Attachment 1a - DLTSS Meeting Agenda 10-09-14

VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, October 9, 2014; 10:00 AM to 12:30 PM

DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00 – 10:10	**Welcome; Introductions; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from July 24, 2014 • Attachment 1c: Minutes from September 11, 2014	 Yes Yes
2	10:10 - 10:40	**DAIL - Developmental Disabilities Services: Participation in the National Core Indicators Project** June Bascom, DAIL	• Attachment 2: National Core Indicators 2013	
3	10:40 – 11:40	**DLTSS-Specific Core Competency Domains for Health Care Service Providers** Deborah Lisi-Baker	• Attachment 3: DLTSS Core Competency Domains 10-2-14	
4	11:40 – 11:55	**ACTT Project Update** Brendan Hogan	• Attachment 4: ACTT Program Update 9-24-14	
5	11:55 – 12:10	**Update on SIM Operations Plan as it relates to the DLTSS Work Plan** Deborah Lisi-Baker and Judy Peterson	• Attachment 5: DLTSS Work Plan	
6	12:10 – 12:30	**Public Comment/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: November 6th 10:00 am - 12:30 pm Williston	

Attachment 1b - DLTSS Meeting Minutes 7-24-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday July 24th, 2014, 10am – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1 Welcome; Introductions; Approval of Minutes	Judy Peterson kicked of the meeting at 10:05, welcomed the work group and moved to approval of the June meeting minutes. Kristen Murphy made a motion for approval and Jeanne Hutchins seconded. Nelson LaMothe collected a vote via roll call. The June meeting minutes were approved unanimously.	
2 DLTSS Quality and Performance Measures	Deborah Lisi-Baker began discussion of this agenda item and welcomed Catherine Fulton and Alicia Cooper from the Quality and Performance Measures (QPM) Work Group. Catherine Fulton indicated that the QPM work group plans to make decisions on the year 2 Medicaid and Commercial ACO SSP measures at their in person meeting on July 29th, and are accepting written comment on the proposals up until Monday July 28th. Catherine requested that comments from DLTSS work group members be submitted in writing. Catherine then reviewed all relevant attachments 2a, 2b, 2c and 2d. She discussed the work group's process for making recommendations and noted that the work group used agreed-upon criteria to score all of the proposed measures. In addition to scoring the measures against criteria, the process for approval of these recommendations will include review of written stakeholder comments and work group discussion. The QPM work group plans to finalize recommendations by September 30th and issue new measure specifications by	

Agenda Item	Discussion	Next Steps
	October 31st. Right now they are on track to meet these deadlines. They have not discussed targets and benchmarks, but this work will begin at an upcoming QPM work group meeting. Discussion ensued and the following comments were made: • Barbara Prine asked for clarification as to why the QPM work group did not accept all of the DLTSS recommendations. Catherine replied that the criteria and work group discussion was used to score each recommendation, and those that did not make it through likely did not have high enough scores. • Kirsten Murphy asked for clarification about developmental screening in the first three years of life, CDC guidance says that it should include counseling. Is this included in this measure? Alicia Cooper replied that the specifications are specific to the screening process and don't include a component of follow-up. This is an NQF-endorsed measure and is also used by CHIPRA. The work group did not review a measure that includes the screening component. • Barbara Prine asked for further clarification of the scoring methodology, and why some recommendations with low scores were still recommended. Catherine replied that the scoring process included a possible 16 points across all of the criteria. Regarding the recommendations, SBIRT is being recommended for monitoring and evaluation and is already being collected in the State. The second recommendation with a low score is for the DLTSS custom survey questions, which would be easier to incorporate than some of the other measures. Regarding those measures that were not recommended for status change, the QPM work group hopes that the work of VITL and other work groups will hopefully make collection more feasible in the near future. • Julie Tessler asked if there is another substance abuse measure that could be incorporated into the program other than SBIRT. Alicia responded that there wasn't an immediately available measure that was nationally recognized and approved that they were aware of, but that this could be possible in the future. • Barbara Prine commented that it is discouraging to say that since it hasn't been done, we can't do it, even though we recognize that it needs to be done and is important. • Madeleine Mongan asked for clarification on how the QPM work group is looking to incorporate the changes to MSSP measures. Catherine replied that they are looking	

Agenda Item	Discussion	Next Steps
	into it. Madeleine also commented that we need to recognize that at the current point in time, reporting can be burdensome. Hopefully EHR and HIE efforts will lighten this load. Furthermore, we have to have a threshold of data that is high quality and actionable. Catherine followed up by saying that this work is building a solid foundation upon which we can expand measurement efforts. • Vicki Loner commented that measures reporting can be extremely burdensome and recalled that some of the practices in OCV's network had to close for a day to do records extraction during the MSSP measure reporting process. • Jackie Majoris asked for clarification on how pending measures are considered by the groups working on HIT/HIE development. Alicia responded that VITL will be invited to QPM to give an update on their efforts to build the systems that will make collection of the ACO measures more feasible. The results of the gap analysis work that VITL is doing will be available soon and will help determine next steps. • Brendan Hogan commented that additional gap analyses will be funded through the ACTT proposal in nursing homes, designated agencies, and home health agencies. Another component of ACTT is to look at DLTSS measures and get a better sense of how the IT challenges to collecting data for DLTSS measures can be improved. • Rachel Seelig asked for clarification on how unknown information about "Opportunity for Improvement" factored in to measure scoring using the criteria. Alicia responded that scoring was based on State data for recent years. Rachel asked if there was a process to do a percentage scoring so a measure wouldn't be negatively impacted for not having past information. She also asked for clarification as to why blood pressure measures were not included. Cathy and Alicia responded that neither blood pressure measure was considered a priority candidate at this time, but that they welcomed written comment on any specific measures to be considered at the upcoming QPM meeting. • Joy commented that is important to consider administrative burden. Although we want to collect and measure as much as we can, there is a cost associated with all of this work. We have to find a balance between spending funds on data collection and spending funds on providing services. Deborah agreed and said that is why the work of creating electronically reported data is so important. • Judy Peterson asked if the group had considered any measures around Adverse Child Experience (ACEs). Catherine commented that the population health work group also	

Agenda Item	Discussion	Next Steps
	brought this consideration forward. Catherine said that right now it is so new that it is difficult to report, but that it is on the work group's radar and will continue to be considered. Deborah asked if DLTSS work group members chose to submit formal recommendation to the QPM work group, that they cc Erin and Julie so we can keep the co-chairs informed.	
3 AHS Survey Results	Deborah began reviewing this agenda item by drawing the work group's attention to attachment 3, AHS survey presentations – common format. Susan Besio reviewed the history behind this template and indicated that the work group had previously discussed the desire to learn more about AHS surveys and how they might inform the work group's goals. This is a proposed format that will ensure consistency amongst presenters. Discussion ensued and the following comments were made: • John Barbour commented that from an AAA perspective, only about 1/3 of the CFC population completes these surveys. It would be helpful to continue to expand the populations represented in these surveys. Deborah commented that this is exactly the type of recommendation she would hope would come out of this work. • Julie Tessler also supported this comment and said that the results may be skewed due to missing populations (such as the uninsured). • Brendan Hogan added that the state plan on aging includes the goals of AAA's and how they performed against these goals. This could be a good source of information. • Madeleine Mongan asked if VDH surveys were included. Susan responded that not at this point as they are more population based, and this group chose to focus on DLTSS based, but that they could be included if the work group chooses. • Jackie Majoris commented that in many cases it is not the (for example) nursing home resident who is completing the survey. It may be interesting to find a way to get a sense of who is actually completing the survey. • Judy Peterson asked if there is a way to judge the validity of all of the survey tools. Susan suggested adding a point about survey validity on the template. • Barbara Prine noted that after we have had a few presentations, we might have a better sense of how we could change the template to better collect the information. • Jackie Majoris suggested that we may want to judge the applicability of the surveys to	

