Medicaid Data Aggregation & Access Program Development

Stakeholder Evaluation & Analysis

Agency of Human Services, Department of Vermont Health Access

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PUBLIC CONSULTING GROUP

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DOCUMENT CONTROL HISTORY

Version	Date	Modifications	Created/Revised By
0.5	04/03/2022	Initial Draft of Stakeholder Evaluation Portion of Deliverable	PCG
1.0	06/01/2023	Initial Full Draft of Stakeholder Evaluation and Analysis	PCG
1.1	06/06/2023	Added Section on Similar Programs	PCG
1.2	06/12/2023	Various Revisions Based on VT Team Feedback	PCG
1.3	06/14/2023	Minor Revisions Based on VT Team Feedback	PCG

EXECUTIVE SUMMARY

Finalization of the Stakeholder Evaluation and Analysis is the culmination of the work effort undertaken in Phase 1 of the Medicaid Data Aggregation and Access Program (MDAAP) development project. To better understand how targeted Medicaid providers store, access, utilize, and share client records, the project team built on the foundation of the Stakeholder Engagement Plan to develop this deliverable, which has two main goals:

- It provides a description or "playbook" for how PCG collected and analyzed primary data from the targeted provider community that was created in collaboration with and approved by the State; and

- It documents the provider data collection and analysis activities completed that yielded quantitative and qualitative data that will be used to inform the design and deployment of the MDAAP.

Primary data collected, compiled, and analyzed from the targeted Medicaid provider community includes over 500 responses from an online survey, input from 35 individuals who took part in a series of focus groups, and targeted interviews with representatives from similar incentive or grant programs in other states. Several themes emerged from the data that should be taken into consideration in the design and deployment of the MDAAP. These include but are not limited to:

- While approximately 59% of the home and community-based services (HCBS) providers surveyed report usage of an electronic health records (EHR) system, there is a significant portion of the HCBS providers (nearly 30%) who report a paper-based or other offline method of client record keeping. The remaining 11% of respondents reported usage of "Other Care Coordination/Practice Management Software" (5.9%) or selected "Other" (6.1%).

- While EHR usage is fairly common among the HCBS provider community that participated in the survey and focus groups, the usage of certified EHR technology (CEHRT) is fairly low. Even though 53% of respondents reported using CEHRT technology, the data collected on EHR vendor solutions used shows that only 16% of reported systems used by survey respondents are actually CEHRT solutions as defined by the Office of the National Coordinator for Health Information Technology.

- Focus group data show that providers fairly unanimously expressed a lack of desire to transition from an existing non-certified EHR to CEHRT, mainly due to cost (both initial and ongoing) and the disruption to their practice. Similarly, providers also expressed concerns about the initial and ongoing costs associated with connectivity to the Vermont Health Information Exchange (VHIE).

- Focus group data points to an overall low level of awareness about VITLAccess across all specialties, which is consistent with the fact that only 2% of providers surveyed utilize VITLAccess. However, a significant portion of survey respondents (43%) said they would be interested in learning more about this service.

- A majority of the provider specialties represented in the survey (approximately 68%) and focus groups (nearly 86%) fall within the realm of mental health and substance use disorder treatment, and as such, one of their major concerns related to sharing client data with the VHIE is in the details of how the VHIE will comply with privacy regulations related to access, consent, and disclosure of client information, particularly records that are governed by 42 CFR Part 2.

INTRODUCTION

The Vermont Agency of Human Services (AHS) contracted with Public Consulting Group (PCG) to design a program that will incentivize targeted Medicaid providers to acquire and utilize the technology needed to

allow patients/people to effortlessly share their health data with their providers as they seek care and automate data collection to improve clinical operations and the health system at large. Through primary data collection and analysis of tools available in the marketplace, PCG was charged with assessing targeted Medicaid providers' current practices related to health data use, access, storage, and sharing data with other providers during transitions of care. Information collected will be used to design a program to enhance electronic data exchanges among Medicaid providers.

PURPOSE & OBJECTIVES

The two-fold purpose of the Stakeholder Evaluation and Analysis is to: 1) Outline the specific methodologies PCG proposed to collect and analyze data from the targeted Medicaid provider population; and 2) Provide an analysis of the data collected, identifying themes in provider needs, challenges, and desires which will help guide the development of the MDAAP.

PCG employed multiple methodologies that collectively formed the "Playbook" for gathering primary data from targeted providers and provider groups. This Playbook consisted of the following tools:

- The results from a web based HCBS Provider Survey that queries providers about patient data usage along with digital health record keeping and exchange challenges. PCG sent this survey to a distribution list of targeted providers compiled by AHS.
- Information gathered from focus groups, where participants answered open-ended questions to provide more specific, qualitative feedback.
- A summary of themes and key points generated from targeted interviews focusing on specific topics in greater detail. Much like focus groups, these sessions allowed for rich, qualitative feedback from subject matter experts.

REFERENCES

- Project Charter
- Stakeholder Engagement Plan
- Stakeholder Evaluation & Analysis Deliverable Expectation Document (DED)

RISKS AND ASSUMPTIONS

The stakeholder evaluation and analysis methodologies herein were executed based on the following assumptions:

- AHS would provide the email distribution list for the provider web survey, and email contact information would be sufficiently accurate to get the surveys into the hands of appropriate respondents.
- All focus groups and targeted interviews would be held virtually, using online conference meeting software. Participants would be asked to utilize web cameras during these sessions, but PCG did not plan to mandate this practice.

The following risks, which could have impacted the volume and accuracy of gathered data and subsequent quality of analysis, were developed and discussed with the project team:

- Low web survey response rate could lead to weaker analysis and conclusions about the challenges and needs of the broader targeted provider base.
- The lack of timely identification and enlistment of providers and subject matter experts for focus groups and targeted interviews could lead to insufficient input to draw meaningful conclusions and/or could result in project delays if an elongated time period is required to complete data collection to ensure sufficient provider input.

EVALUATION APPROACH

PROVIDER WEB SURVEY

This section presents the methodology used for executing a targeted web-based survey of HCBS providers in the State of Vermont. This would serve as the first primary data collection activity of the Vermont MDAAP design project. While the drawbacks and difficulty of getting valuable participation from such survey efforts are well-known, a web-based survey is the most efficient means of reaching the broadest audience possible. To mitigate this risk and enhance the return rate of the survey, PCG planned to offer a financial incentive to the first 500 individuals who submitted completed surveys.

PCG's goal was to develop a well-designed, targeted survey that solicits the required information in the most time-efficient manner for the survey participants. The survey was designed to collect quantitative data about adoption and use of electronic health care data and to uncover barriers to EHR adoption and data sharing. Survey results, along with other forms of data collection described in subsequent sections, would inform the overall design of the MDAAP.

Provider Web Survey Approach

Inputs and Preparation

PCG identified three primary inputs that informed the approach to the web-based survey:

- Analysis of past survey results and lessons learned
- Identification of the survey objectives and key survey questions
- Identification of survey audience and outreach methods

First, the PCG team reviewed past survey efforts as a starting point in order to expedite the development and execution of this stage. Understanding that the objective of this data collection effort differs from prior environmental scan surveys, PCG's approach focused on confirmation of data collected and new information specific to the targeted provider audience.

Concurrently with the development of the survey tool, PCG worked with the Vermont project team to generate a listing of the survey audience that excluded any HCBS providers who were eligible for incentive payments under the Promoting Interoperability Program that was funded by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Methodology

Methods and Tasks

It was determined that once the survey had been approved and the target audience had been identified, PCG would then distribute the survey via e-mail link to the contacts identified for the distribution list. As these types of surveys have historically received low response rates, PCG recommended utilizing multiple channels and approaches to promote the existence and importance of the survey to the provider community. PCG would work with AHS to assess communication methods outside of direct e-mail contact that may be appropriate and effective. For example, an informational webinar about the goals of the MDAAP and the importance of provider participation in the survey along with a frequency asked questions (FAQ) posting were discussed as ways to enhance communication and education to stakeholders. PCG recommended a reasonable window of time (at least 30 days) for survey responses that takes into consideration provider workloads as well as the need to have the survey results inform the MDAAP design. PCG recommended weekly follow-up e-mails to the distribution list in order to remind survey recipients and drive additional responses.

The following assumptions were used in survey design and execution:

- Web-based survey tool: Qualtrics
- Web-based gift card tool: Tango Cards Rewards Genius (integrated with Qualtrics)

- Communication method(s): Introductory email sent by Vermont AHS followed closely by an initial survey invitation email generated by Qualtrics; three subsequent follow up emails generated from Qualtrics to those who have not yet completed the survey.
- E-mail Protocol: AHS approved e-mail templates for all communication would be utilized. Introductory email to all participants would originate from an AHS email address. All subsequent emails would be generated within the Qualtrics application and would appear to recipients as coming from Public Consulting Group.
- Analysis tool: Data would be compiled and analyzed using a combination of Qualtrics reports along with tables, charts, and graphs developed from Excel/CSV extracts of the Qualtrics survey data.

Information Gathered

The survey process was designed to gather information from HCBS providers and provider groups of varying sizes, disciplines, and technical maturity. Examples of the strategic, operational, and technical information to be gathered and assessed included:

- EHR/HIT adoption
- Strategic plans for EHR and non-EHR HIT
- HIE utilization
- Barriers to technology and HIE participation
- Willingness to participate in the MDAAP

Format of Survey

It was determined that the survey would be compiled of mostly multiple-choice questions with the ability to type in free-text responses where "other" is selected. At least one open-ended concluding question would allow participants to share qualitative free-text responses. Survey sequence, layout and branding would be presented to AHS for approval once the questions were finalized and loaded into the survey tool.

Targeted Audience

The preliminary audience for the survey was focused on HCBS providers who: 1) practice in Vermont; 2) provide mental health, substance use disorder treatment, and long-term services and supports; and 3) who have not previously received incentive payments under federal EHR incentive programs. Within those organizations, the survey could be completed by a provider, practice manager, or any individual that is familiar with the facility's health records system.

High Level Timeline

Task #	Task	Due Date / Date Range
1	Complete Preparatory Work	02/24/23
2	Confirm Method and Tools	02/24/23
3	Confirm Audiences and Outreach Plan	02/24/23
4	Confirm Structure and Design	02/27/23

5	Finalize Survey Questions	03/17/23
6	Obtain Final Approval of Survey Questions and Format	03/24/23
7	Finalize Survey and Gift Card Vendor Set-Up & Integration	03/28/23
8	Complete Final Survey Testing	03/29/23
9	Launch Survey and Execute Outreach Plan	03/30/23
10	First Reminder Message	04/06/23
12	Second Reminder Message	04/13/23
13	Third Reminder Message	04/20/23
14	Final Reminder Message	04/26/23
15	Close Survey	04/29/23
16	Provide Analysis in Draft Report	06/01/23

Expected Results

The results of the survey were expected to reveal the level of EHR/HIT/HIE adoption among this targeted group of HCBS providers. Prevalent barriers to EHR adoption or HIE participation would likely include cost, effects on workflow and training, resource availability, and competing priorities. Challenges to clinical data exchange would likely center around education and system capabilities. Without having defined the MDAAP's incentive amounts and criteria for participating, it was expected that many providers would express interest in the program and desire additional information.

Outputs and Results Analysis

Once the survey was completed, data would be parsed and analyzed. The analysis would be two-dimensional:

- Quantitative: where applicable, statistical analysis of data would be applied
- Qualitative: applicable if quantification is not possible; responses received from the survey would be analyzed and interpreted by Subject Matter Experts (SMEs)

The following are examples of potential analysis of the data provided by the survey:

- Response rate
- Geographical and demographic information about respondents
- Level of EHR adoption among the targeted provider audience
- HIT solutions utilized by the targeted provider audience
- Level of and type of VHIE participation among the targeted provider audience
- Barriers to EHR adoption and VHIE participation
- Patterns of EHR adoption and use among provider types
- Geographic patterns of EHR adoption and VHIE participation
- Clinical data exchange sophistication and types of clinical data exchanged

Recommendations and Next Steps

It was recommended that the final web survey analysis be combined with other information obtained through the additional data gathering steps (i.e., targeted interviews and provider focus groups) for final submission to Vermont AHS in the Analysis and Recommendations section of this deliverable.

FOCUS GROUPS

This section presents the methodology developed for conducting focus groups to delve into greater detail about the manner in which targeted provider groups currently manage patient records through the use EHR and potentially other health IT applications and to uncover any challenges or perceived barriers providers might have related to utilizing EHR or similar technology to ultimately connect to the VHIE. This was the second form of primary data collection activity within the overall Stakeholder Evaluation effort, designed to start just after the launch of the HCBS provider survey. The focus groups would be utilized to discuss positive and negative experiences with current patient record management processes, including EHR and HIT adoption and use, EHR/HIT impact on clinical practice and operational workflows, and barriers and other challenges preventing providers from implementing EHR solutions. The focus groups would also attempt to identify specific technical assistance and supports the state may provide within an incentive program to help providers achieve HIT adoption and connectivity with the VHIE. PCG would aim to facilitate highly participatory focus group sessions to yield open and honest opinions from participants. As with the provider survey, focus group findings would be used to inform the MDAAP development.

Focus Group Approach

Inputs and Preparation

The team focused on four main inputs in preparation to facilitate focus groups:

- Analysis of the most recent environmental scan
- Identification of key focus group questions
- Identification of participants and outreach methods
- Identification of topics worthy of further discussion from the web-based provider survey (as survey results were received)

First, the PCG team examined Vermont's most recent environmental scan to determine what new information would be beneficial for the state to learn and what information could be gained from a focus group. In conjunction with analysis of the most recent environmental scan, PCG would collaborate with the Vermont MDAAP project team and MDAAP Subcommittee members to develop focus group questions. PCG would follow a process for the focus group deliverable that called for working closely with the Vermont project team to identify key questions through an iterative process that ensured sufficient time for input, review, and revisions prior to final approval.

In addition to development of the focus group questions, PCG would work with the Vermont MDAAP project team to generate a list of potential focus group participants. Ideal candidates would include providers and other staff that interact with medical records on a daily basis, IT and other administrative staff who maintain and/or interface with medical records systems frequently, and provider organization leaders who not only understand the challenges faced by providers in documenting, accessing, storing, and sharing records but also understand the realities of running a provider practice, which includes decision-making responsibilities in areas such as onboarding and training staff, acquiring and implementing health information technology, maintaining patient privacy and security of records, developing and maintaining operational policies and workflows, etc.

Methodology

Methods and Tasks

The focus group methodology used can be broken down into five main steps:

1. Targeted Participants
2. Structure and Design
3. Recruitment and Preparation
4. Focus Group Sessions
5. Data Analysis

As the target audience was identified and focus group questions were being approved, PCG would complete outreach communications. A combination of emails and announcements at relevant meetings were felt to be the best way to promote focus group attendance. Focus groups would be moderated and recorded by the PCG team, and analysis would be performed following each focus group and at the conclusion of all sessions collectively.

PCG identified the following methods and tools that would be used for the focus group process:

- Communication methods: Email (initial, follow-up, and confirmation), announcements at relevant meetings. One of the provider survey questions would also ask respondents if they would be willing to participate in a focus group.
- Documents: recruitment emails, focus group facilitator script, focus group ground rules, finalized list of focus group questions.
- Locations: All focus group sessions would be virtual meetings using web-based conference meeting software (Microsoft Teams). PCG facilitators would use web cameras for virtual face-to-face interaction and would encourage participants to do the same.
- Focus group sessions: The total number of sessions would be determined in collaboration with the Vermont MDAAP project team, but the total number of invited participants for the focus groups and targeted interviews would be at least 45 individuals.
- Data analysis: Transcription of focus group session recordings, extrapolation of major themes and provider concerns, and Microsoft Excel spreadsheets and Word documents for data tracking and qualitative and quantitative analysis
- Incentive Payment: Each focus group participant would receive a $100 gift card for participation.

