DLTSS Work Group Meeting

Agenda 5-28-15

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Thursday, May 28, 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 April 30, 2015	Yes
2	10:10 - 10:40	**DLTSS-Specific Core Competencies** Susan Besio, PHPG	• Attachments 2a-f: Draft Disability Awareness Briefs, May 18, 2015	
3	10:40 – 11:00	**DAIL's Timeline for Addressing CMS's New HCBS Waiver Regulations** Sue Aranoff, DAIL	• Attachment 3: DAIL HCBS ppt 5-21-15	
4	11:00 – 12:00	**Payment Models Work Group Presentation** Alicia Cooper, DVHA	• Attachment 4a : Payment Models Work Group 2015 Activity ppt • Attachment 4b: ACO Comparison Grid 5-21-15	
5	12:00 – 12:15	**Public Comment/Next Steps** Deborah Lisi-Baker	Next Meeting: Thursday, June 18, 2015, 10:00 am – 12:30 pm Pavilion Building, 4th Floor Conference Room, 109 State Street, Montpelier	

Attachment 1b

April Minutes

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

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

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Judy Peterson called the meeting to order at 10:03am. A roll call attendance was taken and a quorum was present. Judy Peterson entertained a motion to approve the February 19, 2015, meeting minutes. Ed Paquin moved to approve the minutes by exception. Mike Hall seconded. The minutes were approved with three abstentions. Ed Paquin moved to approve the March 26, 2015, minutes by exception. Mike Hall seconded. The minutes were approved with two abstentions.	
2. Review DLTSS Year 2 Work Plan	Deborah Lisi-Baker introduced the DLTSS Work Group Year 2 Workplan. She noted that many of the contents will look familiar to group members, and opened a discussion about the workplan contents. Julie Wasserman described each workplan category and objective. Quality and Performance: • Mike Hall asked whether this workplan includes developing measures for home- and community-based services (HCBS), within or outside VHCIP's Accountable Care Organization (ACO) activities. Julie Wasserman noted that the Agency of Human Services (AHS) has just completed consolidation of the Global Commitment and Choices for Care waivers; Shawn Skaflestad is leading measures-development work for the new consolidated waiver. The workplan does include providing input into waiver measure development as an activity (Workplan item 6). Mike Hall noted that this is a new and evolving area, and that conversations about how DLTSS providers are paid will not be confined to an ACO model in the future, and that this area deserves our attention as we prepare for that change. o Dale Hackett asked whether there was a systemic reason that that this was not included in the workplan, given that it is a gap. Deborah indicated that the involvement in the waiver consolidation measures process is an attempt to proactively work on this issue.	**Sue Aranoff will inquire about a DAIL presentation on plans to implement new CMS Home and Community-Based Services (HCBS) regulations; she will follow up with Deborah Lisi-Baker and Jackie Majoros to clarify the request.**

Agenda Item	Discussion	Next Steps
	o Barb Prine suggested including this as a separate item and moving the expected date sooner to ensure input is included in the process. Julie responded that Shawn Skaflestad set this timeline, that we do know what the current system of care is, and could come up with broad-based measures; and that Shawn Skaflestad has noted that Year 1 consolidated waiver measures will be broad and easy to capture. o Jackie Majoros noted that this timeline on quality measures might work for Shawn, but there are other initiatives within DAIL that are looking at closely related issues, such as coming into compliance with new HCBS regulations. Jackie believes this is a bigger issue, and could be broken down into parts and some discussed sooner. Sue Aranoff asked whether the group wants a presentation from someone at the Department of Disabilities, Aging, and Independent Living (DAIL) at the May meeting. Barb agreed that this would be helpful. Sue will inquire. o Mike Hall noted that while we may have an opportunity to comment on a quality measures draft developed by DAIL or AHS, that this is a critical issue and this group's approach should not be reactive; we should be shaping quality measures and making it part of the construct we're trying to develop for long-term services and supports. Mike would not be opposed to forming a sub-group to work on this, and to making this a separate workplan item. o Susan Besio asked whether the Work Group members' comments were about the quality measures or about broader programmatic things that DAIL is doing to respond to the new HCBS regulations. Barb Prine described the multiple pieces of the new regulations. Susan Besio asked whether the suggestion was to add an activity looking more broadly at quality of services; Barb clarified that this conversation about the new HCBS regulations is more broad than quality of services, and looking at bigger questions of settings and integration. Jackie Majoros noted that this will be challenging before DAIL has defined the parameters. She referenced several DAIL memos have come out but that seem fragmented to her, and noted that it would be helpful to get something from DAIL in writing to summarize what their plan is going forward. Deborah Lisi-Baker noted that a lot of this conversation is based on federal guidance and rules for HCBS. She wants to make sure we can have a proactive dialogue and have input into these services; she suggests working with Sue to get guidance on DAIL's plan, and noted that some of this was included in Monica Light's presentation on the consolidated waiver at the March meeting of the DLTSS Work Group. Julie Wasserman noted that Mike Hall has defined this effort as broader than quality. Deborah suggested that an informal sub-group could also meet before the next meeting. o Sue Aranoff suggested that there is the VHCIP Quality and Performance Measurement Work Group, and that there are also broader quality and measurement activities that this group would like to be involved in and provide input for. Deborah Lisi-Baker pointed out this is already in the DLTSS Work Plan as item #1. o Mike Hall, Kirsten Murphy, Joy Chilton, Ed Paquin, Mary Alice Bisbee, Molly Dugan, Marlys Waller, Jackie Majoros, Pat Jones, and Sue Aranoff volunteered to participate in a sub-group.	**Deborah Lisi-Baker will request written comments from DAIL on their plans to address the new HCBS regulations.** **A small sub-group will meet before the next meeting to discuss HCBS measures.**

Agenda Item	Discussion	Next Steps
	Care Models and Care Management: Julie commented that the DLTSS Work Group is working closely with the Care Models and Care Management (CMCM) Work Group in Year 2, and noted that the Steering Committee recommended approval of expansion of the Integrated Communities Care Management Learning Collaborative to new communities yesterday. Payment Models: Julie noted that DLTSS issues feature heavily in this section as well. Population Health: Julie commented that the Population Health Work Group's activities focus on population health and prevention, as well as payment models to support these activities. • Mike Hall is interested in the potential All-Payer Waiver and possible future global payment models. He noted that hospitals are at the center of these methodologies that are based in hospitals and hospital-owned ambulatory practices. He suggested that there has been minimal discussion of how a global payment model would impact the rest of the delivery system. He asked how we expect hospitals to get the outcomes they are charged with and meet performance measures without talking about how money will flow to the rest of the delivery system. He would like to surface those issues and be able to have the DLTSS Work Group engage Richard Slusky, Lawrence Miller, and others to ask those questions about the potential All-Payer Waiver and other potential future models. Julie Wasserman mentioned the recent CMCM Work Group presentation by Mike and other HCBS providers and suggested that he and his colleagues present to the Core Team. Mike has contacted the Core Team to offer that. Mike has also spoken with Al Gobeille and others recently and has heard that the federal government is accelerating the timeline for an approved All-Payer waiver; this suggests the need to talk about this soon. • Kirsten Murphy requested more information about the objective to provide recommendations to address payment issues and barriers relevant to DLTSS populations and providers, and asked that the cultural barriers also be addressed. Julie Wasserman suggested this would be discussed during today's agenda Item #3. Health Information Exchange (HIE) and Health Information Technology (HIT): • Mike Hall commented that the historical approach to integrating LTSS providers into HIE/HIT has been very primitive, but that work at the federal level is starting to address this. He suggested having a presentation from the Demonstration Program for Testing, Experience, and Functional Tools (TEFT), a project of the Centers for Medicare & Medicaid Services (CMS). He worries that we are moving toward integrated delivery systems but that ability for some provider types to participate is limited by technology capabilities. • Joy Chilton commented that HIT also impacts providers' ability to address quality measures. • Kirsten Murphy noted that true accessibility of personal health records is a particular issue for people with intellectual and other disabilities. Ongoing Education and Updates: Julie noted that coordination and collaboration with other Work Groups is critical.	

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	- Sam Liss thanked Mike Hall for his very constructive input.	
3. DLTSS/CMCM Collaboration on Learning Collaborative; and DLTSS-Specific Core Competency Curriculum Development and Training	Deborah Lisi-Baker provided an update on work the DLTSS Work Group is doing in partnership with the CMCM Work Group's Integrated Communities Care Management Learning Collaborative. (See Attachment 3.) - The DLTSS Work Group is developing a series of briefs on disability competencies, and intends to release an RFP for a contractor to provide DLTSS-specific core competency training to align with the care management professional core competency training planned through the Learning Collaborative. - Susan Besio is working on disability awareness briefs that will act as background materials on particular areas of concern. Susan commented that the topics include cultural competency, accessibility, universal design, disability competency for providers, and disability competency for care management professionals. The briefs will be 6-8 pages and relatively brief, and provide information based on literature and concrete examples. The intent is to distribute briefs broadly. The brief targeted to care management professionals will provide a basis for the DLTSS-specific core competency curriculum. o Dale Hackett asked which disabilities will be included in this brief. He also suggested that accessibility issues are not always physical. Susan Besio responded that the briefs are quite comprehensive and use broad definitions for disability, accessibility, and other terms, but they are a starting point and she welcomes feedback from this group. o Mike Hall noted that there have been discussions of widespread use of community health workers (CHWs) in the state, but that these discussions have not gone far, in part because of questions about how CHWs would be licensed, certified, educated, etc, and because of provider fears of how CHWs will interact with current staffing models. He suggested we come back to some of the original purposes of CHWs, which are to add cultural competency on the ground, rather than retraining existing providers. He noted that CHWs are specifically referenced in the ACA. The concept was initially developed to better serve disenfranchised populations by deploying individuals from within the community to work with individuals on the ground. o Pat Jones noted that when we have talked about core competency training, we had intended for them to apply to all types of people with various degrees and training with the idea that this would be inclusive. o Kirsten Murphy suggested that this group seek input from self-advocacy groups. Deborah Lisi-Baker replied that this would be very welcome. Kirsten suggested it might be helpful to have people with disabilities present their reactions themselves. Deborah replied that this would be welcome but that the briefs would need to be translated for each audience. Susan Besio also noted that these briefs are intended to be high-level. o Barb Prine suggested that cultural competency is a particularly complex issue and invited Susan to contact her as she writes the brief. o Jackie Majoros asked whether the briefs would address the issue of competency across all long-term care settings (including nursing homes), which may have different issues than community	

Agenda Item	Discussion	Next Steps
	settings. Susan Besio replied that this may be an area where it would be very helpful to get input from Jackie when the Work Group members review the briefs. o Dale Hackett suggested that the briefs be written in lay terms so that they are understandable by people with disabilities. Deborah Lisi-Baker suggested that translation will be important for different audiences and purposes. Julie Wasserman noted that these briefs will be the master version, and information can be drawn out to create materials for specific audiences. o Mary Alice Bisbee noted that fear and paranoia are two things we are dealing with in these cultural competencies. o Mike Hall noted that managed care organization cultural competency is a rising issue across the country as implementation of managed LTSS spreads. He noted that the DLTSS-specific core competency training effort is very relevant to this – this work is potentially very relevant to managed care contract language and expectations around the country. ▪ Sue Aranoff noted that the Medicaid ACO contracting process is underway, and language around cultural competency and accessibility will be included in this year's contracts. At the end of this agenda item, Nicole LeBlanc introduced herself. She will be attending meetings with Kirsten Murphy throughout 2015 as a guest from Green Mountain Self-Advocates.	
4. Caledonia & Southern Essex Dual Eligible Project	Treny Burgess (North Countries Health Care) and Pam Smart (Northeastern Vermont Regional Hospital) presented on the Northeast Kingdom Dual Eligible Project (see Attachment 4). Pam and Treny noted that this project builds on past work with people dually eligible for Medicare and Medicaid in Vermont, as well as the Blueprint Community Health Team infrastructure. This project is the recipient of a VHCIP provider grant, and the St. Johnsbury community is also participating in the Integrated Communities Care Management Learning Collaborative, which is helping to further this work and provide support for developing systems. • Provider grant funds are focused on working directly with patients: First hire was a health coach, who works directly with patients to connect them to services and address social determinants of health. • All dual eligibles can participate; for the purposes of the Learning Collaborative, focused on ~30 patients. • Person-centered vs. person-directed care: Working with patients to identify barriers to patient goals and develop a plan of service that is responsive to patient needs and priorities. • How does this overlap with the Learning Collaborative? This project was up and running prior to the Learning Collaborative launch, but the Learning Collaborative provides opportunities for learning and to develop and adopt best practices. • Pam described the process of identifying possible participants and gaining patient consent and buy-in. There are still many dual eligibles in the program's catchment area who are not touched by this program, but the program is reaching new people all the time. • Many area agencies are working together on this project. Agencies share a common release form to support information sharing. There have been some barriers to information sharing. • Treny and Pam distributed copies of intake forms, shared care planning forms, and Camden Cards used to	**Joelle Judge will distribute handouts via email.**

