



**Vermont Health Care Innovation Project  
DLTSS Work Group Meeting Minutes**

**Pending Work Group Approval**

**Date of meeting:** Thursday, April 30, 2015, 10:00am-12:30pm, Pavilion Building - 4th Floor Conf Room, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
<p><b>1. Welcome, Approval of Minutes</b></p>	<p>Judy Peterson called the meeting to order at 10:03am. A roll call attendance was taken and a quorum was present.</p> <p>Judy Peterson entertained a motion to approve the February 19, 2015, meeting minutes. Ed Paquin moved to approve the minutes by exception. Mike Hall seconded. The minutes were approved with three abstentions.</p> <p>Ed Paquin moved to approve the March 26, 2015, minutes by exception. Mike Hall seconded. The minutes were approved with two abstentions.</p>	
<p><b>2. Review DLTSS Year 2 Work Plan</b></p>	<p>Deborah Lisi-Baker introduced the DLTSS Work Group Year 2 Workplan. She noted that many of the contents will look familiar to group members, and opened a discussion about the workplan contents. Julie Wasserman described each workplan category and objective.</p> <p>Quality and Performance:</p> <ul style="list-style-type: none"> <li>• Mike Hall asked whether this workplan includes developing measures for home- and community-based services (HCBS), within or outside VHCIP’s Medicaid and Commercial Accountable Care Organization (ACO) activities. Julie Wasserman noted that the Agency of Human Services (AHS) has just completed consolidation of the Global Commitment and Choices for Care waivers; Shawn Skaflestad is leading measures-development work for the new consolidated waiver. The workplan does include providing input into waiver measure development as an activity (Workplan item 6). Mike Hall noted that this is a new and evolving area, and that conversations about how DLTSS providers payment models will not be confined to an ACO model in the future, and that this area deserves our attention as we prepare for that change.               <ul style="list-style-type: none"> <li>○ Dale Hackett asked whether there was a reason that that this was not included in the workplan. Deborah indicated that the involvement in the waiver consolidation measures process is an attempt to proactively work on this issue.</li> </ul> </li> </ul>	<p><b>Sue Aranoff will inquire about a DAIL presentation on plans to implement new CMS Home and Community-Based Services (HCBS) regulations; she will follow up with Deborah Lisi-Baker and Jackie Majoros to clarify the request.</b></p>

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	<ul style="list-style-type: none"> <li>○ Barb Prine suggested including this as a separate item and moving the expected date sooner to ensure input is included in the process. Julie responded that AHS set this timeline based on expected activities, that we do know what the current system of care is, and could come up with broad-based measures; and that Shawn Skaflestad has noted that Year 1 consolidated waiver measures will be broad and easy to capture.</li> <li>○ Jackie Majoros noted that there are other initiatives within DAIL that are looking at closely related issues, such as coming into compliance with new HCBS regulations. Jackie believes this is a bigger issue, and could be broken down into parts and some discussed sooner. Sue Aranoff asked whether the group wants a presentation from someone at the Department of Disabilities, Aging, and Independent Living (DAIL) at the May meeting. Barb agreed that this would be helpful. Sue will inquire.</li> <li>○ Mike Hall noted that while we may have an opportunity to comment on a quality measures draft developed by DAIL or AHS, that this is a critical issue and this group’s approach should not be reactive; we should be shaping quality measures and making it part of the construct we’re trying to develop for long-term services and supports. Mike would not be opposed to forming a sub-group to work on this, and to making this a separate workplan item.</li> <li>○ Susan Besio asked whether the Work Group members’ comments were about the quality measures or about broader programmatic things that DAIL is doing to respond to the new HCBS regulations. Barb Prine described the multiple pieces of the new regulations. Susan Besio asked whether the suggestion was to add an activity looking more broadly at quality of services; Barb clarified that this conversation about the new HCBS regulations is more broad than quality of services, and looking at bigger questions of settings and integration. Jackie Majoros noted that this will be challenging before DAIL has defined the parameters. She referenced several DAIL memos have come out but that seem fragmented to her, and noted that it would be helpful to get something from DAIL in writing to summarize what their plan is going forward. Deborah Lisi-Baker noted that a lot of this conversation is based on federal guidance and rules for HCBS. She wants to make sure we can have a proactive dialogue and have input into these services; she suggests working with Sue to get guidance on DAIL’s plan, and noted that some of this was included in Monica Light’s presentation on the consolidated waiver at the March meeting of the DLTSS Work Group. Julie Wasserman noted that Mike Hall has defined this effort as broader than quality. Deborah suggested that an informal sub-group could also meet before the next meeting.</li> <li>○ Sue Aranoff suggested that there is the VHCIP Quality and Performance Measurement Work Group, and that there are also broader quality and measurement activities that this group would like to be involved in and provide input for. Deborah Lisi-Baker pointed out this is already in the DLTSS Work Plan as item #1.</li> <li>○ Mike Hall, Kirsten Murphy, Joy Chilton, Ed Paquin, Mary Alice Bisbee, Molly Dugan, Marlys Waller, Jackie Majoros, Pat Jones, and Sue Aranoff volunteered to participate in a sub-group.</li> </ul>	<p><b>Deborah Lisi-Baker will request written comments from DAIL on their plans to address the new HCBS regulations.</b></p> <p><b>A small sub-group will meet before the next meeting to discuss HCBS measures.</b></p>