Targeted Participants

The initial list of targeted focus group participants is provided below. It was determined that the ideal number of participants in each focus group would be between six and ten individuals. It was felt that this smaller group size would encourage varying opinions and help ensure that all voices would be heard.

The preliminary list of targeted groups included provider organization leadership, IT staff, and provider representatives from the following organizations:

- Vermont Care Partners (Designated Agencies and Specialized Service Agencies)
- VNAs of Vermont
- Solo HCBS practitioners and providers from small groups located across the state. The MDAAP provider survey included a question soliciting participants for the focus groups. PCG worked with the Vermont team to review these volunteers and determined the most appropriate participants.

Structure and Design

The number of questions in the focus groups ranged between eight and twelve; fewer, open-ended questions were felt to be preferable to numerous filler questions. Open-ended questions that begin with “what”, “how”, and “why” were used to draw out detailed conversations and answers. PCG included three categories of questions in each of the focus groups:

1. Engagement: Introducing and helping participants gain comfort with the topic
2. Exploration: Asking questions that produced in-depth discussions
3. Exit: Asking for any other opinions or relevant ideas that were not discussed

Question sequence, layout and verbiage were developed and finalized in work sessions with the Vermont MDAAP project team.

Recruitment and Preparation

Once the list of targeted participants was confirmed, recruitment and preparation began. PCG worked with the Vermont project team and MDAAP Subcommittee members to determine targeted participants' contact information. Next, PCG initiated outreach content development and recruitment efforts via email.

As informational email messages were produced, PCG worked with the Vermont project team to confirm the content, such as details regarding the purpose of the focus groups, contact information in the event participants have any questions, and the dates/times of the focus groups. PCG looked to the Vermont team for guidance in scheduling focus group times and ultimately developed a focus group questionnaire that asked potential participants for their best times of availability. Ninety-minute and sixty-minute blocks were reserved for these sessions, with provider focus groups lasting 60 minutes and IT/Leadership/Admin sessions lasting 90 minutes.

For traditional in-person focus groups, it is reasonable to expect a no-show rate of 10 to 20 percent; however, with focus groups conducted via virtual meeting, the no-show rate is generally lower. Even so, PCG recommended inviting as many as 9-10 individuals to each focus group to account for at least some level of no-shows. PCG recommended sending email invitations with information regarding the purpose of the focus group along with the date, time, and web conference details for each session. Participants would be asked to reply with an attendance acceptance or declination. PCG would track the number of participants who accepted an invitation and follow up with an email to those who had not responded within a reasonable timeframe. To maximize attendance, PCG would also send a reminder email 48 hours prior to each session to all participants who had accepted the invitation.

Focus Group Sessions

At least two PCG project team members would be present at each focus group session. One PCG resource would serve as the moderator, and the second person would serve as the assistant moderator. The role of the moderator was to facilitate conversation by asking the pre-determined questions while also ensuring all participants felt comfortable. The main role of the assistant moderator was to manage the meeting recording, capture relevant notes, and assist the moderator in keeping track of time.

Prior to the start of the focus group, participants would be notified that the discussion would be recorded, and their identity would remain anonymous in the subsequent analysis and final report. Additionally, PCG would develop a script containing ground rules that would be shared to help guide the focus groups. This would promote professionalism and standardization across all sessions. As with all other content and deliverables, PCG would provide sufficient time for the Vermont team to review, provide input, and approve focus group materials.

Data Analysis

The focus group process would seek to gather specific information from various HCBS provider group stakeholders about their current records management processes along with the strategic, operational, and technical challenges associated with HIT implementation, use, and electronic data sharing. Whereas the web-based survey would mainly provide quantitative data from the viewpoint of providers, leaders, and other frontline staff that touch medical records daily, the focus groups would analyze the same topics but glean qualitative data that would hopefully lead to a deeper understanding of the challenges and barriers HCBS providers face in implementing and using EHR or similar HIT solutions. A running list of all key comments and themes would be tracked to identify trends that could lead to conclusions for MDAAP design recommendations. Examples of the strategic, operational, and technical information PCG would gather and assess include:

- Strategic plans for EHR or other HIT solutions
- HIE membership and utilization plans
- Challenges in capturing patient care processes electronically
- Barriers and challenges in implementing EHR technology
- Privacy and security concerns
- Network, infrastructure, hardware plans, challenges, and concerns
- Issues related to staffing and training to support EHR and similar technology

High Level Timeline

Task #	Task	Due Date / Date Range
1	Complete Preparatory Work	02/20/23
2	Confirm Initial Target Audience to Begin Outreach	02/27/23
3	Finalize Format, Design, Plan, and Questions	04/14/23
4	Finalize Focus Group Participants (Upon Conclusion of Provider Survey)	04/29/23
5	Facilitate Focus Group Sessions	05/15 – 05/26/23
6	Analyze Results	05/15 - 05/31/23
7	Provide Analysis in Draft Report	06/01/23

Expected Results

It was expected that the qualitative data from the focus groups would shed light on the current practices for health records management among HCBS providers along with their perceived challenges and barriers associated with utilizing electronic health records and electronic data exchange. The participants in the focus groups would likely voice a wide range of concerns and perceived barriers related to EHR and HIE usage ranging from startup and ongoing maintenance costs, workflow disruption, privacy/security concerns, and staffing and training concerns. It was anticipated that an incentive program to assist providers in acquiring health IT and connecting with the VHIE would be positively received although determining the details on how best to support providers within such an incentive program will be critical, as the needs of the targeted provider community will likely be significant and varied.

Output and Results Analysis

Once all focus groups were conducted, data would be transcribed, analyzed, and interpreted to identify themes in opinions and experiences.

The following areas would be subject to analysis:

- Focus group attendance rate
- Participation per focus group
- Key response themes and trends
- Geographic and demographic information about participants
- Experience with EHR systems and other similar HIT solutions
- Experience with exchanging clinical data and how it has impacted patient care delivery
- Opinions, feedback, and general knowledge on VITL/VHIE, current products/services/value

Recommendations and Next Steps

It was recommended that the final focus group analysis be combined with other information obtained through the additional data gathering steps (i.e., provider surveys and targeted interviews) for final submission to Vermont AHS in the Analysis and Recommendations section of this deliverable.

TARGETED INTERVIEWS

This section presents the methodology developed for conducting and analyzing any targeted interviews deemed necessary. As PCG conducted the HCBS provider survey and focus groups, it was felt that this data collection effort may be further enhanced by a few targeted interviews with key individuals. From a

timeline perspective, it was determined that any targeted interviews would occur in parallel with provider surveying and focus groups. It was originally anticipated that targeted interviews would be designed to be held with technical and administrative subject matter experts from among the targeted HCBS provider groups to solicit feedback on challenges providers face in using EHR and related HIT systems and how a properly designed incentive program might offer technical assistance to HCBS provider groups with the goal of EHR adoption and data exchange with the Vermont Health Information Exchange. As it turned out, the project team gleaned extremely useful information from targeted interviews held with representatives from similar incentive and grant programs designed by other states (New Jersey, Colorado, and the District of Columbia). Along with the survey data and focus group themes, these findings will be used to inform the MDAAP design.

Targeted Interview Approach

Inputs and Preparation

The two main prerequisites to prepare for performing targeted interviews included:

- Identifying key technology subject matter experts within the targeted HCBS provider community willing to serve as interview participants
- Developing appropriate interview questions to solicit desired feedback

Methodology

Methods and Tools

PCG worked with the Vermont project team to develop interview questions and schedule interviews to begin the targeted interview process. Ultimately, the Vermont team established contact with representatives from the other states' programs and scheduled the interview dates. The PCG team assisted in facilitating these meetings by developing lists of questions for the teams interviewed.

Information Gathered

The targeted interview process sought to gather information from specific stakeholders about HCBS provider groups' current records management processes along with the strategic, operational, and technical challenges associated with HIT implementation, use, and electronic data sharing. Unlike the focus groups, the targeted interviews were designed to gain the perspective of program leaders in other states who were already in the process of designing and implementing programs similar to the MDAAP. Examples of specific topic areas that were discussed include :

- Current status of EHR or other HIT solution use among their HCBS provider population
- Challenges associated with current EHR/HIT use among their HCBS provider population
- Program details, including participation tracks, incentive payment milestones, program funding information, etc.
- Forms of technical assistance (TA) and program support provided
- Any lessons learned and other guidance regarding program design, program support/TA, funding, provider participation, etc.
- Information on provider integration with state HIEs and any associated challenges in data sharing

Structure and Design

An informal list of interview questions and discussion topics was developed and used for each interview. This helped ensure the project team obtained desired responses for pre-identified questions. However, the project team allowed significant flexibility so that each targeted interview was not just a strict question and answer session but allowed for an interactive conversation that hopefully allowed for the discovery of additional useful information not previously identified through other methods of information gathering.

Target Audience

A preliminary list of potential targeted audiences included Vermont Care Partners and VNAs of Vermont. However, representatives from these agencies were well-represented in the HCBS Provider Survey and Focus Groups. After discussion with the project team, it was ultimately determined to utilize targeted

interviews to meet with representatives from other states to learn more about similar incentive/grant programs.

High Level Timeline

Task #	Task	Due Date / Date Range
1	Complete Preparatory Work	02/20/23
2	Confirm Target Audience	02/27/23
3	Finalize Structure, Methods, and Tools	02/27/23
4	Conduct any Interviews in Parallel with Survey & Focus Groups	03/01 – 05/26/23
5	Analyze Interview Results	05/15 - 05/31/23
6	Include Analysis in Draft Report	06/01/23

Expected Results

The results of the targeted interviews were expected to reflect the varying sentiments and experiences each program team has experienced with respect to designing and implementing programs to incentivize EHR/HIT adoption among HCBS providers. Even though each state program is slightly different, PCG suspected that several common themes would emerge related to program implementation challenges and barriers associated with utilizing electronic health records and electronic data exchange.

Outputs and Analysis

Ongoing analysis of results from interviews would be performed in order to confirm with the Vermont project team that the desired information is being discovered. This would enable PCG to ensure all key information is being gathered as well as allow for any modification in questions or tactics to ensure the Stakeholder Evaluation and Analysis will meet its objectives. Since these targeted interviews did not easily translate into quantitative data (with the exception of program statistics shared by program leaders), it was understood that the results would be largely qualitative.

Recommendations and Next Steps

It was recommended that the final targeted interview summary, analysis, and recommendations be added to the data collected from the other two methods of primary information gathering conducted for completion of the Stakeholder Evaluation and Analysis. All information would be combined for review and approval in this final deliverable.

REVIEW OF HEALTH DATA COLLECTION TOOLS

HEALTH IT TOOLS AVAILABLE IN THE MARKETPLACE

Providers may employ a variety of tools in their practices to capture, store, and manage patient health records. Options run from a traditional paper chart at one end of the spectrum to certified and FHIR-enabled electronic health records technology (CEHRT) at the opposite end of the spectrum.

The U.S. hospital EHR market has experienced significant consolidation over the past decade due largely to healthcare system mergers and acquisitions. However, the ambulatory and long-term care services market segments are still highly fragmented, with many EHR/HIT vendors competing for providers across all specialties. Some EHR vendors have developed solutions that are designed to be configured for use

across a wide range of practitioners and specialties while other vendors have developed niche-specific solutions designed for certain provider and specialty types.

While a significant number of vendors serve these markets, a provider or provider group should consider a few key questions when selecting EHR or practice management software:

- Does the EHR vendor's solution maintain current certification (CEHRT attestation) with the Office of the National Coordinator for Health Information Technology (ONC)?
- Does the software comply with industry-standard security protocols? (e.g., HIPAA, HITRUST, NIST, PCI-DSS, etc.)
- Does the vendor follow industry best practices/industry certification for hosting client data? (e.g., SOC 2 compliance)
    - Where are servers being hosted? How are they secured? (e.g., physical, technical, and administrative safeguards)
    - How rigorous are the vendor's disaster recovering and business continuity procedures?

When researching actual user experience with software vendors, KLAS Research is recognized as an industry leader in scoring and ranking EHR and other HIT vendors. While KLAS data is a good place to start, it is always recommended to speak with reference sites for personal experiences before selecting a vendor solution for implementation.

TOOLS USED SUCCESSFULLY TO COLLECT AND MANAGE DATA

The table below contains normalized data from the 2021 HIT Survey that was conducted as part of Vermont's most recent State Medicaid Health Information Technology Plan (SMHP). This table indicates whether the software solutions providers reported using are certified according to 2015 Edition Cures Update, the most recent certification offered by ONC.

It is important to note that this represents a large cross section of popular EHR tools already deployed in the Vermont provider community. Also of note, even if a software vendor is not certified by ONC (CEHRT), it may still meet HIPAA and HITRUST certification requirements. For instance, Simple Practice is not on the CEHRT list, but it is marketed by the vendor as HIPAA compliant and HITRUST certified. Additional research will need to be performed to gauge whether products/vendors in this category also have interoperability frameworks to support FHIR APIs to secure HL7 flat file SFTP capabilities.

Count	Which electronic health record system do you currently use?	CEHRT
4	Allscripts	Yes
4	Amazing Charts	Yes
15	athenahealth	Yes
3	Care 359	No
4	Centricity	No
4	Cerner	Yes
3	Dentrix	Yes
13	Eaglesoft	No
11	eClinicalWorks	Yes
2	e-MDs	No
5	Epic	Yes

4	Greenway	Yes
5	McKesson	Yes
14	Medent	Yes
3	Meditech	Yes
3	NextGen	Yes
3	Practice Fusion	Yes
8	PointClickCare	Yes
53	Simple Practice	No
8	Chirotouch	No
5	Credible	Yes
21	TherapyNotes	No
8	Theranest	No
4	ICanNotes	Yes
20	MyClientsPlus	No
7	NetSmart	Yes
234	Total	

REVIEW OF SIMILAR PROGRAMS

The MDAAP project team recognizes that other states have developed similar programs and that design of the MDAAP could benefit from guidance and lessons learned from these states. To best take advantage of this opportunity, the project team scheduled targeted interviews with representatives from three similar programs:

- The District of Columbia's Home and Community Based Services Digital Health Technical Assistance Program
  - Targeted interview held on March 1, 2023
- New Jersey's Promoting Interoperability Program for Substance Use Disorder (SUD) Facilities
  - Targeted interview held on March 22, 2023
- Colorado's Dollars to Digitize (ARPA 6.06) Program
  - Targeted interview held on May 11, 2023

In addition to interviewing program management representatives, the project team also reviewed program websites and educational materials that were emailed to the project team by program representatives from each of the jurisdictions listed above. The following sections highlight the structure of each program and include relevant information gleaned from program representatives that should be considered in the MDAAP's design.

HCBS DIGITAL HEALTH TECHNICAL ASSISTANCE PROGRAM

The DC Department of Health Care Finance (DHCF) oversaw the creation of the HCBS Digital Health Technical Assistance Program, which received American Rescue Plan Act (ARPA) funding in August 2021. Technical assistance and monetary incentives are offered to HCBS providers under two subprograms:

- HCBS Promoting Interoperability Program: This program contains $9.6 million to reward providers for meeting milestones to adopt and implement certified EHR technology (CEHRT) systems and connect to the DC health information exchange (HIE).

- HCBS Telehealth Program: This program contains $920,000 to provide technical assistance and investment to promote the use of telehealth services and remote patient monitoring devices.

- The Digital Health Technical Assistance Program also set aside an initial amount of $1.5 million in the first year to be awarded to qualified firms to provide technical and program support to providers. Such support includes practice readiness assessments, assistance in acquiring and implementing CEHRT, assisting providers with program documentation requirements, connecting providers to the DC HIE, and supporting telehealth adoption. The budget also included one option year (not to exceed $1.5 million) with consideration for an additional option year (not to exceed $1 million).

