VT Health Care Innovation Project

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

Thursday, December 10, 2015; 10:00 PM to 12:30 PM

DVHA Large Conference Room

312 Hurricane Lane, Williston

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; Approval of Minutes** Deborah Lisi-Baker	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from September 24, 2015 • Attachment 1c: Minutes from October 15, 2015	 Yes Yes
2	10:10 – 10:35	**DLTSS Data Gap Remediation Project and Funding Proposal** Susan Aranoff, DAIL	• Attachment 2a: *Link to* DLTSS Information Technology Assessment Report, October 2015 • Attachment 2b: DLTSS Data Gap Remediation Project and Funding Proposal	
3	10:35 – 11:10	**Innovation, Teamwork and Payment Reform in the Northeast Kingdom** Patrick Flood, Executive Director, Northern Counties Health Care	• Attachment 3: St. Johnsbury Pilot on Payment Reform	
4	11:10 – 11:55	**HIPAA Compliant "Releases", Privacy and Confidentiality Issues** • **Tools for Enabling Information Sharing for Care Coordination Teams** David Epstein, DAIL; Brad Wilhelm, DVHA	• Attachment 4a: Care Team Consent guide • Attachment 4b: Care Team Release template • Attachment 4c: Care Team Sample Notice for Providers	

5	11:55 – 12:10	**Updates:** • **CMMI's Request for a No-Cost Extension** • **Schedule for Review of New SIM Merged Work Group Work Plans** Georgia Maheras		
5	12:10 – 12:30	**Public Comment/ Updates/ Next Steps** Deborah Lisi-Baker	Next Meeting: Thursday, January 14, 2016 • 10:00 am – 12:30 pm, Pavilion Building, 4th Floor Conference Room, 109 State Street, Montpelier	

Attachment 1b: Minutes from September 24, 2015

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, September 24, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:05am. A roll call attendance was taken and a quorum was not present. Deborah noted a few changes in agenda order. A quorum was present following the fourth agenda item. Deborah Lisi-Baker entertained a motion to approve the August meeting minutes. Ed Paquin moved to approve the minutes by exception. Julie Tessler seconded. The minutes were approved with one abstention.	
2. VHCIP Restructuring and Incorporation of DLTSS Work Plan Activities	Deborah Lisi-Baker introduced the agenda item. She noted that Attachment 2 shows how DLTSS workplan activities align with the project's Year 2 milestones. Julie Wasserman walked through Attachment 2. • Dale Hackett asked a question about evidence-based practices to serve people with disabilities. Deborah noted that many emerging practices do not yet have a large amount of research or evidence. Julie noted that on a recent webinar related to ACOs, Health Management Associates advocated for broadening the definition of "medically necessary" to include a broader range of services. • Dale Hackett asked whether learning collaboratives are meant to be just for ACOs, or are they meant to be a learning tool for DVHA or anyone else. Pat Jones clarified that the Integrated Communities Care Management Learning Collaborative focuses on high risk patients, and includes organizations that provide direct patient care and care management – including Medicaid care managers, among others. The Learning Collaboratives are not meant to be just for ACOs. • Sue Aranoff commented that the new Health Data Infrastructure workplan also includes additional activities relevant to DLTSS populations and providers that were never on the DLTSS Work Group workplan. • Sam Liss asked whether a plan would be developed to integrate input across all of the work groups, including the DLTSS Work Group, now meeting quarterly. Georgia Maheras responded that the cornerstone of that plan is that people on the DLTSS Work Group are also on our other work groups and can share	

Agenda Item	Discussion	Next Steps
	information – this is how we're ensuring information is shared and integrated. Georgia noted that the Core Team requested two sets of workplans – one for the remainder of 2015, and another for 2016. Workplans for 2016 will be presented to work groups in December for additions and modifications prior to the start of the year. The Core Team also requested that new work groups' membership lists are well balanced and no constituency is marginalized – in addition to asking participants to self-select, we have asked co-chairs and staff to review to make sure nothing has fallen through the cracks. New workplans will look slightly different than in the past, and will follow our Year 3 milestones. A new educational webinar series will also provide an opportunity for information sharing; we invite the DLTSS Work Group to suggest topics. • Dale Hackett noted that data so far is based on averages and could result in continued marginalization. People not at that average need representation and participation, and participation that is respected and listened to whether data represents marginalized groups or individuals or not. • Sue Aranoff commented that the Core Team approved governance changes contingent on the fact that the members and work of the Population Health and DLTSS Work Groups be integrated into new workplans. • Sue Aranoff commented that a new study by Families USA reviewed participation by advocates and self-advocates in governance and activities, and that Vermont scored highly on this review. • Sue Aranoff commented that the DLTSS Work Group has been unique in ensuring that people with disabilities and other needs can participate fully, and has made accommodations to ensure full participation. She requested that continued accommodations be made to ensure continued participation, and requested that individuals speak up if they need accommodations in new work groups. • Dale Hackett noted that it can be challenging to review a hundred page (or more) document, and hopes that summaries will be available. Georgia agreed and noted that project staff are working on this. • Nancy Briden asked what the process will be for integrating membership. Georgia responded that we have opened participation to any interested member of the public; membership is open, with the caveat that organizations/state agencies are limited to one voting member (plus alternates) per work group. (Legal Aid is the exception, with two voting members per work group.) Co-chairs and staff are now reviewing draft member lists to ensure there are no holes.	
3. DLTSS Feedback on Shared Care Plans	Deborah Lisi-Baker thanked participants for providing comments on shared care plans. • Dale Hackett thanked the group for this summary. • Sam Liss commented that language needs to be understandable and made clear to anyone who signs it. Deborah agreed, and noted these comments were seconded by Legal Aid. She commented that this is an area for confusion, because we're talking about two different parts of our system – what happens in the room, and what happens in our IT systems. Georgia responded that HIPAA, consent, and information sharing issues are now with DVHA's general counsel to ensure we're fully compliant. Pat Jones is also talking directly with Legal Aid. We will report back to this group on the results of those discussions when the right lawyers and VITL are in the room. • There are no proposed changes to the approved consent policy for the Vermont Health Information	