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	<p>Care Models and Care Management: Julie commented that the DLSS Work Group is working closely with the Care Models and Care Management (CMCM) Work Group in Year 2, and noted that the Steering Committee recommended approval of expansion of the Integrated Communities Care Management Learning Collaborative to new communities yesterday.</p> <p>Payment Models: Julie noted that DLSS issues feature heavily in this section as well.</p> <p>Population Health: Julie commented that the Population Health Work Group’s activities focus on population health and prevention, as well as payment models to support these activities.</p> <ul style="list-style-type: none"> <li>• Mike Hall is interested in the potential All-Payer Waiver and possible future global payment models. He noted that hospitals are at the center of these methodologies that are based in hospitals and hospital-owned ambulatory practices. He suggested that there has been minimal discussion of how a global payment model would impact the rest of the delivery system. He asked how we expect hospitals to get the outcomes they are charged with and meet performance measures without talking about how money will flow to the rest of the delivery system. He would like to surface those issues and be able to have the DLSS Work Group engage Richard Slusky, Lawrence Miller, and others to ask those questions about the potential All-Payer Waiver and other potential future models. Julie Wasserman mentioned the recent CMCM Work Group presentation by Mike and other HCBS providers and suggested that he and his colleagues present to the Core Team. Mike has contacted the Core Team to offer that.</li> <li>• Kirsten Murphy requested more information about the objective to provide recommendations to address payment issues and barriers relevant to DLSS populations and providers, and asked that the cultural barriers also be addressed. Julie Wasserman suggested this would be discussed during today’s agenda item #3.</li> </ul> <p>Health Information Exchange (HIE) and Health Information Technology (HIT):</p> <ul style="list-style-type: none"> <li>• Mike Hall commented that the historical approach to integrating LTSS providers into HIE/HIT has been very primitive, but that work at the federal level is starting to address this. He suggested having a presentation from the Demonstration Program for Testing, Experience, and Functional Tools (TEFT), a project of the Centers for Medicare &amp; Medicaid Services (CMS). He worries that we are moving toward integrated delivery systems but that ability for some provider types to participate is limited by technology capabilities.</li> <li>• Joy Chilton commented that HIT also impacts providers’ ability to address quality measures.</li> <li>• Kirsten Murphy noted that true accessibility of personal health records is a particular issue for people with intellectual and other disabilities.</li> </ul> <p>Ongoing Education and Updates: Julie noted that coordination and collaboration with other Work Groups is critical.</p> <ul style="list-style-type: none"> <li>• Sam Liss thanked Mike Hall for his very constructive input.</li> </ul>	