The HCBS Promoting Interoperability Program is most similar to the goals of the MDAAP, so the project team devoted its time learning more about this program, which offers technical assistance and incentive payments for HCBS providers in one of three tracks described below, all of which culminate with connectivity and clinical data exchange with the DC HIE:

- Track 1: Implement New EHR – Provider does not currently use an EHR or needs to migrate to a new Certified EHR to connect to DC HIE (Total incentives: $44,000)
- Track 2: Upgrade Existing EHR – Provider has an existing EHR but is not using the latest or Certified version of the EHR to connect to DC HIE (Total incentives $26,000)
- Track 3: Optimize Existing EHR or Case Management System – Provider using Certified EHR or case management system but is not yet fully connected to DC HIE (Total incentives $17,000)

In addition to incentive payments for achievement of program milestones, the HCBS PI Program offers various forms of technical assistance and program support, including:

- Vendor-neutral, tailored EHR and HIE expertise
- Information exchange privacy and security support
- Cures Act Final Rule guidance
- Office hours and scheduled individual assistance
- EHR selection, contracting, and negotiation support
- Best practices and tools from similar organizations
- DC HIE (CRISP) connectivity support and training
- Identification of eligible providers and completion of needs assessments
- Performing provider outreach and enrollment services
- Conducting practice readiness assessments of eligible and targeted HCBS providers
- Documenting and reporting provider/program participation status
- Performing customized, practice specific TA services based on PIP track
- Providing initial and ongoing user education services

SUD PROMOTING INTEROPERABILITY PROGRAM

The New Jersey Department of Health and Department of Human Services developed the Substance Use Disorder (SUD) Promoting Interoperability Program that set aside $6 million to equip SUD clinics with electronic health records systems and connect these providers through the New Jersey Health

Information Network (NJHIN). CMS approved the SUD 1115 demonstration Waiver HIT Plan in May 2018. Program participation officially started in June 2019. In March 2021, a program extension was approved, and the current program is slated to run through June 2023.

The main goals of the program include:

- Aiding in shorter-term response efforts to the opioid abuse crisis
- Encouraging the adoption of CEHRT among SUD/mental health providers
- Utilizing health information exchange; admission, discharge, and transfer (ADT) notifications; and prescription drug monitoring program (PDMP) databases to improve medication reconciliation and promote integration

Participating organizations have to select from one of two program tiers:

- Tier 1: Implement new Certified EHR Technology (CEHRT)
- Tier 2: Upgrade existing system to the required edition of the Office of the National Coordinator for HIT (ONC) Certified EHR Technology (CEHRT)

Regardless of participation tier, the incentive milestones and payments are as follows:

- Milestone 1: Participation Agreement/EHR Vendor Contract Agreement ($5,000)
- Milestone 2:
  - Tier 1 – EHR Go-Live ($20,000)
  - Tier 2 – Upgrade to 2015 ONC Edition CEHRT ($7,500)
- Milestone 3: NJHIN/HIE Connectivity ($7,500)
- Milestone 4: NJ Prescription Monitoring Program Connectivity ($5,000)
- Milestone 5: NJ Substance Abuse Monitoring System (NJSAMS) Connectivity ($5,000)
  - Note: To date, no providers have achieved Milestone 5, as the NJSAMS is not yet ready to begin connecting interfaces to provider organization EHRs.

DOLLARS TO DIGITIZE (D2D) PROGRAM

The American Rescue Plan Act (ARPA) 6.06 Provider Digital Transformation and EHR Upgrades Grant, also known as Dollars to Digitize (D2D), is a federally funded ARPA Home and Community-Based Services (HCBS) grant program that will award $18 million to assist eligible HCBS and behavioral health providers in the adoption, implementation, and/or upgrade of integrated Electronic Health Record (EHR) systems, Electronic Billing Systems (EBS), telehealth systems, and other digital tools or technology. This ARPA HCBS grant opportunity is administered by Colorado's Office of eHealth Innovation (OeHI) and the Department of Health Care Policy and Financing with support from the Colorado Health Institute.

Colorado's D2D Program, which opened in October 2022, allows qualifying organizations to request up to $500,000 per grant, with payments provided on a cost-reimbursement basis. The grant period will run from April 1, 2023 to September 30, 2024. Allowable program expenses include:

- New or enhanced electronic systems (e.g., EHR and other client management systems)
- Telehealth systems

- Devices and equipment that support digital transformation/interoperability, care coordination, or delivery of virtual care (e.g., laptops, tablets, modems)

- Connection to statewide health and social information networks (e.g., Contexture, Quality Health Network, Colorado Community Managed Care Network)

- Technical support, training, and assistance (i.e., outside assistance in configuring, implementing, and training staff in the use of new technology)

- Indirect/administrative expenses, which includes costs that are associated with or support technology adoption, up to 10% of total grant amount

PROGRAM GUIDANCE AND FEEDBACK

In the process of interviewing representatives from each of the programs highlighted in the previous sections, the Vermont project team was able to ask questions and solicit feedback on program design guidance and lessons learned. The following items represent the most valuable feedback and themes the project team feels should be considered in the MDAAP's design.

- Per the DC team, providing program milestones that allow early incentive payments to providers helps get them the funding they need to purchase EHR technology. Feedback they have received from participating providers indicates that many providers and organizations would not have had the capital available to purchase a certified EHR solution without the incentive dollars.

- The DC team has identified the need to potentially increase the milestone incentive values given the feedback they have received from the provider community, particularly the incentive amount provided for successfully connecting to the DC HIE, as tech costs related to these interfaces have inflated significantly even within the first year's span of the program.

- The DC team stressed the importance of offering a full spectrum of technical assistance (TA) and program support. Provider feedback has highlighted the importance of the "handholding" needed to assist many providers in achieving program milestones. The DC team successfully utilized college interns to provide onsite TA to providers under a different program and had hoped to utilize interns again under this program. It ultimately wasn't approved, but they felt that the use of college interns as a way to provide onsite resources would have been an asset to this program.

- The New Jersey team noted that they provide incentives to facilities/organizations only, not individual providers, due to limited dollars and program simplification. They reported initially receiving more program applicants than they could include in their first cohort but then had difficulty recruiting additional providers in the second cohort. They theorized that the program requirement to only allow for implementation of CEHRT solutions could be a contributing cause, as many EHR solutions used in the SUD/mental health care provider space are non-certified solutions.

- The New Jersey team shared that due to the complexities of complying with patient data privacy rules governed by 42 CFR Part 2, very limited client data is required to be shared with NJHIN. SUD providers are sharing only Admission, Discharge, and Transfer (ADT) information with NJHIN. For participating facilities, this includes items like a patient roster and active care relationships. In turn, NJHIN provides a notification to participating facilities when one of their SUD clients is hospitalized or has an emergency department encounter. NJHIN is in the process of developing the technology (eConsent management) and data governance policies necessary to appropriately handle and store Part 2 data, and the hope is that in the future, SUD providers will be able to share more clinical data with the HIE.

- The Colorado team repeatedly expressed the importance of "meeting providers where they are" in terms of technology adoption, which factored into their program design in a couple significant ways:
  - They do not require providers to acquire certified EHR systems (CEHRT) but rather allow the program to accommodate a much broader range of EHR technology and other HIT solutions. In reviewing survey feedback from their provider population, Colorado felt that many HCBS providers would be unrealistically saddled with more expensive CEHRT to maintain on an ongoing basis when much more affordable, non-certified EHR solutions would equally serve provider needs.
  - Connectivity with Colorado's health information exchange is one possible program participation path, but it is not a required milestone for participation. Similar to their thoughts on the ongoing expense of CEHRT, the Colorado team felt that the ongoing expense of maintaining connectivity to the state HIE could impose an unsustainable expense on solo providers and small groups.

- Colorado recommends developing an objective process for reviewing and approving program applicants. They received over 400 intent-to-apply forms, which was twice as many as they originally anticipated. Fortunately, they had already built into the program a process under which a panel of impartial and diversity, equity, and inclusion (DE&I) conscientious reviewers would evaluate applications. Technical aspects of applications were assessed based on the soundness of the applicant's approach, financial risk, technical readiness, and the potential for sustained impact.

DATA ANALYSIS AND RECOMMENDATIONS

The Data Analysis and Recommendations portion of this deliverable is designed to present the findings collected through the primary data collection methodologies discussed in the preceding sections of this document. The following sections detail the specific methodologies, results, and insights gleaned from the HCBS Provider Web Survey and Focus Groups that should be used to inform program design for the MDAAP.

PROVIDER SURVEY METHODOLOGY

The State intends the MDAAP design to follow a phased approach that initially focuses on mental health providers, substance use disorder (SUD) treatment providers, and long-term services and supports (LTSS) providers that predominantly serve the Medicaid population. In pursuit of that goal, the project team developed a target contact list of HCBS providers and organizations that represent the various providers and specialty types that comprise these three broad categories. (See Survey Results Table Q1.2 for a complete listing of all targeted provider and specialty types.) Email contact information was gathered initially from Vermont's MMIS using provider type and specialty code queries that match the target provider population. Members of the Vermont project team further supplemented and updated the target email list by querying available agency directories and reaching out to sister agencies for additional contact information. The final de-duplicated list that was utilized for the online survey consisted of 2,104 unique email addresses.

The MDAAP project team collaboratively developed a survey designed for HCBS providers and other individuals working for HCBS provider organizations that have a firsthand understanding of how providers currently store, access, utilize, and share client records. In addition to learning how HCBS providers are documenting and maintaining client records, the survey sought to understand any challenges providers face in electronically maintaining and exchanging client data.

The survey consisted of structured and unstructured responses to several different question types, including multiple choice with single selection, multiple choice with multi-selection, yes/no questions, rating of multiple items, and open-ended questions. The survey instrument was designed and administered using the web

based Qualtrics XM survey application. This online tool offers several features that facilitated data collection and encouraged provider participation:

- Each participant received a unique URL that could be used only once to complete a survey. This prevented duplicate responses and the same link from being used multiple times.
- The Qualtrics tool provided branching logic that presented respondents with certain follow-up questions based on their response to preceding questions.
- The online solution allowed for scheduling automated email survey reminders that were only sent to individuals who had not yet submitted a completed survey.
- The Qualtrics application integrates electronically with Tango Card's Rewards Genius solution. This integration allowed $50 gift cards to be immediately awarded via email to respondents upon survey completion. The use of unique survey URLs for each participant and the integration of the Qualtrics URL with Rewards Genius prevented anyone from receiving more than one gift card.

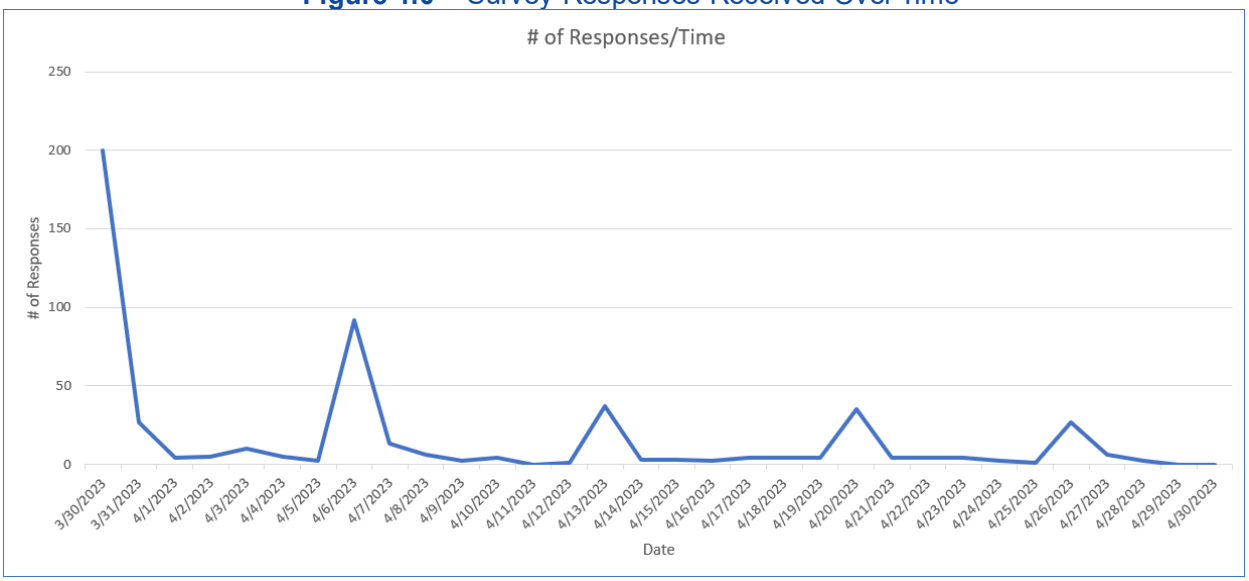
After several rounds of internal testing and validation of survey workflows by the project team, the survey was distributed to 2,104 unique email addresses on March 30, 2023. Based on discussions with the project team, a 30-day survey window was agreed upon, with weekly email reminders generated for all individuals who had not completed a survey. The survey closed at 12:00 midnight on April 29.

PROVIDER SURVEY RESULTS

Response Rate

Of the 2,104 surveys distributed, the team received 513 completed surveys, representing a 24.4% response rate. The chart below illustrates the number of survey responses received over time, with spikes in survey receipts corresponding closely with the dates of the weekly email reminders, which were sent on 4/6, 4/13, 4/20, and 4/26, respectively. Based on this data, the project team concluded that the excellent survey response rate can be attributed to the $50 gift card incentive and weekly email reminders sent to those who had not yet completed the survey.

Figure 1.0 – Survey Responses Received Over Time



Individual Question Results and Analysis

Q1: Medicaid Provider and Specialty Type Selection

This initial question aimed to elicit the Medicaid provider and specialty type(s) of the participant and their associated organization, if applicable. The data collected can be used to categorize participants by their specialization, which is relevant to specific needs, preferences, or limitations in the context of EHR use. The vast majority of provider specialty types represented in the survey (nearly 86%) fall within the realm

of MH/SUD specialties. This statistic is meaningful when considering some of the provider concerns raised in the survey and the focus groups around sharing sensitive client data with the Vermont Health Information Exchange, which are discussed in subsequent sections.