Agenda Item	Discussion	Next Steps
	the general population as so many of them are service specific. Susan reminded the group that this framework is for the presenters to use. • Marie Zura commented that a 5 month time frame may be too stretched out to effectively retain information and make analysis and maybe the presentations could be shortened. Susan responded that it seems that the work group may want to have discussion regarding the findings and applicability of the surveys, and that we want to be sure we allow the necessary time for those conversations. • Madeleine Mongan recommended that in order to facilitate ease of discussion, numbers 1 and 2 could be received before the meeting and that a separate document tracking common elements from each presentation could be developed in order to track the discussion over time. • Barbara Prine asked for clarification on what the group may or may not do based on the results of this work. Deborah responded that there is information out there that may or may not be used, and once we see what it is we will have a better sense of what to do with it. • Joy commented that this exercise would provide information on the efficacy of long term services and supports, and if this group is going to make recommendations on how those services are delivered, this information would be helpful. Joy echoed that she would like to look at the tools side by side to compare and contrast.	
4 DLTSS Recommendation for Criteria for Second Round of Provider Grant Program	Georgia began review of this agenda item by summarizing the activity of the last core team meeting and indicated that the second round provider grant RFP will go out today and that decisions will be made by September 4th. As described in attachment 4, based on work group feedback to the Core Team, the provider grant application was edited to include four additional points. Furthermore, the additional recommendations will be included in the core teams scoring sheets. Georgia clarified that the reason this distinction was made is because the core team wanted to keep the application broad enough that they could receive proposals from many domains. Discussion ensued and the following comments were made: • Kirsten Murphy commented that she is concerned about how smaller organizations may be able to stay competitive against larger organizations in the provider grant program. Georgia commented that awards were given to small organizations in the	

Agenda Item	Discussion	Next Steps
	first round, and the core team is mostly interested in the quality of the organizations idea, and whether or not they will be able to implement the proposal. • Judy Peterson asked for clarification as to whether the applicants would be aware that the core team is considering work groups recommendations when completing their scoring sheets. Georgia indicated that this will be included in the FAQ.	
5 **Provider Training Discussion**	Deborah Lisi-Baker began conversation around this agenda item, summarizing that provider capacity and ability to effectively work with the DLTSS population is an important goal of this work group. She then began to review attachment 5 and asked for work group members to draw on their personal and professional experiences in order to provide feedback to the group about how to proceed with meeting this goal. Discussion ensued and the following comments were made: • Joy commented that awareness of the importance of effectively populating EHRs and other electronic information sources is important. • Kirsten Murphy suggested that this document focuses on the what, not the why. Some conversation about models and theory of disability might be helpful to start with. People with disabilities and clinicians may have different cultural views on this. • Julie Tessler suggested including case studies to help illustrate this topic. • Jackie Majoris suggested that we have to further define what it means to be person directed and person centered, more information needs to be presented on these concepts. • Dion LaShay commented that best practices in information sharing across providers should be incorporated. • Barbara Prine suggested that we consider mental disability, communication ability, and technological adeptness of the population. Not everyone communicates in the same way. • Kirsten suggested a focus on people who use augmentative and alternative forms of communication be included. • Judy Peterson suggested that language be included about seeing the person as an individual not as a disability. • Deborah summarized Ed Paquin and Sam Liss's comments (sent to Deborah before	

Agenda Item	Discussion	Next Steps
	the meeting) that you must look at the whole person and not let the disability dictate how the person is served. • Marie Zura commented that people with developmental disabilities and mental health issues are often judged on their disability rather than their legitimate health concern. Furthermore, protocols and admission procedures for people with disabilities need to be considered. • Marie Zura commented that including an advocate or other types of informal and formal support for navigating care is important for the DLTSS population. Furthermore, training on how to incorporate the broader DLTSS support team is important. • Jason Williams noted that he has been involved in conversations about how to educate and reeducate providers in other settings. He indicated that he supports this opportunity, but that it may be best to align with existing efforts in order to avoid duplication. Furthermore, he suggested that it is important to understand that this is fundamentally about culture change, and we have to be reasonable in the pace of progress that we expect to see (don't try for too much or you might end up with nothing). He then offered suggestions for tools to aid in this work including grand rounds, champions (nurses, doctors and other care providers), staff meeting presentations, etc. It is important to reach not only clinical staff but also support staff. Where possible we should leverage existing efforts, for example, possibly train community health teams which clinicians already support and rely on for a team based approach. OCVT has a regional clinical advisory board, we could bring concepts like this to them. Furthermore, offering continuing medical education credits would be helpful. FAHC/UVM has a clinical simulation lab could be a possible forum for this type of work. Jason offered to put the group in touch with any FAHC/UVM contacts to assist in these efforts. Finally conferences such as the UVM Jeffords Institute for Quality or the annual VAHHS conference could be utilized as forums for this conversation. • Jackie Majoris asked for clarification about grand rounds. Jason clarified that there are different approaches depending on specialty, but generally speaking at FAHC there are presentations on tools and resources and how these tools can be utilized. Georgia commented that this tool is very hands on and focuses on practical use of process improvement tools.	

Agenda Item	Discussion	Next Steps
	• John Barbour commented that we need to try to create a no wrong door approach. Dion LaShay commented that eligibility criteria for services can create a wrong door. • Barbara Prine commented that when technology is used, people have to understand how to use it. • Madeleine asked if there are models or examples of training that we could learn from to further reach our goals. • Kirsten Murphy commented that the transition from pediatric primary care to adult primary care is important. She further commented that training even in settings such as MRI is important so that technicians understand how to interact with certain disabilities and needs.	
6 DLTSS Consultant Support Contract – RFP Process	Georgia reviewed this agenda item and indicated that the AOA has required that existing contracts supporting this work group go out to bid. This will be a simple bid, which means it is a slightly shorter process, and that less information will be required from applicants allowing a decision to be made sooner. There is currently an RFP out for these services, and applications are expected in the first or second week of August. More information will be given to the work group at its next meeting.	
7 Public Comment/Updates/Next Steps	Deborah Lisi-Baker invited comment from the public, and hearing none thanked the group for participation and called the meeting adjourned.	