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<p><b>3. DLSS/CMCM Collaboration on Learning Collaborative; and DLSS-Specific Core Competency Curriculum Development and Training</b></p>	<p>Deborah Lisi-Baker provided an update on work the DLSS Work Group is doing in partnership with the CMCM Work Group’s Integrated Communities Care Management Learning Collaborative. (See Attachment 3.)</p> <ul style="list-style-type: none"> <li>• The DLSS Work Group is developing a series of briefs on disability competencies, and intends to release an RFP for a contractor to provide DLSS-specific core competency training to align with the care management professional core competency training planned through the Learning Collaborative.</li> <li>• Susan Besio is working on disability awareness briefs that will act as background materials on particularly relevant topics. Susan commented that the topics include cultural competency, accessibility, universal design, disability competency for providers, and disability competency for care management professionals. The briefs will be 6-8 pages and relatively brief, and provide information based on literature and concrete examples. The intent is to distribute the briefs broadly. <ul style="list-style-type: none"> <li>○ Dale Hackett asked which disabilities will be included in this brief. He also suggested that accessibility issues are not always physical. Susan Besio responded that the briefs are quite comprehensive and use broad definitions for disability, accessibility, and other terms, but they are a starting point and she welcomes feedback from this group.</li> <li>○ Mike Hall noted that there have been discussions of widespread use of community health workers (CHWs) in the state, but that these discussions have not gone far, in part because of questions about how CHWs would be licensed, certified, educated, etc, and because of provider fears of how CHWs will interact with current staffing models. He suggested we come back to some of the original purposes of CHWs, which are to add cultural competency on the ground, rather than retraining existing providers. He noted that CHWs are specifically referenced in the ACA. The concept was initially developed to better serve disenfranchised populations by deploying individuals from within the community to work with individuals on the ground.</li> <li>○ Pat Jones noted that core competency training in the care management learning collaborative setting is intended to apply to all types of people with various degrees and training.</li> <li>○ Kirsten Murphy suggested that this group seek input from self-advocacy groups. Deborah Lisi-Baker replied that this would be very welcome. Kirsten suggested it might be helpful to have people with disabilities present their reactions themselves. Deborah replied that this would be welcome but that the briefs would need to be translated for each audience. Susan Besio also noted that these briefs are intended to be high-level.</li> <li>○ Barb Prine suggested that cultural competency is a particularly complex issue and invited Susan to contact her as she writes the brief.</li> <li>○ Jackie Majoros asked whether the briefs would address the issue of competency across all long-term care settings (including nursing homes), which may have different issues than community settings. Susan Besio replied that this may be an area where it would be very helpful to get input from Jackie when the Work Group members review the briefs.</li> <li>○ Dale Hackett suggested that the briefs be written in lay terms so that they are understandable by people with disabilities. Deborah Lisi-Baker suggested that translation will be important for different audiences and purposes. Julie Wasserman noted that these briefs will be the master</li> </ul> </li> </ul>	

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	<p>version, and information can be drawn out to create materials for specific audiences.</p> <ul style="list-style-type: none"> <li>○ Mary Alice Bisbee noted that fear and paranoia are two things we are dealing with in these cultural competencies.</li> <li>○ Mary Alice Bisbee noted that fear and paranoia are two things that are relevant when considering cultural competencies.</li> <li>○ Mike Hall noted that cultural competency within managed care organizations is a rising issue across the country as implementation of managed LTSS spreads. He noted that the DLTSS-specific core competency training effort is very relevant to this – this work is potentially very relevant to managed care contract language and expectations around the country. <ul style="list-style-type: none"> <li>▪ Sue Aranoff noted that language around cultural competency and accessibility is part of the current Medicaid ACO SSP contract negotiations.</li> </ul> </li> </ul> <p>At the end of this agenda item, Nicole LeBlanc introduced herself and noted that she will be attending meetings with Kirsten Murphy throughout 2015 as a guest from Green Mountain Self-Advocates.</p>	
<p><b>4. Caledonia &amp; Southern Essex Dual Eligible Project</b></p>	<p>Treny Burgess (North Countries Health Care) and Pam Smart (Northeastern Vermont Regional Hospital) presented on the Northeast Kingdom Dual Eligible Project (see Attachment 4). Pam and Treny noted that this project builds on past work with people dually eligible for Medicare and Medicaid in Vermont, as well as the Blueprint Community Health Team infrastructure. This project is the recipient of a VHCIP provider grant, and the St. Johnsbury community is also participating in the Integrated Communities Care Management Learning Collaborative, which is helping to further develop multi-disciplinary community teams to deliver person-directed, team based care.</p> <ul style="list-style-type: none"> <li>● Provider grant funds are focused on working directly with patients: First hire was a health coach, who works directly with patients to connect them to services and address social determinants of health.</li> <li>● All dual eligibles can participate in the provider grant program, however; for the purposes of the Learning Collaborative, a subset of about 25 people was chosen to start.</li> <li>● Person-directed care: Working with patients to identify barriers to patient goals and develop a plan of service that is responsive to patient needs and priorities.</li> <li>● How does this overlap with the Learning Collaborative? The interventions being tested in the learning collaborative have the potential to improve care management for all, especially the often complex dual eligible population. In addition to these interventions, the provider grant has allowed them to offer additional services such as a health coach, as well as flexible funding to support participants in the dual eligible provider grant program.</li> <li>● Pam described the process of identifying possible participants and gaining patient consent and buy-in. There are still many dual eligibles in the program’s catchment area who are not touched by this program, but the program is reaching new people all the time.</li> <li>● Many agencies are working together on this project. Agencies share a common release form to support information sharing. There have been some barriers to information sharing.</li> <li>● Treny and Pam distributed copies of intake forms, shared care planning forms, and Camden Cards used to</li> </ul>	<p><b>Joelle Judge will distribute handouts via email.</b></p>