Figure Q1.1 - Analysis: Frequency of Selection for Provider and Specialty type (Top >10)

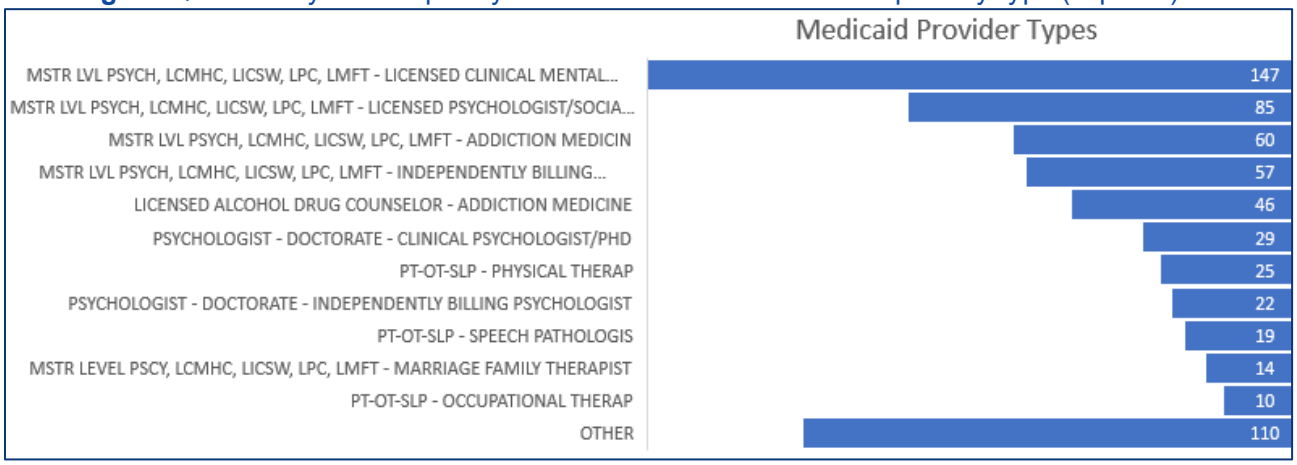


Figure Q1.2 - Table: Frequency of Selection for Provider and Specialty Type (All)

Role	Count
MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - LICENSED CLINICAL MENTAL HEALTH COUNSELOR	147
MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - LICENSED PSYCHOLOGIST/SOCIAL WORKER	85
MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - ADDICTION MEDICINE	60
MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - INDEPENDENTLY BILLING PSYCHOLOGIST	57
LICENSED ALCOHOL DRUG COUNSELOR - ADDICTION MEDICINE	46
PSYCHOLOGIST - DOCTORATE - CLINICAL PSYCHOLOGIST/PHD	29
PT-OT-SLP - PHYSICAL THERAPY	25
PSYCHOLOGIST - DOCTORATE - INDEPENDENTLY BILLING PSYCHOLOGIST	22
PT-OT-SLP - SPEECH PATHOLOGIST	19
MSTR LEVEL PSCY, LCMHC, LICSW, LPC, LMFT - MARRIAGE FAMILY THERAPIST	14
PT-OT-SLP - OCCUPATIONAL THERAPY	10
OTHER (Breakout Below)	110
NUTRITIONAL EDUCATORS - REGISTERED DIETICIANS	9
BEHAVIORAL ANALYST - BOARD CERTIFIED BEHAVIORAL ANALYST	7
LICENSED NURSE - RN	7
INDEPEND. BILLING HIGH TECH NURSES - RN	6
STATE DEFINED TARGETED CASE MANAGEMENT - CASE MANAGEMENT	6
STATE DESIGNATED MH CLINIC - COMMUNITY BEHAVIORAL HEALTH	6
HOME HEALTH AGENCY - NON-PROFIT	5
STATE DEFINED CASE RATE AGENCY - STATE DEFINED CASE RATE SERVICES	5
STATE DEFINED CHILDREN AND FAMILY WAIVER CLINIC - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES	5
LICENSED PHYSICAL THERAPY ASSISTANT - PHYSICAL THERAPY	4
NURSING HOME - MEDICARE PARTICIPATING	4
STATE DEFINED ADULT DAY FACILITY - REHABILITATION	4
STATE DEFINED RESIDENTIAL CARE WAIVER - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES	4

STATE DESIGNATED INTELLECTUAL DISABILITY CLINIC - STATE DEFINED INTELLECTUAL DISABILITY SERVICES	4
WAIVER CASE MANAGER - AGING AND ADULT - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES	4
DCF STATE DEFINED DESIGNATED CASE MANAGEMENT - CASE MANAGEMENT	3
STATE DEFINED INDIVIDUAL CASE MANAGER - CASE MANAGEMENT	3
STATE DEFINED RESIDENTIAL CARE WAIVER - MEDICARE NON-PARTICIPATING	3
STATE DEFINED VOCATIONAL REHAB AGENCY - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES	3
AUDIOLOGIST - INDEPENDENTLY BILLING AUDIOLOGIST	2
BEHAVORIAL ANALYST - BOARD CERTIFIED ASSISTANT BEHAVIORAL ANALYST	2
DME SUPPLIER - MEDICAL SUPPLY COMPANY	2
STATE DEFINED ADAP FACILITY - SUBSTANCE ABUSE TREATMENT SERVICES	2
STATE DEFINED INDEPENDENT AGING AND LIVING WAIVER - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES	2
FAMILY SUPPORTIVE HOUSING - FAMILY SUPPORTIVE HOUSING	1
INDEPEND. BILLING HIGH TECH NURSES - LPN	1
LICENSED NURSE - STATE DEFINED DME NURSING - HIGH TECH	1
PERSONAL CARE SERVICES - PERSONAL CARE SERVICES	1
PTF PSYCH RESIDENTIAL FACILITY - PSYCHIATRIC	1
STATE DEFINED DEPARTMENT OF EDUCATION - PUBLIC HEALTH AGENCY	1
STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY - CASE MANAGEMENT	1
STATE DESIGNATED CHILDRENS MEDICAL SERVICES - PUBLIC HEALTH AGENCY	1
DCF STATE DEFINED DESIGNATED CASE MANAGEMENT - PUBLIC HEALTH AGENCY	0
DME SUPPLIER - STATE DEFINED DME NURSING - HIGH TECH	0
NURSING HOME - MEDICARE NON-PARTICIPATING	0
NUTRITIONAL EDUCATORS - DIABETIC COUNSELORS	0
STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY - REHABILITATION	0
STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY - RESIDENTIAL TREATMENT SERVICES	0

Q2: Workplace Zip Code

This question was designed to gather geographical information about the respondent's or organization's work location. This data can be analyzed to map out the distribution of respondents. Information about areas with high concentrations of respondents may be significant when considering regional disparities or similarities in responses. A total of 92 unique zip codes were identified. When one considers the State of Vermont has 308 postal zip codes, the location of survey respondents collectively represents around 30% of the state's zip codes. The highest geographic concentration of responses corresponds with Vermont's more populous areas such as Burlington (including South Burlington, Essex, and Colchester), Montpelier, Brattleboro, Bennington, Barre, and Rutland. Individuals working in these locations comprise approximately 50% of all survey responses.

Figure Q2.1 - Analysis: Frequency of Selection for Responses by Zip code (Top >10)

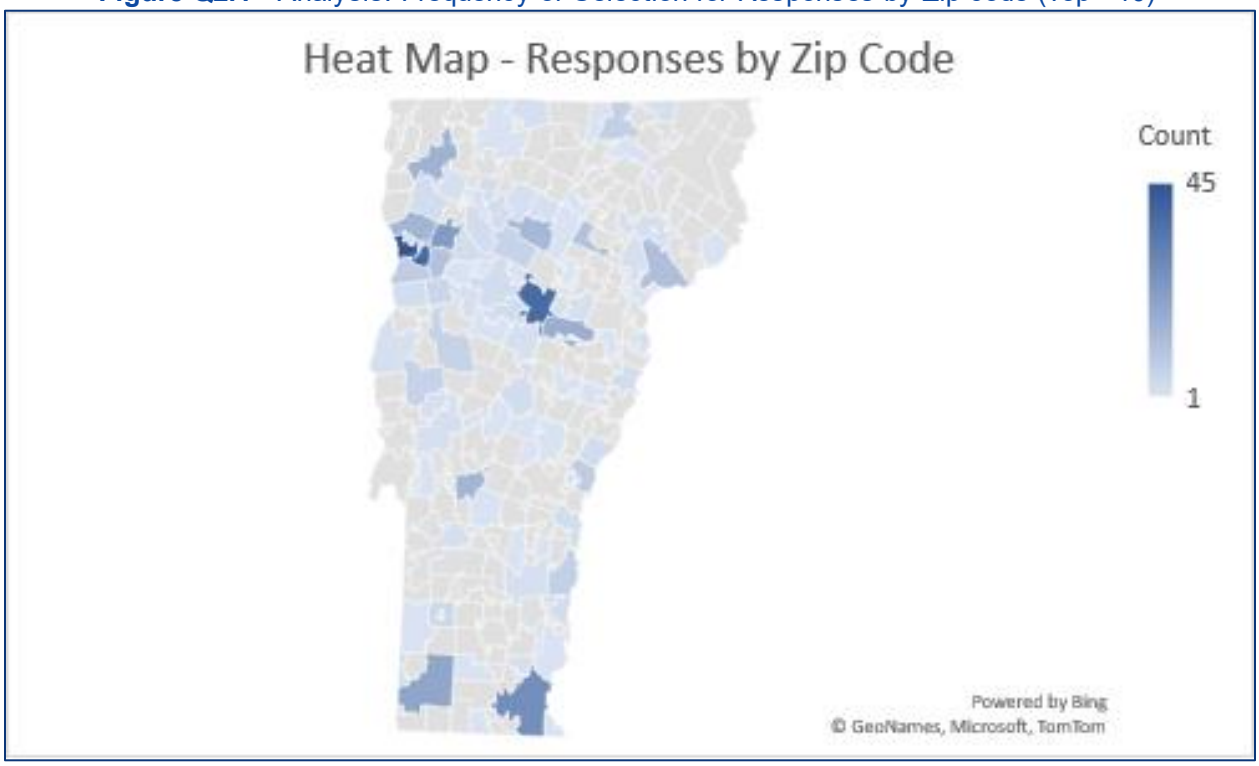


Figure Q2.2 - Frequency of Selection for Responses by Zip Code (All)

Zip Code	Count	Zip Code	Count	Zip Code	Count	Zip Code	Count	Zip Code	Count
05401	45	05672	6	05828	2	05857	1	05250	1
05403	39	05443	6	05830	2	05356	1	05860	1
05602	38	05753	6	05345	2	05076	1	05680	1
05301	27	05461	5	05491	2	05260	1	05677	1
05452	23	05408	5	05656	2	05254	1	05446	1
05201	20	05255	4	05143	2	05149	1	05738	1
05641	17	05445	3	05663	2	05403	1	05477	1
05478	16	05257	3	05773	2	05142	1	05906	1
05446	15	05464	3	05851	2	05079	1	05401	1
05701	15	05089	3	05081	2	05038	1	05059	1
05661	14	05660	3	05769	2	05088	1	05346	1
05819	12	05465	3	05667	2	05032	1	05601	1
05495	11	05055	3	05454	2	05354	1	05702	1
05843	11	05060	3	05733	2	05068	1	05826	1
05482	8	05101	3	05462	2	05767	1	05673	1
05001	8	05468	3	05476	2	05821	1	05450	1
05404	8	05033	3	05655	2	05361	1		
05156	7	05489	3	05651	2	05750	1		
05855	7	05676	3	05444	2	05650	1		

Q3: Client Records Collection and Storage Methods

The goal of this question was to assess the current methods providers and organizations use to collect and store client records. Trends could be identified concerning the predominance of electronic over offline methods, although a substantial portion of respondents (29%) indicate they utilize paper or other offline methods to manage client records. Of note, while 53% of respondents reported using CEHRT technology, the data collected on EHR vendor solutions used (Q4 below) shows that only 16% of reported systems currently used by survey respondents are actually CEHRT solutions as defined by the Office of the National Coordinator for Health Information Technology. This data, along with qualitative data gleaned from the survey and focus groups, leads to the conclusion that many respondents did not understand the concept of CEHRT, and as a result, the percentage of CEHRT identified in the data from this question is highly inflated, while the percentage of non-certified EHR software in use is underreported.

Figure Q3.1 - *Table:* Frequency of Client Records Systems by Type

How are client records collected and stored at your organization?	Count	Percent
Certified Electronic Health Record (EHR) technology	270	**53.1%***
Offline Documentation (paper charts/local files)	149	29.3%
Non-certified Electronic Health Record (EHR) technology	28	5.5%
Other Care Coordination/Practice Management software	30	5.9%
Other (specified as other by respondent)	31	6.1%

***This statistic is considered inaccurate. Please see narrative above for explanation.**

Q4: EHR or other Health IT Solution Vendor

This question was intended to identify the EHR system or other health IT solution(s) currently used by participants. Figure Q4.1 depicts the most frequently reported vendors used by respondents. **Bolded** systems in Figure Q4.2 denote CHPL (CEHRT) electronic health records software systems. As noted in Q3 above, when calculating the total number of known certified systems reported compared to the number of respondents who indicated their organization uses an EHR system, the actual percentage of CEHRT systems reported in use is only 16%.

Interestingly, the most commonly reported EHR system, Simple Practice, accounts for over 39% of all systems reported, and the top two most commonly reported systems, Simple Practice and MyClientsPlus, account for a little over half (52%) of all EHR systems reported by survey respondents. Neither of these solutions is CEHRT.

Figure Q4.1 - Analysis: Prevalence of EHR by Vendor

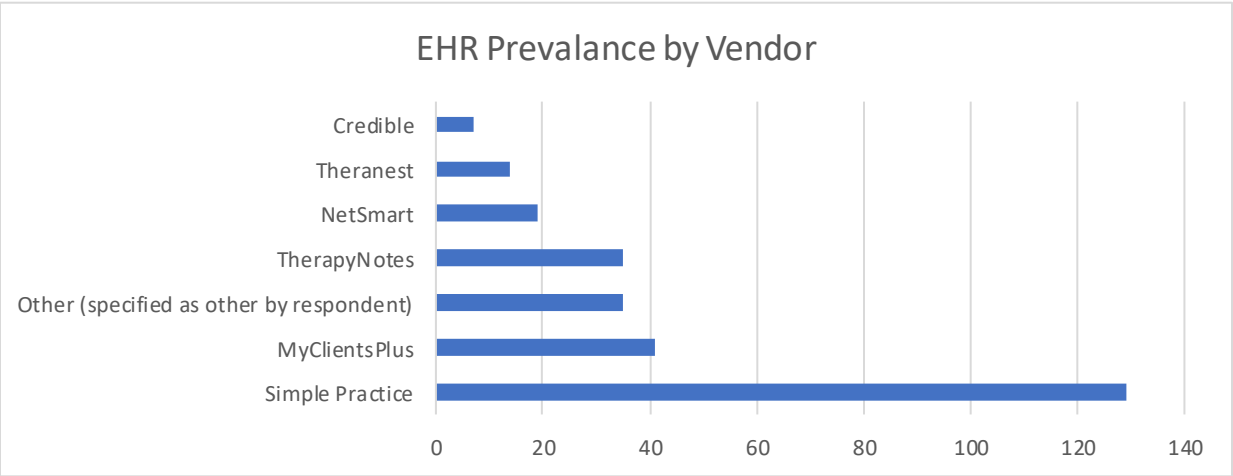


Figure Q4.2 - Table: Prevalence of EHR by Vendor

What EHR or other health IT solution vendor do you currently use?	Count	Percent
Simple Practice	129	39.2%
MyClientsPlus	41	12.5%
Other (specified as other by respondent)	35	10.6%
TherapyNotes	35	10.6%
NetSmart	19	5.8%
Theranest	14	4.3%
Credible	7	2.1%
WebPT	6	1.8%
None	6	1.8%
Epic	5	1.5%
eClinicalWorks	4	1.2%
AthenaHealth	3	0.9%
PointClickCare	3	0.9%
Apricot	3	0.9%
MWTherapy	3	0.9%
TherapyMate	3	0.9%
OfficeAlly	3	0.9%
Practice Better	3	0.9%
Healthie	2	0.6%
Wellsky	2	0.6%
Allscripts (Altera)	1	0.3%
McKesson	1	0.3%
NextGen	1	0.3%

Q5: Difficulties with Current Client Record Management System

This question attempted to identify the presence of any significant challenges participants might be facing with their current client record management system. An overwhelming 91% of respondents indicated no significant difficulties related to their current client record management system.