Agenda Item	Discussion	Next Steps
	guide discussions with patients and develop a care plan based on the person's priorities. • Developing relationships between patients and key care coordinators has been one of the most effective strategies; relationship building between agencies has also been a critical step and has allowed local agencies to better collaborate and serve patients. Provider communication and information sharing are still barriers, but are improving. • Some individuals in this program do have Medicaid-funded long-term care. • The program has some flexible funds to be used when Medicare, Medicaid, and other funding sources are not available. Pam and Treny closed their presentation with a series of case studies. The group discussed the following: • Sue Aranoff suggested a presentation from a program participant would be very interesting. Pam noted that one participant presented to the Community Health Team at the previous meeting, but knew that the presentation was very challenging for the participant; she's hesitant to ask unless participants are ready and willing. Sue commented that personal stories and case studies are a powerful way to demonstrate the impacts of this program. • Dion suggested that other communities around the state would benefit from similar programs. Erin Flynn responded that there is a proposal before the Core Team on Monday to expand the Learning Collaborative to different communities, though this does not come with flexible funding. • Sam Liss thanked Pam and Treny for this presentation. He suggested that the term "patient" is loaded, and that terms like "client" might be more sensitive. He also asked whether the program works to support employment. Pam responded that yes, it does. • Mary Alice Bisbee noted that language is very important ("elders" vs. "the elderly"). She suggested "care management" rather than "case management" – people are not cases. Nicole LeBlanc suggested "service coordination" as another possible term.	
5. Update on DLTSS Gap Analysis/ Technology Assessment and Remediation (ACTT)	Beth Waldman (Bailit Health Purchasing) provided a brief update on the DLTSS Gap Analysis/Technology Assessment and Remediation Project, formerly a part of the Advancing Care Through Technology (ACTT) project (it is now a separate project). Elise Ames from HIS Professionals is the lead contractor for this project; it is in part an update of technology assessments Elise performed with various types of DLTSS providers in 2012 and 2013, and also new assessments of providers who had not been previously included. Elise sought to understand how different provider types used technology to support their work, barriers/challenges, and next steps/needs. She found broad variation across DLTSS providers; most often, providers used technology to support care coordination and care planning, but could not share information with other providers. Elise also surfaced key issues to think about in coming months. There will be a more substantial presentation on this project, including the final report and recommendations for next steps, at a future meeting (likely June 2015).	

Agenda Item	Discussion	Next Steps
6. Public Comment/Next Steps	Public comment: • Relevant to Item #4, Barb Prine commented that it's frustrating to hear that the Learning Collaborative model is being replicated but without the flexible funding that has been so critical to the success in St. Johnsbury. • Dale Hackett noted that different communities have different needs. • Deborah Lisi-Baker suggested that lessons from these pilots can support learnings that will help shape how we pay for DLTSS services in the future. • Sue Aranoff suggested that a presentation from another community participating in the Learning Collaborative could be helpful to tease out the impact of the flexible funding vs. the Learning Collaborative. • Erin Flynn noted that organizations performing care management have been presenting to the CMCM Work Group over the past year, and that lessons from these presentations are being compiled. Two key challenges have been data sharing and lack of flexible funding. • Nicole LeBlanc asked whether Medicaid is examining cost savings due to use of flexible funds. Pam noted that the team in St. Johnsbury is trying to document this but it's challenging to document savings. • Mike Hall suggested compiling lessons learned so they can be embedded in the design of the next payment model. He gave the example of Home Share Vermont. **Next Meeting:** Thursday, May 28, 2015, 10:00am-12:30pm, EXE - 4th Floor Conf Room, Pavilion Building, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

1) Feb minutes approved by exception; 2 abstentions

2) March minutes approved by exception; 3 abstentions

VHCIP DLTSS Work Group Member List

Roll Call: 4/30/2015

Ed 1° Paquin
Mike Hall 2°

Ed Paquin 1°
Mike Hall 2°

Member		Member Alternate		① February Minutes	② March 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 ✓ A	→	A	Home Health and Hospice
Dale	Hackett ✓			A		None
Mike	Hall ✓					Champlain Valley Area Agency on Aging
Jeanne	Hutchins					UVM Center on Aging
Pat	Jones ✓	Richard	Slusky	A		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 ✓				A	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 ✓				A	UVM Medical Center
	31		9			

VHCIP DLTSS Work Group Participant List

Attendance: 4/30/2015

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	here	SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	X
Mary Alice	Bisbee	here	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		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	phone	Cathedral Square and SASH Program	M

Gabe	Epstein	here	AHS - DAIL	S
Patrick	Flood		CHAC	M
Erin	Flynn	here	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	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	here	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
Deborah	Lisi-Baker	here	SOV - Consultant	C/M
Sam	Liss	phone	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Georgia	Maheras	here	AOA	S
Jackie	Majoros	here	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		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		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
Judy	Peterson	here	Visiting Nurse Association of Chittenden and Grand Isle Countie	C/M
John	Pierce			X
Luann	Poirer		AHS - DVHA	S
Barbara	Prine	here	VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Rachel	Seelig	here	VLA/Senior Citizens Law Project	M
Susan	Shane	phone	OneCare Vermont	MA
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S/MA
Kara	Suter		AHS - DVHA	S
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	phone	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	phone	UVM Medical Center	M
Cecelia	Wu		AHS - DVHA	S

Marie	Zura		DA - HowardCenter for Mental Health	X
				86
Jenney	Samuelson	here	DVHA - Blueprint for Health	
		here	QI facilitator	
Nicole	Le Blanc	here	Green Mt Self Advocates	

Attachments 2a-f

Disability Awareness Briefs

Vermont Health Care Innovation Project

VHCIP Disability Awareness Briefs:

INTRODUCTION TO DISABILITY AWARENESS

OVERVIEW OF DISABILITY AWARENESS BRIEFS

The purpose of this Disability Awareness packet is to provide an overview of the essential information necessary for providers to deliver effective and quality care for individuals with disabilities. In addition to this Introduction, the packet contains Disability Awareness Briefs for the following five topics:

- Disability Competency for Providers
- Disability Competency for Care Management Practitioners
- Cultural Competency
- Accessibility
- Universal Design

Each Brief focuses on a specific topic and, with the exception of the Brief on Disability Competency for Care Management Practitioners which contains some overlapping information, effort has been made to ensure that the information in each Brief is not redundant with that provided in one of the other five Briefs. However, the information in this Introduction and each of the five Awareness Briefs is inter-dependent. As such, **this Introduction and the five topical Briefs should be considered together in order to inclusively address the health care needs of individuals with disabilities.**

The Briefs are intended to serve as foundational documents for the development of more targeted materials for specific audiences and purposes (e.g., provider educational brochures, training modules). They provide basic information that will facilitate:

- A general understanding of health, wellness, and care issues for individuals with disabilities;
- Familiarity with provider practices that improve quality health care, services and supports and ways to reduce communication, attitudinal and structural barriers*;*
- Appreciation of the organizational capacities that can support best practices for providing care for individuals with disabilities;
- Awareness of key skills and behaviors necessary to promote good communication

and rapport between providers and individuals with disabilities and to enhance provision of quality care; and

- Awareness of the supports, structures, systems, and values that an organization needs to support disability and culturally-competent care.

In addition, the information in these Briefs should serve as an introduction, but not as a substitute, for more in-depth education and experience necessary to become familiar with best practices in each area. For this reason, each Brief contains endnotes with links to key resources to facilitate more in-depth exploration of the content that is presented.

WHAT IS DISABILITY?

The Americans with Disabilities Act[1] defines the term "disability" with respect to an individual as:

- a physical or mental impairment that substantially limits one or more major life activities of the individual –major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working;
- a record of such an impairment; or
- being regarded as having such an impairment.

Individuals with disabilities include children, adults of all ages, individuals with vision or hearing loss, as well as individuals with physical, mental health, developmental, or intellectual disabilities. [2,3] While individuals with disabilities are often thought of as a similar group, in fact each type of disability has unique characteristics that require specific strategies to ensure quality care and well-being. Furthermore, while there are disability-specific categories (e.g., mobility, sensory, mental health, cognitive), it is important to recognize that each individual's experience of their disability is unique to that person, and their care must be approached differently based on the individual's specific strengths, values, preferences and needs.

Health disparities and environmental factors (e.g., physical environment, culture, attitudes, economics, and policies that shape our life experiences) also affect an individual's ability to obtain needed services and supports. Thus, disability is the combination of an individual's functional limitations and the environmental factors that create additional barriers and limitations.[4,5]

Note: A number of different terms are used to refer to individuals with disabilities within the context of health care and services delivery (e.g., patient, client, consumer, member, recipients). Each of these terms can have different meanings and implications for various audiences, and it is clear that no single term is preferred by, and perhaps even acceptable to everyone. As such, these Briefs use the term “individual” due to its universal meaning and applicability across all settings.

In addition, because family members often serve as a primary support for an individual with disabilities, they have been referenced throughout these Briefs. However, family members should only be included in activities related to the care of an adult with disabilities when the individual has expressed the desire and has given permission to have them involved.

WHY IS DISABILITY AWARENESS IMPORTANT?

An estimated one in five Vermonters has a disability.[6] As a group, individuals with disabilities fare far worse than their nondisabled counterparts across a broad range of health indicators and social determinants of health. [7,8,9,10] They also experience significant barriers to health care and health disparities when compared with individuals who do not have disabilities.[11,12]

Disability is now understood to be more than a physical, cognitive, or emotional condition. Effective care must address the full range of barriers, including environmental, architectural, logistical, societal, and cultural, that impact the health of disabled individuals as much as their biologic impairments. Disability competent care can help prevent unnecessary emergency-room visits, costly case mismanagement, and dangerous secondary medical conditions,[13] as well as support the individual’s overall well-being and quality of life.

Individuals with disabilities frequently struggle to find providers who are sensitive to their needs.[14] Often, health care facilities or offices are not accessible or do not have the equipment needed to serve individuals with disabilities. Also, individuals can be embarrassed because their disability requires them to obtain additional assistance from staff, requiring them to surrender some of their independence. Sometimes, staff may not know how to assist an individual with a disability, causing frustration for both the individual and the staff member. From the providers’ perspective, limitations in the physical environment, such as the lack of appropriate equipment, may cause them to forgo procedures for individuals with disabilities that would otherwise be commonplace. As a result, some individuals with disabilities only pursue medical attention for emergency or acute conditions,[15] or they may not access other services and supports that can increase their quality of life, including primary and preventive health care.

The lack of provider knowledge, erroneous assumptions about disabilities, and poor accessibility can pose significant barriers that prevent individuals with disabilities from receiving appropriate and effective treatment, services and supports.[16,17,18] Expanding providers' knowledge, improving communication between individuals and providers, and ensuring access to information and services are highly critical to the delivery of quality care to individuals with disabilities.

Implementation of the strategies presented in these Briefs will not be possible without an organizational commitment to provide disability and culturally-competent care. Organizational governance, leadership, policies, procedures, structures and resources all must reflect awareness of the needs of individuals with disabilities and support providers and staff to implement practices to best meet those needs.[19]

OVERARCHING CONCEPTS ABOUT MEDICAL CARE AND DISABILITY AWARENESS [20]

- **Individuals with disabilities require the same quality of medical service and preventive care** as individuals without disabilities, but they may be underserved and receive less than quality care.

- **Defining "health" as the absence of disability or chronic illness** negatively affects individuals with disabilities. Many lead active, fulfilling lives, which include work and community, sexual relationships and parenting, or could achieve these with appropriate community resources.

- While a disability doesn't necessarily imply illness, some disabilities may lower the threshold to secondary conditions. **Preventive care and early intervention can reduce complications.**

- **For accurate assessments, providers need to listen attentively to individuals with disabilities** in order to understand their background and functional needs. They also need to avoid assumptions about disability and not make unnecessary referrals to specialists.

- A **team approach** works best to accommodate complex medical and support needs.

- Barriers to receiving quality health care include **physical/architectural barriers, communication barriers, attitudinal barriers, and social/economic policy barriers**. Understanding these barriers and obtaining accessibility training will be helpful for both medical and support staff.

- **Medical facilities and practitioners are required** by the ***Americans with Disabilities Act*** to provide access for individuals with disabilities to health care services. The law requires **reasonable accommodations,** meaning those that are **readily achievable** and do not present an **undue hardship** on the facility. Practitioners and facilities need to learn about and provide specific accommodations for individuals with a full range of disabilities.