VHCIP DLTSS Work Group Attendence Sheet 7-24-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

	First Name	Last Name		Title	Organization	DLTSS
1	April	Allen		Director of Policy and Planning	AHS - DCF	X
2	Debbie	Austin			AHS - DVHA	M
3	Ena	Backus			GMCB	X
4	John	Barbour		Executive Director	Champlain Valley Area Agency on Aging	M
5	Susan	Barrett		Executive Director	GMCB	X
6	Susan	Besio	Susan W Besio	Senior Associate	Pacific Health Policy Group	X
7	Bob	Bick		Director of Mental Health and Subs	HowardCenter for Mental Health	X
8	Denise	Carpenter		Business Manager	Specialized Community Care	X
9	Alysia	Chapman		Developmental Services	HowardCenter for Mental Health	X
10	Joy	Chilton	X (Phone)	Compliance Officer	Central Vermont Home Health and Hos	MA
11	Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
12	Peter	Cobb		Executive Director	VNAs of Vermont	X
13	Pamela	Coleman				X
14	Amy	Coonradt	Amy Coonradt	Health Policy Analyst	AHS - DVHA	X

15	Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	MA
16	Alicia	Cooper	X	Quality Oversight Analyst	AHS - DVHA	X
17	Molly	Dugan	X (phone)	SASH Program Director	Cathedral Square and SASH Program	M
18	Patrick	Flood		CEO - Northern Counties Health Car	CHAC	M
19	Erin	Flynn	Erin Flynn	Health Policy Analyst	AHS - DVHA	S
20	Mary	Fredette		Executive Director	The Gathering Place	M
21	Joyce	Gallimore		Director, Community Health Payme	Bi-State Primary Care/CHAC	M
22	Lucie	Garand		Senior Government Relations Speci	Downs Rachlin Martin PLLC	X
23	Christine	Geiler		Grant Manager & Stakeholder Coor	GMCB	S
24	Larry	Goetschius		CEO	Addison County Home Health & Hospic	M
25	Bea	Grause		President	Vermont Association of Hospital and He	X
26	Dale	Hackett		Consumer Advocate	None	M
27	Janie	Hall		Corporate Assistant	OneCare Vermont	A
28	Bryan	Hallett				X
29	Selina	Hickman		Policy Director	AHS - DVHA	X
30	Bard	Hill		Director - Policy, Planning & Data U	AHS - DAIL	X
31	Churchill	Hindes		COO	OneCare Vermont	X
32	Brendan	Hogan		Consultant	Bailit-Health Purchasing	X
33	Jeanne	Hutchins		Executive Director	UVM Center on Aging	M
34	Craig	Jones		Director	AHS - DVHA - Blueprint	MA
35	Pat	Jones			GMCB	M
36	Margaret	Joyal		Director of Adult Outpatient Service	Washington County Mental Health Serv	X

37	Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
38	Tony	Kramer	X (phone)		AHS - DVHA	X
39	Nelson	Lamothe			UMASS	S
40	Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
41	Dion	LaShay	X (phone)		Consumer Representative	M
42	Diane	Lewis			AOA - DFR	A
43	Deborah	Lisi-Baker		Disability Policy Expert	Unknown	C/M
44	Sam	Liss		Chairperson	Statewide Independent Living Council	M
45	Vicki	Loner	X (phone)	Director of Quality and Care Manage	OneCare Vermont	X
46	Georgia	Maheras	GM		AOA	S
47	Jackie	Majoros	JM	State Ombudsman	VLA/LTC Ombudsman Project	M
48	Carol	Maroni			Community Health Services of Lamoille	M
49	David	Martini			AOA - DFR	M
50	Lisa	Maynes		Associate Director of family Suppor	Vermont Family Network	X
51	Marybeth	McCaffrey		Principal Health Reform Administra	AHS - DAIL	M
52	Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
53	Madeleine	Mongan		Deputy Executive Vice President	Vermont Medical Society	M
54	Todd	Moore		CEO	OneCare Vermont	M
55	Mary	Moulton		CEO	Washington County Mental Health Serv	X
56	Kirsten	Murphy			AHS - Central Office - DDC	M
57	Floyd	Nease			AHS - Central Office	X
58	Nick	Nichols		Planning/Development/Policy Dire	AHS - DMH	M

59	Miki	Olszewski		Assistant Director of Blueprint for H	AHS - DVHA - Blueprint	X
60	Jessica	Oski			Sirotkin & Necrason	X
61	Ed	Paquin		Ed Paquin	Disability Rights Vermont	M
62	Annie	Paumgarten	Annie Paumgarten	Eveluation Director	GMCB	X
63	Laura	Pelosi		Executive Director	Vermont Health Care Association	M
64	Eileen	Peltier		Executive Director	Central Vermont Community Land Trus	M
65	Judy	Peterson		President and CEO	Visiting Nurse Association of Chittende	C/M
66	John	Pierce				X
67	Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
68	Barbara	Prine	Barbara Prine	Attorney	VLA/Disability Law Project	MA
69	Paul	Reiss		Executive Director,	Accountable Care Coalition of the Greer	M
70	Virginia	Renfrew			Zatz & Renfrew Consulting	X
71	Rachel	Seelig	Rachel Seelig	Attorney	VLA/Senior Citizens Law Project	M
72	Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	X
73	Richard	Slusky		Payment Reform Director	GMCB	MA
74	Kara	Suter		Reimbursement Director	AHS - DVHA	X
75	Beth	Tanzman		Assistant Director of Blueprint for H	AHS - DVHA - Blueprint	X
76	Julie	Tessler	Julie B Tessler	Executive Director	Vermont Council of Developmental and	M
77	Bob	Thorn		Executive Director	Counseling Services of Addison County	MA
78	Anya	Wallack		Chair	SIM Core Team Chair	X
79	Marlys	Waller			Vermont Council of Developmental and	MA
80	Norm	Ward		Medical Director	OneCare Vermont	X

81	Nancy	Warner		Board Member	COVE	M
82	Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	S/MA
83	Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
84	Jason	Williams		Government Relations Strategist	Fletcher Allen Health Care	M
85	Jennifer	Woodard		Long-Term Services and Supports I	AHS - DAIL	X
86	Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
87	Dave	Yacovone		Commissioner	AHS - DCF	X
88	Marie	Zura		Director of Developmental Services	HowardCenter for Mental Health	M
						88

Attachment 1c - DLTSS Meeting Minutes 9-11-14

VT Health Care Innovation Project

DLTSS Work Group Meeting Minutes

Date of meeting: Thursday, September 11, 2014, 10am – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1 Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker began the meeting and moved to approve the July 24th meeting minutes. Georgia Maheras said we did not have a quorum so a vote could not be taken. The group will approve the July minutes at the September meeting.	
2 Updates • **DLTSS Model of Care presentation to Care Models/Care Management Work Group**	Erin Flynn gave an overview of the DLTSS Team's presentation of the DLTSS Model of Care at the August Care Models/Care Management (CM/CM) meeting. The DLTSS Model of Care (Attachment 2a) is relevant to the CM/CM Learning Collaborative "Integrated Community Care Management", a 1-year initiative to improve integration of care management activities for at-risk people and provide learning opportunities for best practices for care management in at least 3 pilot communities. Erin gave an overview of the Learning Collaborative's potential Session Topics. Pat Jones said the RFP for the 2 Learning Collaborative Facilitators has been posted. Pat Jones discussed the care management standards for Accountable Care Organizations being developed for the Medicaid and Commercial shared savings programs. These Standards have been discussed and developed in the CM/CM Work Group and are currently under review by a small group of ACO and payer representatives. The current timeline indicates that the Standards will be discussed at the October CM/CM meeting, and that a vote will be taken in November. The CM/CM Work Group is also charged with developing a statewide Strategic Plan for care management.	