Agenda Item	Discussion	Next Steps
	Exchange. Georgia noted that we are doing some preliminary work around 42 CFR Part 2, but need to wait for SAMHSA for clarity on this. • Dale Hackett noted that information sharing is a balance between privacy and ensuring optimal care. Julie Wasserman noted that the current VITL consent policy is all or nothing – a global opt in. Georgia clarified that this is part of the Vermont HIT Plan. She also noted that 42 CFR Part 2 governs provider types and services, not just services – substance abuse services delivered at primary care practices, for example, are not covered by 42 CFR Part 2 because those are not SAMHSA governed providers. This consent policy was approved by the Green Mountain Care Board after extensive public comment. Georgia will convey this discussion to the Board and Steve Maier. • Pat Jones commented that the shared care plan is not the entire medical record; it is a high-level document including person-developed goals, including clinical goals, and ensuring this information is available to individuals involved in their care. The Learning Collaborative model is based on sharing learning across different communities. • Sam Liss asked whether there is a distinction in the care plans between person-centered and person-directed. Pat noted that the focus is on having person-directed goals. The shared care plan is a way of prioritizing person-developed goals. • Julie Wasserman noted that Annie Paumgarten shared the Self-Sufficiency Matrix tool, included as a separate attachment – this could be helpful to communities or other organizations.	
4. Nursing Home Bundled Payments for Care Improvement (BPCI) Initiative	Amanda Ciecior (DVHA) and Judy Morton (Vermont Health Care Association) presented on BPCI. • Dale Hackett asked whether this payment model could create gaps in patient care. Mandy clarified that the aim of this model is to ensure smooth continuity of care. • Mike Hall asked which of the options to deliver bundled services was selected by Vermont facilities. Mandy noted that Phase 1 was a planning phase, so each facility selected episodes for which they received analytics. • Episode options were selected by Medicare. • Dale Hackett asked whether the risk taken on through bundled payments is more predictable than other payment models. Mandy responded that she assumes organizations are selecting episodes in which they are confident and taking on minimal risk. Georgia noted that data availability is critical to allowing facilities to take on an amount of risk they are comfortable with. Medicare is doing this for the first time, and will evaluate this demonstration at the end of the demonstration period. • Mike Hall asked whether we have insights into why no Vermont facilities decided to move forward with optional conditions. Judy commented that few Vermont facilities have enough volume to balance the cost of additional reporting and administrative burden that this would require. In addition, Vermont's cost of care is already low compared to other states – it's less likely we can achieve savings than states that are currently high cost. Judy noted that it is particularly challenging for homes that are not owned by national organizations to participate. Partnership with home health after discharge is critical.	

Agenda Item	Discussion	Next Steps
	• Sam Liss asked a follow-up: Is the profit motive getting in the way of care improvement? Judy does not think so. Dale Hackett noted that Vermont doesn't have enough of a health care crisis for organizations to have the profit that they want, or to have an efficient system. • Sue Aranoff noted that small numbers is a problem across a number of our payment models. Georgia commented that Vermont's Medicaid Episodes of Care work has considered the BPCI experience, Arkansas's episodes work (also Medicaid focused), and commercial insurers' work in this area. Moving forward, we'll be relying on Vermont providers and insurers with experience in this area as well as Arkansas and other states as we get further along with different episodes – it's good not to be first sometimes! • Mike Hall commented that this is a less-than-impressive demonstration. Mike believes the payment model, rather than increased risk, is pushing providers away. Administrative burden is also an issue. Georgia commented that one of our goals is to decrease the administrative burden by increasing passive data collection. These lessons and others are informing our future work and sustainability plans. We can always have more discussions with providers about what's preventing them from participating.	
5. Public Comment/Next Steps	Ed Paquin observed that the Self-Sufficiency Matrix line on disability is very medically modeled, and suggested the "5" column should include "thriving with accommodations". Deborah and Georgia welcome comments on any part of this matrix; please send comments to Annie Paumgarten (annie.paumgarten@vermont.gov). Annie initially shared three versions of this with the DLTSS Work Group leadership team; she will share those with the entire group. Pat commented that this is a program capacity evaluation, not an evaluation tool for individuals. Pat agreed that the language in some sections is not what we might choose. Dale Hackett noted that providers' assumptions can negatively impact care for people with disabilities. Sue Aranoff pointed out that the DLTSS Core Competency Briefs are helpful tools for providers in helping them provide optimal care for and with people with disabilities. **Next Meeting:** Thursday, October 15, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier	

Ed Paquin 1°
Julie Tessler 2°
motion to approve minutes by exception
Carried w/ 1 Abstention

VHCIP DLTSS Work Group Member List

Roll Call: 9/24/2015

Member		Member Alternate		August Minutes	
First Name	**Last Name**	**First Name**	**Last Name**		**Organization**
Susan	Aranoff ✓				AHS - DAIL
Debbie	Austin	Craig	Jones		AHS - DVHA
Mary Alice	Bisbee				Consumer Representative
Molly	Dugan				Cathedral Square and SASH Program
Patrick	Flood				CHAC
Mary	Fredette				The Gathering Place
Joyce	Gallimore				Bi-State Primary Care
Martita	Giard	Susan	Shane ✓		OneCare Vermont
Larry	Goetschius	Joy	Chilton ✓		Home Health and Hospice
Dale	Hackett ✓				None
Mike	Hall ✓	Angela	Smith-Dieng		Champlain Valley Area Agency on Aging
Jeanne	Hutchins				UVM Center on Aging
Pat	Jones ✓	Richard	Slusky		GMCB
Dion	LaShay ✓				Consumer Representative
Deborah	Lisi-Baker ✓				SOV - Consultant
Sam	Liss ✓				Statewide Independent Living Council
Jackie	Majoros	~~Barbara~~ Nancy	~~Prine~~ Breiden ✓	A	VLA/Disability Law Project
Carol	Maroni				Community Health Services of Lamoille Valley
Madeleine	Mongan ✓				Vermont Medical Society
Kirsten	Murphy ✓				Developmental Disabilities Council
Nick	Nichols				AHS - DMH
Ed	Paquin ✓				Disability Rights Vermont
Laura	Pelosi	Judy	Morton ✓		Vermont Health Care Association
Eileen	Peltier				Central Vermont Community Land Trust
Judy	Peterson				Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper		Accountable Care Coalition of the Green Mountains
Rachel	Seelig	Trinka	Kerr		VLA/Senior Citizens Law Project
Julie	Tessler ✓	Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Services
Nancy	Warner ✓	Mike	Hall		COVE
Julie	Wasserman ✓				AHS - Central Office
Jason	Williams				UVM Medical Center
	31		10 ✓	1	