- **Advanced planning** to ensure access to care can save time and improve the quality of care.

- **Health Care Providers need to check accessibility** when referring individuals to diagnostic testing and specialty clinics.

- **Many individuals with disabilities have expertise** in living with their disabilities and managing any related health conditions. This expertise should be respected. Others, particularly newly disabled individuals, may need information, education and support to become active partners in managing their health and disability-related services.

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[1] *The Americans with Disabilities Act of 1990 and Revised ADA Regulations Implementing Title II and Title III.* United States Department of Justice; March 15, 2011. Available at: http://www.ada.gov/2010_regs.htm

[2] *Disability Competent Care Self-Assessment Tool*. Resources for Integrated Care, a collaboration between the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS), The Lewin Group, and the Institute for Healthcare Improvement; May 22, 2013. Available at: https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool_508%20Compliant.pdf

[3] The US Department of Health and Human Services has established the following data standards for defining disability: deafness or serious difficulty in hearing (all ages); blindness or serious difficulty in seeing (all ages); serious difficulty in concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (5 years or older); serious difficulty walking or climbing stairs (5 years or older); difficulty dressing or bathing (5 years or

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older); or difficulty doing errands alone (e.g., visiting a doctor's office or shopping) because of a physical, mental, or emotional condition (15 years or older). US Department of Health and Human Services. Final data collection standards for race, ethnicity, primary language, sex, and disability status required by section 4302 of the Affordable Care Act, October 31, 2011.

[4] *International Classification of Functioning, Disability and Health.* World Health Organization. Geneva, Switzerland: World Health Organization; 2001.Available at: http://www.who.int/classifications/icf/en/

[5] *Individuals with Disabilities as an Unrecognized Health Disparity Population.* Gloria L. Krahn, PhD, MPH, Deborah Klein Walker, EdD, and Rosaly Correa-De-Araujo, MD, PhD. American Journal of Public Health, April 2015. Available at http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2014.302182

[6] *How many individuals have disabilities?* Centers for Disease Control and Prevention: Atlanta, GA. Available at: http://www.cdc.gov/ncbddd/documents/Disability%20tip%20sheet%20_PHPa_1.pdf

[7] *Closing the Gap: A National Blueprint to Improve the Health of Individuals with Mental Retardation: Report of the Surgeon General's Conference on Health Disparities and Mental Retardation.* US Department of Health and Human Services. Rockville, MD: US Department of Health and Human Services; 2002. Available at: http://www.nichd.nih.gov/publications/pubs/closingthegap/Pages/index.aspx

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[9] *World Report on Disability,* World Health Organization. Geneva, Switzerland; 2011. Available at: http://www.who.int/disabilities/world_report/2011/report.pdf.

[10] For example, adults with disabilities are 3 times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities. http://www.cdc.gov/vitalsigns/disabilities/

[11] *CDC Grand Rounds: Public Health Practices to Include Individuals with Disabilities.* Centers for Disease Control and Prevention: Atlanta, GA; August 30, 2013. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a3.htm?s_cid=mm6234a3_w

[12] *CDC Vital Signs: Adults with Disabilities*. Centers for Disease Control and Prevention: Atlanta, GA; May, 2014. Available at: http://www.cdc.gov/vitalsigns/disabilities/

[13] *A Training Curriculum on Improving Access and Quality of Care for Individuals with Disabilities.* World Institute on Disability, Berkeley, CA; 2011. Available at: http://wid.org/publications/access-to-medical-care-training-tools-for-health-care-providers-disabled-individuals-and-advocates-on-culturally-competent-care-and-compliance-with-disability-law/

[14] *ibid.*

[15] *Removing Barriers to Health Care.* North Carolina Office on Disability and Health: Chapel Hill, NC; 2007. Available at: http://fpg.unc.edu/sites/fpg.unc.edu/files/resources/other-resources/NCODH_RemovingBarriersToHealthCare.pdf

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Vermont Health Care Innovation Project

Disability Awareness Brief:

DISABILITY COMPETENCY FOR PROVIDERS

Note: This is one in a series of six Disability Awareness Briefs: Introduction to Disability Awareness, Disability Competency for Providers, Disability Competency for Care Management Practitioners, Cultural Competency, Accessibility, and Universal Design. This Brief on Disability Competency for Providers should be considered together with the other five documents in order to have the comprehensive, basic information needed to inclusively address the unique health care needs of individuals with disabilities.

WHAT IS DISABILITY COMPETENCY?

Individuals with disabilities are a diverse group of people who share the experience of living with mobility, sensory, mental health, and cognitive limitations or differences that affect their functioning. As a result, they often experience barriers to health care and full participation in their communities. (See Introductory Brief for more complete definition).

Disability Competency is the ability to provide person-centered and appropriate treatment, services, supports and related accommodations to individuals with disabilities while ensuring that the individual's goals, values, interests and preferences inform the design and delivery of care. Disability-competent care recognizes each individual as a whole individual, not a diagnosis or condition, and focuses on providing treatment, services and supports that maximize health, function and independence.[1]

Examples of Disability Competency include reducing barriers to integrated, accessible care; comfortably and respectfully communicating with individuals with disabilities and their families; understanding the values, interests and needs of individuals with disabilities; honoring the individual's central role in all care planning and delivery; encouraging self-advocacy skills of individuals with disabilities and families; and acknowledging the core values of disability culture, including the emphasis on interdependence as well as independence.[2,3]

Also inherent in person-centered disability-competent care is the concept of dignity of risk, which honors and respects individual's choices to take some risk in engaging in life experiences, even if that choice is not one recommended by a health professional (e.g., choosing to live at home instead of in a supervised setting; electing to forego psychotropic medications that have significant side effects).[4,5]

WHY DO PROVIDERS NEED COMPETENCY REGARDING DISABILITY?

Individuals with disabilities need health care for the same reasons that the general population does. However, they often experience barriers to preventive and quality health care services, which can lead to poor health status, delayed treatment of chronic illnesses, and failure to prevent secondary conditions or health problems related to a disability. As such, in the broadest sense, disability competency can improve health and save lives.

Research indicates that individuals with disabilities may be disproportionately affected by excess weight or obesity; increased risk for diabetes, hypertension, substance abuse, injury, depression, and stress; and receive less frequent preventative screenings compared to individuals without disabilities.[6] Adults with disabilities who do not partake in physical exercise are 50% more likely to have certain chronic diseases; however less than half of adults with disabilities who visit a doctor are counseled about the benefits of physical exercise even though they are significantly more likely to be physically active if their doctor recommends it.[7] In addition, the stigma of mental health disorders and a lack of proper training in dealing with episodic behaviors prevent some health care professionals from properly treating individuals manifesting mental health problems.

Lack of disability competency contributes to the barriers that affect the quality of care received by individuals with disabilities. Unfortunately, most providers receive little training regarding respectfully interacting with individuals with disabilities, disability culture, or the issues that affect disabled individuals and their unique health circumstances. Disability competency is not required in most medical schools, internships and residency programs and has not been identified as a federal priority for provider training funds. Without training and awareness, health care providers hold incorrect assumptions and stereotypes about individuals with various disabilities, which can affect every aspect of care and result in inadequate and inappropriate care.[8,9,10]

Individuals with disabilities may encounter providers who are not able to appropriately address their needs, reducing the quality of care they receive. Expanding providers' knowledge about disability and how to interact with individuals who have disabilities are key to quality health care.

Note: This Brief focuses on respectful communication, while the Brief on Accessibility addresses the use of auxiliary and assistive devices and other communication accommodations to support access to services and information.

INDICATORS OF DISABILITY COMPETENCY: [11]

Following are examples of disability competency:

ORGANIZATIONAL CHARACTERISTICS:

- Awareness and sensitivity training for all staff on interacting with individuals with diverse disabilities.
- Training staff on evidence-based guidelines for each of the disability populations served, as well as how disability may affect the provision of medical treatment for primary and other care.
- Identifying a practitioner within the organization who is disability-competent and designating them to provide ongoing oversight and coaching to the practice and its other practitioners.
- Maintaining a list of disability-competent sub-specialists and other provider organizations that are experienced in providing care for individuals with disabilities and keeping it in a centrally accessible record.
- Partnering with peer support and disability service organizations.

PROVIDER KNOWLEDGE:

- Recognition of practitioner‘s own comfort level when working with individuals with disabilities. (If practitioners do not believe that they can appropriately treat, serve or support an individual because of their lack of knowledge or their biases due to assumptions, emotions or values, a referral may be the best practice.)
- Understanding the importance of treating individuals with disabilities with respect and dignity.
- Understanding and practicing person-centered care by honoring and respecting the individual’s choices, including a choice to take some risks in engaging in life experiences (i.e., the concept of “dignity of risk”).
- Recognizing the individual as an important source of information.
- Familiarity with the core values of disability culture, including the emphasis on interdependence as well as independence.
- Understanding of the developmental stages regarding identity as an individual with a disability in order to have insight into the individual’s possible perceptions and struggles.
- Familiarity with primary disabling conditions and associated medical conditions.
- Awareness of the potential for earlier onset of common chronic conditions.
- Recognition that physical problems can be obscured by, or overlooked because of, an individual’s mental health condition.

- Recognition that mental health conditions can be obscured by physical symptoms or the individual’s reluctance to acknowledge them.
- Awareness of the range of treatment options for mental health conditions.
- Understanding that individuals with disabilities can lead long, healthy, productive lives.
- Recognition by all staff, including reception-area personnel, that individuals with a disability are potentially fully or partially employed, contributing to their community, a competent parent, an independent individual, and are knowledgeable about self-care.
- Appreciation of the importance individuals with disabilities place on preserving function and maintaining their lifestyles.
- Recognition that individuals with disabilities can promote their own good health by developing and maintaining healthy lifestyles.
- Recognition that individuals with disabilities can and should be physically active.
- Recognition of the sexuality and reproductive health of individuals with disabilities.
- Understanding that many individuals, including those with disabilities, have stronger receptive (understanding) communication skills than expressive skills.
- Understanding and being aware of the effects of disability on family and social relationships and functioning.
- Awareness to treat family members, caregivers, and personal assistants with appreciation and respect and avoidance of stereotypes of family members as being “saints” or “amazing.”
- Awareness of the community resources available to individuals with disabilities and their families, including peer counseling, mutual support groups, independent living services and supports, advocacy organizations, and recreational services.
- Appreciation of the need to advocate for resources for individuals with disabilities, including the ability to demonstrate medical necessity for services and equipment in requests to insurers.
- Knowledge of requirements regarding mandated reporting of abuse, and that the rate of sexual and other kinds of abuse is higher for individuals with disabilities.
- Familiarity with legal requirements applicable to health care, including the Americans with Disabilities Act.

PROVIDER SKILLS/BEHAVIORS:

For all individuals who have a disability:

- Treating the individual with respect.
- Showing warmth and a positive regard.
- Calling the individual by his or her first name only when you're extending this familiarity to everyone present.
- Focusing on the individual's abilities rather than disabilities.
- Using "People First" language that emphasizes the individual not the disability (e.g., "individual with a disability" rather than "disabled individual").
- Avoid talking to an adult as if he/she were a child.
- Talking directly to the individual rather than to someone who accompanies them, and managing discussions to ensure the individual's participation when a caregiver or family member is involved.
- Offering assistance to an individual with a disability if it appears it might be helpful, but waiting until the offer is accepted before helping, and listening to any instructions the individual may want to give about the best way to assist them.
- Asking the individual, their family members, or guardians for suggestions about what to keep in mind when providing services to the individual, noting the solutions in the individual's chart and plan of care, and anticipating those needs prior to the next visits.
- Providing educational information to the individual about their disability, if needed.
- Unless a communication barrier is obvious, not assuming one exists unless the individual, a family member, or other caregiver tells you about the barrier.
- Allowing more time for appointments.
- Looking beyond an individual's disability and recognizing unrelated acute and chronic care issues and other non-medical factors that may impact their health and well-being.
- Asking adults with disabilities how much physical activity they get each week, reminding them to get regular physical activity consistent with their abilities, recommending physical activity options that match the specific abilities of each person, and connecting them to resources that can help them be physically active.
- Partnering with the individual to ensure treatment or care recommendations are accessible, acceptable, and doable.
- Referral of individuals with disabilities to the full range of preventive, reproductive and sexual health care services and, when appropriate, mental health or

substance abuse services.

- Finding out about a specialist's experience or willingness to treat individuals with disabilities before referring for an appointment.
- Flagging indications of disability-related needs and accommodations in information being sent related to referrals.
- Promoting and participating in interdisciplinary and collaborative practice, including routine communication with the individual's lead care manager (if permission has been granted by the individual) to ensure adherence to care plans and follow up on referrals.