Agenda Item	Discussion	Next Steps
• **DLTSS Quality and Performance Measures** • **Provider Training: Available Resources**	Alicia Cooper presented the content and process to date for the Year 2 Medicaid and Commercial ACO Quality and Performance Measures – Attachment 2b. Alicia pointed out the summary on Slide 4 of this Attachment, with backup detail contained on the other slides. The Quality and Performance Measures (QPM) Year 2 recommendations were presented to the Steering Committee at their August meeting; this was followed by a 2-week public comment period. At the September Steering meeting, members voted to send the QPM Year 2 recommendations to the Core Team without support or opposition. The QPM presentation to the Core Team was followed by a second 2-week public comment period. It is not clear whether the Core Team will vote on the QPM Year 2 recommendations at their upcoming September 29th meeting. The QPM Year 1 data will be available in the summer of 2015 with a final report available in the Fall of 2015. Georgia Maheras presented her memo on DLTSS Provider Training – see Attachment 2c, and indicated that opportunity exists for the CM/CM and DLTSS Work Groups to collaborate on recommendations for learning collaborative funding moving forward. Deborah Lisi-Baker suggested that a meeting of the CMCM and DLTSS work groups would be helpful to gain a better understanding of opportunities for collaboration that can be brought back to the DLTSS Work Group. It was agreed that the Integrated Communities Care Management Learning Collaborative would be one vehicle to incorporate Provider Training input from the DLTSS Work Group in the short term.	
3 DAIL Long Term Care Consumer Survey: Choices for Care, Attendant Services	DLTSS participants had requested presentations on AHS Surveys to better capture quality of life and quality of care concerns that the Medicaid ACO quality and performance measures do not currently address. It was felt that this kind of information might be helpful for informing DLTSS Work Group discussions and decision-making. Bard Hill presented DAIL's Long Term Care Consumer Survey on Choices for Care (CFC) and Attendant Services – see Attachments 3a and 3b. The presentation was as follows: CFC Objectives include supporting individual choice; shifting the balance between the number and percentage of people served in nursing homes vs in home and community-based settings; and expanding the range of services options, to name a few. The survey instrument, methodology, population and sample size, evaluation, and survey results (posted online) were discussed. Bard described the key finding as "Yes, individuals' needs are being met." CFC	

Agenda Item	Discussion	Next Steps
	services target needed personal care for people 18 to 100+ years old; however, there are scheduling challenges for delivering services on week nights and weekends. Survey results also show that participants have unmet transportation; hearing, dental and vision care; housing; and social needs yet those services are not included in the scope of the CFC program. More than half of the CFC participants hire their own caregivers. Barb Prine complimented DAIL on the implementation of such a successful program and asked, "Once CFC is merged into the Global Commitment Waiver, how can we operationalize the results of data related to utilization of savings?" Sam Liss asked whether DAIL has the authority and resources to improve CFC in terms of hospice care where VT ranks 49th in the nation. Bard explained that hospice care is not a CFC covered service. Work Group participants seemed interested in future Survey presentations on CRT (next meeting), Children's Mental Health, and Developmental Services.	
4 Next Steps for Updating the DLTSS Work Plan	Deborah Lisi-Baker gave an overview of the current DLTSS Work Plan and timeline– see Attachment 4. A more detailed review of the work plan is planned for the October Work Group meeting, however the work group began an initial discussion of potential adjustments and additions to the work plan for year two of the VHCIP. Georgia Maheras noted that the deadline for the submission of year two updates of the SIM Operational Plan to CMMI is November 1st, and that this process may also lead to additional updates to the work plan. Work group recommendations for adjustments to the work plan are as follows: Julie Tessler would like to hear from the Population Heath, Payment Models, and Workforce Work Groups. Payment Models is scheduled to present to the DLTSS Work Group at our November meeting. The Work Group was also interested in hearing from the HIE Work Group about the Federal rules contained in 42CFR Part 2 Confidentially Protections for people with mental health and substance abuse needs.	

Agenda Item	Discussion	Next Steps
5 Public Comment Updates/Next Steps	Barb Prine expressed concern about people who have multiple DLTSS needs but are siloed in one Waiver program. A question was posed: "How will ACOs and DApartners allocate savings?" Georgia Maheras answered, "It's spelled out in the contract between the ACO and the DAs." Another person voiced concern over how this will work for the "non-traditional" providers of care who do not have formal relationships with the ACOs but provide critical services. Next meeting will be on October 9th, 10:00 – 12:30 in the DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Attendance 9-11-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

First Name	Last Name		Title	Organization	DLTSS
April	Allen		Director of Policy and Planning	AHS - DCF	X
Debbie	Austin			AHS - DVHA	M
Ena	Backus			GMCB	X
Susan	Barrett		Executive Director	GMCB	X
Susan	Besio	here	Senior Associate	Pacific Health Policy Group	X
Bob	Bick		Director of Mental Health and Substa	HowardCenter for Mental Health	X
Denise	Carpenter		Business Manager	Specialized Community Care	X
Alysia	Chapman		Developmental Services	HowardCenter for Mental Health	X
Joy	Chilton		Compliance Officer	Central Vermont Home Health and Hospi	MA
Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
Peter	Cobb		Executive Director	VNAs of Vermont	X
Amy	Coonradt		Health Policy Analyst	AHS - DVHA	X
Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	MA
Alicia	Cooper	AC	Quality Oversight Analyst	AHS - DVHA	X
Molly	Dugan		SASH Program Director	Cathedral Square and SASH Program	M
Patrick	Flood		CEO - Northern Counties Health Care	CHAC	M
Erin	Flynn		Health Policy Analyst	AHS - DVHA	S
Mary	Fredette		Executive Director	The Gathering Place	M
Joyce	Gallimore		Director, Community Health Paymen	Bi-State Primary Care/CHAC	M
Lucie	Garand		Senior Government Relations Special	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coordi	GMCB	S
Larry	Goetschius		CEO	Addison County Home Health & Hospice	M
Bea	Grause		President	Vermont Association of Hospital and Hea	X
Dale	Hackett	Veh	Consumer Advocate	None	M
Mike	Hall		Executive Director	Champlain Valley Area Agency on Aging	M
Janie	Hall		Corporate Assistant	OneCare Vermont	A
Bryan	Hallett				X

Carolynn	Hatin			AHS - Central Office - iFS	X
Selina	Hickman		Policy Director	AHS - DVHA	X
Bard	Hill	here	Director - Policy, Planning & Data Un	AHS - DAIL	X
Churchill	Hindes		COO	OneCare Vermont	X
Brendan	Hogan		Consultant	Bailit-Health Purchasing	X
Jeanne	Hutchins		Executive Director	UVM Center on Aging	M
Craig	Jones		Director	AHS - DVHA - Blueprint	MA
Pat	Jones			GMCB	M
Margaret	Joyal		Director of Adult Outpatient Services	Washington County Mental Health Servic	X
Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
Tony	Kramer			AHS - DVHA	X
Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Dion	LaShay	phone		Consumer Representative	M
Diane	Lewis			AOA - DFR	A
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	C/M
Sam	Liss	Sam Liss	Chairperson	Statewide Independent Living Council	M
Vicki	Loner		Director of Quality and Care Manage	OneCare Vermont	X
Georgia	Maheras			AOA	S
Jackie	Majoros		State Ombudsman	VLA/LTC Ombudsman Project	M
Carol	Maroni			Community Health Services of Lamoille V	M
David	Martini			AOA - DFR	M
Mike	Maslack				X
Lisa	Maynes		Associate Director of family Support	Vermont Family Network	X
Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
Madeleine	Mongan	phone	Deputy Executive Vice President	Vermont Medical Society	M
Todd	Moore		CEO	OneCare Vermont	M
Mary	Moulton		CEO	Washington County Mental Health Servic	X
Kirsten	Murphy			AHS - Central Office - DDC	M
Floyd	Nease			AHS - Central Office	X
Nick	Nichols	NN	Planning/Development/Policy Direct	AHS - DMH	M
Miki	Olszewski		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Jessica	Oski			Sirotkin & Necrason	X
Ed	Paquin	Ed Paquin	Ed Paquin	Disability Rights Vermont	M
Annie	Paumgarten		Eveluation Director	GMCB	X
Laura	Pelosi		Executive Director	Vermont Health Care Association	M
Eileen	Peltier		Executive Director	Central Vermont Community Land Trust	M