Figure Q5.1 - Analysis: Difficulties with Current Client Records Management System

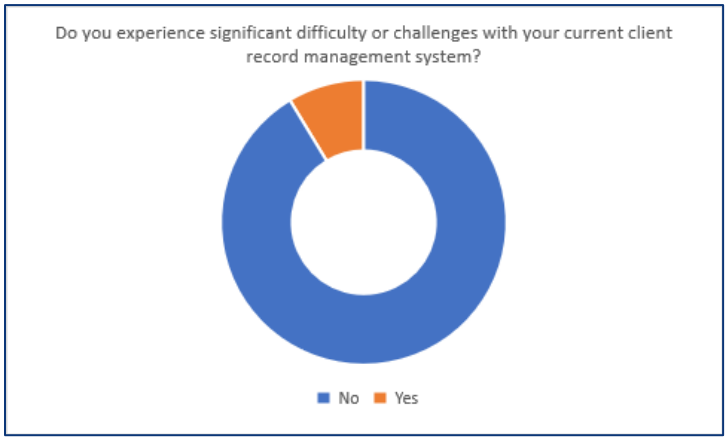


Figure Q5.2 - Table: Difficulties with Current Client Records Management System

Do you experience significant difficulty or challenges with your current client record management system?	Count	Ratio
No	433	91%
Yes	41	9%

Q6: Factors for Not Using an EHR System

This question sought to understand the reasons why participant organizations are not using an EHR system. This item provided a number of common challenges that prevent providers from using EHR systems along with a free text field for entering any reasons not already identified. (Please see *Q16: Additional Feedback* for a discussion of themes that emerged from free text entry by survey respondents.) The top six reasons listed below were separated by only 2.6 percentage points. Also, the two reasons in bold font could conceivably be directly addressed through milestone incentive payments and program support within MDAAP:

- **Lack of support staff – IT/Technology/Administrative**
- Not confident EHR will lower cost or improve quality
- Perceived little or no value to clients/patients
- Perceived little or no value to provider(s)
- **Financial limitations – Lack of funds for initial investment**
- Privacy concerns.

Figure Q6.1 - Analysis: Factors for Not Using an EHR System

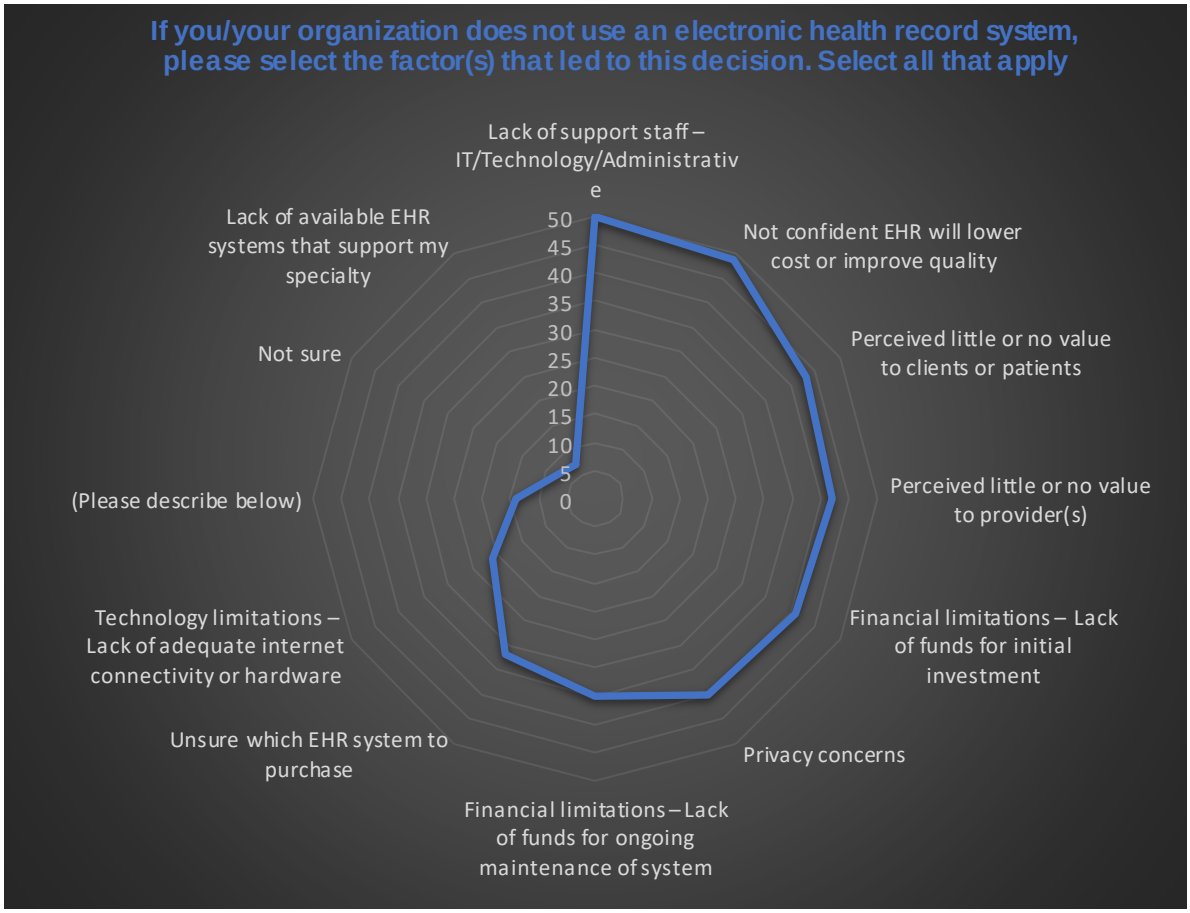


Figure Q6.2 - Table: Factors for Not Using an EHR System

If you/your organization does not use an electronic health record system, please select the factor(s) that led to this decision. Select all that apply:	Count	Percent
Lack of support staff – IT/Technology/Administrative	50	13.1%
Not confident EHR will lower cost or improve quality	49	12.8%
Perceived little or no value to clients or patients	43	11.3%
Perceived little or no value to provider(s)	42	11.0%
Financial limitations – Lack of funds for initial investment	41	10.7%
Privacy concerns	40	10.5%
Financial limitations – Lack of funds for ongoing maintenance of system	35	9.2%
Unsure which EHR system to purchase	32	8.4%
Technology limitations – Lack of adequate internet connectivity or hardware	21	5.5%
Free Text Response (Please describe below)	14	3.7%
Not sure	8	2.1%
Lack of available EHR systems that support my specialty	7	1.8%

Q7: Current Use of VITLAccess

This question evaluated current use of VITLAccess by survey respondents. Only two percent of respondents indicated that they currently use VITLAccess, which is consistent with qualitative data gleaned from the survey and focus groups. (See *Q16:Additional Feedback* for survey respondent open-ended comments and *Provider Focus Group Results* for themes that arose in the focus groups.)

Figure Q7.1 - Analysis: Providers that currently use VITLAccess

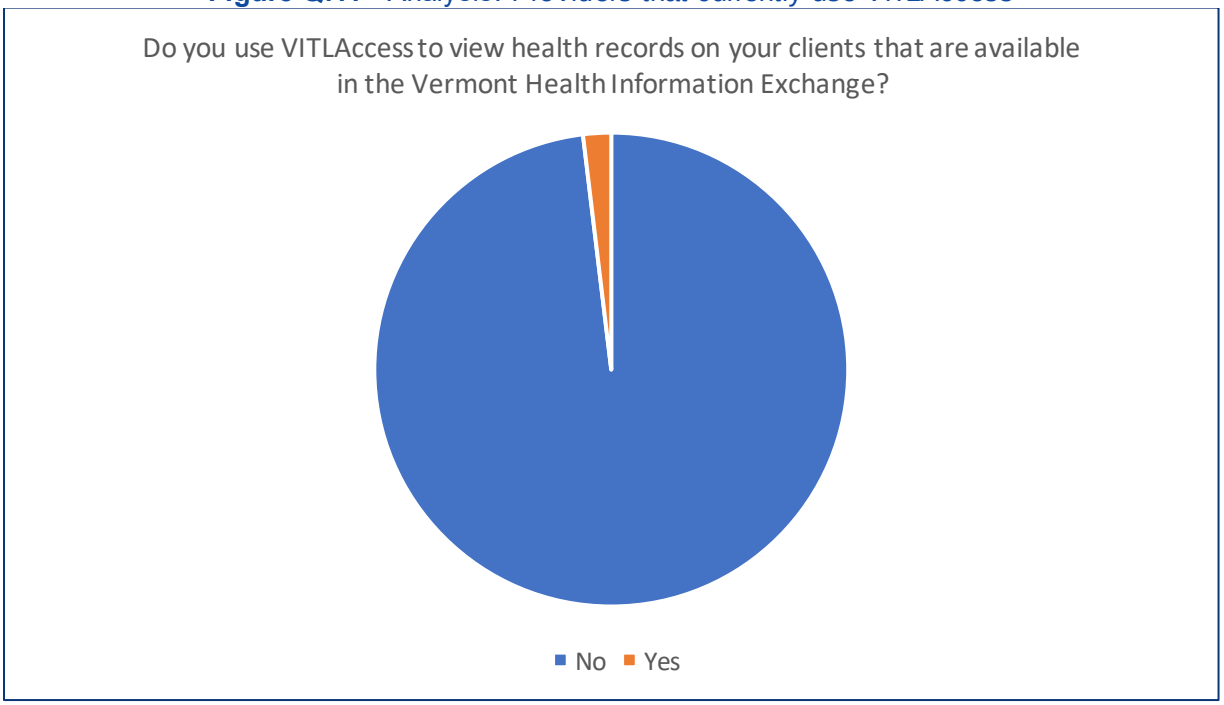


Figure Q7.2 - Table: Providers that currently use VITLAccess

Do you use VITLAccess to view health records on your clients that are available in the Vermont Health Information Exchange?	471	
No	462	98%
Yes	9	2%

Q8: Future Opportunity for VITLAccess - Interest in Training

This question evaluated potential interest in future use of VITLAccess by asking respondents about their interest in training. While very few respondents reported currently using VITLAccess, a significant portion of respondents (43%) indicated that they would be interested in receiving training on how to acquire and utilize this service. Since a significant proportion of providers expressed an interested in acquiring VITLAccess, and it is also a cost-free service to Vermont providers, it is highly recommended that VITLAccess be included as a component of the MDAAP.

Figure Q8.1 - Analysis: Providers that are interested in VITLAccess Training

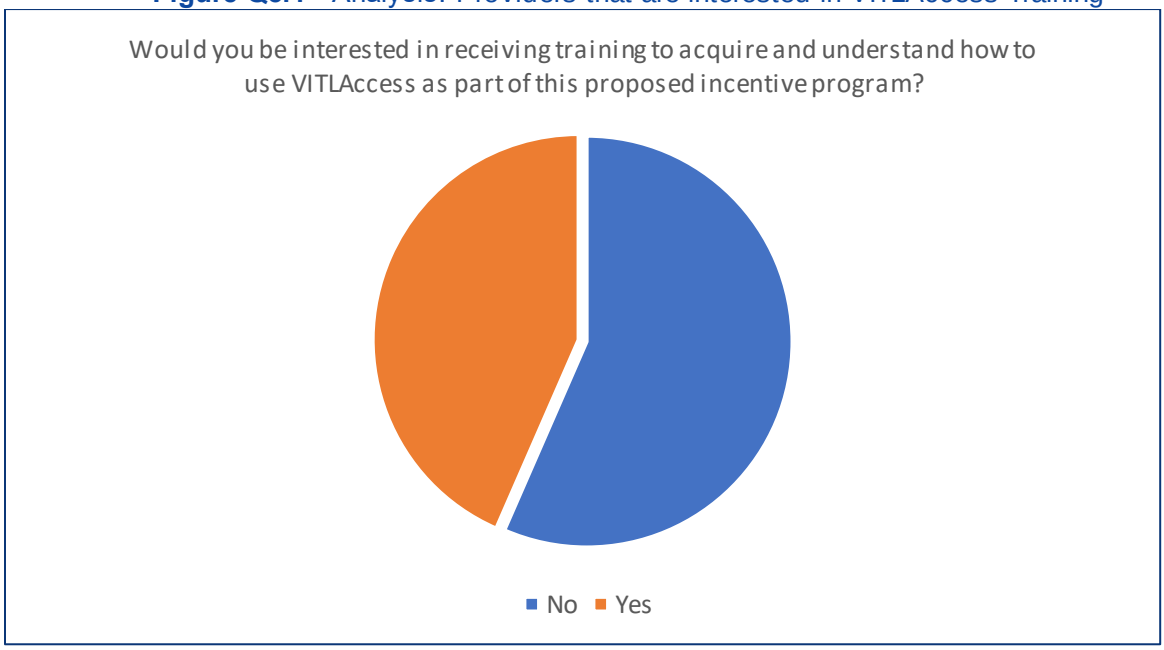


Figure Q8.2 - Table: Providers that are interested in VITLAccess Training

Would you be interested in receiving training to acquire and understand how to use VITLAccess as part of this proposed incentive program?	Count	Percent
No	259	57%
Yes	199	43%

Q9: Benefits of VITLAccess

This question aimed to understand how participants perceive the benefits of using VITLAccess for their client population. Among the small number of respondents utilizing VITLAccess, the most valuable perceived benefits are the ability to develop a more accurate patient medical history and the time-saving feature of accessing records from multiple providers in one place. Since such a small number of survey respondents (9 individuals) currently use VITLAccess, it is not advisable to draw any conclusions about these reported benefits across the larger HCBS provider population.

Figure Q9.1 - Table: Providers that use VITLAccess today – Perceived Benefits

How does VITLAccess benefit your clients? (Select all that apply)	Count	Percent
Leads to a more accurate patient medical history	5	19.2%
Supports trauma-informed care by providing medical histories in situations where recounting past history may be re-traumatizing to the client	2	7.7%
Supports shared care planning	2	7.7%
Saves time by providing ease of access to records from multiple providers	5	19.2%
Facilitates improved communication with clients and other providers of care	4	15.4%
Supports improved quality of care and outcomes	4	15.4%
Eliminates redundant or unnecessary testing	3	11.5%
I have access. Hardly ever use it.	1	3.8%

Q10: Current Provider Data Sharing with the VHIE

The next three survey questions focused on whether organizations' EHR systems send data to the VHIE; if so, the specific information sent; and if not, the barriers preventing data sharing with VHIE. Similar to the question about VITLAccess usage, a small percentage (9%) of respondents indicated that their EHR system currently contributes data electronically to the VHIE.

Figure Q10.1 - Analysis: Current Provider Data Sharing with VHIE

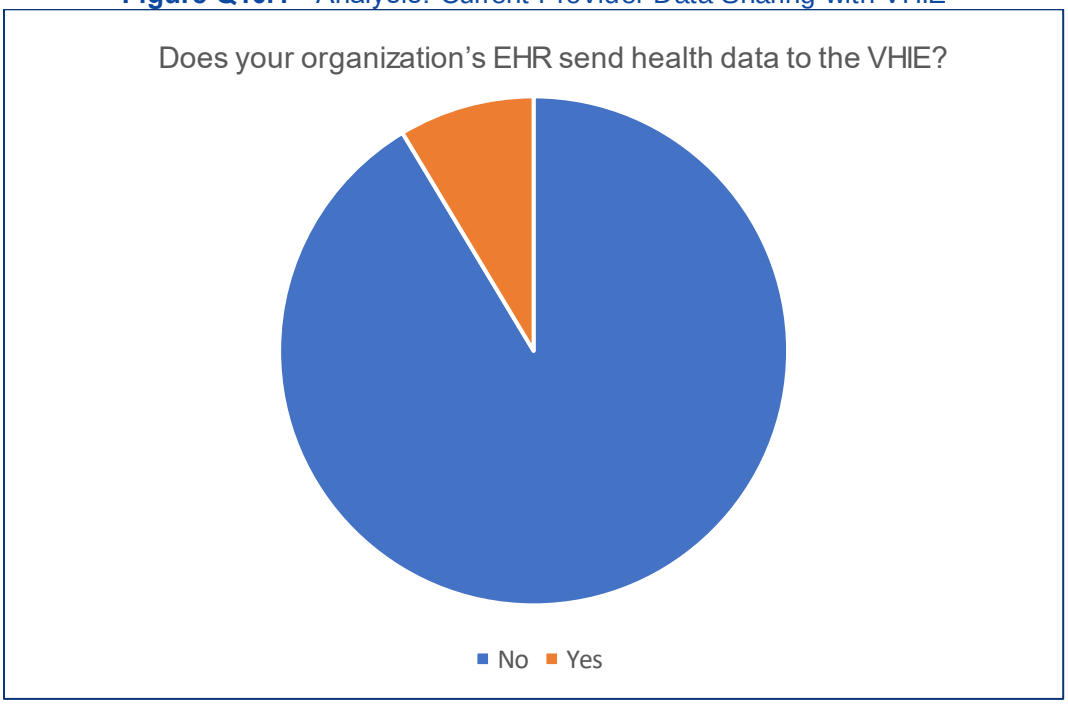


Figure Q10.2 - Table: Current Provider Data Sharing with VHIE

Does your organization's EHR electronically send health data to the Vermont Health Information Exchange (VHIE)?	Count	Percent
No	265	91%
Yes	25	9%

Q11: Current Data Types Being Shared with the VHIE

For the providers and organizations whose EHR systems are sending data to the VHIE, this question attempts to identify the specific types of information being sent.