For individuals who use wheelchairs or have mobility impairments:

- Shaking hands even when the individual's hand is immobile.
- When conversing at length with an individual in a wheelchair, sitting at eye level but do not kneel.
- Respecting the individual's personal space, including wheelchairs and assistive devices.
- Not touching, pushing, pulling or otherwise physically interacting with an individual's body or equipment (including wheelchair) unless requested to do so.
- If it is necessary to move an individual's mobility device, never doing so without asking first.
- Not patronizing individuals who use wheelchairs by patting them on the head or talking about them rather than to them.

For individuals with intellectual disabilities or whose disabilities directly affect sight, hearing, or speech:

- Allowing additional time to exchange information.
- Inquiring about how best to communicate, with the recognition that communication needs vary from individual to individual and from situation to situation.
- Assessing language skills to choose the level of language to use (i.e., talking with someone with a mild communication difficulty is very different than talking with a individual with a moderate or severe communication difficulty).
- Checking the individual's understanding of discussions or information that is provided.
- Not completing sentences or second-guessing the individual.
- If the environment is busy with many distractions, moving to a quieter location.
- Use of alternate interviewing/discussion strategies, such as the use of yes/no questioning or visual aids.

- Using concrete as opposed to abstract language (e.g., say “Are you upset? Are you sad? Are you happy?” instead of “What are you feeling?”).
- Communicating clearly about what is occurring during a physical exam.
- Working within the individual’s attention span.
- Minimizing time in the waiting room.
- Scheduling several appointments to conduct exams or assessments to minimize the individual’s frustration if the exams / assessments are lengthy.
- If needed, giving the individual the same information more than once in different ways.

For individuals who are blind or visually impaired:

- When offering to assist someone with a vision impairment, allowing the individual to take your arm so that they are guided rather than being propelled or led.
- When greeting an individual with a severe loss of vision, always identifying yourself and others who may be with you.
- Speaking in a normal tone of voice, and letting it be known when the conversation is at an end.
- Announcing your presence and not leaving without letting the individual know.
- Indicating when you move from one place to another.
- Explaining procedures before beginning treatment, and asking if there are any questions.
- Indicating where to leave clothing and personal items in the exam room, and not moving these without letting the person know.

For individuals who are deaf or have a hearing loss:

- Directly addressing the individual and not a real-time captioner or sign-language interpreter.
- Not talking to the individual from a distance or from another room.
- Looking at the individual while speaking and making sure she/he can see your mouth to allow for lip reading.
- Speaking in a normal tone of voice, avoiding exaggerating mouth movements and rapid talk.
- Facing the light source to facilitate lip reading.
- Keeping your hands and food away from your mouth when speaking, and keeping mustaches and beards well-trimmed.
- Minimizing background noise.

For individuals who have a speech impairment:

- Being patient, and not completing sentences for or second-guessing the individual.
- Allowing sufficient time for the individual to communicate verbally or via a word board or computer display, without pressure to hurry.

For individuals who have a mental health disability:

- Allowing extra time to perform a comprehensive mental health screening and to discuss underlying concerns.
- Looking beyond behavioral manifestations during a crisis in order to treat the underlying condition or address the triggering situation.
- Implementing interventions that focus on improving patient function and well-being, rather than simply symptom reduction.
- Emphasizing recovery and self-management.
- Supporting the individual's medication management.
- Including crisis planning in the plan of care.
- Using behavioral contracts to promote consensus with the individual regarding goals and plan of care.
- Identifying severity level of the individual's mental health problem in order to triage care.
- If needed, timely referral to specialty care to address the mental health disorder, and following-up to ensure that the individual accesses the referred services.
- Supporting an individual while they are waiting for access to specialty mental health services.

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[1] *Disability-Competent Care Self-Assessment Tool*. Resources for Integrated Care, a collaboration between the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS), The Lewin Group, and the Institute for Healthcare Improvement; May 22, 2013. Available at: https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool_508%20Compliant.pdf.

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[5] *Person-Directed Strengths and Risk Inventory Tool.* New York Office for People with Developmental Disabilities: Albany, NY; 2014. Available at: http://www.opwdd.ny.gov/node/5521

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Vermont Health Care Innovation Project

Disability Awareness Brief:

DISABILITY COMPETENCY FOR CARE MANAGEMENT PRACTITIONERS

Note: This is one in a series of six Disability Awareness Briefs: Introduction to Disability Awareness, Disability Competency for Providers, Disability Competency for Care Management Practitioners, Cultural Competency, Accessibility, and Universal Design. This Brief on Disability Competency for Care Management Practitioners should be considered together with the other five documents in order to have the comprehensive, basic information needed to inclusively address the unique health care needs of individuals with disabilities.

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Individuals with disabilities are a diverse group of people who share the experience of living with mobility, sensory, mental health, and cognitive limitations or differences that affect their functioning. As a result, they often experience barriers to health care and full participation in their communities. (See Introductory Brief for more complete definition).

Disability Competency is the ability to provide person-centered and appropriate treatment, services, supports and related accommodations to individuals with disabilities while ensuring that the individual's goals, values, interests and preferences inform the design and delivery of care. Disability-competent care recognizes each individual as a whole individual, not a diagnosis or condition, and focuses on providing treatment, services and supports that maximize health, function and independence.[1]

Examples of Disability Competency include reducing barriers to integrated, accessible care; comfortably and respectfully communicating with individuals with disabilities and their families; understanding the values, interests and needs of individuals with disabilities; honoring the individual's central role in all care planning and delivery; encouraging self-advocacy skills of individuals with disabilities and families; and acknowledging the core values of disability culture, including the emphasis on interdependence as well as independence.[2,3]

Also inherent in person-centered disability-competent care is the concept of dignity of risk, which honors and respects individual's choices to take some risk in engaging in life experiences, even if that choice is not one recommended by a health professional (e.g., choosing to live at home instead of in a supervised setting; electing to forego psychotropic medications that have significant side effects).[4,5]

WHAT IS INTEGRATED CARE MANAGEMENT? [6]

Integrated Care Management (ICM) is a person-centered, evidence-based care delivery model that emphasizes active and responsive coordination and support for the individual and his or her care needs across providers, settings and time. The individual's preferences, values, and goals are the central drivers of care. ICM uses a collaborative partnership with the individual and the care team to address the interests and needs of the individual, not just one aspect of his or her condition. ICM is especially useful for individuals with disabilities since they often need multiple services and supports to address their disability related needs, health conditions that may accompany disability, and access to primary and preventive services.

One key element of the Integrated Care Management model is the Care Management practitioner who serves as the individual's primary point of contact across all of his or her primary, acute, medication, mental health, substance abuse, developmental, and long term care services and support needs. In addition, the Care Management practitioner is responsible for assessment, planning, identification of service resources, service facilitation, and advocacy to meet an individual's needs, including at times of transition. It is essential that the practitioner work with the individual to determine how much care coordination is helpful and how it can best be provided.

Integrated care management is not a profession in itself, but an area of practice within one's profession. As such, in this Brief the term "Care Management Practitioners" refers to any person whose core job responsibility is to perform the integrated care management roles described in this Brief, regardless of degree or job title. As such, Care Management Practitioners can have a wide variety of education, training, and experience. This can include but is not limited to graduate trained, licensed and/or certified professionals as well as direct care staff with on the job training and experience; individuals such as nurses, social workers, therapists, addiction and mental health counselors, those working directly with elders and individuals with physical disabilities, community health workers, peer support specialists, and recovery coaches; as well as staff whose job titles include case manager, care manager, care coordinator, service coordinator, etc.

Another key element of the Integrated Care Management Model is the Integrated Care Team (ICT), which is comprised of the individual, selected health care, service and support professionals as well as chosen family members, advocates, or peer support providers. The team shares collective responsibility for the development and execution of the individual's plan of care as well as the health and well-being of the individual. This requires health care professionals to collaborate across disciplines and care settings and engage in a meaningful partnership with the individual. This integrated, team-based care management for individuals is quite different from traditional case management, and requires a unique set of skills. As such, ICT members must be disability-competent and may need to develop new capabilities in person-directed care, interdisciplinary collaboration, and team-based care.

Integrated care requires that organizations make system-level changes. Practices must develop new workflows and clinical operations in order to effectively deliver integrated care. In addition, innovative leadership is essential to creating an organization focused on advancing the practice of integrated person and family-centered care.

WHY DO CARE MANAGEMENT PRACTITIONERS NEED DISABILITY COMPETENCY?

The effects of living with a disability reflect a complex interplay among individual, interpersonal, institutional, community, and societal factors. Some individuals with disabilities and their families require services from multiple providers and are looking for improved access to a continuum of services that will help maintain health and independence, while addressing changing personal, health and disability related needs and concerns. Yet in the existing health care and service delivery systems, health care treatment and support services for individuals with disabilities are piecemeal and reactive. Understanding the unique needs, values and preferences of the individual with a disability and aligning their social services and supports with health care delivery is critical to their health and well-being.

Care management practitioners who support individuals with disabilities must have the knowledge and skills necessary to provide service coordination and support to people from diverse social economic backgrounds and life experiences. In addition, care management practitioners and the organizations they work for must also develop the skills and capacity to perform these functions for individuals with diverse disabilities.

INDICATORS OF DISABILITY COMPETENCY:

Following are examples of disability competency within care organizations that support integrated care management, and the competencies (knowledge and skills/behaviors) that care management practitioners should have to serve individuals with disabilities.

Note: These competencies are not meant to be comprehensive, in that they do not reflect all competencies that are essential for the provision of integrated care management nor many of the basic or specialty competencies required by specific disciplines. Rather the intent of this Brief is to highlight competencies that are specifically related to the effective delivery of integrated care management for supporting individuals with disabilities.

ORGANIZATIONAL CHARACTERISTICS:

- A culture focused on providing population-based, whole-individual, person-centered care rather than a focus on one specialty service.
- Teaching and supporting whole health self-management and recovery approaches and self-directed service options.
- Organizational ability to determine the types of staff expertise needed to deliver integrated care management for individuals with disabilities.
- Organizational awareness of the complexity of home and community-based long term care services and supports.
- Advocating for and fostering the use of peer support approaches and peer support providers as a component of care delivery.
- Commitment to providing continuity of care/services and a stable, positive relationship with the individual’s care management practitioner.

KNOWLEDGE FOR SUPPORTING INDIVIDUALS WITH DISABILITIES:

- Familiarity with the information provided in the five other VHCIP Disability Awareness Briefs: Introduction, Disability Competency for Providers, Cultural Competency, Accessibility, and Universal Design.
- Knowledge of socio-economic indicators of health, including generational poverty, health literacy, etc. and their impact on overall health status and well-being.
- Knowledge of quality of life issues often associated with chronic conditions, disabilities or other functional limitations.
- Understanding of the concept of “Dignity of Risk” and its application in practice (i.e., the right of individuals to choose to take some risk in engaging in life

experiences, even if that choice is not one recommended by a health professional.

- Familiarity with the specialized community services, community resource and advocacy networks, and peer support opportunities available to individuals with disabilities in the region.
- Knowledge of eligibility requirements for accessing specialized programs, services and supports for individuals with disabilities (e.g., Choices for Care, Community Rehabilitation and Treatment, services for children with Severe Emotional Disturbances, Developmental Disability Services, Traumatic Brain Injury Services).
- Knowledge of screening tools and assessments available to identify an individual's needs and strengths across primary, acute, medication, mental health, substance abuse, developmental, and long term care supports and services.
- Familiarity with entitlement programs such as Medicare and Medicaid, Veterans' Administration, SSD, SSI, and their eligibility requirements.
- Knowledge of the available social services that may benefit an individual's health and well-being, including housing, nutrition assistance, employment counseling and supports, transportation, language and literacy training, legal and financial services, and/or other supports that aid individuals with day-to-day living and optimal functioning.
- Knowledge of federal and state laws, policies and standards including but not limited to:
    - Americans with Disabilities Act of 1990
    - National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care of 2013
    - Complaint and Grievance Procedures
    - Abuse and Critical Incident Reporting
    - Acceptable Use of Medicaid Funds
    - Specific Vermont Specialized Program Regulations and Guidelines (e.g., Services Funding Guidelines, Quality Guidelines, Self-Management Guidelines)

SKILLS AND BEHAVIORS OF CARE MANAGEMENT PRACTITIONERS FOR SUPPORTING INDIVIDUALS WITH DISABILITIES:

The following presents major domains of competency for care management practitioners, descriptions of the domains, and examples of the unique skills and behaviors that exemplify each of the domains when supporting individuals with disabilities.