Judy	Peterson		President and CEO	Visiting Nurse Association of Chittenden	C/M
John	Pierce				X
Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
Barbara	Prine		Attorney	VLA/Disability Law Project	MA
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
Virginia	Renfrew			Zatz & Renfrew Consulting	X
Rachel	Seelig		Attorney	VLA/Senior Citizens Law Project	M
Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	X
Richard	Slusky		Payment Reform Director	GMCB	MA
Kara	Suter		Reimbursement Director	AHS - DVHA	X
Beth	Tanzman		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Julie	Tessler		Executive Director	Vermont Council of Developmental and M	M
Bob	Thorn		Executive Director	Counseling Services of Addison County	MA
Anya	Wallack		Chair	SIM Core Team Chair	X
Marlys	Waller			Vermont Council of Developmental and M	MA
Norm	Ward		Medical Director	OneCare Vermont	X
Nancy	Warner		Board Member	COVE	M
Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	S/MA
Kendall	West				X
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Jason	Williams		Government Relations Strategist	Fletcher Allen Health Care	M
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Marie	Zura		Director of Developmental Services	HowardCenter for Mental Health	M

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VHCIP DLTSS Work Group Roll Calls 9-11-14

Minutes 1°
2°

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate

minutes

First Name	Last Name						Title	Organization	DLTSS
Debbie	Austin							AHS - DVHA	M
Joy	Chilton						Compliance Officer	Central Vermont Home Health and Hospi	MA
Amy	Cooper						Executive Director	Accountable Care Coalition of the Green	MA
Molly	Dugan						SASH Program Director	Cathedral Square and SASH Program	M
Patrick	Flood						CEO - Northern Counties Health Care	CHAC	M
Mary	Fredette						Executive Director	The Gathering Place	M
Joyce	Gallimore						Director, Community Health Paymen	Bi-State Primary Care/CHAC	M
Larry	Goetschius						CEO	Addison County Home Health & Hospice	M
Dale	Hackett						Consumer Advocate	None	M
Mike	Hall						Executive Director	Champlain Valley Area Agency on Aging	M
Leanne	Hutchins						Executive Director	UVM Center on Aging	M
Craig	Jones						Director	AHS - DVHA - Blueprint	MA
Pat	Jones							GMCB	M
~~Trinka~~	~~Kerr~~						Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
Dion	LaShay							Consumer Representative	M
Deborah	Lisi-Baker						Disability Policy Expert	Unknown	C/M
Sam	Liss						Chairperson	Statewide Independent Living Council	M
~~Jackie~~	~~Majoros~~						State Ombudsman	VLA/LTC Ombudsman Project	M
Carol	Maroni							Community Health Services of Lamoille V	M
~~David~~	~~Martini~~							AOA - DFR	M
Madeleine	Mongan						Deputy Executive Vice President	Vermont Medical Society	M
Todd	Moore						CEO	OneCare Vermont	M
Kirsten	Murphy							AHS - Central Office - DDC	M
Nick	Nichols						Planning/Development/Policy Direct	AHS - DMH	M
Ed	Paquin						Ed Paquin	Disability Rights Vermont	M
~~Laura~~	~~Pelosi~~						Executive Director	Vermont Health Care Association	M
Eileen	Peltier						Executive Director	Central Vermont Community Land Trust	M
~~Judy~~	~~Peterson~~						President and CEO	Visiting Nurse Association of Chittenden	C/M
Barbara	Prine						Attorney	VLA/Disability Law Project	MA

	Paul	Reiss						Executive Director,	Accountable Care Coalition of the Green	M
✓	Rachel	Seelig						Attorney	VLA/Senior Citizens Law Project	M
	~~Richard~~	~~Slusky~~						Payment Reform Director	GMCB	MA
✓	Julie	Tessler						Executive Director	Vermont Council of Developmental and M	M
	Bob	Thorn						Executive Director	Counseling Services of Addison County	MA
✓	~~Marlys~~	~~Waller~~						member here, a	~~Vermont Council of Developmental and M~~ It not needed	~~MA~~
	Nancy	Warner						Board Member	COVE	M
✓	Julie	Wasserman						VT Dual Eligible Project Director	AHS - Central Office	S/MA
	Jason	Williams						Government Relations Strategist	Fletcher Allen Health Care	M
✓	Marie	Zura						Director of Developmental Services	HowardCenter for Mental Health	M

Attachment 2 - NCI Indicators 2013

National Core Indicators (NCI)

I. Individual Outcomes

Individual outcome indicators address how well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.

A. Relationships

People have friends and relationships.

Indicators:

- The proportion of people who are able to see their families and friends when they want.
- The proportion of people who can go out on a date if they want to.
- The proportion of people who feel lonely.
- The proportion of people who have a close friend, someone they can talk to about personal things.
- The proportion of people who have friends and caring relationships with people other than support staff and family members.
- The proportion of people who report that they get to help others.
- The proportion of people who talk with their neighbors.

B. Satisfaction

People are satisfied with the services and supports they receive.

Indicators:

- The proportion of people who are satisfied with their day program or other daily activity.
- The proportion of people who are satisfied with their job.
- The proportion of people who are satisfied with where they live.
- The proportion of people who go to a day program or have other daily activity who would like to go somewhere else or do something else during the day.
- The proportion of people who have a community job who would like to work somewhere else.
- The proportion of people who report that they would like to live somewhere else.

C. Self-Determination

People have authority and are supported to direct and manage their own services.

Indicators:

- The proportion of people self-directing who get the help they need to work out problems with their support workers.
- The proportion of people self-directing who have help in deciding how to use their individual budget/services.
- The proportion of people self-directing who receive information about their budget/services that is easy to understand.
- The proportion of people self-directing who report that someone talked with them about their individual budget/services.
- The proportion of people self-directing who report that they can make changes to their budget/services if they need to.
- The proportion of people self-directing who report that they need more help in deciding how to use their budget/services.
- The proportion of people self-directing whose support workers come when they are supposed to.
- The proportion of people who are currently using a self-directed supports option.

D. Choice and Decision-Making

People make choices about their lives and are actively engaged in planning their services and supports.

Indicators:

- The proportion of people who make choices about their everyday lives, including: housing, roommates, daily routines, jobs, support staff or providers, what to spend money on, and social activities.
- The proportion of people who report having been provided options about where to live, work, and go during the day.

E. Community Inclusion

People have support to participate in everyday community activities.