16 Q✓

VHCIP DLTSS Work Group Participant List

Attendance: 9/24/2015

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

First Name	Last Name		Organization	DLTSS
Susan	Aranoff	here	AHS - DAIL	S/M
Debbie	Austin		AHS - DVHA	M
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
~~Susan~~	~~Besio~~		SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	X
Mary Alice	Bisbee		Consumer Representative	M
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		DA - HowardCenter for Mental Health	X
Joy	Chilton	Phone	Home Health and Hospice	MA
Amanda	Ciecior	phone	AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper		AHS - DVHA	S
Molly	Dugan		Cathedral Square and SASH Program	M

Gabe	Epstein	here	AHS - DAIL	S
Patrick	Flood		CHAC	M
Erin	Flynn		AHS - DVHA	S
Mary	Fredette		The Gathering Place	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard		OneCare Vermont	M
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett	Phone	None	M
Mike	Hall	here	Champlain Valley Area Agency on Aging / COVE	M/MA
~~Bryan~~	~~Hallett~~		GMCB	S
Carolynn	Hatin		AHS - Central Office - IFS	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Jeanne	Hutchins		UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones	Phone	GMCB	S/M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Sarah	Kinsler	here		S
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay	Phone	Consumer Representative	M
Nicole	LeBlanc	here	Green Mountain Self Advocates	X
Deborah	Lisi-Baker	here	SOV - Consultant	C/M
Sam	Liss	here	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Carole	Magoffin	Phone	AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maroni		Community Health Services of Lamoille Valley	M

Mike	Maslack			X
Lisa	Maynes		Vermont Family Network	X
Madeleine	Mongan	phone	Vermont Medical Society	M
Todd	Moore		OneCare Vermont	X
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy	phone	AHS - Central Office - DDC	M
Floyd	Nease		AHS - Central Office	X
Nick	Nichols		AHS - DMH	M
Miki	Olszewski		AHS - DVHA - Blueprint	X
Jessica	Oski		Vermont Chiropractic Association	X
Ed	Paquin	here	Disability Rights Vermont	M
Annie	Paumgarten	here	GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
John	Pierce			X
Luann	Poirer		AHS - DVHA	S
Barbara	Prine		VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Rachel	Seelig		VLA/Senior Citizens Law Project	M
Susan	Shane	here	OneCare Vermont	MA
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S/MA
Angela	Smith-Dieng		Area Agency on Aging	MA
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	here	DA - Vermont Council of Developmental and Mental Health Serv	M
Bob	Thorn		DA - Counseling Services of Addison County	X
Beth	Waldman	phone	SOV Consultant - Bailit-Health Purchasing	S
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	MA
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/M
Kendall	West			X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	M

Cecelia	Wu		AHS - DVHA	S
Marie	Zura		DA - HowardCenter for Mental Health	X
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Nancy Foreiden none
Suzanne Santarcangelo none
Judy Morton - none-VT Health Care Association

Attachment 1c: Minutes from October 15, 2015

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, October 15, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:01am. A roll call attendance was taken and a quorum was not present.	
2. VHCIP Restructuring and Incorporation of DLTSS Work Plan Activities	Deborah Lisi-Baker introduced a set of revised Year 2 Workplans for the new Payment Model Design and Implementation, Practice Transformation, and Health Data Infrastructure Work Groups. Sarah Kinsler and Georgia Maheras made a few general notes about these workplans: • These workplans take into account feedback from this group's leadership team and members (including Deborah, Julie Wasserman, and Susan Aranoff). • These workplans represent work for *only* the remainder of 2015 (October-December). Year 3 (2016) workplans will be created in November/December, and hopefully adopted in January. • These are still relatively high-level documents – they don't include full project plans for every project. Each project has a plan with resources, staff and contractors, and detailed tasks. Our milestones, workplans, and project plans work as a full package. Payment Models (Attachment 2a): • ACO Shared Savings Programs: o Dale Hackett asked ACO SSP Downside Risk in Year 3 (Row 2). Georgia responded that the Payment Models Work Group and DVHA have been taking many things into account, and will be discussed at Payment Models next week. o Julie Wasserman added that it was announced at the last Payment Models Work Group meeting that DVHA and the ACOs have decided not to expand total cost of care to non-core services for the Medicaid ACOs. Georgia noted that this decision strengthens our negotiating position for the All-	

Agenda Item	Discussion	Next Steps
	Payer Waiver. Deborah asked whether there were plans to include a broader scope of services in later waiver years, and noted that work in the next few years will be critical to increase DLTSS provider readiness. Patrick Flood commented that CMS has said we need to fold in behavioral health in later years. The All-Payer Model planning group is meeting with the DAs and ACOs later this month to discuss this. Deborah commented that it would be helpful to know more about this as discussions evolve. Georgia replied that she, Michael Costa, and Ena Backus are developing a set of questions to support provider readiness and planning. o Joy Chilton asked about the Year 1 SSP result report. Georgia replied that the results were released at a Green Mountain Care Board meeting, but the more detailed report is not yet available. The results are available on GMCB's website, and will be sent to all VHCIP participants. o Dale Hackett asked whether we should aim to have behavioral health as our first priority. • Episodes of Care (EOCs): o Julie Wasserman noted that the last two lines come from the DLTSS Work Group Workplan: "Recommend an EOC that bridges the gap between medical care and long-term services and supports. Recommend an EOC with DLTSS-specific outcomes." • Accountable Communities for Health: o Dale Hackett asked how this reflects the vast number of factors that impact community health. Deborah noted that she has seen presentations on the Population Health Work Group's work, and it's very impressive and reflects some DLTSS concerns, but doesn't always reflect the needs of people with diverse disabilities, and suggested this be a continued focus of this work. • Ongoing Updates, Education, and Collaboration: o Deborah noted that all of the work groups have a process for receiving continued updates on projects and work across VHCIP. Deborah suggested that this group will need to have robust agendas to continue to provide input into various other work groups' efforts. o Dale Hackett asked where Blueprint and primary care fit into this. Deborah responded that we are working to ensure there's a continued focus on inclusiveness and competent care for people with disabilities. Patrick Flood noted that the ACO & Blueprint's Unified Community Collaboratives (UCCs) which are required to include AAAs, behavioral health, housing, and more. The Blueprint is also starting a very small pay-for-performance incentive payment. Patrick suggested an update from Craig Jones at a future meeting. Practice Transformation (Attachment 2b): • Sub-Grant Program: No comments. • Learning Collaboratives: o Deborah noted work to ensure that disability competency is addressed in the Learning Collaborative initiative continues. The State released an RFP and is currently reviewing proposals for a contractor to develop disability core competency training and care management core competency training.	