Person-Centered Care: *The ability to engage, communicate effectively with, and take direction from the individual in decisions affecting the design, delivery and evaluation of care management activities and service delivery, including honoring and respecting the individual's choices to take some risk in engaging in life experiences (i.e., the concept of "dignity of risk").*

Examples include:

- Seeing the individual as a whole person with hopes, values, preferences and strengths as well as limitations.
- Honoring self-determination, which is the basic right of all people to have as much control as they desire over the aspects in life that are important to them.
- Recognizing that the individual is not a passive recipient of care, but should create, direct and participate in their care plan and services to the fullest extent possible.
- Informing the individual and their family members of available self-directed service options and related supports.
- Using the individual's preferred mode of communication. ~~.~~
- Adapting communication to meet the individual's needs for receiving information and reflecting back information to ensure that the individual has been accurately understood.
- Supporting the individual to understand the concept of dignity of risk, to explore areas of possible risks in his or her life, and allowing flexibility in negotiating risks based on their potential for harm vs. growth and improved quality of life.
- As appropriate advocating within the care setting for the role of the individual and appropriate family members in care decisions.
- As appropriate, representing the point of view of individuals when they are unable to participate in discussions.
- Where applicable, including the person's legal guardian or agent in accordance with that individual's legal responsibility.
- Adhering to and respecting all policies regarding the rights, anonymity, and confidentiality of individuals with disabilities, and ensuring that they are fully informed of their rights and protections.
- Being careful when discussing with others sensitive or potentially stigmatized issues related to the individual's disabilities.

Screenings and Needs Assessment: *The ability to conduct or arrange for brief, evidence-based and disability specific screenings and assessments in a timely manner and to conduct or arrange for more detailed assessments when indicated.*

Examples include:

- Detecting signs of abuse, neglect, domestic violence, and other trauma in individuals across the lifespan.
- Assuring that evidence-based and developmentally appropriate screenings occur, as indicated (e.g., screens for cognitive impairment, common mental health problems, behaviors that compromise health, risk related to self-harm or harm to others, impairments in functional self-care, abuse, neglect and domestic violence).
- Understanding the assessment tools and processes used to identify mental health, substance abuse, developmental, and long term care services and support needs.
- Assisting the individual in obtaining relevant assessments in order to develop an appropriate care plan and/or to access Medicaid specialized service programs.
- Following up, as needed, to ensure in-depth assessments are conducted for more specialized needs (e.g., severe and persistent mental illness, long-term care).
- Ensuring that the assessment process occurs whenever a significant change occurs that would alter the services and supports needed.

Care Planning: *The ability to utilize information from assessments and from the individual and their family members to develop a comprehensive care plan that includes all of the individual's needs, goals, and interventions to address them.*

Examples include:

- Creating integrated care plans in consultation with the individual, family members, other providers, and other people identified by the individual to be part of the care team.
- Ensuring the individual's short and long-term goals and preferences are addressed in care planning.
- Utilizing information from the needs assessments across primary, acute, mental health, substance abuse, developmental, medication and long term care service and support settings to develop a comprehensive integrated care plan.
- Incorporating the individual's culture, language and disability-related needs in care planning to identify effective social services and supports.
- Identifying the individual's informal support systems/networks in relation to functional and safety needs, and inclusion in the care plan as appropriate.
- Addressing the challenges, risks, and rewards inherent in the individual's choices and working with the individual to define the risks that are real and tolerable to be included in the care plan.

<u>Integrated Care Coordination:</u> *The ability to ensure that an individual's care is integrated across all settings; that needed information is routinely exchanged among individuals, family members, and providers; and that relevant parties are informed of changes in an individual's health, functional or situational status to ensure responsive and high quality services.*

Examples include:

- Coordinating the individual's care across primary, acute, mental health, substance abuse, developmental, medication, and long term care service and support settings by referring, educating, negotiating, and mediating with the individual and formal and informal providers in order to meet care plan goals.
- Linking multiple health care providers and community services to meet the individual's needs.
- Creating and convening person-centered interdisciplinary care teams for individuals with complex needs as necessary to ensure the individuals' needs are met.
- Explaining to the individual and family the roles and responsibilities of each team member and how they will work together to provide services and to support the individual in meeting his/her care plan goals.
- Educating members of the team about the individual's characteristics, healthcare needs, health behaviors, disability-specific needs and views toward illness and treatment due to cultural influences or personal preferences.
- Linking the individual and family members with resources, including but not limited to specialty health care, rehabilitation and social services, peer support, legal and advocacy services, financial assistance, and transportation; and following up to ensure that effective connections have been made.
- Maintaining working relationships with the individual's primary care provider and other team members, especially in situations where the individual is mainly served by a specialist.

<u>Routine Support for and Collaboration with the Individual Receiving Services:</u> *The ability to serve as the individual's single point of contact across all of their service and support needs, and to provide on-going information and assistance to individuals to ensure that they have the supports necessary to maintain well-being.*

Examples include:

- Serving as the individual's single point of contact across his or her primary, acute, mental health, substance abuse, developmental, medication, and long term care service and support needs.

- Maintaining regular contact with the individual, his or her caregivers and service providers.
- Understanding the individual's living environment to assure basic necessities are available (e.g., food, heat, running water) and to identify need for accommodations (e.g., inaccessible entrance, bathroom or sleeping area).
- Understanding the nature of the individual's family and social support system and other socio-economic resources that have an impact on his or her health and well-being.
- Ensuring the individual has accessible information about his or her health care conditions, prevention, available treatments, self-management, peer support and recovery (where appropriate).
- Ensuring that all services are adapted to the individual's language, cultural norms, and personal preferences, and that accommodations (physical, cognitive, cultural, and other) are in place to support active participation in care planning, receipt of quality services and positive health and social outcomes.
- Ensuring the individual receives services in the least restrictive and most appropriate setting in accordance with their needs and preferences.
- Recognizing self-neglecting behaviors and offer intervention, when such behaviors jeopardize the person's wellbeing; this may include a referral to Vermont Adult Protective Services.
- Monitoring the delivery of formal and informal services and supports to ensure that services are being provided as planned, the individual's identified needs are being met, and that his or her goals are being pursued.

Support During Care Transitions: *The ability to work across multiple settings in times of individual 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 individual.*

Examples include:

- For facility-based transitions, contacting facility case managers/discharge planners to assist with the transition in care and follow up after discharge to ensure that all aspects of the plan of care are in place and the individual's ongoing needs are met.
- Managing non-facility-based transitions (e.g., changes in health status or socio-economic factors) through home visits to ensure the individual's medication, living skills, social supports, and functional and behavioral health needs are addressed.

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[1] *Disability-Competent Care Self-Assessment Tool*. Resources for Integrated Care, a collaboration between the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS), The Lewin Group, and the Institute for Healthcare Improvement; May 22, 2013. Available at: https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool_508%20Compliant.pdf.

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[3] *Disability-Competent Care Self-Assessment Tool*. Resources for Integrated Care, a collaboration between the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS), The Lewin Group, and the Institute for Healthcare Improvement; May 22, 2013. Available at: https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool_508%20Compliant.pdf.

[4] *ibid*

[5] *Person-Directed Strengths and Risk Inventory Tool.* New York Office for People with Developmental Disabilities: Albany, NY; 2014. Available at: http://www.opwdd.ny.gov/node/5521

[6] The information in the remaining sections of this Brief was obtained or adapted from the following sources:

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dds/policies-dds-documents/guide-for-people-who-self-or-family-mng-medicaid-funding-ds

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Vermont Health Care Innovation Project

Disability Awareness Brief:

CULTURAL COMPETENCY

Note: This is one in a series of six Disability Awareness Briefs: Introduction to Disability Awareness, Disability Competency for Providers, Disability Competency for Care Management Practitioners, Cultural Competency, Accessibility, and Universal Design. This Brief on Cultural Competency should be considered together with the other five documents in order to have the comprehensive, basic information needed to inclusively address the unique health care needs of individuals with disabilities.

WHAT IS CULTURAL COMPETENCY?

Culture can be defined as the behaviors, values and beliefs shared by a group of people. Characteristics that can define cultural groups include, but are not limited to:[1]

- Race
- Ethnicity
- Country Of Origin
- Language
- Sexual Orientation
- Gender Identity
- Age
- Education
- Disability
- Family and Household Composition
- Class/Socioeconomic Status
- Religious/Spiritual Orientation
- Political Beliefs
- Geography
- Tribal Affiliation
- Military Affiliation

Everyone belongs to multiple cultural groups, so that each individual is a blend of many influences. Culture also is dynamic in nature, and individuals may identify with multiple different cultures over the course of their lifetimes. Culture includes or influences dress, language, religion, customs, food, laws, codes of manners, behavioral standards or patterns, and beliefs. It plays an important role in how people express themselves, seek help, cope with stress and develop social supports. Culture affects every aspect of an individual’s life, including how we experience, understand, express, and address physical, emotional, and mental distress.

Cultural competence is the ability to relate effectively to individuals from various groups and backgrounds, and to recognize the broad scope of influences on an individual’s personal identity. Culturally competent services respond to the unique needs of members of various groups and are sensitive to the ways they experience the world.[2]

Cultural competence does not mean knowing everything about every culture. It does mean understanding that beliefs and attitudes about health, illness and disability vary from culture to culture and, as a result, responses to providers and to treatment, services and supports also may vary. It also means being curious about other cultures, becoming aware of one's own cultural biases, and being sensitive to cultural differences while avoiding stereotypes.[3] Cultural Competence also includes the provision of health care in the language that is preferred by the individual and/or meets the needs of all individuals, including those who have low literacy skills or are not literate.

WHY DO PROVIDERS NEED COMPETENCY REGARDING CULTURAL DIVERSITY?

The nation's population is rapidly diversifying, and this also is true in Vermont. The percentage of racial and ethnic minorities, refugees, and people who speak English as a second language are all increasing in the State.[4]

Recognition of disability culture also is growing internationally and in Vermont. Although the range of differences among individuals with disabilities is enormous, the common bond within disability culture are twofold: 1) a recognition of the impact of social beliefs and practices on the experience of disability, and 2) the acknowledgement and celebration of disability a way of life, rather than a life that is tragic or devalued. It is about visibility and self-value and social transformation. This shared understanding reframes/remakes the concept of disability, allowing individuals with a disability to claim disability *and* dignity and to work together to establish disability rights and social equality. The common bond created by disability culture creates powerful opportunities for individuals with diverse disability experiences to pursue personal goals while working together for social transformation of disability experience.[5]

It is imperative that providers understand cultural differences and become culturally competent in order to provide quality care. Cultural barriers that prevent individuals from receiving appropriate care include mistrust and fear of treatment; alternative ideas about disability and about what constitutes illness and health; language barriers and ineffective communication; access barriers, such as inadequate insurance coverage, or inaccessible architectural and structural design; and a lack of diversity in the health care workforce. In addition, cultural biases and stereotypes can cause inequity in service provision and can prevent people from seeking help.[6] Physicians may be especially vulnerable to the use of stereotypes in forming impressions of individuals since time pressure, brief encounters, and the need to manage very complex tasks are common characteristics of their work.[7]

Recent federal laws have been enacted to reinforce the need for cultural competency in the health care and services arena. Section 1557 of the Affordable Care Act of 2010 prohibits discrimination in health care programs on the basis of race, color, national origin, sex, sex stereotypes, gender identity, age, or disability; the Department of Health and Human Services' Office for Civil Rights holds the authority and obligation to investigate potential violations of the law and enforce this new civil rights guarantee.[8]

More recently, in 2013 the U.S. Department of Health and Human Services, Office of Minority Health published enhanced national *Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. The CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services.

Following are the fifteen CLAS standards, which as a whole represent organizational opportunities to address health care disparities at every point of contact along the health care services continuum. The first is the Principal Standard which guides all others; Standards 2 through 15 represent the practices and policies that are the fundamental building blocks of culturally and linguistically appropriate services necessary to achieve the Principal Standard.