Indicators:

- The proportion of people who regularly participate in everyday integrated activities in their communities.
    - Amount of Times Went on Vacation in Past Year
    - Amount of Times Went Out for Entertainment in Past Month

- Amount of Times Went Out for Exercise in Past Month
- Amount of Times Went Out on Errands/Appointments in Past Month
- Amount of Times Went Out To a Restaurant/Coffee Shop in Past Month
- Amount of Times Went Out To Religious Services in Past Month
- Amount of Times Went Shopping in Past Month
- In the Past Month Person Went Out for Entertainment
- In the Past Month Person Went Out for Exercise
- In the Past Month Person Went Out on Errands/Appointments
- In the Past Month Person Went Shopping
- In the Past Month Person Went To Religious Services
- In the Past Month Went Out To a Restaurant or Coffee Shop
- In the Past Year Person Went on Vacation

F. Work

People have support to find and maintain community integrated employment.

Indicators:

- Of people who have a job in the community, the average length of time they have been working at their current job.
- Of people who have a job in the community, the percent who receive vacation and/or sick time benefits.
- Of people who have a job in the community, the percent who were continuously employed during the previous year.
- The average bi-weekly earnings of people who have jobs in the community.
- The average number of hours worked bi-weekly by people with jobs in the community.
- The percent of people earning at or above the State minimum wage
- The proportion of people who do not have a job in the community but would like to have one.
- The proportion of people who do volunteer work.
- The proportion of people who go to a day program or have some other daily activity.
- The proportion of people who have a goal of integrated employment in their individualized service plan.
- The proportion of people who have a job in the community.

II. Health, Welfare, and Rights

These indicators address the following topics: (a) safety and personal security; (b) health and wellness; and (c) protection of and respect for individual rights

A. Safety

People are safe from abuse, neglect, and injury.

Indicators:

- The incidence of serious injuries reported among people with MR/DD in the course of service provision, during the past year.
- The mortality rate of the served ID/DD population compared to the general area population, by age, by cause of death (natural or medico-legal), and by ID or DD diagnosis.
- The proportion of people who report having someone to go to for help when they feel afraid.
- The proportion of people who report that they feel safe in their home, neighborhood, workplace, and day program/ at other daily activity.
- The proportion of people who were victims of selected crimes reported to a law enforcement agency during the past year, by type of crime (rape, aggravated assault, and theft).

B. Respect/Rights

People receive the same respect and protections as others in the community.

Indicators:

- The proportion of people indicating that most staff treat them with respect.
- The proportion of people who have participated in a self-advocacy group meeting, conference, or event.
- The proportion of people who report satisfaction with the amount of privacy they have.
- The proportion of people whose basic rights are respected by others.
    - Allowed to Use Phone or Internet at Any Time
    - Can be Alone with Friends/Visitors when They Come to Visit
    - Mail or Email is Read without Asking Permission
    - People Let You Know Before Entering Your Bedroom
    - People Let You Know Before Entering Your Home

C. Health

People secure needed health services.

Indicators:

- The proportion of men over 50 who have had a PSA test within the past year.
- The proportion of people age 50 and older who have had a screening for colorectal cancer within the past year.
- The proportion of people described as having poor health.
- The proportion of people reported as having a primary care doctor.
- The proportion of people who have ever had a vaccination for pneumonia.
- The proportion of people who have had a complete annual physical exam in the past year.
- The proportion of people who have had a flu vaccination within the past 12 months.
- The proportion of people who have had a hearing test within the past 5 years.
- The proportion of people who have had a routine dental exam in the past year.
- The proportion of people who have had a vision screening within the past year.
- The proportion of women 18 and over who have had a Pap test screening in the past year.
- The proportion of women over 40 who have had a mammogram within the past 2 years.

D. Medications

Medications are managed effectively and appropriately.

Indicators:

- The proportion of people taking medications for mood, anxiety, behavior problems, or psychotic disorders.

E. Wellness

People are supported to maintain healthy habits.

Indicators:

- The proportion of people who maintain healthy habits in such areas as smoking, weight, and exercise.

F. Restraints

The system makes limited use of restraints or other restrictive practices.

Indicators:

- The incidence of restraints reported in the past year, by type of restraint and by living arrangement.
- The incidence of serious injuries resulting from the use of restraints.

III. System Performance

The system performance indicators address the following topics: (a) service coordination; (b) family and individual participation in provider-level decisions; (c) the utilization of and outlays for various types of services and supports; (d) cultural competency; and (e) access to services.

A. Access

Publicly-funded services are readily available to individuals who need and qualify for them.

Indicators:

- The proportion of people who feel their support staff have been appropriately trained to meet their needs.
- The proportion of people who report having adequate transportation when they want to go somewhere.
- The proportion of people who report that they are able to go to the doctor when they need to.
- The rate at which people report that they do not get the services they need.
    - Gets Needed Services
    - If Does Not Get Needed Services Needs Benefits/Insurance Info
    - If Does Not Get Needed Services Needs Communication Technology
    - If Does Not Get Needed Services Needs Dental Care
    - If Does Not Get Needed Services Needs Education or Training
    - If Does Not Get Needed Services Needs Environmental Adaptations/Home Modifications
    - If Does Not Get Needed Services Needs Health Care
    - If Does Not Get Needed Services Needs Help Finding/Changing Housing
    - If Does Not Get Needed Services Needs Help Finding/Changing Jobs
    - If Does Not Get Needed Services Needs Social/Relationships
    - If Does Not Get Needed Services Needs Transportation

B. Service Coordination

Service coordinators are accessible, responsive, and support the person's participation in service planning.

Indicators:

- The proportion of people reporting that service coordinators ask them what they want.
- The proportion of people reporting that service coordinators help them get what they need.
- The proportion of people who have met their service coordinators.
- The proportion of people who report that their service coordinators call them back right away.
- The proportion of people who were involved in creating their service plan

C. Service Coordination

Service coordinators are accessible, responsive, and support the person's participation in service planning.

Indicators:

- The proportion of people reporting that service coordinators ask them what they want.
- The proportion of people reporting that service coordinators help them get what they need.
- The proportion of people who have met their service coordinators.
- The proportion of people who report that their service coordinators call them back right away.
- The proportion of people who were involved in creating their service plan

IV. Staff Stability

These indicators address provider staff stability and competence of direct contact staff.

A. Staff Stability

Direct contact staff turnover ratios and recruitment and training absentee rates are low enough to maintain continuity of supports and efficient use of resources.

Indicators:

- Average length of service for all direct contact staff who separated in the past year, and for all currently employed direct contact staff.
- The crude separation rate, defined as the proportion of direct contact staff separated in the past year.
- The vacancy rate, defined as the proportion of direct contact positions that were vacant as of a specified date

V. Family Indicators

The family indicators address how well the public system assists children and adults with developmental disabilities, and their families, to exercise choice and control in their decision-making, participate in their communities, and maintain family relationships. Additional indicators probe how satisfied families are with services and supports they receive, and how supports have affected their lives.

A. Choice and Control

Families/family members with disabilities determine the services and supports they receive, and the individuals or agencies who provide them.

Indicators:

- The proportion of families reporting that they control their own budgets/supports (i.e. they choose what supports/goods to purchase).
- The proportion of families who report that staff are respectful of their choices and decisions.
- The proportion of families who report they choose, hire and manage their service/support providers.

B. Family Outcomes

Individual and family supports make a positive difference in the lives of families.

Indicators:

- The proportion of families who feel that services and supports have helped them to better care for their family member living at home.

C. Satisfaction

Families/family members with disabilities receive adequate and satisfactory supports.

Indicators:

- The proportion of families who report satisfaction with the information and supports received, and with the planning, decision-making, and grievance processes.

D. Family Involvement

Families maintain connections with family members not living at home.