Agenda Item	Discussion	Next Steps
	This work was informed by the briefs authored by PHPG. o Dale Hackett asked what the next step is for this initiative. Deborah agreed that sustainability is a key issue, and one of the things the bid review team is looking at. o Jackie Majoros asked about progress toward a HIPAA-compliant release for shared care plans. Georgia responded that there is no target date because there is an assumed December 2015 target date for this workplan. This work is currently with DVHA's General Counsel, who has also talked with Sue Aranoff about what makes sense here. This work depends on various private and public sector legal staff – the State cannot do this alone. Work continues to move forward appropriately across this team. Julie Wasserman noted that there is concern about privacy and confidentiality issues more broadly than HIPAA-compliance. This group will be kept informed of progress. Susan Aranoff suggested someone keep track of the communities that have joined the Learning Collaborative as part of the newly launched cohort, and that guidance or templates could help providers as they develop releases. Jackie Majoros encouraged caution in this area. Jackie and Georgia noted that there are upcoming meetings between the State, Legal Aid, and others. Susan and Julie noted that there are compliant release templates available, including from Integrated Family Services, the Blueprint Community Health Teams. Dale Hackett noted that when confidentiality prevents providers from sharing appropriate information, it can be life threatening. Julie noted that lack of confidentiality can also have negative impacts on peoples' lives. Georgia noted that there are areas where Vermont law is more strict than HIPAA, and areas where that is not the case. Georgia does not know of any legislation on the table to change this. Ed Paquin noted that the State is generally more protective of health care information, and that the way to get around this is to get patient permission to share information. Ed noted that VITL's releases go in the opposite direction – if a patient consents to have their information in the VHIE, any provider within an organization with appropriate privileges can view it. Deborah suggested the group receive an update on this issue in December. • Regional Collaboratives: o These are also known as Unified Community Collaboratives (UCCs). Deborah noted that these are expanding to become more inclusive, and that early work in many communities is impressive. o Sam Liss asked how we are gathering lessons learned about addressing social determinants of health. Deborah noted that this is an area of continued work. Patrick Flood replied that in St. Johnsbury, the collaborative is paying strong attention to social determinants: the group includes housing, the food bank, the CAP agency, and more. The group frequently expends funds to address non-medical issues that impact health. Sam commented that we need to formalize a model around how to address this. Patrick responded that we should ensure that the UCCs include non-health care organizations like food, housing, and more, to ensure these needs are at the forefront. He also suggested that flexible funding to invest in non-traditional ways is a critical factor. Sue Aranoff commented that the Learning Collaborative shared care planning process reviews housing, food, transportation, employment, and other non-medical needs and has a patient-directed process to	

Agenda Item	Discussion	Next Steps
	prioritize addressing their needs. Julie Wasserman suggested this be more explicitly described in Year 3 workplans. Dale Hackett asked whether confidentiality could be added to the shared care planning process to support a patient-directed discussion of this issue. Sue commented that the CHT and IFS release forms are detailed and allow individuals to indicate the organizations with which they would like to share information. Kirsten Murphy noted that communication about privacy is as important as the legal form, especially for people with cognitive disabilities. Brenda Lindemann (alternate for Mary Alice Bisbee) asked how this could be operationalized when a group of providers is actively care managing an individual together. Deborah suggested we discuss this concern further in December. Health Data Infrastructure (Attachment 2c): • Expand Connectivity to Health Information Exchange (HIE): o Deborah noted that this group spent time early in the process ensuring there were funds for DLTSS providers to connect to the VHIE. Georgia noted that the LTSS Technology Assessment report should be finalized and distributed by the end of the month; this will support further planning in this area. Year 3 workplans will have more information on next steps. Georgia commented that selecting solutions is a collaborative process that happens in partnership with providers. o Dale Hackett asked what the error rate is for data being shared. Georgia replied is that data isn't being shared very well at this point, so there's a low error rate. • Improve Quality of Data Flowing into HIE: No comments. • Telehealth: No comments. • EMR Expansion: No comments. • Data Warehousing: No comments. • Care Management Tools: Julie Wasserman noted that DAIL and others have expressed concern about privacy in the context of electronic care plans as well, and suggested we cannot let technology drive decisions about privacy and confidentiality. Dale Hackett noted that errors in data and provider communication can make it challenging for individuals to receive the care they need. Joy Chilton suggested that we should ensure patients have access to their own information. Sam Liss commented that patients need to understand exactly what the implications of data sharing are. • Continued Updates, Education, and Collaboration: No comments. List: Current Efforts to Incorporate DLTSS Activities into New Work Groups (Attachment 2d) • Georgia walked through this attachment. • Sue Aranoff emphasized that work group members from all work groups can send requests for reasonable accommodation to her: susan.aranoff@vermont.gov.	
3. Payment Models, Value-	Deborah Lisi-Baker introduced the agenda item. This presentation comes out of a broader scope of work to explore alternative payment models that are inclusive of DLTSS providers and could support better care for people with	

Agenda Item	Discussion	Next Steps
Based Purchasing, and DLTSS Design Considerations	LTSS needs. Georgia Maheras added that this connects with broader conversations about Medicaid value-based purchasing, and invited input from this group. She noted that it's critical not to assume the population, services, payment model, or quality measures for any potential value-based purchasing model – deliberate conversations in these areas can support better planning in the long-term, and will help ensure sufficient provider readiness prior to launch. Suzanne Santarcangelo and Scott Whitman of PHPG presented on Payment Models, Value-Based Purchasing Design Elements, and Vermont Models (Attachment 3). • Base Payment Models: Value-based purchasing can be overlayed on any of these models. o Fee-for-Service (FFS) o Bundled Payments: Bundles are very new – there is limited evaluation or literature at this point on impacts (positive and negative). o Population-Based Payments: Georgia noted that we have a lot of tools to avoid past mistakes from things like HMOs, including quality measurement, provider training, etc. Suzanne agreed, and noted that this is just the theory behind the base models. o Specific models that are being tested out in one or more of Vermont's payment reform related projects such as SSP, P4P, Hub and Spoke, etc. • Objectives and overarching principles o Triple Aim-based o Ensuring the appropriate allocations and resources and managing costs o Improve care coordination and integration • Design Principles with DLTSS objectives o Tailoring to specific DLTSS programs o Promoting integration and coordination across the full array of healthcare services o Fiscally rewarding change while not compromising DLTSS objectives • Structural Considerations o DLTSS providers receiving majority of funding from Medicaid o Several regulatory systems in place o Coordination and alignment of providers can vary widely • Design Considerations o What providers or entities to target o Which payment types to use • Measures o Types ▪ Structural ▪ Process ▪ Performance and outcomes	