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Advanced and sustained organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruitment, promotion, and support for a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educated and trained governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
5. Offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
9. Establishing culturally and linguistically appropriate goals, policies, and management accountability, and infusing them throughout the organization's planning and operations.
10. Conducting ongoing assessments of the organization's CLAS-related activities and integrating CLAS-related measures into measurement and continuous quality improvement activities.
11. Collecting and maintaining accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conducting regular assessments of community health assets and needs and using the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partnering with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Creating conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicating the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Although implementation of the enhanced National CLAS Standards is not mandated by federal law, failure to provide services consistent with Standards 5 through 8 could result in a violation of Title VI of the Civil Rights Act of 1964 regulation that requires recipients of Federal financial assistance to take reasonable steps to provide meaningful access to their programs for persons with limited English proficiency.[9]

INDICATORS OF CULTURAL COMPETENCY: [10]

Following are examples of cultural competency:

ORGANIZATIONAL CHARACTERISTICS:

- Organizational governance, leadership, policies and procedures that are committed to the implementation of the CLAS standards and the provision of culturally competent care.
- Identifying and developing informed and committed champions of cultural competency throughout the organization to focus efforts around providing culturally competent care.
- Surveying staff to elicit their cultural biases, and understanding of cultural competence and culturally competent practice, and providing training to address staff educational needs.
- Employing staff that is fluent in the languages of the groups being served.
- Ensuring that staff is fully aware of, and trained in, the use of language assistance services, policies, and procedures.
- Printed information takes into account the average literacy levels of individuals and families receiving services.
- Assessing intake and assessment documentation, as well as policies and procedures, to be more inclusive.
- Creating forms that are easy to fill out, and offering assistance in completing forms.
- Displaying pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of people served by the organization..
- Establishing accountability mechanisms throughout the organization, including staff evaluations, individuals' satisfaction measures, and quality improvement measures.
- Providing notice about the right of each individual to provide feedback, including the right to file a complaint or grievance, in translated signage and materials.

PROVIDER KNOWLEDGE:

- Knowledge of the impact of culture on health, illness, health practices, health beliefs, access to care, and participation in treatment.
- Knowledge of the role of social functioning and family in health, illness, health practices, responses to disability, health beliefs, and participation in treatment and services.
- Knowledge of the CLAS standards and how to apply them when working with

culturally diverse individuals.

- Recognition that limitations in English proficiency do not reflect the individual's level of intellectual functioning or their ability to communicate effectively in their language of origin.
- Recognition that individuals may not be literate in their language of origin nor in English.
- Recognition that people from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
- Understanding that family is defined differently by different cultures (e.g. extended family members, godparents) and that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).
- Understanding that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
- Keeping abreast of the major health and mental health concerns, disparities and issues for ethnically and racially diverse client populations residing in the geographic locale served.
- Awareness of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served.

PROVIDER SKILLS/BEHAVIORS:

- For individuals and families who speak languages or dialects other than English, attempting to learn and use key words to increase the ability to communicate with them during assessment, treatment, and other interventions and services.
- Attempting to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.
- Avoiding imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than that of the provider.
- Screening books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families receiving services.
- Intervening in an appropriate manner when observing other staff or service recipients engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
- Using alternatives to written communications for some individuals and families,

as word of mouth may be a preferred method of receiving information.

- Seeking information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups.
- Before visiting or providing services in the home setting, seeking information on acceptable behaviors, courtesies, customs, and expectations that are unique to the person's culture.
- Using open-ended questions to identify each person's unique cultural outlook.
- Identifying resources, such as natural supports, within the person's cultural community that can assist the person with their needs.
- Developing culturally sensitive plans of care.
- Taking professional development courses and training to enhance knowledge and skills in the provision of services and supports to culturally and linguistically diverse groups.
- Advocating for the review of the organization's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

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[1] *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* U.S. Department of Health and Human Services, Office of Minority Health; April, 2013. Available at: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

[2] *Cultural Competence in Mental Health.* Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities. Temple University: Philadelphia, Pennsylvania. Available at: http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf

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Associates Information Services Webinar; March 12, 2105. Available at: http://www.healthmanagement.com/news-and-calendar/article/350

[9] *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* U.S. Department of Health and Human Services, Office of Minority Health; April, 2013. Available at: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

[10] This information was obtained from the following sources:

- *Cultural Competence in Mental Health.* Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities. Temple University: Philadelphia, Pennsylvania. Available at: http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf
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Vermont Health Care Innovation Project

Disability Awareness Brief:

ACCESSIBILITY

Note: This is one in a series of six Disability Awareness Briefs: Introduction to Disability Awareness, Disability Competency for Providers, Disability Competency for Care Management Practitioners, Cultural Competency, Accessibility, and Universal Design. This Brief on Accessibility should be considered together with the other five documents in order to have the comprehensive, basic information needed to inclusively address the unique health care needs of individuals with disabilities.

This Brief only offers an overview of accessible practice. It is not intended to replace a more complete review of facility, program and communication access that should be conducted by staff, technical experts and individuals with disabilities. Links to federal and other technical assistance websites and resources are provided at the end of this Brief.

WHAT IS ACCESSIBILITY?

Individuals with disabilities are a diverse group of people who share the experience of living with mobility, sensory, mental health, and cognitive limitations or differences that affect their functioning. As a result, they often experience barriers to health care and full participation in their communities. (See Introductory Brief for more complete definition).

Accessibility is the provision of architectural, programmatic and communication elements and services that enable individuals with disabilities to utilize health care and support services in a manner that is equal to individuals without disabilities. In general, there are two broad categories of accessibility: accessible design (architecture, structures) and program accessibility (information and supports for receiving services).

Architectural access refers to the absence of barriers that physically prohibit an individual from obtaining services. Examples include parking spaces close to entrances, well-placed ramps or curb cuts, and doors that are wide and easy to open so that individuals with disabilities can get into buildings. Once inside, individuals with disabilities need access to counters and exam tables that are low enough to reach, an unobstructed path of travel, and equipment that is easy to use.[1,2]

Program access recognizes that individuals who have vision, hearing, speech, mental health or cognitive or other disabilities may need accommodations or assistance in order to participate in and benefit from programs and services and to communicate effectively with providers and others. For example, individuals who are blind may give and receive information audibly rather than in writing; individuals with limited vision need print materials that are large enough to read or offered in alternative formats; use of images rather than or in addition to written information may be important for some individuals with cognitive or learning disabilities or who are deaf; and some individuals who are deaf give and receive information through writing or sign language rather than through speech. In addition, medical records, web pages, brochures, and other information should be accessible to individuals with disabilities. The goal of effective communication is to ensure that the individual with a disability can communicate with, receive information from, and convey information to, the service delivery provider.

WHY DO PROVIDERS NEED TO BE AWARE OF ACCESSIBILITY?

Getting health care and other support services can be difficult for individuals with disabilities due to structural design issues or communication barriers. These barriers can prevent access altogether, or can significantly impact the effectiveness of care.

Physical accessibility of doctors’ offices, medical facilities, and other health and disability services makes it possible for individuals with disabilities to receive quality health care and disability-related services and supports. Effective communication makes it possible for individuals with disabilities to receive and share information and make essential decisions about health issues (e.g., discuss disability accommodations, explore treatment and services options, review health plan benefits and services, and, when necessary, file complaints).[3] As such, provider knowledge about physical and communication accessibility is important not only because providing accessible services is a federal requirement, but also because these accommodations significantly improve the effectiveness of care.

Two federal civil rights laws, the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973 require that health care providers provide individuals with disabilities full and equal access to health care services and facilities. The ADA prohibits discrimination against individuals with disabilities in everyday activities, including health care services. Title II of the ADA applies to public hospitals, clinics and health care services operated by state and local governments, and Title III of the ADA applies to privately-owned and operated hospitals, clinics and health care providers. Section 504 of the Rehabilitation Act prohibits discrimination against individuals with disabilities on the basis of their disabilities in programs or activities that receive federal financial assistance such as Medicaid, Medicare and federally conducted programs.[4,5]

The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504. They both require: 1) the provision of full and equal access to health care services and facilities; 2) reasonable modifications to polices, practices, and procedures when necessary to make services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services; and 3) effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.[6,7]

INDICATORS OF DISABILITY-COMPETENCY REGARDING ACCESSIBILITY [8]

Following are examples of disability-competency related to Accessibility:

ORGANIZATIONAL CHARACTERISTICS:

- Having administrative systems (e.g., policies, procedures and data systems) that enable staff to anticipate and plan ahead for disability-related needs.
- Planning for emergency evacuation procedures for individuals with disabilities.
- Having capacities, policies and procedures for achieving and maintaining facility accessibility, such as but not limited to:
    - Maintaining a checklist on the structural elements needed to provide disability-competent care (e.g., ramps, scales, accessible entry points, and signage).
    - Assessing and documenting the availability of accessible and adaptive equipment most often used by individuals with disabilities.
- Having capacity, policies and procedures for communication and access to information, such as but not limited to:
    - Provisions for intake forms to be completed by individuals with visual impairments with the same confidentiality afforded other individuals.
    - Providing training, guidance and support for alternative communication methods between office staff and individuals with speech or language impairments.
    - Ensuring the availability of communication access, including but not limited to American Sign Language (ASL) and ASL interpreters, teletypewriter (TTY) and text support for mobile phone or Internet-based communication, amplification devices, in-office communication devices, and communications facilitators.

    - Provisions for making auditory or visual information (e.g., automated phone menus or messages, print materials) available via alternative means.
- Having policies and procedures regarding appointment scheduling and waiting, such as but not limited to:
    - Policies that allow scheduling additional time for the duration of appointments for individuals with disabilities who may require it.
    - Policies to enable individuals who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival.
    - Policies to allow flexibility in appointment times for individuals who require transportation or supportive assistance.
    - Policies to enable compliance with the federal law that guarantees access to medical offices for individuals with disabilities who use service animals.
- Having policies and procedures related to conducting medical exams, such as but not limited to:
    - Training staff to effectively and respectfully communicate with and assist individuals with different disabilities.
    - Training of nurses and other medical staff to safely assist or lift individuals from wheelchairs to examination tables or other equipment, and return them safely after the exam.
    - Staff training to appropriately help an individual who may need assistance with dressing both before and at the conclusion of the exam.
    - Purchasing accessible medical equipment, repairing and/or replacing it.
    - Training of doctors, nurses, and other medical staff in the operation of accessible equipment.

PROVIDER KNOWLEDGE:

- Knowledge about the accessibility requirements within the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act.
- Awareness that a provider cannot refuse to provide an individual with services because of an individual’s disability, unless the provider’s refusal to provide treatment relates to the individual’s disability and is outside the area of that provider’s expertise.
- Knowledge about the differentiation between hearing-impaired individuals (hard-of-hearing) and those who are culturally Deaf.[9]
- Awareness that the vast majority (97.5%) of all individuals who have a hearing loss use spoken language skills and that only a small minority (2.5%) uses American Sign Language (ASL) as a primary means of communication.
- Awareness of availability of ASL interpreter services.

- Awareness that individuals cannot be charged for ASL interpreting or real time captioning services when receiving services, and that family members should not be pressured to function as ASL interpreters to save time or expense.
- Staff familiarity with Telecommunication Devices for the Deaf (TDDs) and available communication relay services, such as Video Relay, CapTel, or WebCapTel, as well as health information tools that are effective for individuals with cognitive, visual and mobility disabilities.
- Ability to identify and access necessary and appropriate adaptive equipment to assure an exam or procedure can be conducted.
- Awareness that service dogs are legally allowed in medical facilities and that guide dogs should not be petted or distracted, and respecting the blind individuals' instructions regarding their guide dogs. However, the same protection does not apply to emotional support animals.[10]

PROVIDER ACCOMMODATIONS:

For all individuals who have a disability:

- Asking individuals with disabilities if and how they would like to be assisted.
- Providing flexible appointment or meeting times.
- Providing longer appointment or meeting times to allow for adequate communication; history taking; thorough examination, assessment or planning; and care coordination.
- Providing assistance filling out forms, if needed.
- Ensuring that informational materials are accessible.
- Availability of accessible parking close to entrances.
- Directional signage that indicates accessible routes and building entrances.
- Accessible routes that lead to accessible entrances.
- Signage that uses simple, san serif fonts such as Arial or Verdana.
- Floor spaces and hallways that are free of equipment and other barriers.
- Alarm systems that can be both seen and heard.
- Involving individuals with a variety of disabilities as part of a team for assessing facility and provider accessibility and recommending additional accommodations.

For individuals who are wheelchair users or have a mobility impairment:

- Accessible parking places, including designated van parking spaces, which means room for a lift or ramp to deploy and the individual to exit the vehicle.
- Accessible curb ramps at building entrance.
- Accessible, stairs-free route from parking and loading zones up to building entrance.