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	<p>guide discussions with patients and develop a care plan based on the person’s priorities.</p> <ul style="list-style-type: none"> <li>• Developing relationships between patients and key care coordinators has been one of the most effective strategies; relationship building between agencies has also been a critical step and has allowed local agencies to better collaborate and serve patients. Provider communication and information sharing are still barriers, but are improving.</li> <li>• Some individuals in this program do have Medicaid-funded long-term care.</li> <li>• The program has some flexible funds to be used when Medicare, Medicaid, and other funding sources are not available.</li> </ul> <p>Pam and Treny closed their presentation with a series of case studies.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> <li>• Sue Aranoff suggested a presentation from a participant in this program would be very interesting. Pam noted that she’s hesitant to put participants through a stressful experience if they are not ready, but that participation by teleconference may be an option.</li> <li>• Dion LaShay suggested that other communities around the state would benefit from similar programs. Erin Flynn responded that there is a proposal before the Core Team on Monday to expand the Care Management Learning Collaborative to other communities in the state that are interested in participating, however the dual eligible provider grant is unique to the St. Johnsbury community.</li> <li>• Sam Liss thanked Pam and Treny for this presentation. He suggested that the term “patient” is loaded, and that terms like “client” might be more sensitive. He also asked whether the program works to support employment. Pam responded that yes, it does.</li> <li>• Mary Alice Bisbee noted that language is very important (“elders” vs. “the elderly”). She suggested “care management” rather than “case management.” Nicole LeBlanc suggested “service coordination” as another possible term.</li> </ul>	
<p><b>5. Update on DLTSS Gap Analysis/ Technology Assessment and Remediation (ACTT)</b></p>	<p>Beth Waldman (Bailit Health Purchasing) provided a brief update on the DLTSS Gap Analysis/Technology Assessment and Remediation Project, formerly a part of the Advancing Care Through Technology (ACTT) project (it is now a separate project). Elise Ames from HIS Professionals is the lead contractor for this project; it is in part an update of technology assessments Elise performed with various types of DLTSS providers in 2012 and 2013, and also new assessments of providers who had not been previously included. Elise sought to understand how different provider types used technology to support their work, barriers/challenges, and next steps/needs. She found broad variation across DLTSS providers; most often, providers used technology to support care coordination and care planning, but could not share information with other providers. Elise also surfaced key issues to think about in coming months.</p> <p>There will be a more substantial presentation on this project, including the final report and recommendations for next steps, at a future meeting (likely June 2015).</p>	
<p><b>6. Public</b></p>	<p>Public comment:</p>	

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<p><b>Comment/Next Steps</b></p>	<ul style="list-style-type: none"> <li>• Relevant to Item #4, Barb Prine commented that given how much success the St. Johnsbury community has met with their Dual Eligible Provider Grant, it is unfortunate that this model is not currently available to all communities across the state.</li> <li>• Dale Hackett noted that different communities have different needs.</li> <li>• Deborah Lisi-Baker suggested that lessons from these pilots can support learnings that will help shape how we pay for DLTSS services in the future.</li> <li>• Sue Aranoff suggested that a presentation from another community participating in the Learning Collaborative could be helpful to tease out the impact of the provider grant vs. the Learning Collaborative.</li> <li>• Erin Flynn noted that organizations performing care management have been presenting to the CMCM Work Group over the past year, and that lessons from these presentations are being compiled. Two key challenges have been sharing of information and the lack of payment mechanisms to support care management activities.</li> <li>• Nicole LeBlanc asked whether Medicaid is examining cost savings due to use of flexible funds. Pam noted that the team in St. Johnsbury is trying to document this but it can be challenging to document savings.</li> <li>• Mike Hall suggested that compiling lessons learned so they can be embedded in the design of the next payment model. He gave the example of Home Share Vermont.</li> </ul> <p><b>Next Meeting:</b> Thursday, May 28, 2015, 10:00am-12:30pm, EXE - 4th Floor Conf Room, Pavilion Building, DVHA Large Conference Room, 312 Hurricane Lane, Williston.</p>	