Agenda Item	Discussion	Next Steps
	o Those specific to each unique program The group discussed the following: • Dale Hackett asked about the data that will be used. Scott responded that Vermont may have a small population but makes up a very large portion of Vermont's Medicaid population, and a good amount of data can be collected. • Conversation on the diversity of interventions and ability to measure them, as well as the need to establish process and outcome measures to identify the smaller interventions and their unique successes. • Discussion around the measures and outcomes that might be used with how broad and diverse this DLTSS population tends to be. • Any estimate yet made on what impact new payment model(s) might have on the Medicaid budget? Scott responded that one of the goals of the All Payer Model is to lead to a sustainable growth rate, and that these models will provide flexibility and a potential cost savings. Scott also understood that CMS guidance was to include behavioral health and LTSS in the All Payer Model, and he mentioned the need to begin early planning efforts. • Sue requested an illustration around how current services provided are being funded in Vermont. It is hard to identify opportunities for improvement if we have no baseline information. • Will the approach toward Value Based Purchasing provide an opportunity to streamline some relationships with the State? Possibly, that would be hard to answer right now. • Workgroup staff and leadership will continue to discuss critical questions – potential to bring PHPG back to continue this discussion and provide more concrete steps for Vermont.	
4. Public Comment/Next Steps	**Next Meeting:** Thursday, December 10, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Member List

Roll Call: 10/15/2015

Member		Member Alternate		August Minutes	
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Debbie	Austin	Craig	Jones		AHS - DVHA
Mary Alice	Bisbee	Brenda	Lindemann ✓		Consumer Representative
Molly	Dugan				Cathedral Square and SASH Program
Patrick	Flood ✓				CHAC
Mary	Fredette				The Gathering Place
Joyce	Gallimore				Bi-State Primary Care
Martita	Giard ✓	Susan	Shane		OneCare Vermont
Larry	Goetschius	Joy	Chilton ✓		Home Health and Hospice
Dale	Hackett ✓				None
Mike	Hall ✓	Angela	Smith-Dieng ✓		Champlain Valley Area Agency on Aging
Jeanne	Hutchins ✓				UVM Center on Aging
Pat	Jones	Richard	Slusky		GMCB
Dion	LaShay ✓				Consumer Representative
Deborah	Lisi-Baker ✓				SOV - Consultant
Sam	Liss ✓				Statewide Independent Living Council
Jackie	Majoros ✓	Barbara	Prine		VLA/Disability Law Project
Carol	Maroni				Community Health Services of Lamoille Valley
Madeleine	Mongan ✓				Vermont Medical Society
Kirsten	Murphy ✓				Developmental Disabilities Council
Nick	Nichols ✓				AHS - DMH
Ed	Paquin ✓				Disability Rights Vermont
Laura	Pelosi				Vermont Health Care Association
Eileen	Peltier				Central Vermont Community Land Trust
Judy	Peterson				Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper		Accountable Care Coalition of the Green Mountains
Rachel	Seelig	Trinka	Kerr		VLA/Senior Citizens Law Project
Julie	Tessler	Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Services
Nancy	Warner	Mike	Hall		COVE
Julie	Wasserman ✓				AHS - Central Office
Jason	Williams				UVM Medical Center
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Ile Q ✓

VHCIP DLTSS Work Group Participant List

Attendance: 10/15/2015

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

First Name	Last Name		Organization	DLTSS
Susan	Aranoff	new	AHS - DAIL	S/M
Debbie	Austin		AHS - DVHA	M
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
~~Susan~~	~~Besio~~		SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	X
Mary Alice	Bisbee		Consumer Representative	M
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		DA - HowardCenter for Mental Health	X
Joy	Chilton	phone	Home Health and Hospice	MA
Amanda	Ciecior	new	AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper		AHS - DVHA	S
Molly	Dugan		Cathedral Square and SASH Program	M

Gabe	Epstein	here	AHS - DAIL	S
Patrick	Flood	here	CHAC	M
Erin	Flynn		AHS - DVHA	S
Mary	Fredette		The Gathering Place	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard	Phone	OneCare Vermont	M
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett	here	None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M/MA
~~Bryan~~	~~Hallett~~		GMCB	S
Carolynn	Hatin		AHS - Central Office - IFS	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Jeanne	Hutchins	Phone	UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones		GMCB	S/M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Sarah	Kinsler	here		S
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay	Phone	Consumer Representative	M
Nicole	LeBlanc		Green Mountain Self Advocates	X
Deborah	Lisi-Baker	here	SOV - Consultant	C/M
Sam	Liss	Phone	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras		AOA	S
Jackie	Majoros	Phone	VLA/LTC Ombudsman Project	M
Carol	Maroni		Community Health Services of Lamoille Valley	M

Mike	Maslack			X
Lisa	Maynes		Vermont Family Network	X
Madeleine	Mongan	here	Vermont Medical Society	M
Todd	Moore		OneCare Vermont	X
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy	here	AHS - Central Office - DDC	M
Floyd	Nease		AHS - Central Office	X
Nick	Nichols	phone	AHS - DMH	M
Miki	Olszewski		AHS - DVHA - Blueprint	X
Jessica	Oski		Vermont Chiropractic Association	X
Ed	Paquin	here	Disability Rights Vermont	M
Annie	Paumgarten	here	GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
John	Pierce			X
Luann	Poirer		AHS - DVHA	S
Barbara	Prine		VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Rachel	Seelig		VLA/Senior Citizens Law Project	M
Susan	Shane		OneCare Vermont	MA
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S/MA
Angela	Smith-Dieng	here	Area Agency on Aging	MA
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler		DA - Vermont Council of Developmental and Mental Health Serv	M
Bob	Thorn		DA - Counseling Services of Addison County	X
Beth	Waldman	phone	SOV Consultant - Bailit-Health Purchasing	S
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	MA
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/M
Kendall	West			X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	M

Cecelia	Wu		AHS - DVHA	S
Marie	Zura		DA - HowardCenter for Mental Health	X
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Suzanne Santarchangelo - PHPG - here
Scott Whitman - PHPG - here
Brenda Hindemann - here

Attachment 2b: DLTSS Data Gap Remediation Project and Funding Proposal

DISABILITY AND LONG-TERM SERVICES AND SUPPORTS DATA GAP REMEDIATION PROJECT: NEXT STEPS

Susan Aranoff, Esq.

