested data to Credible. This includes information related to: Revenue Recognition practices, Chart of Accounts, Client Demographic information, defining Programs, Teams, Payers, Prescriber Information, to name a few.
4. Participate in a two (2) day on-site Credible Tour with Credible's Implementation and Learning and Development team, as well as complete additional trainings in Credible's Learning Management System.
5. Participate in a one and a half (1.5) to two (2) day on-site with Credible's Implementation team to further understand the basic Credible concepts, make decisions regarding the configuration of the Agency's Credible domain, identify and make decisions regarding State Reporting configuration (if applicable), and provide/clarify all remaining data needed for configuration.

Goal: At the end of the Credible Tour / Data Gathering phase, RMHS was asked to sign the Data Gathering Milestone. This Milestone sign-off indicates that both RMHS and Credible have all the data needed to complete the configuration of the domain. RMHS did sign off on this Milestone being completed.

Phase 2: Configuration. This Milestone began in early January of 2019 and was completed on July 12th 2019.

Purpose: During the Configuration phase, Credible's Implementation Manager, Configuration Analyst, and Billing Specialist will be actively reviewing the data provided by RMHS's project team and completing the configuration of your Credible Domain. During the Configuration phase, RMHS's project team can expect to:

1. Attend remote calls through Go-To-Meeting with the Implementation Manager to review progress and learn more about Credible features and functionality.
2. You will be introduced to and make decisions about utilizing Credible features and functionality. When necessary, RMHS will provide needed information to allow Credible to complete configuration. As Credible Best Practice or State-Specific forms are reviewed RMHS will also provide input on minor changes needed to these forms.
3. Attend remote calls, as requested, by the Credible Billing Specialist or Configuration Analyst for the purpose of clarifying questions related to the data provided in Data Gathering.
4. Receive weekly updates on the status of configuration.

5. Attend a 1-2 hour call at the end of the Configuration phase to review the configuration and Milestone.

Goal: At the completion of the Configuration phase, RMHS's Domain will be completed based on the data provided in the Credible Tour / Data Gathering phase. RMHS signed the Configuration Milestone indicating that configuration is completed on July 12 2019 with addendums for state reporting, approvals and notification triggers to be completed later.

Phase 3: Testing and Training. We started this Milestone on July 15th. The goal to complete the Testing and Training Phase is by September 3rd, 2019.

Purpose: During the Testing and Training phase, Credible and RMHS project team will work together to validate the accuracy of configuration, and make any final edits to configuration needed prior to GoLive. Testing also includes Payer Testing of 90% of the Partner's Revenue Sources or top 10 Payers. During the Testing and Training phase, RMHS's project teams can expect to:

1. Attend regularly scheduled calls through Go-To-Meeting with the Credible Implementation Manager to review accuracy of clinical and administrative areas of the configuration.
2. Attend regularly scheduled calls through Go-To-Meeting with Credible Billing Specialist to review accuracy of billing configuration.
3. Receive training on how to enter services into the domain.
4. RMHS will practice entering test services into the domain for purposes of Workflow, Form and Payer testing.
5. Credible Billing Specialists will work with members of the RMHS project team to learn how to resolve Red Xs, run Pre-Billing Checks, and Generate a Batch.
6. Payer Testing will be completed: RMHS with the support of the Credible Billing Specialist will complete File Acceptance and Live Payer Testing.
7. RMHS staff will work with the Credible State Reporting team to submit test submission of State Reports.
8. RMHS staff will complete End User training.
9. Final data imports are completed to enter all Client demographic and needed clinical data.
10. RMHS Project Team is introduced to Credible Partner Services, who will provided ongoing support throughout the contract with Credible.

Goal: At the completion of the Testing and Training phase, RMHS and Credible will have confirmed the accuracy of the configuration completed, successfully passed Live Payer Testing for 90% of Revenue or Top 10 Payers, and RMHS staff will have completed End User training. RMHS will be asked to sign the Payer Testing Milestone indicating the successfully completion of Payer Testing, and the GoLive Readiness Milestone indicating the configuration has been validated and the domain is ready for production use. **RMHS expects to attain the September 3rd, 2019 Testing and Training completion date goal.**

Phase 4: Post GoLive Support

Purpose: RMHS anticipates being Live on Credible as of September 3, 2019. Meaning that RMHS would be actively using the Credible software. During the Post GoLive Support phase, Credible's Implementation Manager, Configuration Analyst, and Billing Specialist will continue to work with RMHS's project team to ensure a successful transition to the utilization of Credible. During the Post GoLive Support phase, RMHS's project teams can expect to:

1. Complete a weekly Post GoLive checklist form in the Partnership domain. The Post GoLive checklist will assist RMHS identify workflow or configuration issues before they become large problems or staff bad habits. The Credible Implementation Manager, Configuration Analyst, or Billing Specialist will be available to assist RMHS with a resolution of identified concerns.

2. Complete a daily 15-minute Touch Point with a member of the Credible Implementation team for at least the first 2 weeks following GoLive. The daily Touch Point is a brief call to check on progress, troubleshoot any issues/concerns, or answer questions.
3. Complete a Pre-Billing/Batching Training Call with the Credible Billing Specialist. This call will walk RMHS's Billing staff through Credible's Best Practice workflow for Pre-Billing checks and batching files using RMHS's actual production data. The goal of this call is to ensure the successful batch submission of production files to RMHS's Payers.
4. Complete a Posting Training Call with the Credible Billing Specialist. This call will walk RMHS's Billing staff through Credible's Best Practice workflow for manually and electronically posting claims, as well as how to address splitting revenue on a remit between Credible and RMHS's legacy software.
5. Complete 1-3 Month End Closing Calls with the Credible Billing Specialist. These calls will walk RMHS staff through Credible's Best Practice workflow for closing the month, resolving any transactional mapping issues, and generating the first AR Export Batch.
6. During this Phase, RMHS is expected to enter Task Tickets for any concerns/questions and a Credible Services Coordinator and/or Billing Specialist will address concerns via the Task Ticketing System.

Goal: To provide a smooth transition from Implementation to ongoing Credible Partner Support and to ensure successful billing from GoLive. RMHS will be asked to sign the Post GoLive Milestone indicating that training and completion of 1st month end close and payment posting. **RMHS expects to attain the Post GoLive Milestone by mid October 2019.**

Core Team

Staff	**Area/Role**
Jit Singh	Project Manager
Ellen Malone	Developmental Services (DS)
Dustin Redlein	DS - Residential and Specialized Supports
Laura Kass	Mental Health (MH)
Scott Louiselle	MH - Child and Family
Clay Gilbert	MH - Adults
Leslea Kessler	EMR Coordinator
Claire Waterman	Compliance and Front Desk Support
Linda Heald	Billing
Diana Fouracre	Records

Superusers

Staff	**Area/Role**
Deb Avison	Administration
Karen Grimm	MH - Child and Family
Ajay Shah	Emergency Services
Joanne Matthew	APRN
Hillary Ward	CRT
Natalie Brewster	DS - Child and Family
Jennafyr Flood	DS - Service Coordinator
Michel Kersten	DS - Shared Living
Melissa Hamblin	DS - Nurse
Jenna Laplante	Residential