Indicators:

- The proportion of families/guardians of individuals not living at home who report the extent to which the system supports continuing family involvement.

E. Community Connections

Families/family members use integrated community services and participate in everyday community activities.

Indicators:

- The proportion of .families who report they are supported in utilizing natural supports in their communities (e.g., family, friends, neighbors, churches, colleges, recreational services).
- The proportion of families/family members who participate in integrated activities in their communities.

F. Access and Support Delivery

Families/family members with disabilities get the services and supports they need.

Indicators:

- The proportion of eligible families who report having access to an adequate array of services and supports.
- The proportion of families reporting that staff or translators are available to provide information, services and supports in the family/family member's primary language/method of communication.
- The proportion of families who indicate that services/supports provided outside of the home (e.g., day/employment, residential services) are done so in a safe and healthy environment.

- The proportion of families who report that service and support staff/providers are available and capable of meeting family needs.
- The proportion of families who report that services/supports are available when needed, even in a crisis.
- The proportion of families who report that services/supports are flexible to meet their changing needs.

G. Information and Planning

Families/family members with disabilities have the information and support necessary to plan for their services and supports.

Indicators:

- The proportion of families reporting that their support plan includes or reflects things that are important to them.
- The proportion of families who report that staff who assist with planning are knowledgeable and respectful.
- The proportion of families who report they are informed about the array of existing and potential resources (including information about their family member's disability, services and supports, and public benefits), in a way that is easy to understand.
- The proportion of families who report they have the information needed to skillfully plan for their services and supports.

Attachment 3 - DLTSS Core Competency Domains

DLTSS Work Group
Recommended DLTSS-Specific Core Competency Domains
for Health Care Service Providers
October 2, 2014
DRAFT

The DLTSS Work Group discussion will focus on ensuring that disability competencies are reflected in the Core Competency domains below (or other domains identified by the Work Group), with special emphasis on the desired skill set in working with people with disabilities.

DOMAINS:

1. *INTERPERSONAL COMMUNICATION: The ability to establish rapport quickly, communicate effectively and build trusting relationships with people receiving services, their family members and other providers involved in their care.*

2. *COLLABORATION AND TEAMWORK: The ability to function effectively as a member of an inter-professional team that includes people receiving services and their family members, and multiple providers across a variety of health care and support services.*

3. *PERSON-CENTEREDNESS: The ability to keep the person receiving services at the center of all care management activities and service delivery.*

4. *NEEDS ASSESSMENT: Knowledge of the various screening tools and assessments that are available to identify the person's needs and strengths across primary, acute, medication, mental health, substance abuse, developmental, and long term care supports and services; and the ability to arrange for the relevant screenings and assessments to be conducted in a timely manner.*

5. *CARE PLANNING: The ability to utilize information from assessments and the people receiving services and their family members to develop a comprehensive care plan that includes all the person's needs, goals, and interventions to address them.*

6. *INTEGRATED CARE COORDINATION AND TEAMING: The ability to ensure that a person's care is integrated across all settings, that needed information is routinely exchanged among consumers, family members, and providers, and that relevant parties are informed of changes in a person's health, functional or situational status to ensure responsive and high quality services.*

7. *ROUTINE SUPPORT FOR THE PERSON RECEIVING SERVICES: The ability to provide on-going information and assistance to people receiving services to ensure that they have the supports necessary to maintain well-being.*

8. *SUPPORT DURING CARE TRANSITIONS: The ability to work across multiple settings in times of personal crisis, change in health status, or change in socio-economic factors (e.g., housing, financial resources, informal supports) to support a seamless and effective outcome for the person receiving services.*

9. *KNOWLEDGE: Knowledge of relevant information and processes to provide high quality and responsive care management for people receiving services.*

10. *SKILLS: Skills that support the provision of high quality and responsive care management for people receiving services.*

Work Group Recommendations for Relevant Sources:

Attachment 4 - ACTT Program Update

ACTT Project Update

September 24, 2014

ACTT Program: Overview

The ACTT Partnership is supporting three primary projects:

1) DA/SSA Data Quality and Repository
2) DLTSS Data Planning Project
3) Universal Transfer Protocol and Form

Program Overview:

- Schedule Kickoff meeting
- Assigned Roles & Responsibilities
- Most vendor contracts still being approved

Project 1: DA/SSA Data Quality and Repository

DA/SSA Data Repository:

- Hired BHN HIT Director
- Core Group within BHN Provider Network has been developed.
  - Decision making process involves all EDs, IT Directors, Outcomes Workgroup, Compliance Officers.
- Some Next Steps:
  - Finalize business requirements around desired solution
  - Meet to discuss architectural design possibilities within VITL
  - Choose platform and specifications and develop plan and proposal for Core Team

Project 1: DA/SSA Data Quality and Repository

DA/SSA Data Quality:

- Working with Council Outcomes Workgroup
- Developing Outcomes/Measurement Spreadsheets
- Posting position for BHN Quality Manager (funded by a separate grant that will benefit this project)
- Some Next Steps:
  - "Identify" data and reporting needs
  - Create data dictionary
  - Develop toolkit to help member agencies

EHR Procurement:

- Contracts need to be finalized with ARIS and VITL prior to moving forward. BHN HIT Director is now involved in that process as well

Project 2: DLTSS Data Planning Project

DLTSS Data Planning Project:

- Contracts being finalized
- Roles & Responsibilities defined
- High level project and resource planning completed
- Some Next Steps:
  - Review current status existing non-claims data sets in LTSS systems
  - Meet with DLTSS workgroup representatives and others to review DLTSS measures that could potentially be used in future data and IT capacity
  - Meet with QPM workgroup representatives and others to review the process for recommending future measures
  - Planning for the LTSS provider technology assessment

Project 3: Universal Transfer Protocol and Form

Universal Transfer Protocol and Form:

- Contracts being finalized
- Roles & Responsibilities defined
- High level project and resource planning completed
- Some Next Steps:
  - Review examples of other unified transfer information data sets and workflows provided by the State
  - Review best practices and lessons learned in other states
  - Define targeted pilot stakeholder groups. Create a communication and outreach strategy for engagement.

Attachment 5 - DLTSS Work Plan

Work Plan for DLTSS Work Group - April 24, 2014

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Finalize Work Group logistics: Charter, membership, meeting schedule, resource needs, etc.	• Redraft Charter following VHCIP standardized template • Review membership list: each entity should assign 1 voting member (+ backup), others can be "interested parties" • Identify representation from commercial payers and other entities • Distribute 2014 monthly meeting schedule • Develop resources identified as needed by Work Group	• Approve Charter for official use • Provide input on and final approval of membership list • Identify information /resources needed to inform discussions and decision-making • Identify mechanisms for broader beneficiary engagement	February - April 2014 and on-going (for development of resources for Work Group)	• Charter scheduled for March Work Group approval • Membership list: 1. Need to identify representation from commercial payers, others 2. Need to finalize membership list • 2014 Meeting Schedule has been distributed	• Final Charter • Comprehensive membership list • 2014 meeting schedule • Resources are adequate to accomplish objectives • Successful beneficiary engagement
Complete Action Plan for Inclusion of DLTSS Quality and Performance Metrics and review performance on an on-going basis	• Develop on-going list of currently collected AHS measures • Develop timeline (short and long-term) for incorporating DLTSS input into Quality and Performance Measures Work Group activities • Identify DLTSS quality and performance measures for Years 2	• Review core principles of Developmental Disabilities Act, Choices for Care regulations, and Mental Health Care Reform Act as they relate to quality and performance measures and desired outcomes • Review list of currently collected	February - July 2014 and on-going (for performance measure review)	• Initial list of currently collected AHS measures needs to be fleshed out • Timeline and recommendations to be presented at March DLTSS Work Group meeting • Initial list of DLTSS quality and performance measures needs to be discussed,	• Recommended DLTSS Quality and Performance Measures to be incorporated /adapted into the Medicaid ACO Standards for Years 2 and 3 • Reduction of preventable hospitalizations, ER visits and nursing home admissions;