Health Integration Quality Analyst

Vermont Department of Disabilities, Aging, and Independent Living

December 10, 2015

BACKGROUND

- Since its inception, increasing the Health Information Technology capacity of Vermont's Disability and Long-Term Services and Supports (DLTSS) Providers and other "non-Meaningful Use providers" has been a stated goal of the Vermont Health Care Innovation Project. (See-application, operational plans, work plans, and milestones).

- The DLTSS Data Gap Analysis and Remediation Project began as part of the Accessing Care Through Technology (ACTT) suite of HIE/HIT projects.

DLTSS Data Gap Remediation Project-Phases

- This project is a “planning phase to build a comprehensive budget request for Phase Two that allows for IT gap remediation work to occur.”

- The gap analysis was submitted in April 2015 and finalized in November 2015.

Next Steps

- Disseminate Report
  - MMIS Implementation Team
  - HDI Work Group
  - State HIT Plan Leadership
  - HIS Implementation Team
- Gap Remediation
  - Allocate Funds
  - Identify Priorities

Context

- Vermont's Home Health Agencies and Area Agencies on Aging make it possible for aging Vermonters and Vermonters with disabilities to live independently in the community – which is not only what most people prefer – it is required by law- e.g. the Olmstead decision.
- Home Health Agencies and Area Agencies on Aging need robust connections to the VHIE in order to implement the Next Generation Medicare Shared Savings Program.
- Home Health Agencies and Area Agencies on Aging need robust connections to the VHIE in order to comply with the IMPACT Act.

Continued

- Vermont is one of the leaders in shifting the balance from people living in institutions to living in the community. At present, more than 50 % of people receiving Disability and Long Term Services and Supports live in the community.
- Vermont has the second oldest average population and the need for Disability and Long Term Services and Supports, including Home and Community Based Services, is rapidly increasing.
- Home and Community Based Services are essential for improving and maintaining the health of Vermonters- especially Vermonters living with disabilities, chronic and/or complex health conditions.

Continued

- Vermont's Home Health Agencies serve approximately 23,000 Vermonters per year. In FY 2013, Vermont's HHAs made nearly 950,000 home visits.
- Vermont's Area Agencies on Aging serve approximately 45,000 Vermonters per year.
- SIM has allocated the following for hospitals, primary care providers, specialists, ACOS, skilled nursing facilities, and SSAs/DAs:
  - Year 1 Actuals: $3,003,982.64
  - Year 2 Budget: $3,574,117.50
  - Year 3 Budget: $2,917,500

The Core Team will be considering requests for several proposals at its December meeting, including those discussed earlier today that total approximately $3 million dollars that will benefit hospitals, primary care providers, specialists, ACOS, and SSAs/DAs.

- To date, no SIM funds have been allocated to increase HIE/HIT connectivity for Vermont's Home Health Agencies and Area Agencies on Aging.

PROPOSAL

- Expand the scope of VITL's SIM-funded work to include connecting the remaining HHAs and AAAs to the VHIE if funding is approved for additional interfaces.
- Recommend that the Core Team allocate $800,000.00 of remaining funds to remediate some of the highest priority gaps identified in the DLTSS data gap analysis.
- Specifically recommend providing VITLAccess to the Home Health Agencies and Area Agencies on Aging.

Attachment 3: St. Johnsbury Pilot on Payment Reform

ST. JOHNSBURY PILOT ON PAYMENT REFORM

Patrick Flood

December 10, 2015

Northeast Vermont Regional Hospital, Northeast Kingdom Human Services, and Northern Counties Health Care (which includes Caledonia Home Health) have a strong interest in payment reform to afford us more flexibility in service delivery. We want this flexibility to advance our efforts to build an "accountable health community" in the NVRH hospital service area. Last spring we asked the Legislature to let us have a "global budget" for Medicaid. The administration was less than enthusiastic about that idea and we agreed as a next step to pursue flexibility in three service areas: Choices for Care, Integrated Family Services, and mental health funding and reporting.

Background. The Choices for Care reimbursement rates for personal care, respite and companion services have not increased appreciably in years. As a result, Caledonia Home Health is losing approximately $200,000 per year on the program. This creates a real disincentive to grow the program. If it were to grow, participants would be happier, and the state would save more money. So we need to create the right incentives and manage the program differently.

The discussions related to Choices for Care focus on three key elements so far:

1. A bundled rate or case rate for personal care, respite, and companion care provided by Caledonia Home Health. A bundled rate would give us more flexibility in assigning staff and meeting patient needs. It is possible there could be some savings from this approach.
2. A team approach to case management. Currently only the AAA or the VNA can provide care management. In St. Johnsbury, we have well developed teamwork and would like to apply it to Choices for Care for better coordination and better outcomes. The concept is still under development, but it has three key components:
    a. The team would include the VNA, AAA, Adult day, SASH, the community health team and others to ensure we had the best coordination possible.
    b. The consumer would choose a lead case manager, which could be one of the other agencies.
    c. The team would develop the care plans and manage the funding for case management.
3. We are pursuing a shared savings arrangement with the state. We recognize that some savings need to go towards the state's budget deficit. However, we think some of the savings should be directed to both re-investments in other community services and also to help cover the deficit in the VNA budget.

There are many details still to be worked out, but we are working closely with the state and consultants on those details. We recognize that changes along these lines require the approval of the legislature and CMS. If the changes were approved as a pilot, we would anticipate a start date of July 1, 2016.