- An accessible entrance to the facility that is clearly marked.
- Doorways throughout the facility that are wide enough to ensure safe and accessible passage by individuals using mobility aids.
- Accessible routes of travel into and throughout buildings that are free of objects that block aisles and doorways (e.g., trash cans, carts, plants, objects protruding from the walls, and storage containers).
- Restrooms that have adequate maneuvering space for wheelchairs around toilets, grab bars mounted next to and behind toilets, and accessible lavatories.
- Drinking fountains, public telephones, and service counters low enough for an individual who uses a wheelchair or scooter.
- Exam rooms that are accessible to wheelchair users.
- Adjustable exam tables for clinical services.
- Examination rooms that have clear floor space for an individual to turn in a wheelchair or scooter.
- A minimum clear floor space of 30 by 48 inches next to exam tables so that individuals using a wheelchair or other mobility aid can transfer onto the tables.
- Use of proper positioning techniques to provide adequate physical examinations and comfortable and safe experiences for the individual.
- Accessible medical equipment and health care devices (e.g., mammograms or x-ray equipment that can be used by individuals who use wheelchairs, scales that are capable of weighing an individual using a mobility aid like a wheelchair).
- Provision of physical assistance, if necessary, for a full and complete medical exam, even if it requires more time or assistance; this includes provision of personal assistance for dressing and undressing.
- If requested, assistance with arranging for accessible transportation to and from appointments for individuals who use wheelchairs or have limited mobility.

<u>For individuals who are blind or visually impaired:</u>

- Front office staff who recognize the possible need for and can assist in orienting the individual to the office environment (e.g., describe the office, including doors, steps, or ramps) and to locate specific areas in the facility.
- Raised tactile lettering that use uppercase and Braille on signs at office, elevator and restroom doors.
- Signs are in large size font for individuals with limited vision.
- No objects protruding into routes of travel that would pose a hazard for someone who is blind or has limited vision.

- Provision of print information in alternative formats, such as large print, Braille, and an audio recording or computer disk for use with a screen reader.
- With the individual's permission, providing a qualified reader (i.e., someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary).
- Web sites that can be used by all individuals, including those who are blind and may use computer screen reading technology.

For individuals who are deaf or have a hearing loss:

- Facing the individual when speaking.
- Use of written notes for uncomplicated, short, routine communication.
- As appropriate, provision of a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter when requested or for more complex situations. A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the individual with a disability is saying) and expressively (i.e., having the skill needed to convey information back to that individual) using any necessary specialized vocabulary. An interpreter generally will be needed for situations such as taking the medical history of an individual or for discussing a serious diagnosis and its treatment options.
- Provision of a qualified note-taker, when requested.
- Provision of assistive listening systems that help amplify sounds the individual wants to hear.
- Provision of computer assisted real time transcription services (CART) that provide instant translation of the spoken word into English text using a stenotype machine, notebook computer and real-time software.
- Provision of text-to voice relay service and video-relay service for individuals whose primary language is American Sign Language (ASL).
- Provision of real time captioning services, when requested.
- Videos on the provider's web-site that have captioning or written versions.

For individuals who have a speech impairment:

- Listening attentively and not being afraid or embarrassed to ask the individual to repeat a word or phrase that is not understood.
- Providing a qualified speech-to-speech transliterator (an individual trained to recognize unclear speech and repeat it clearly).
- Taking more time to communicate with someone who uses a communication device.

- Keeping paper and pencil on hand so the individual can write out words that cannot be understood.

For individuals who have an intellectual or developmental disability or cognitive impairment:

- If the individual is having difficulty with communication, showing patience, presenting information simply and clearly, repeating the information if necessary and asking the individual to verify their understanding.
- Allowing for more time to enable the individual to speak as well as more time to understand what is being said.
- Accommodating use of a personal communication device.
- Use of diagrams and pictures to improve communication.
- With the individual's permission, providing a reader.
- Presence of staff able to assist the individual to enter and negotiate exam rooms and provide any necessary assistance with undressing or other relevant procedures.

For individuals who have a mental health disability:

- Awareness that a provider cannot require an individual with a mental health disability to bring someone with them to a medical appointment if the individual would prefer to attend the appointment alone.
- Allowing the individual to bring a support individual with them to a medical examination or consultation if the individual desires this because of their mental health disability.
- Scheduling an appointment at a specific time if the individual's disability makes it difficult to wait in a crowded waiting room.
- Taking extra time for an appointment, if the individual's disability affects the amount of time it takes to process information and ask questions.

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[1] *Accessibility*. Centers for Disease Control and Prevention; Atlanta Georgia. Available at: http://www.cdc.gov/ncbddd/disabilityandhealth/accessibility.html.

[2] *ADA Checklist for Existing Facilities.* New England ADA Center at the Institute for Human Centered Design(IHCD); December 2011. Available at: http://www.adachecklist.org/

[3] *Improving Access to Health Care for Individuals with Disabilities – Module 3: Effective Communication*. Disability Rights Education & Defense Fund, Berkeley, CA; October, 2014. Available at: http://dredf.org/2014/11/28/improving-access-health-care-individuals-disabilities/ .

[4] *Accessible Health Care Fact Sheet*. ADA National Network; 2014. Available at: https://adata.org/factsheet/accessible-health-care.

[5] The Department of Justice's revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. These regulations

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adopted revised, enforceable accessibility standards called the 2010 ADA Standards for Accessible Design, "2010 Standards." On March 15, 2012, compliance with the 2010 Standards was required for new construction and alterations under Titles II and III. March 15, 2012, is also the compliance date for using the 2010 Standards for program accessibility and barrier removal. http://www.ada.gov/2010ADAstandards_index.htm.

[6] *The Americans with Disabilities Act of 1990 and Revised ADA Regulations Implementing Title II and Title III.* United States Department of Justice; March 15, 2011. Available at: http://www.ada.gov/2010_regs.htm

[7] *Access to Health Care for Individuals with Mental Health Disabilities.* Disability Rights California. Available at: http://www.disabilityrightsca.org/pubs/CM2601.pdf.

[8] This information was obtained from the following sources:

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[9] *Hearing Impairment vs. Deafness*. Audiology Awareness Campaign. Available at: http://www.audiologyawareness.com/hearinfo_impairdeaf.asp

[10] *Access to Health Care for Individuals with Mental Health Disabilities.* Disability Rights California. Available at: http://www.disabilityrightsca.org/pubs/CM2601.pdf.

Vermont Health Care Innovation Project

Disability Awareness Brief:

UNIVERSAL DESIGN [1]

Note: This is one in a series of six Disability Awareness Briefs: Introduction to Disability Awareness, Disability Competency for Providers, Disability Competency for Care Management Practitioners, Cultural Competency, Accessibility, and Universal Design. This Brief on Universal Design should be considered together with the other five documents in order to have the comprehensive, basic information needed to inclusively address the unique health care needs of individuals with disabilities.

WHAT IS UNIVERSAL DESIGN?

Universal Design is the concept of simplifying life for everyone by making products, communications, and the physical environment benefit as many individuals as possible. Universal design benefits individuals of all ages and abilities, and takes into account the full range of human diversity, including physical, perceptual and cognitive abilities, communication and language differences, as well as different body sizes and shapes. Everyone, even the most able-bodied individual, passes through childhood, periods of temporary illness, injury and old age. Designing for this natural human diversity makes things more functional and user-friendly for everyone.

Universal Design is an ongoing design process that is always evolving and improving as we continue to learn more about how to best meet individuals' different needs rather than a final type of product, space or system. Universal Design can apply to anything that can be designed, including products like door handles, kitchen utensils and smartphones; architecture and the built environment, including public and commercial buildings, as well as residential buildings and family homes; and the community at large through urban planning and public transportation. Universal Design for Learning (UDL) addresses the design of communication and educational information and services and the diversity of human differences in how we communicate and learn. Universal Design can also help older adults by designing products and spaces that are safer and easier for them to use.

Universal Design evolved from Accessible Design, as described in the Americans with Disabilities Act (ADA) accessibility requirements for buildings and facilities. There is a great deal of overlap between what is required under the ADA and what would be suggested by Universal Design, but there are also differences. The ADA outlines the bare minimum necessary in order to curb discrimination against individuals with disabilities, while Universal Design strives to incorporate best practices for design. The ADA focuses on the civil rights of individuals with disabilities, while Universal Design benefits everyone.

WHY DO CARE ORGANIZATIONS NEED TO BE AWARE OF UNIVERSAL DESIGN?

Offices, parks, health care facilities, schools, or any other public spaces should be built to meet the needs of all of the individuals who will use the space. Going beyond the minimum requirements makes facilities more usable for all individuals, employees, clients, program participants and customers, not just those with disabilities. Universal Design for Learning also address inclusive practices in communication and services, resulting in programs and communication practices that work for people from diverse cultural and language backgrounds and with different learning styles and disabilities.

INDICATORS OF COMPETENCY REGARDING UNIVERSAL DESIGN

ORGANIZATIONAL CHARACTERISTICS:

The following presents the Seven Principles of Universal Design and their associated Guidelines which may be applied to evaluate existing designs, guide new design processes, and educate both designers and consumers about the characteristics of more usable products and environments:

1. **Equitable Use**: The design is useful and marketable to individuals with diverse abilities.

   Guidelines:
   - Provide the same means of use for all users: identical whenever possible; equivalent when not.
   - Avoid segregating or stigmatizing any users.
   - Provisions for privacy, security, and safety should be equally available to all users.
   - Make the design appealing to all users.

2. **Flexibility in Use:** The design accommodates a wide range of individual preferences and abilities.

Guidelines:

- Provide choice in methods of use.
- Accommodate right- or left-handed access and use.
- Facilitate the user's accuracy and precision.
- Provide adaptability to the user's pace.

3. **Simple and Intuitive Use:** Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

Guidelines:

- Eliminate unnecessary complexity.
- Be consistent with user expectations and intuition.
- Accommodate a wide range of literacy and language skills.
- Arrange information consistent with its importance.
- Provide effective prompting and feedback during and after task completion.

4. **Perceptible Information:** The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.

Guidelines:

- Use different modes (pictorial, verbal, tactile) for redundant presentation of essential information.
- Provide adequate contrast between essential information and its surroundings.
- Maximize "legibility" of essential information.
- Differentiate elements in ways that can be described (i.e., make it easy to give instructions or directions).
- Provide compatibility with a variety of techniques or devices used by individuals with sensory limitations.

5. **Tolerance for Error:** The design minimizes hazards and the adverse consequences of accidental or unintended actions.

Guidelines:

- Arrange elements to minimize hazards and errors: most used elements, most accessible; hazardous elements eliminated, isolated, or shielded.
- Provide warnings of hazards and errors.
- Provide fail safe features.
- Discourage unconscious action in tasks that require vigilance.

6. **Low Physical Effort:** The design can be used efficiently and comfortably with minimum fatigue.

   Guidelines:
   - Allow user to maintain a neutral body position.
   - Use reasonable operating forces.
   - Minimize repetitive actions.
   - Minimize sustained physical effort.

7. **Size and Space for Approach and Use:** Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.

   Guidelines:
   - Provide a clear line of sight to important elements for any seated or standing user.
   - Make reach to all components comfortable for any seated or standing user.
   - Accommodate variations in hand and grip size.
   - Provide adequate space for the use of assistive devices or personal assistance.

EXAMPLES OF UNIVERSAL DESIGN:

- Weather protection at entrance doors (e.g., overhead roofs and side protections from precipitation and wind).
- Power door operators at interior and exterior entrances that work well for everyone including children and older adults.
- Wide doors.
- Using lever door handles instead of round door knobs.
- Lighting and acoustics in the built environment that optimize hearing and sight for diverse users.
- Quiet spaces available for conversations and for people who work best with less environmental noise or visual distractions.
- Standard decision making aids and resources designed to accommodate diverse learning styles and disability-related needs.
- Chairs for use by individuals who cannot stand while transacting business.
- Chairs that can be set at different heights for use by children, adults and older individuals, some equipped with arm rests for those who need assistance rising to their feet.
- Spacious toilet rooms, which provide space for wheelchair users but also

accommodate parents with strollers or several children.

- Scales that allow individuals with difficulty standing to hold on.
- Individuals alerted in a pharmacy or waiting room environment with a verbal announcement plus light-emitting diode (LED) signage, which benefits individuals who are distracted or attending to small children as well as individuals who are deaf, hard of hearing, or visually impaired.
- Motorized, adjustable-height treatment and examining tables and chairs, diagnostic equipment, and fitness equipment which work well for everyone including children, older adults, and individuals with mobility disabilities.
- Signs and service information designed for individuals with diverse communication and language requirements.
- More than one accessible toilet and dressing room, some with left-handed levers and some with right-handed levers.
- Building entrances without steps.
- Curb cuts at sidewalks, which can be used by individuals who use wheelchairs and by pedestrians with strollers or rolling luggage.
- Tactile marking as well as print and graphic signage on routes of travel.

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[1] The information in this Brief was obtained from the following sources:.

- *Accessibility*. Centers for Disease Control and Prevention, Atlanta, GA; April 2, 2014. Accessed at: http://www.cdc.gov/ncbddd/disabilityandhealth/accessibility.html.
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- *What is Universal Design?* Accessed at: http://www.universaldesign.com/about-universal-design.html.