Figure Q11.1 - Analysis: Current Data Types Being Shared with VHIE

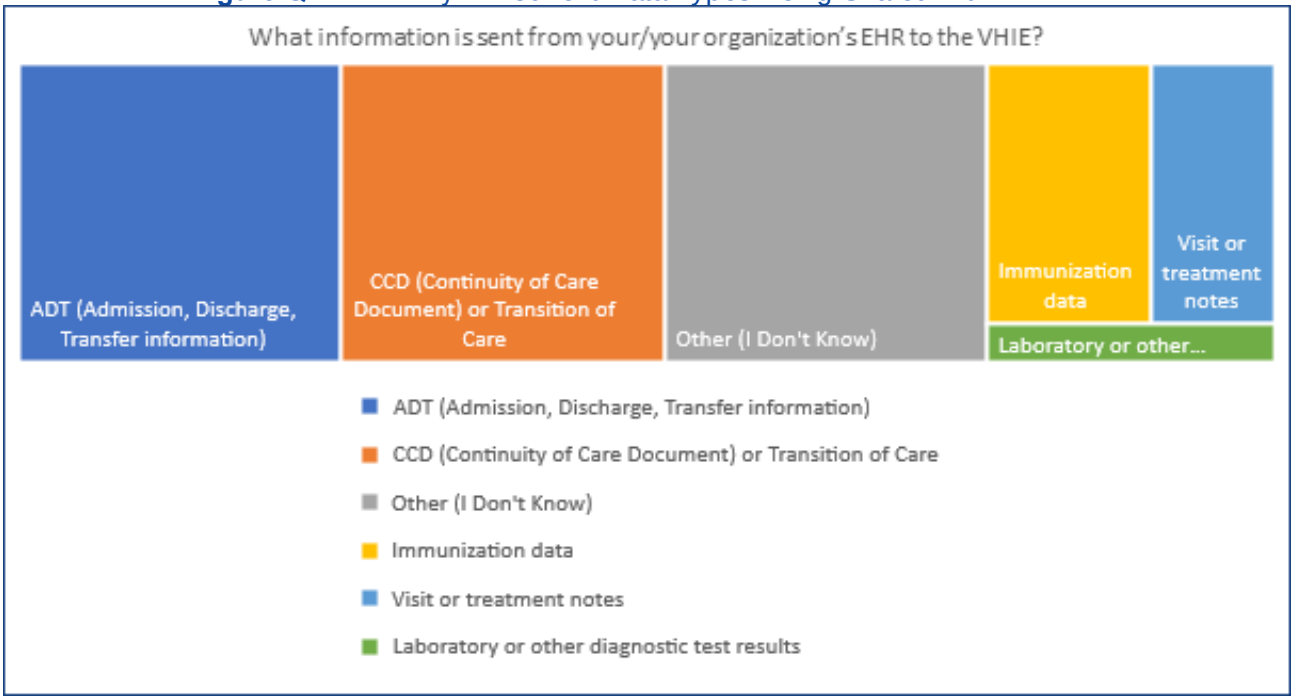


Figure Q11.2 - Table: Current Data Types Being Shared with VHIE

What information is sent from your/your organization's EHR to the Vermont Health Information Exchange (VHIE)?	Count	Percent
ADT (Admission, Discharge, Transfer information)	9	25.7%
CCD (Continuity of Care Document) or Transition of Care	9	25.7%
Other (I Don't Know)	9	25.7%
Immunization data	4	11.4%
Visit or treatment notes	3	8.6%
Laboratory or other diagnostic test results	1	2.9%

Q12: Perceived Barriers with Connecting to the VHIE

For providers and organizations that do not send data electronically to the VHIE, this question attempted to identify potential barriers to data sharing. Respondents were asked to select from a list of identified barriers, and they also had the option to type in additional perceived barriers within a free text field. (Please see *Q16: Additional Feedback* for a discussion of themes that emerged from free text entry by survey respondents.)

The most commonly reported barrier was limited technical resources/staff expertise to set up this integration, which could be directly addressed through the MDAAP's design.

Figure Q12.1 - Analysis: Perceived Barriers with Connecting to the VHIE

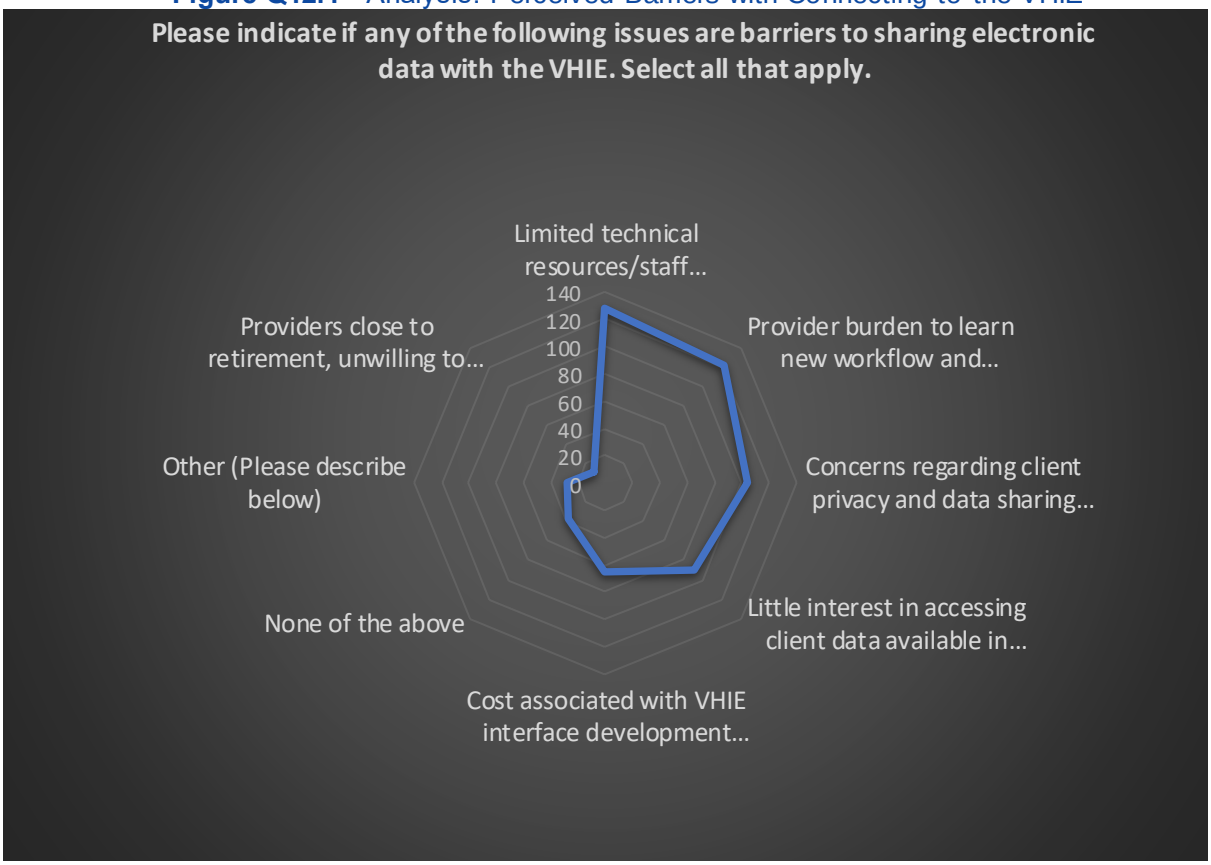


Figure Q12.2 - Table: Perceived Barriers with Connecting to VHIE

Please indicate if any of the following issues are barriers to sharing electronic data with the VHIE. Select all that apply.	Count	Percent
Limited technical resources/staff expertise to set up this integration	128	21.8%
Provider burden to learn new workflow and access VHIE in addition to EHR functions	123	20.9%
Concerns regarding client privacy and data sharing policies for VHIE members	104	17.7%
Little interest in accessing client data available in VHIE	91	15.5%
Cost associated with VHIE interface development from your EHR vendor	65	11.1%
None of the above	38	6.5%
Other (Please describe below)	28	4.8%
Providers close to retirement, unwilling to learn new workflow	11	1.9%

Q13: Interest in Future Incentive Programs

This question sought to gauge interest in a future incentive program like the MDAAP that would support provider adoption and use of EHR technology to contribute data to the VHIE. Participant responses leaned more favorably towards the incentive program, with over 55% of respondents indicating they would either be “Definitely”, “Probably”, or “Possibly” interested in the MDAAP incentive. This is consistent with qualitative feedback received from the focus groups, in which participants were generally in favor of such a program but also desired to know additional details yet to be finalized about participation.

Figure Q13.1 - Analysis: Interest in Future Incentive Programs

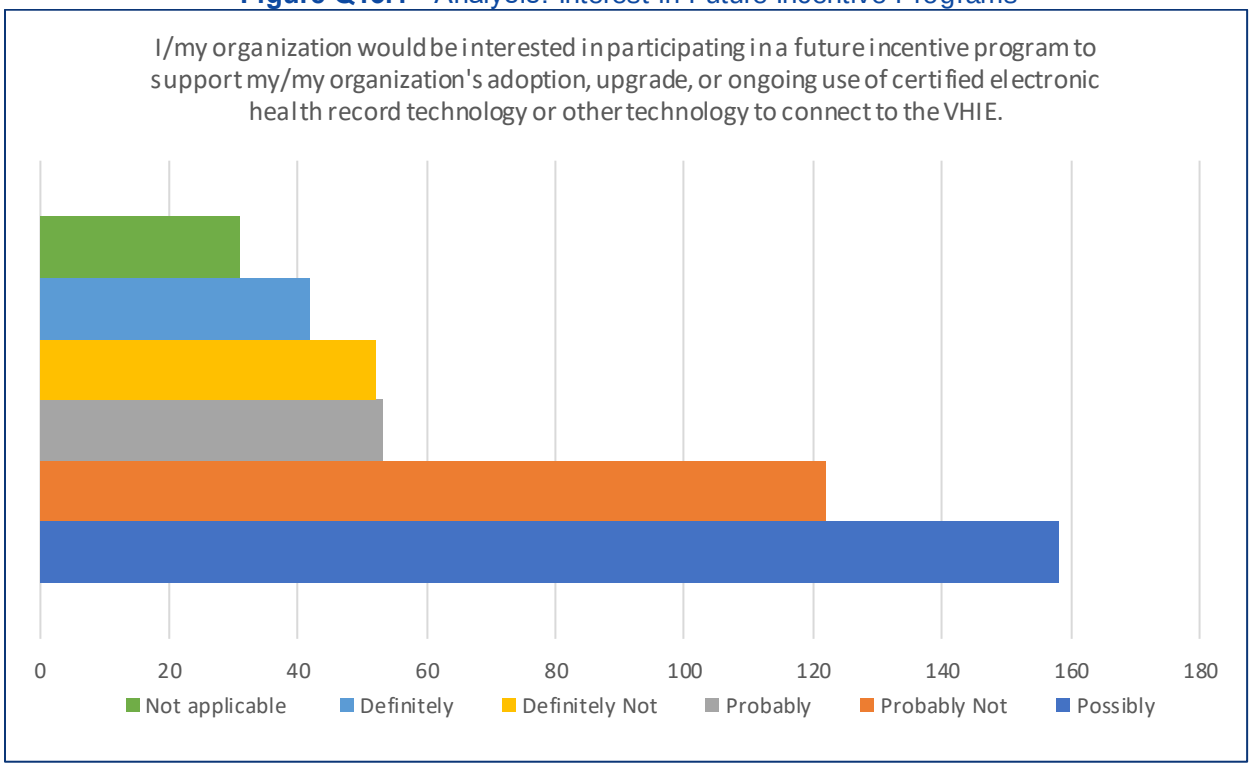


Figure Q13.2 – Table: Interest in Future Incentive Programs

***Please rate your agreement with the following statement*: I/my organization would be interested in participating in a future incentive program to support my/my organization's adoption, upgrade, or ongoing use of certified electronic health record technology or other technology to connect to the Vermont Health Information Exchange.**	**Count**	**Percent**
Possibly	158	34.5%
Probably Not	122	26.6%
Probably	53	11.6%
Definitely Not	52	11.4%
Definitely	42	9.2%
Not applicable	31	6.8%

Q14: Areas of Needed Support for Future EHR Incentive Program

This question aimed to understand where participants believe they would require the most assistance in participating in a future EHR incentive program. Results from this question show that perceived support needs are fairly significant across all the categories provided for rating, with the highest areas of perceived support needed for security risk assessment; identifying, selecting, and installing a certified EHR system that connects to the VHIE, and onboarding/connecting to the VHIE (areas in bold font in the table on the following page).