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	and 3 of Medicaid ACO • Develop a plan to incorporate/adapt DLTSS Quality and Performance Measures into the VHCIP Quality and Performance Measures Work Group deliverables • Develop materials for Work Group Review of ACO / provider performance on DLTSS-specific measures and DLTSS-related measures (e.g., preventable hospitalizations, ER visits, and nursing home admissions; appropriate use of medications; and rebalancing the use of institutional vs home and community-based care)	AHS measures • Review Quality and Performance Measures Work Group process, criteria, and accomplishments to date • Discuss timeline (short and long-term) for incorporating DLTSS input into Quality and Performance Measures Work Group activities • Make recommendations to incorporate DLTSS Quality and Performance Measures into the VHCIP Quality and Performance Measures Work Group • On an on-going basis, review ACO and provider performance on DLTSS-specific measures and DLTSS-related measures and provide input to VHCIP leadership regarding performance		critiqued, and refined • Action plan for inclusion of quality and performance metrics needs to be developed	appropriate use of medications; and rebalancing the use of institutional vs home and community-based care

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Recommend DLTSS Model of Care Elements	• Review DVHA Duals Model of Care with Work Group • Develop DLTSS Model of Care PowerPoint • Develop a plan for incorporating/adapting the elements of the Duals Care Model into the VHCIP Care Models/Care Management Work Group activities	• Review DLTSS Model of Care Elements; elicit feedback and approval • Review, provide input on, and approve a plan for incorporating /adapting the elements of the DLTSS Care Model into the VHCIP Care Models/ Care Management Work Group activities	January - July 2014	• DVHA Duals Model of Care presented to DLTSS Work Group in January 2014 • DLTSS Model of Care Elements to be presented at April DLTSS Work Group • DLTSS Model of Care Elements to be presented at May Care Models/Care Management Work Group	• Successful incorporation of DLTSS Model of Care into service delivery for people with disabilities, related chronic conditions and those needing long term services and supports
Recommend technical and IT needs to support new payment and care models for integrated care	• Collaborate with the VHCIP HIE Work Group on development and approval of the ACTT proposal for DLTSS providers • Draft memo regarding HIT needs to support new payment and care models for DLTSS integrated care to include both high-tech and low-tech solutions/options • Determine process for collaborating with the VHCIP HIE Work Group to include relevant DLTSS HIT needs.	• Review ACTT grant proposal • Review and provide input on memo regarding DLTSS HIT needs for inclusion by the VHCIP HIE Work Group. • Review and provide input on process for collaborating with the VHCIP HIE Work Group to include relevant DLTSS HIT needs. • Receive status reports on progress regarding DLTSS HIT needs	March - December 2014 and on-going	• ACTT grant proposal to be presented at March DLTSS Work Group • VCHIP HIE Work Group recommended ACTT grant proposal (with conditions) to be sent to VHCIP Steering Committee March 5, 2014	• Initial planning funding and subsequent implementation funding of the ACTT proposal and successful completion of grant activities • Completed memo on DLTSS HIT issues • Action plan for inclusion of these issues in HIE Work Group activities

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	• Provide on-going status reports to DLTSS Work Group on progress regarding HIT needs				
Complete Action Plan for inclusion of person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group activities	• Develop a list of items (e.g. accessibility of information and services, training for professionals, etc.) • Develop a strategy for identified items, including incorporation into VHCIP Work Group efforts • Develop an approach to monitor whether incorporation of these items occurs over the long term	• Review, provide input on, and approve strategy for inclusion of person-centered, disability-related, person-directed, and cultural competency issues into VHCIP activities • Receive status updates on incorporation of identified items	March – August 2014 and on-going (for status updates)	• Dual Eligible Work Group list of person-centered, disability-related, person-directed and cultural competency items will inform this work	• List of person-centered, disability-related, person-directed, and cultural competency items • Action plan for inclusion of identified items into VHCIP Work Group efforts • Action plan for monitoring whether items are incorporated into VHCIP activities • Vermont health care reform initiatives are person-centered, disability-related, person-directed and culturally sensitive
Recommend payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and	• Collaborate with the VHCIP Payment Models Work Group as it determines the methodology for bundled payments,	• Review and provide input on payment model designs as they relate to DLTSS (i.e., design of bundled payment, blended	September -December 2014	• Activities have not yet begun	• Finalized payment methodologies that incentivize providers to integrate medical care with DLTSS service delivery

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
long term services and supports	blended payment mechanisms, and Episodes of Care • Research payment methodologies that promote flexible service delivery models that integrate medical/DLTSS care • List current DLTSS provider payments that may prove challenging to bundle and describe the challenges (e.g. nursing home payments, CRT/DS payments, others) • Develop recommendations for integrated provider reimbursement mechanisms for medical/LTSS services	payment mechanisms, Episodes of Care, and integrated reimbursement mechanisms) • Review and provide input on payment methodologies that promote flexible service delivery models • Provide recommendations to VHCIP Payment Models Work Group for integrated provider reimbursement mechanisms for medical/LTSS services			• Incorporation of payment models in VHCIP Payment Models Work Group that enable flexible service delivery models into VHCIP Care Models and Care Management Work Group deliverables.
Recommend incentives for ACOs to reinvest savings to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and promote appropriate use of medications	• Research and develop a list of incentives that encourage ACOs to reinvest savings to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and promote appropriate use of medications	• Review and provide input on list of incentives developed by supporting staff • Recommend strategies for incorporation of incentives into the Payment Models and Care Models/Care Management Work Groups' deliverables	September -December 2014	• Activities have not yet begun	• Incorporation of ACO incentives into payment and service delivery models

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Recommend mechanisms to reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.	• Research and develop a list of mechanisms to reduce the incentive to cost shift among payers • Develop indicators to gauge level of cost shifting among payers	• Review and provide input on list of mechanisms to reduce the incentive to cost shift • Review and provide input on indicators of cost shift	September-December 2014	• Activities have not yet begun	• Finalized list of mechanisms to reduce the incentive to cost shift among payers • Indicators to measure cost shift • Reduction of cost shifting among Medicare, Medicaid and commercial payers
Complete Action Plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies for people needing DLTSS services	• Research and develop list of current barriers in Medicare, Medicaid and commercial coverage and payment policies • Prioritize the barriers that can be acted upon dependent upon federal or state statutory and or regulatory requirements • Develop strategies to address these barriers • Work with CMS, DVHA and commercial insurers to obtain approval to implement strategies, if applicable	• Review and provide input on list of current barriers • Review, provide input on, and approve strategies for addressing coverage and payment barriers	January - April 2015	• Initial list of barriers identified by Dual Eligible Service Delivery workgroup in summer/fall 2011	• Completed list of current Medicare, Medicaid, and commercial coverage and payment barriers • Action plan to implement strategies to address coverage and payment barriers