Attachment 4a: Care Team Consent guide

Tools for Sharing Private Client Information in an Interdisciplinary Care Team

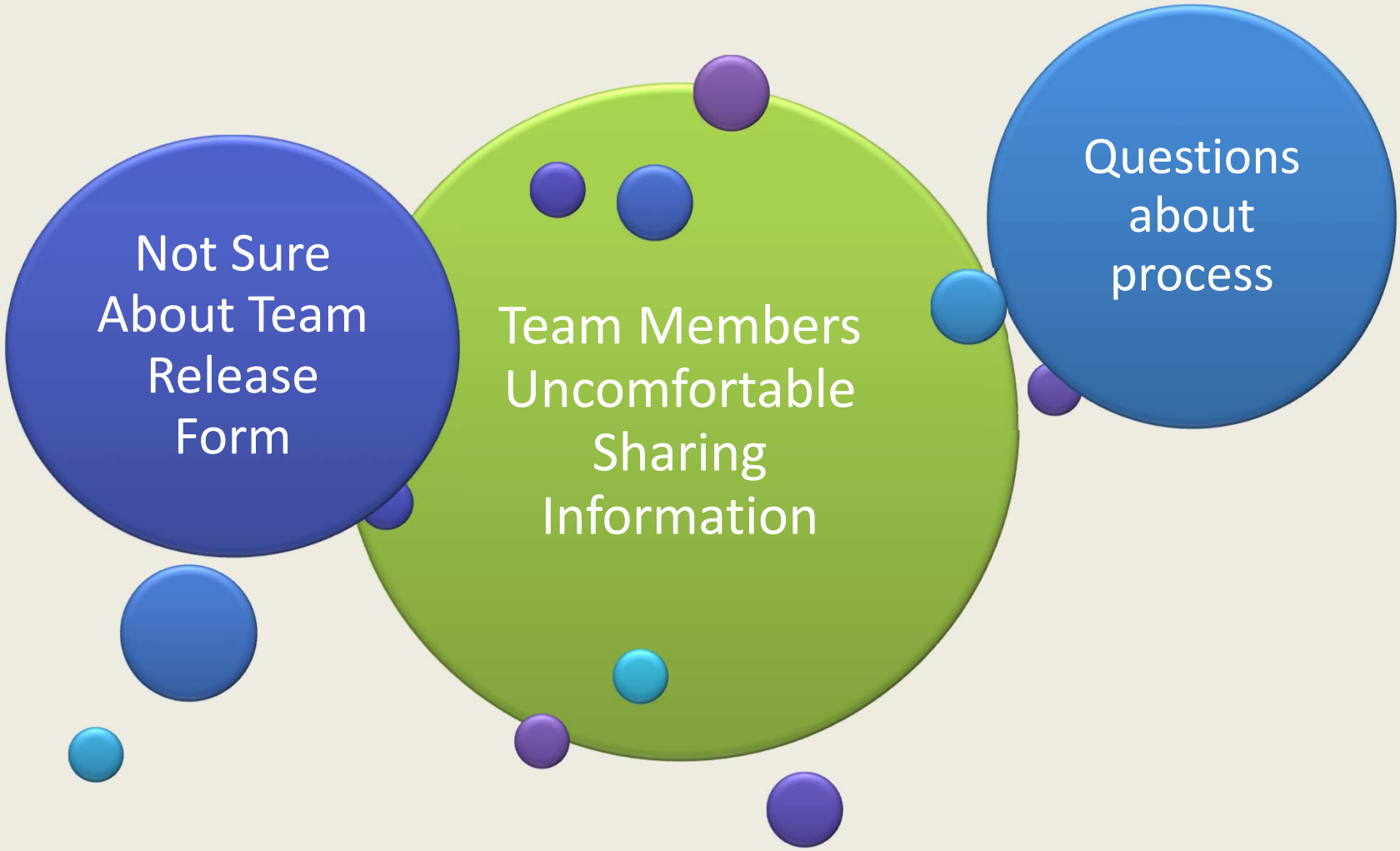
Gabe Epstein – Health Policy Analyst
DAIL

Level Setting – In this Presentation:

- "Consent", "Release", and "Authorization" all mean a form that documents a client's permission to share private information
- Interdisciplinary Care Teams can be any team of providers from different organizations working together to help one client

For Informational Purposes Only - This is not legal advice

Problem: Team Members Unwilling to Share Client Information



Release Forms Are Easy

- Clients has the right to share private information
- A valid release form lets providers know that sharing is allowed
- A properly written release form can be relied on by virtually any provider

Release Forms Are SO HARD

- Clients often sign releases without reading them, sometimes without understanding what they are signing
- Team releases can be even harder to write and understand
- Providers are almost never REQUIRED to honor a release form, and may resist if they believe that doing so will violate an ethical duty to their clients

How to Disclose with Confidence

- ✓ Have a legally valid consent form
- ✓ Ensure client makes informed choice to share information
- ✓ Clear expiration date or event
- ✓ A procedure to alert all providers promptly when consent has been revoked

Release Form Design Choices

- Plain Language: 7.1 Grade Reading Level
- Person directed: Choice of team members, limits on sharing
- Accessible fonts, distinct sections
- Addresses Risks: Specifies non-HIPAA providers, risks of re-disclosure
- Tells client and providers how to communicate revocation

Walking Through The Form

- Page 1:
  - Choosing a Care Team
  - Non-HIPAA Providers
  - Part 2, Family Educational Rights and Privacy Act (FERPA), and Mental Health Information

Walking Through The Form

- Page 2
  - Purpose
  - Consequences of Sharing
  - Privacy Practices

Walking Through The Form

- Page 3
  - Choosing Information
  - Limiting by time and subject matter
- Page 4
  - Revocation Protocol
  - Expiration
  - Signature

Making It Work

- The form needs to be customized to suit the team's goals and vetted by community providers and their attorneys
- The team needs to reach consensus on a consent and sharing processes

Consent Process Recommendations

To facilitate sharing:

- Document consent with a release; don't rely on exemptions
- Practice with the form and be ready to help the client use it
- Have a plan to clarify, document, and honor a client's wishes to stop sharing
- "Scrub in" at the team meetings and over-protect information

Scrubbing In

- Only identify and share information about patients who have provided a release; don't rely on exemptions
- Agree ahead of time how to use the information they receive
- Give clear instructions if sharing Part 2, FERPA, or Mental Health Information

Recommended Standards

Be a little more careful with information received from other providers

- Keep information secure, even if you are not regulated by HIPAA
- Only use the information in the Care Team context.

Use caution when working with people outside the care team so as not to disclose Part 2, FERPA, or Mental Health Information

Written Guidance for the Team

- Example Notice form lists standards and provides redisclosure warnings

Questions and Feedback

- Would you accept this release as a provider?
- Would you be able to use this release as a patient?
- Could your team function under these rules?
- Any other questions?

Attachment 4b: Care Team Release template

Release form provided by (name and organization): _____

[INTERDISCIPLINARY CARE TEAM]'S PERSON-DIRECTED RELEASE OF INFORMATION FORM [For informational purposes - not legal advice]

Name _____ Date of Birth _____

I WANT MY PROVIDERS TO WORK AS A TEAM

I am naming a team of providers to work together on my care. I am in charge of this team. I choose who is on my team and what information they can share.

These are the providers whose employees can be on my team. **If I do not want or need any of these providers on my team, I will write my initials next to the words "Do not include this provider**." I can keep seeing my providers even if I do not put them on my team.