Figure Q14.1 - Analysis: Areas of Needed Support for Future EHR Incentive Program

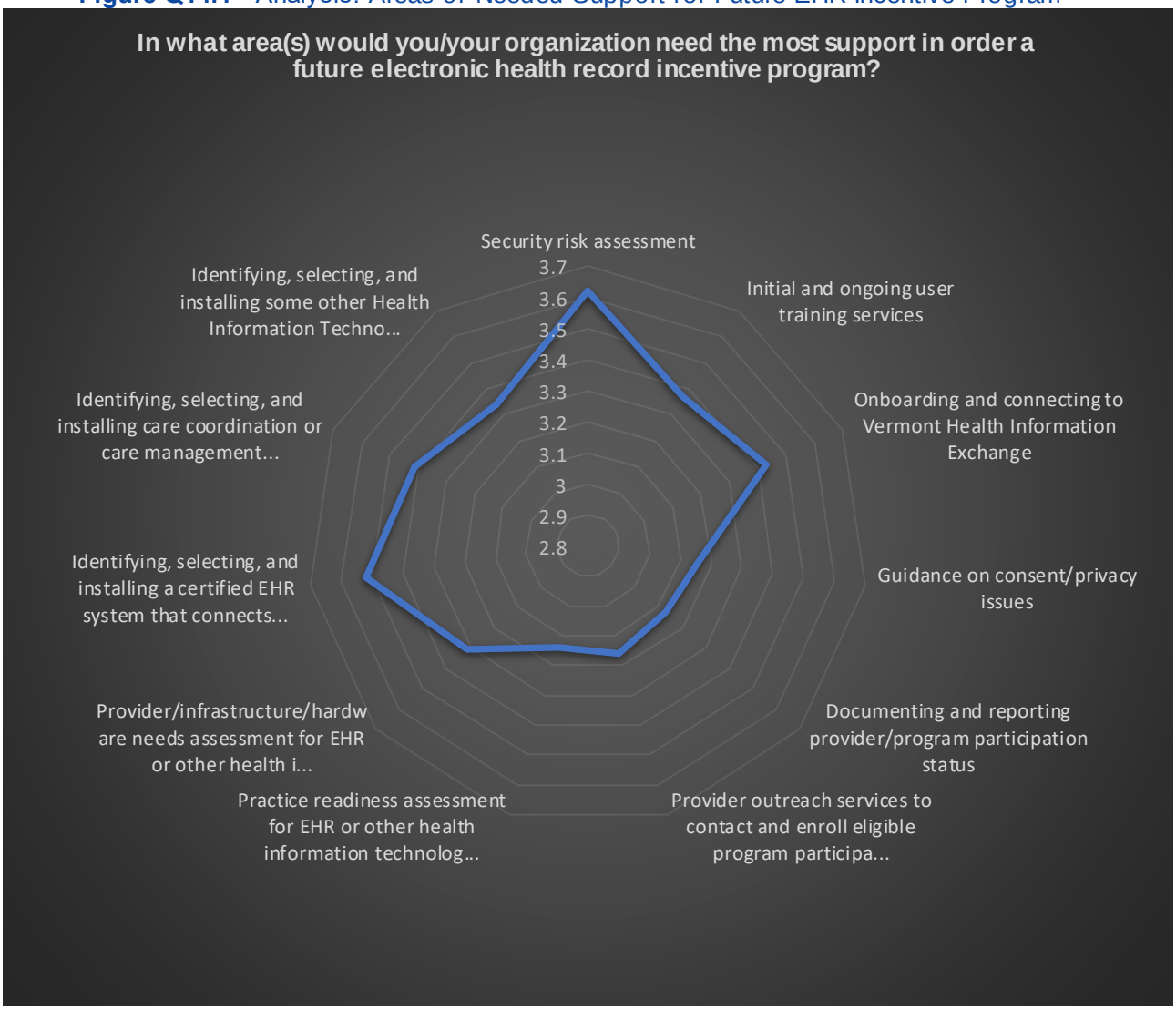


Figure Q14.2 - Table: Areas of Needed Support for Future EHR Incentive Program

In what area(s) would you/your organization need the most support in order to participate in a future electronic health record initiative? (Adjust the slider to denote the level of assistance you believe you/your organization would require in each area. A "0" means no assistance would be required while a "5" means significant assistance would be needed.)	Average	Count
Security risk assessment	**3.62**	224
Initial and ongoing user training services	3.37	235
Onboarding and connecting to Vermont Health Information Exchange	**3.43**	234
Guidance on consent/privacy issues	3.16	229
Documenting and reporting provider/program participation status	3.13	225
Provider outreach services to contact and enroll eligible program participants	3.16	212
Practice readiness assessment for EHR or other health information technology	3.14	225
Provider/infrastructure/hardware needs assessment for EHR or other HIT	3.31	225
Identifying, selecting, and installing a certified EHR system that connects to the VHIE	**3.52**	230

Identifying, selecting, and installing care coordination or care management software that connects to the VHIE	3.41	230
Identifying, selecting, and installing some other Health Information Technology that connects to the VHIE	3.34	223

Q15: Focus Group Follow-Up

This question sought to identify survey respondents who would be willing to participate in a focus group to provide further input on MDAAP development. While well over 100 individuals responded in the affirmative, only 48 individuals completed a focus group questionnaire that was subsequently provided, which was used as a screening tool in scheduling participants for the various focus groups. (Please see the *Focus Group Methodology* and *Focus Group Results* sections for more detailed information.)

Figure Q15.1 - Table: Willingness to Participate in a Focus Group

Would you be willing to participate in a focus group or interview in order to provide additional information to the incentive program development team?	Count
No	333
Yes	116

Q16: Additional Feedback

This was an open-ended question intended to solicit any additional feedback from participants. There were 102 meaningful free-text responses received within this question. In addition, respondents had opportunities to enter free text responses within three other survey questions within strategically placed "Other" or "Please describe" free-text box options. While each comment received was unique, a few main themes emerged when the entire body of comments was analyzed:

- Concerns about the cost of EHR technology and VHIE connectivity (both initial and ongoing cost)
- Confidentiality/privacy concerns around sharing sensitive client records with the VHIE
- The difficulty and disruption in practice involved in implementing/switching EHR solutions
- General lack of knowledge about the VHIE
- Lack of IT support resources to assist in implementing and maintaining an EHR system and connectivity to the VHIE
- Representative Comments:
  - "Costs associated with implementation and ensuring privacy are a major concern as a solo practitioner. Also, being later in my career as well as time limitations around training and implementation are concerns."
  - "Up front time needed to set up system is daunting, not sure it is cost-effective given my small practice."
  - "Facility is small."
  - "Overwhelmed by technology"
  - "We don't know how to use systems like this, there is no money at all to use, train, purchase or maintain."

- "I have no background knowledge about or experience with the Vermont Information Health Exchange [sic]. My responses reflect initial thoughts to the posed questions. Those responses could potentially be different in the future with additional information learned."

- "I would be interested in this incentive if it connected easily to Simple Practice. I'm not planning on or interested in changing EHR platforms at this time unless their ease of use and functionality and price are similar to SP."

PROVIDER FOCUS GROUP METHODOLOGY

The MDAAP project team was given an initial goal of holding focus groups to solicit input from 45 – 50 total individuals. As mentioned above, the online provider survey contained a question asking for focus group volunteers, and many of the participants were recruited in this manner. In addition to the request contained within the survey, members of the project team reached out to sister agencies and known contacts in HCBS provider organizations in an effort to recruit volunteers.

Similar to the HCBS provider survey, focus group participants received a gift card for attending a focus group. However, focus groups participants received a more substantial gift card ($100) in recognition of the greater time commitment involved in focus group participation compared to completing a 15-minute online survey. Additionally, the incentive amount provided is consistent with industry data on focus group compensation.

All individuals who agreed to participate in a focus group, whether recruited through the provider survey or via more direct outreach means, were sent a short online focus group questionnaire to complete using the Qualtrics survey application. This questionnaire contained questions to validate the individual's provider type and specialty (or job title if not a provider), the size of the organization in terms of number of HCBS providers, and each individual's best day(s) and time(s) of availability to attend a focus group.

A total of 48 individuals completed the focus group questionnaire electronically through Qualtrics, and questionnaire data was manually obtained from a few other participating individuals who were recruited directly by the project team. The PCG team then analyzed the results of the questionnaire results and slotted individuals into focus groups of similar providers during times that attempted to accommodate each individual's scheduling constraints. This resulted in a series of nine (9) focus groups that were held during the two-week period of May 15 – May 26, 2023. All focus groups were virtual sessions facilitated using Microsoft Teams. All participants received an initial email invitation that was sent two weeks before the date of the first focus group, and a follow-up reminder email was sent to each participant 48 hours before his/her scheduled focus group. Several individuals initially declined their email invitation due to conflicts; in every case, the PCG team reached out to the individual and attempted to slot that person into an alternate focus group that did not conflict with their schedule.

PROVIDER FOCUS GROUP RESULTS

Participant Demographics

The following statistics provide some demographic information on the focus group participants.

- 53 individuals were invited to attend one of 9 scheduled focus groups

- 35 individuals actually attended a focus group (66% show rate). This consisted of:
  - 6 representatives from the Designated Agencies
  - 3 representatives from the Specialized Service Agencies
  - 2 providers of physical/medical services (1 speech/language pathologist, 1 independently billing high tech registered nurse)
  - The remainder of participants are solo or small group mental health/substance use disorder (SUD) providers in private practice or individuals working for MH/SUD treatment organizations

- Only 6 participants do not personally provide HCBS services

- The majority of focus group participants (30 individuals) utilize some form of EHR system. The other five participants either maintain client charts on paper or in some type of offline electronic repository such as Google Drive.

- Few focus group participants (only the Designated Agency reps and two private practice providers) utilize certified electronic health record technology (CEHRT)

Postive Feedback Themes

Focus group questions were designed to expand on questions asked in the provider survey about provider needs and challenges related to documenting, maintaining, and sharing client data electronically. (See *Appendix C: Focus Group Questions* for more detail.) In addition, participants were shown two presentation slides that depicted a draft framework for program incentive payment milestones and forms of potential program support and were asked for their feedback. Several themes emerged that are positive in regard to support of the MDAAP:

- Participants agreed that HCBS providers would benefit from incentives to digitize records, much like other providers benefitted from HITECH/Meaningful Use/Promoting Interoperability incentive payments to implement and utilize CEHRT in the past.

- Participants are generally interested in supporting the concept of a single patient record, hosted within the VHIE.

- Many providers were not aware of VITLAccess but are interested in potentially pursuing this feature to access the VHIE.

- Participants from the Designated Agencies are already working towards connectivity with the VHIE and are very interested in any incentives that may support this effort.

- Several providers noted that it would be helpful to access the VHIE to review a client's current medication list and to refer to any records from recent emergency room visits or inpatient hospitalizations.

Provider Concerns

While focus group participants were generally supportive of the concept of the incentive program, they also voiced a number of concerns that will need to be addressed in the details of program design in order to secure program participants. These concerns generally fall into one of the following categories:

- Cost and Value of CEHRT and VHIE Connectivity

    - The non-certified EHR solutions used by many participants (e.g., Simple Practice, MyClientsPlus) have nominal ongoing fees (e.g., $100/month) that are significantly less than what the ongoing maintenance and support fees would cost for an ONC-certified EHR solution. Additionally, CEHRT solutions contain some functions and features they wouldn't utilize.

    - While the MDAAP might cover the initial implementation cost of a new CEHRT system, how is a solo provider supposed to absorb the much higher system maintenance and support fees after implementation if only certified EHR systems are allowed under this program?

- Similarly, while the MDAAP incentive might cover the initial cost to connect to the VHIE, how can a solo provider or small practice justify the ongoing fees related to interface maintenance to maintain VHIE connectivity?

- Outside of a current medication list from a primary care provider or psychiatrist and any recent ER/hospitalization notes, there are very few third-party medical records that participant providers ever request or review. In short, there is concern that the cost to set up and maintain VHIE connectivity may be greater than the value HCBS providers will realize from connectivity.

► Lack of Technical Support / Disruption to Practice

- Aside from the Designated Agencies and a couple larger group practices, the vast majority of focus group participants have little to no IT support. Most are using software-as-a-service (SaaS) based EHR solutions that provide self-help manuals and articles online. Some vendors offer help desk services that can be contacted via phone and others offer chat and/or email support only for issues that cannot be resolved via self-help materials.

- With no IT/application support, providers are concerned about how to implement new technologies on their own. Several shared past experiences of how disruptive implementing their EHR was to their practice and how it took a lot of their personal time and effort, which impacted their ability to see clients and ultimately their compensation.

- Every participant polled said he/she would <u>not</u> be willing to switch from their current non-certified EHR to CEHRT technology even if MDAAP provided the funds to switch. In addition to the greater ongoing cost associated with maintaining CEHRT already mentioned above, they cited disruption to their practice and temporary loss of compensation due to inability to see as many clients during the implementation and learning curve period as the main reasons.

► Privacy Concerns

- Virtually all the MH/SUD providers expressed concerns about how sensitive client information, particularly SUD treatment records governed by 42 CFR Part 2, is handled by the VHIE. Many have reservations about setting up interfaces that would automatically share therapy notes and other sensitive treatment notes directly with the VHIE. Everyone that expressed this concern indicated that they would need to learn more about how the VHIE proposed to comply with existing regulations around access, consent, and disclosure.

APPENDIX A: HCBS PROVIDER SURVEY

VERMONT

This survey is being administered by the State of Vermont to understand the extent of electronic health record (EHR) use and potential barriers to EHR adoption among Home and Community Based Services (HCBS) providers. We are surveying mental health, substance use disorder treatment, and long-term services and support providers who were not eligible for incentive payments under the Promoting Interoperability Program (formerly known as the Electronic Health Record Incentive Program).

We understand that your time is valuable. In recognition of that, our survey is brief and should take approximately 15 minutes to complete. Additionally, Public Consulting Group, the firm conducting this survey, will provide $50 in the form of an online gift card to the first 500 individuals who submit completed surveys. Instructions for claiming your gift card will be provided via email upon completion of your survey.

Feedback from this survey will be used to help design a new incentive program that will initially target HCBS providers who were not eligible for earlier federal EHR incentive programs. The overarching goals of the new incentive program will include assisting HCBS providers in implementing EHR technology and connecting with the Vermont Health Information Exchange.

This survey may be filled out by a provider, practice manager, or any individual that is familiar with the organization's health records system.

Solo practitioners – Please complete this survey or designate an appropriate representative to complete it on your behalf.

Group practice organizations – Please fill out this survey from your perspective or on behalf of the organization at which you are employed. Multiple individuals affiliated with an organization are welcome to complete the survey.

Multiple Locations – If your organization has multiple locations or if you are a provider who practices in multiple locations, please fill out this survey based on the location that you feel would benefit most from this potential incentive program.

If you have any questions regarding the survey, please contact representatives of Vermont's Promoting Interoperability Program at: AHS.VTProviderSurvey@vermont.gov.

Your opinions matter to our team and are important to our understanding of the HCBS recordkeeping landscape in Vermont. The Vermont Agency of Human Services welcomes your frank and honest feedback when answering these questions. Any individually identifiable information will be kept confidential. Thank you for your participation.

I have read the information above and understand the purpose of the survey.

- Yes, Begin Survey

Please select your Medicaid provider and specialty type(s) below. Select all that apply to you or the organization with which you are associated.

- AUDIOLOGIST - INDEPENDENTLY BILLING AUDIOLOGIST
- BEHAVORIAL ANALYST - BOARD CERTIFIED ASSISTANT BEHAVIORAL ANALYST
- BEHAVIORAL ANALYST - BOARD CERTIFIED BEHAVIORAL ANALYST
- DCF STATE DEFINED DESIGNATED CASE MANAGEMENT - CASE MANAGEMENT
- DCF STATE DEFINED DESIGNATED CASE MANAGEMENT - PUBLIC HEALTH AGENCY
- DME SUPPLIER - MEDICAL SUPPLY COMPANY
- DME SUPPLIER - STATE DEFINED DME NURSING - HIGH TECH
- FAMILY SUPPORTIVE HOUSING - FAMILY SUPPORTIVE HOUSING
- HOME HEALTH AGENCY - NON-PROFIT
- INDEPEND. BILLING HIGH TECH NURSES - LPN
- INDEPEND. BILLING HIGH TECH NURSES - RN
- LICENSED ALCOHOL DRUG COUNSELOR - ADDICTION MEDICINE
- LICENSED NURSE - RN
- LICENSED NURSE - STATE DEFINED DME NURSING - HIGH TECH
- LICENSED PHYSICAL THERAPY ASSISTANT - PHYSICAL THERAPY
- MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - ADDICTION MEDICINE
- MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - INDEPENDENTLY BILLING PSYCHOLOGIST
- MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - LICENSED CLINICAL MENTAL HEALTH COUNSELOR
- MSTR LVL PSYCH, LCMHC, LICSW, LPC, LMFT - LICENSED PSYCHOLOGIST/SOCIAL WORKER
- MSTR LEVEL PSCY, LCMHC, LICSW, LPC, LMFT - MARRIAGE FAMILY THERAPIST
- NURSING HOME - MEDICARE NON-PARTICIPATING
- NURSING HOME - MEDICARE PARTICIPATING
- NUTRITIONAL EDUCATORS - DIABETIC COUNSELORS
- NUTRITIONAL EDUCATORS - REGISTERED DIETICIANS
- PERSONAL CARE SERVICES - PERSONAL CARE SERVICES
- PSYCHOLOGIST - DOCTORATE - CLINICAL PSYCHOLOGIST/PHD
- PSYCHOLOGIST - DOCTORATE - INDEPENDENTLY BILLING PSYCHOLOGIST
- PTF PSYCH RESIDENTIAL FACILITY - PSYCHIATRIC
- PT-OT-SLP - OCCUPATIONAL THERAPY
- PT-OT-SLP - PHYSICAL THERAPY
- PT-OT-SLP - SPEECH PATHOLOGIST
- STATE DEFINED ADAP FACILITY - SUBSTANCE ABUSE TREATMENT SERVICES
- STATE DEFINED ADULT DAY FACILITY - REHABILITATION
- STATE DEFINED CASE RATE AGENCY - STATE DEFINED CASE RATE SERVICES

- STATE DEFINED CHILDREN AND FAMILY WAIVER CLINIC - STATE DEFINED COMMUNITYBEHAVIORAL HEALTH SERVICES
- STATE DEFINED DEPARTMENT OF EDUCATION - PUBLIC HEALTH AGENCY
- STATE DEFINED INDEPENDENT AGING AND LIVING WAIVER - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES
- STATE DEFINED INDIVIDUAL CASE MANAGER - CASE MANAGEMENT
- STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY - CASE MANAGEMENT
- STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY - REHABILITATION
- STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY - RESIDENTIAL TREATMENT SERVICES
- STATE DEFINED RESIDENTIAL CARE WAIVER - MEDICARE NON-PARTICIPATING
- STATE DEFINED RESIDENTIAL CARE WAIVER - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES
- STATE DEFINED TARGETED CASE MANAGEMENT - CASE MANAGEMENT
- STATE DEFINED VOCATIONAL REHAB AGENCY - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES
- STATE DESIGNATED CHILDRENS MEDICAL SERVICES - PUBLIC HEALTH AGENCY
- STATE DESIGNATED INTELLECTUAL DISABILITY CLINIC - STATE DEFINED INTELLECTUAL DISABILITY SERVICES
- STATE DESIGNATED MH CLINIC - COMMUNITY BEHAVIORAL HEALTH
- WAIVER CASE MANAGER - AGING AND ADULT - STATE DEFINED COMMUNITY BEHAVIORAL HEALTH SERVICES

What is the zip code of the location or site you work at?

- [Free text field configured to accept zip code format only]

How are client records collected and stored at your organization?

- Certified Electronic Health Record (EHR) technology
- Non-certified Electronic Health Record (EHR) technology
- Other Care Coordination/Practice Management software
- Offline Documentation (paper charts/local files)
- Other (Please describe below)

[If the respondent indicated that they utilize Offline Documentation to maintain client records in the previous question, the following question is <u>not</u> presented.] **What EHR or other health IT solution vendor do you currently use?**

- Allscripts (Altera)
- Amazing Charts
- AthenaHealth
- Cerner
- Credible

- Dentrix
- Eaglesoft
- eClinicalWorks
- Epic
- Greenway
- iCanNotes
- McKesson
- Medent
- Meditech
- MyClientsPlus
- NetSmart
- NextGen
- PointClickCare
- PracticeFusion
- Simple Practice
- Theranest
- TherapyNotes
- VistA/CPRS
- Other (Please enter your vendor below)

Do you experience significant difficulty or challenges with your current client record management system?

- No
- Yes (please describe below)

[If the respondent indicated that they utilize Offline Documentation to maintain client records, the following question is presented.] **If you/your organization does not use an electronic health record system, please select the factor(s) that led to this decision. Select all that apply:**

- Financial limitations – Lack of funds for initial investment
- Financial limitations – Lack of funds for ongoing maintenance of system
- Technology limitations – Lack of adequate internet connectivity or hardware
- Not confident EHR will lower cost or improve quality
- Lack of support staff – IT/Technology/Administrative
- Privacy concerns
- Unsure which EHR system to purchase
- Lack of available EHR systems that support my specialty
- Perceived little or no value to provider(s)
- Perceived little or no value to clients or patients
- Not sure
- Other (Please describe below)

VITL (pronounced "Vital") is the non-profit organization that operates the Vermont Health Information Exchange. VITLAccess is VITL's secure, web-based clinical portal that enables authorized users to view clinical data submitted to the Vermont Health Information Exchange from

participating health care organizations. Do you use VITLAccess to view health records on your clients that are available in the Vermont Health Information Exchange?

- Yes
- No

[If the previous question was answered "no", the following question is presented.] **Would you be interested in receiving training to acquire and understand how to use VITLAccess as part of this proposed incentive program?**

- Yes
- No

[If the question about VITLAccess usage was answered "yes", the following question is presented.] **How does VITLAccess benefit your clients? (Select all that apply)**

- Leads to a more accurate patient medical history
- Supports trauma-informed care by providing medical histories in situations where recounting past history may be re-traumatizing to the client
- Supports shared care planning
- Saves time by providing ease of access to records from multiple providers
- Facilitates improved communication with clients and other providers of care
- Supports improved quality of care and outcomes
- Eliminates redundant or unnecessary testing
- Other (Please specify below)

[If the respondent indicated they do <u>not</u> utilize an EHR, the following question is <u>not</u> presented.] **Does your organization's EHR electronically send health data to the Vermont Health Information Exchange (VHIE)?**

- Yes
- No

[If the previous question was answered "yes", the following question is presented.] **What information is sent from your/your organization's EHR to the Vermont Health Information Exchange (VHIE)?**

- ADT (Admission, Discharge, Transfer information)
- CCD (Continuity of Care Document) or Transition of Care
- Visit or treatment notes
- Laboratory or other diagnostic test results
- Immunization data
- Other (Please specify below)

[If the respondent indicated that their EHR does <u>not</u> send health data to the VHIE, the following question is presented.] **Please indicate if any of the following issues are barriers to sharing electronic data with the Vermont Health Information Exchange (VHIE). Select all that apply**.

- Cost associated with VHIE interface development from your EHR vendor
- Limited technical resources/staff expertise to set up this integration
- Concerns regarding client privacy and data sharing policies for VHIE members

- Provider burden to learn new workflow and access VHIE in addition to EHR functions
- Little interest in accessing client data available in VHIE
- Providers close to retirement, unwilling to learn new workflow
- None of the above
- Other (Please describe below)

Please rate your agreement with the following statement: I/my organization would be interested in participating in a future incentive program to support my/my organization's adoption, upgrade, or ongoing use of certified electronic health record technology or other technology to connect to the Vermont Health Information Exchange.

- Definitely
- Probably
- Possibly
- Probably Not
- Definitely Not
- Not applicable

[If the previous question was answered with "Definitely", "Probably", or "Possibly", the following question is presented.] **In what area(s) would you/your organization need the most support in order to participate in a future electronic health record incentive program? (Adjust the slider to denote the level of assistance you believe you/your organization would require in each area below. A "0" means no assistance would be required while a "5" means significant assistance would be needed.**

- Provider outreach services to contact and enroll eligible program participants
- Practice readiness assessment for EHR or other health information technology implementation
- Provider/infrastructure/hardware needs assessment for EHR or other health information technology implementation
- Identifying, selecting, and installing a certified EHR system that connects to Vermont Health Information Exchange
- Identifying, selecting, and installing care coordination or care management software that connects to Vermont Health Information Exchange
- Identifying, selecting, and installing some other Health Information Technology (HIT) tool that connects to the Vermont Health Information Exchange (VHIE)
- Security risk assessment
- Initial and ongoing user training services
- Onboarding and connecting to Vermont Health Information Exchange
- Guidance on consent/privacy issues
- Documenting and reporting provider/program participation status

Would you be willing to participate in a focus group or interview in order to provide additional information to the incentive program development team?

- Yes
- No

Please provide any additional thoughts, comments, or feedback you feel would be useful to consider.

- [Large free text field to type narrative response]

Thank you for your feedback. Please provide your contact information below in order to be eligible to receive a $50 gift card that will be provided to the first 500 survey respondents. Important respondents. Important Note: Gift cards for eligible participants will be sent to the email account that originally received the survey invitation message.

- [Text fields provided to capture First Name, Last Name, and Email Address]

APPENDIX B: FOCUS GROUP SCREENING QUESTIONNAIRE

What organization or practice do you work for? (If you work for multiple organizations, list each.)

- Text field to capture narrative response

What is your title or role in your organization? (List all titles/roles if you work in multiple organizations.)

- Text field to capture narrative response

How many independently billing HCBS providers work in your organization/practice? Please do not include the following provider types: physician, dentist, certified nurse midwife, nurse practitioner, physician assistant, podiatrist, optometrist, chiropractor, or pediatrician.

- Single provider
- 2 - 5 providers
- 6 - 10 providers
- More than 10 providers

Do you personally provide billable health services to clients?

- Yes
- No

[If the previous question was answered "yes", the following question is presented. **] What is your provider type or specialty?**

- Text field to capture narrative response

Focus group sessions will be 60-90 minutes in length. What day(s) of the week and time(s) of day would work best for you to attend an online focus group? Check all applicable options below.

	Morning (8 AM - 12)	Noon (12 - 1 PM)	Afternoon (1 - 5 PM)	Evening (After 5PM)
Monday	☐	☐	☐	☐
Tuesday	☐	☐	☐	☐
Wednesday	☐	☐	☐	☐
Thursday	☐	☐	☐	☐
Friday	☐	☐	☐	☐

If applicable, please add any comments that are relevant to further explain your days and times of availability.

- Text field to capture narrative response

APPENDIX C: FOCUS GROUP QUESTIONS

The following set of questions was utilized as the basis for facilitating the nine focus groups. Some questions were altered slightly depending on the group make-up (i.e., types of providers, providers vs. IT/Leadership participants, EHR vs. non-EHR users, etc.)

1. Intro Question: I'd like each of you to introduce yourself by telling us your name, where you work, and your title or role within the organization.

2. Intro Question: What client/patient workflows do you capture in your EHR or other electronic records system? (e.g., registration, scheduling, clinical documentation, billing, etc.)

3. How is training provided to staff that use your EHR or other records system?

4. What are the main benefits of your EHR or other records system?

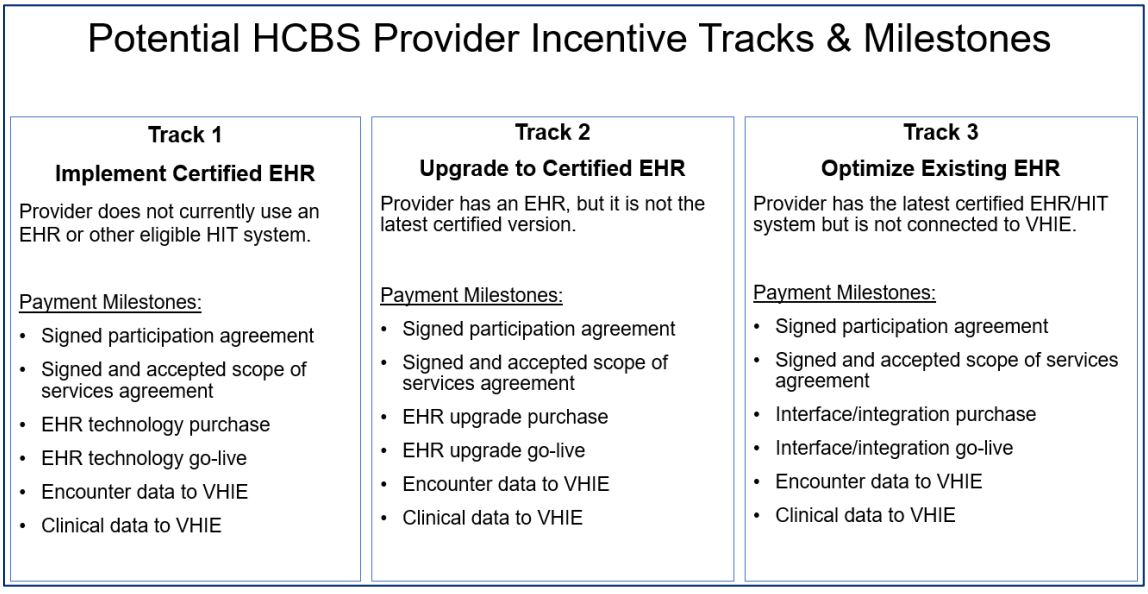
5. What are the main challenges with your EHR or other records system?

6. *[Question for participants who do not utilize an EHR system]* If you do not use an EHR system, what are the main reasons you have not purchased one?

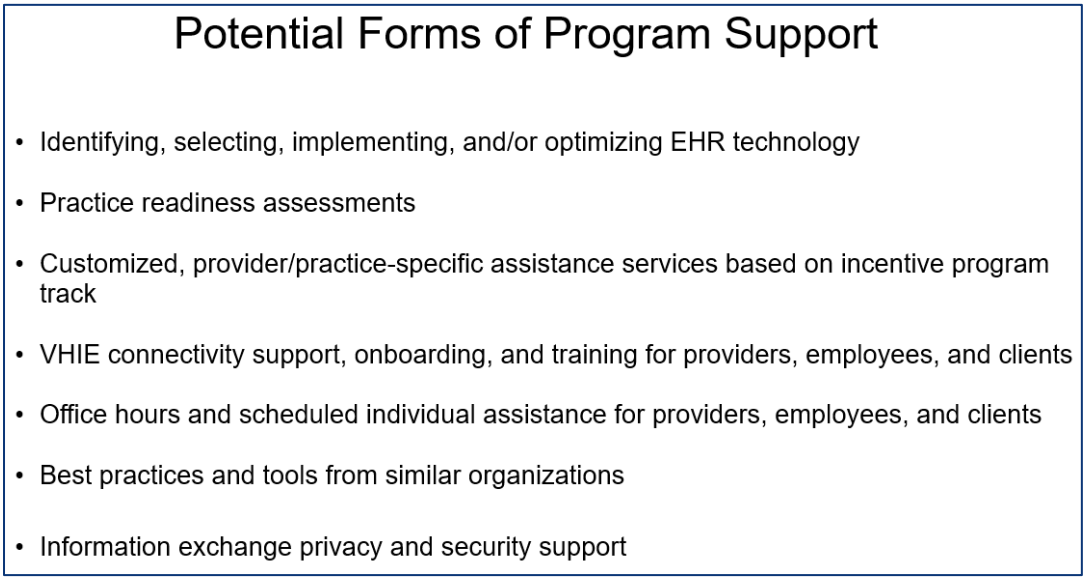
7. How is your EHR or other records system managed by your organization? For example, how are staff added to or removed from the system; how are reports created or modified; how is system configuration managed?

8. What potential barriers, if any, might you foresee in electronically connecting your EHR and sharing data with the VHIE?

9. I'm going to display a slide that contains potential participation tracks and milestones for this incentive program. This is preliminary at this point, but under each track, a provider or provider organization would receive monetary incentives at the successful completion of each milestone. What are your thoughts and opinions on these potential tracks and milestones? *[See slide below.]*



10. I'm going to display a second slide that shows potential forms of program support that may be available under this incentive program. What are your thoughts and opinions on these potential forms of assistance for incentive program participants? *[See slide below.]*



11. What client/patient information do you routinely request from other providers of care? Phrased differently, what client information would be of significant value if it were available to you through VHIE?

12. Have you or others in your organization recently researched the possibility of switching EHR vendors or implementing an EHR system? If so, what prompted this research?

13. Concluding Question: Reflecting on all the discussion today, what do you feel is the most important feedback or concern shared?

14. Concluding Question: What question or topic did we not cover that we should have?