[Hospital]	____ Do not include this provider
[Home health agency]	____ Do not include this provider
[FQHC]	____ Do not include this provider
[Mental Health DA]	____ Do not include this provider
[Family Practice A]	____ Do not include this provider
[Family Practice B]	____ Do not include this provider
[Agency of Human Services]	____ Do not include this provider
[DVHA/VCCI]	____ Do not include this provider

I also want to include these providers on my team. I know that these providers will respect my privacy, but the records I share with them will no longer be protected by the privacy law known as HIPAA.

[Housing agency]	____ Do not include this provider
[Area Agency on Aging?]	____ Do not include this provider
[Patient Advocate/Legal Advocate]	____ Do not include this provider

Other Team Member Requests:

_____

_____

_____

_____

I know that some of my records could be protected by other laws. I know that team members who receive records of substance use treatment from [part 2 facility/facilities], educational records from [FERPA entity], and mental health treatment from [Title 18 Part 8 mental health treatment] will be warned not to share those records outside of the team without my permission.

HOW MY TEAM WILL USE MY INFORMATION

My team is allowed to use my private information to help me make a plan for my care and to provide services to help me reach my plan's goals. It could list private things like my need for help with my money, mental health, education, disability, substance use issues, or medical care. My team will be allowed to share this plan with each other **and give each other updates about my care**.

I GIVE MY TEAM PERMISSION TO SHARE MY PRIVATE INFORMATION

I give my team of providers permission to share my private information with all the other members of the team. **I give my team members permission to pass along the information they receive to the other member of the team**.

I know that **my health records could be shared again**. Information that is shared may no longer by protected under the privacy law known as HIPAA. This could include some information about substance use, HIV/AIDS status, and mental health.

I know that I can cancel this release in writing at any time. I know that even if I cancel this release, **my providers may still have a right to keep and use information that has already been shared.**

MY PROVIDERS AND THEIR PRIVACY PRACTICES

I know that I can have other releases with my providers that let them share my private information for other reasons. If I want to cancel those releases, I have to talk to those providers and ask them how to do that.

I know that my providers can share some of my private information without asking me. If I want to know more about this, I can ask each of my providers to tell me about their privacy practices.

THESE ARE THE RECORDS MY TEAM CAN SHARE

I give the whole team permission to give and to receive the information chosen in this section. I can write a date next to the words "Do not share records from before this date" if I want to keep my older records private.

Do not share records from before this date:_____

I give my providers permission to share the types of information I select from the list below. **Each type of information can be shared if I write my initials on the line next to it**.

_____Name and date of birth
_____Address, phone number(s)
_____Whether I am a client, when my appointments are, if I miss appointments, if I am making progress
_____[Current and past diagnoses]
_____[Current and past medications]
_____[Current living situation]
_____[Public assistance information]
_____[Department for Children and Families history of involvement]
_____[Children's health and safety assessments]
_____[Criminal history and current and past involvement with Department of Corrections]
_____[Current or past drug and/or alcohol use information, including diagnosis, treatment, progress, and discharge summary]
_____[Current or past mental health information, including assessment, diagnosis, treatment, progress and discharge summary]
_____[All test results, including drug testing, HIV, hepatitis, tuberculosis, etc.]
_____[WIC program participation history]
_____[Psychotherapy Notes. I know that HIPAA requires my permission before these records can be shared outside the team, but that some of my providers may not have to follow HIPAA.]

I also give my providers permission to share the private information that I list here:

_____

_____

_____

_____

_____

_____

HOW TO END OR CHANGE THIS RELEASE

I know that this release will end on its own if I do not see any of the providers on my team for one year.

I can also set my own end date here: _____

End Date

I can cancel or change this release by contacting:

[Person X]
[Address]
[City], VT [ZIP]
[Phone]

[Person X] will then tell my team members that this release has been cancelled. I know that even if I cancel this release, my providers may still have a right to keep and use information that has already been shared.

I know that I have a right to keep working with my providers even if I tell them not to share my information.

SIGNATURE

I know this release will only start once I sign and date this page. I know that **if I do not give the team permission to share my information, they will not be able to work together as a team or share a plan for my care. I know that I have a right to keep working with my providers even if I tell them not to share my information.**

I know I have a right to get a copy of this form.

_____ _____

Signed by me or my representative Date

_____

Reason why my representative is allowed to sign for me

_____

Signature of my parent or guardian if I am too young to sign by myself

Attachment 4c: Care Team Sample Notice for Providers

[INTERDISCIPLINARY CARE TEAM] NOTICES FOR PROVIDERS REGARDING REDISCLOSURE OF PRIVATE INFORMATION [For informational purposes - not legal advice]

Notice of Privacy Standards

Only individuals authorized by the **[CARE TEAM] PERSON DIRECTED RELEASE FORM** may receive the protected information specified in the release.

Providers are advised to keep the information they receive pursuant to the release separate and distinct from the information obtained directly from the client in the course of practice.

Providers are expected to follow the confidentiality laws and ethical standards of their practice. Providers are also asked to do the following with information received pursuant to the release, even when not required to do so:

- Keep this information secure
- Use or disclose this information only as authorized by the release or with the client's written permission
- Seek legal advice if required to disclose records by law or in an emergency situation

NOTICES FOR PROVIDERS REGARDING PRIVACY REQUIREMENTS OF LAWS MORE STRINGENT THAN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The laws referenced below protect specific kinds of private information. This information should not be used or disclosed except as described in the release. Providers should contact the source of this information and/or seek legal advice if such use or disclosure is:

- Requested by the client or required for the client's treatment
- Required by law
- Made without permission or in an emergency

Part 2 Warning for [Part 2 Facility]'s Records

Information disclosed by [Part 2 Facility] in this team is protected by 42 CFR Part 2.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any

use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FERPA Warning for [Educational institution]

Personally identifiable information from an educational records disclosed by [Educational Institution] is protected by the Family Educational Rights and Privacy Act (34 CFR part 99). The disclosure of this information is made on the condition that the parties receiving this information will not disclose the information to any other party without the prior consent of the parent or eligible student, except as permitted by FERPA.

Title 18 Part 8 Warning

Any records created pursuant to State Mental Health Statutes (18 V.S.A. §§ 7101 - 9335) are protected by state law as well as HIPAA. Written consent is required for certain disclosures, including some disclosures which are otherwise permissible without written consent under HIPAA. Seek legal advice before disclosing such information without permission.