Attachment 3

DAIL Timeline for HCBS

2014 CMS Regulations for Home and Community Based Services

DAIL Presentation to the Disability and Long Term Services and Supports Workgroup

May 28, 2015

The new rule includes Person-Centered Standards in 3 subsections

- Person-Centered Care Planning
- Person-Centered Service Plan
- Required Plan Review Process

Subsection 1: Person-Centered Care Planning

Two overarching Principles:

- The individual leads the care planning process

  E.G., Who- what- where- when

- The individual is empowered to make informed choices.

  Informed choice means individuals must receive meaningful and easily understood information about available services, supports and providers.

Subsection 2: Person-Centered Service Plan

Three overarching principles:

- The plan must reflect the individual’s needs and preferences.
- The plan must include all paid and unpaid supports and services, as well as the providers of those services.
- The plan must be agreed to by the individual and the parties responsible for implementing the plan.

Regulations require such agreement to be documented by signature.

Subsection 3: Required Plan Review

Three overarching principles:

- The Service Plan must be reviewed annually.
- The Service Plan must be reviewed at the individual’s request.
- The Service Plan must be reviewed upon significant change of circumstances.

VERMONT GLOBAL COMMITMENT TO HEALTH COMPREHENSIVE QUALITY STRATEGY TIMELINE

June 11: Review Draft with External Stakeholders DAIL Advisory Board

June 18: Review Draft with External Stakeholders DDS Standing Committee

June 30: Develop Final Draft

July 1: Begin Public Notice and Comment Process

July 3: Review Final Draft with Internal Stakeholders AHS PAC – (Performance Accountability Committee)

July 15: Review Final Draft with External Stakeholders Medicaid and Exchange Advisory Board (MEAB)

July 23: Public Hearing

July 31: Submit Draft of Revised Comprehensive Quality Strategy to CMS

Attachment 4a

Payment Models Work Group Update

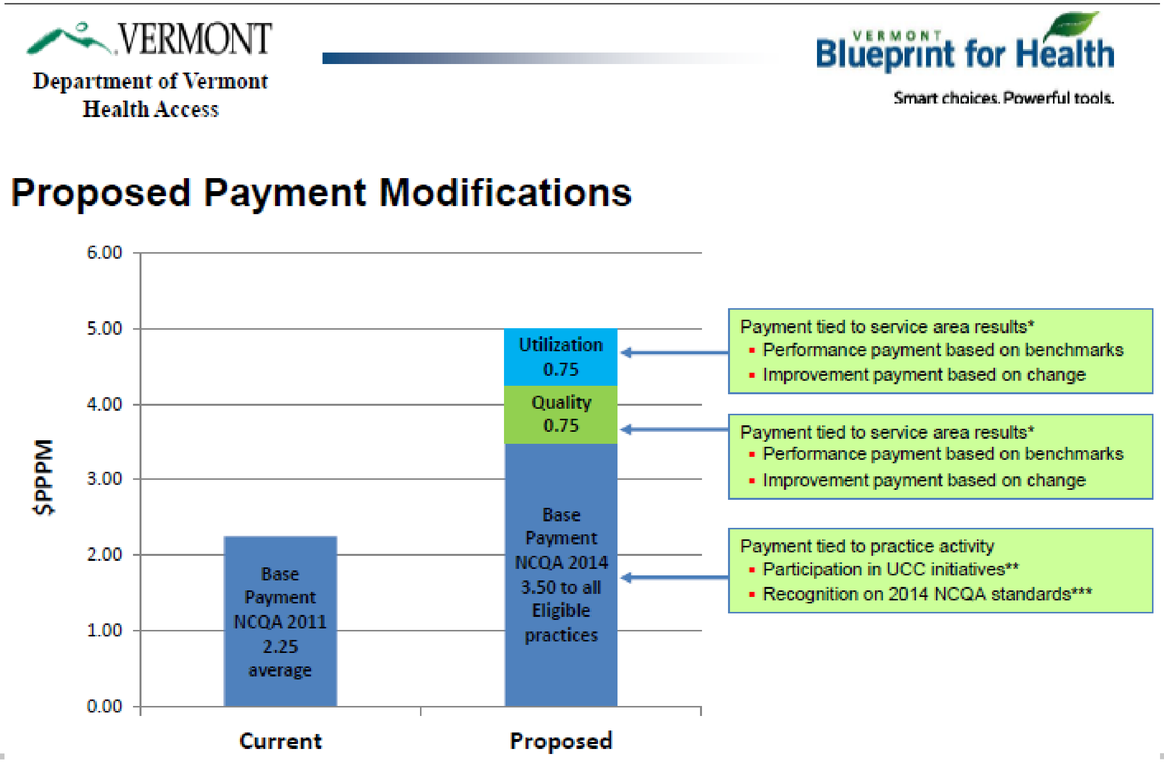
Payment Models Workgroup: Year 2 Progress and Outlook

DLTSS Workgroup

May 28, 2015

Proposed Blueprint Payment Methodology

- Blueprint for Health brought forth a proposal to change the payment methodology for their practices
- Workgroup members discussed proposal and provided BP leadership with feedback



VERMONT
Department of Vermont
Health Access

VERMONT
Blueprint for Health
Smart choices. Powerful tools.

Proposed Payment Modifications

Payment tied to service area results*
- Performance payment based on benchmarks
- Improvement payment based on change

Payment tied to service area results*
- Performance payment based on benchmarks
- Improvement payment based on change

Payment tied to practice activity
- Participation in UCC initiatives**
- Recognition on 2014 NCQA standards***

VMSSP Year 2 Gate and Ladder

- Workgroup members voted to **approve** modifications to the VMSSP G&L Methodology for Year 2
- Presentations and public commentary occurred November 2014 through March 2015
- Changes included:
  - Increasing the minimum quality performance threshold for shared savings eligibility;
  - Including the use of <u>absolute points earned</u> in place of a percentage of points earned to eliminate the need for rounding; and
  - Allowing ACOs to earn “bonus” points for significant quality improvement <u>in addition to</u> points earned for attainment of quality relative to national benchmarks.

Episodes of Care Sub-group

- An EOC focused sub-group was established in Jan 2015
- The sub-group met a total of five times
- Consensus has been positive around the utility of this type of analysis in Vermont
- Details around sustainability, appropriate data sources and dissemination of information were major areas of discussion among sub-group members
- Sub-group meetings are at a hiatus until next steps are discussed

Episodes of Care Sub-group Representation

- Blue Cross Blue Shield of Vermont
- Blueprint for Health
- DAIL
- DVHA
- GMCB
- MVP Health Care
- OneCare Vermont
- Vermont Association of Hospitals and Health Systems
- Vermont Medical Society
- Vermont Program for Quality in Health Care

Next Generation ACO - Overview

- The workgroup received a presentation on CMS's Next Generation ACO
- The Next Generation model is aimed at helping CMS reach their goal of 85 percent of Medicare fee-for-service payments linked to a quality component by 2016 and 90 percent by 2018
- Higher risk, higher reward – coupled with increased flexibility for ACOs and their beneficiaries
- Applications due June 1st, 2015 for a January 1st, 2016 start

See Comparison Grid Handout

	Pioneer	Medicare Shared Savings Program	Next Generation	Vermont Medicaid Shared Savings Program	Vermont Commerical Shared Savings Program
Attribution methodology	Prospective alignment with year-end reconciliation: Beneficiaries will first be aligned with the group of primary care providers (same as MSSP, but including NPs and PAs) who billed for the plurality of primary care allowed charges during combined 3 year period. If a beneficiary had less than 10% of E&M allowed charges billed by primary care physicians (in or out of the ACO), alignment will be with the group of eligible specialistswho billed for the plurality of allowed charges	Retrospective alignment in two steps: 1.) Assign a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. 2.) For beneficiaries who have not received primary care services from PCPs within the ACO, assign beneficiaries if they receive the plurality of primary care services from other ACO professionals within the ACO.	Prospective beneficiary alignment using Pioneer claims-based model and voluntary affiliation.	Retrospective alignment in two steps: 1) attributed through claims with qualifying CPT codes in performance year with Medicaid-enrolled primary care providers 2) eligible beneficiaries not assigned through claims, assign them to PCP they selected or were auto-assigned to in PY.	Retrospective alignment in two steps: 1) attribute to PCP if beneficiary selects one 2) if not assigned, look at claims in most recent 24 months for qualifying CPT codes of providers with internal medicine subspecialties 3) assign members to practice where they had greatest # of qualifying claims
Minimum population	15,000 non-rural /5,000 rural	5,000	10,000 non-rural/7,500 rural	5,000	5,000
Benchmarking methodology	Prospectively set: Based on weighted prior 3 year average of actual expenditures for each of ACO's aligned beneficiaries, most recent year weighted most heavily (60%, 30%, 10%).This baseline will be increased by average percentage growth rate (50%), and absolute dollar equivalent of growth rate (50%) for a national reference population ("matched cohort")	Retrospectively set: based on weighted prior 3 year expenditures of Medicare Parts A and B services, most recent year weighted most heavily (60%, 30%, 10%), trended forward to the third benchmark year by employing the national growth rate for those Part A and B services.	Prospectively set with four components: 1.) one year of historical baseline expenditures, 2.) applying a regional trend, 3.) risk adjustment 4.) applying a discount derived from a quality adjustment and two efficiency adjustments (regional and national ratios).	Retrospectively set: Expected TCOC PMPM calculated using calendar year claims for the attributed beneficiary population, trended forward two years using calculated CAGR and risk-adjustment. 3 benchmark years are used and rolled forward one year at the beginning of each performance year.	Retrospectively set: Years 1 and 2 benchmarks are based on Green Mountain Care Board-approved exchange premium (medical expense portion only)
Base years (and how trended?)	For Performance Years 1-3, base years are 2010, 2009, 2008. Base years updated for Performance Years 4-5 to 2013, 2012, 2011	For example, for ACOs starting in 2012, benchmarking years will be 2009, 2010, and 2011	For Performance Years 1-3, the base year will be 2015 and will remain static	For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years. Performance years continue to trend forward in this pattern.	N/A (XSSP target is premium-based)
TCOC	Medicare Parts A and B	Medicare Parts A and B	Medicare Parts A and B	All Medical Services in line with Part A and B	Most benefits offered through exchange insurance plans, with the following exceptions: 1.) services carved out by self insured employers, 2.) prescription retail (potential inclusion in expanded TCOC in Years 2/3), 3.) dental benefits (to be revisited when pediatric dental is mandated)
MSR/MLR	±1%	Track 1: +2% to +3.9% (depends on ACO size) Track 2: ±2%	none	+2% to +3.9% (depends on ACO size)	No MSR/MLR, instead expected spending and target spending amounts.
Savings/Risk	60 % of savings in the first year (70 % in the second year). ACOs have two other options from which to choose: one would increase the financial risk and reward, the other would decrease the risk and reward	Two risk arrangements: Track 1 - share up to 50% savings with no downside risk and Track 2 - up to 60% share in savings, with downside risk	Two risk arrangements: 1) 80% sharing rate for performance years 1 to 3 and 85% for performance years 4 and 5; 2) 100% risk for Part A and Part B expenditures in each year	2 risk arrangements (one-sided or two-sided model) for 3 performance years. 1-sided maximum sharing rate is 50%, two-sided is 60%. All VMSSP ACOs have selected one-sided model (upside risk only).	Upside risk only for 2 years and both upside/downside risk in Year 3 - risk amount yet to be specified.
Savings/Loss Caps	10% savings/loss cap in PY1; 15% savlings/loss cap in PY2	Savings caps:10% in Track 1, 15% in Track 2; loss caps (Track 2 only): 5% in PY1, 7.5% in PY2; 10% in PY3	15% savings/loss cap in all years	10% savings cap in all years	Savings cap of 10% in all years; loss cap between 3-5% in PY3 - specific cap yet to be specified
Quality Metrics	33 quality measures in four categories: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations	33 quality measures in four categories: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations.	The Next Generation Model will adopt the MSSP quality measure set, except for the electronic health record (EHR) measure (ACO-11: Percent of PCPs Who Successfully Meet Meaningful Use Requirements), for a total of 32 measures.	Currently 32 Payment and Reporting Measures, 8 of which are Payment Measures that impact shared savings	Currently 31 Payment and Reporting Measures, 7 of which are Payment Measures that impact shared savings
Shared savings rate impacted by quality metrics	Yes - Gate and Ladder methodology	Yes - Gate and Ladder methodology	Quality and performance to impact discount applied to benchmark	Yes - Gate and Ladder methodology similar to MSSP	Yes - Gate and Ladder methodology similar to MSSP
Start date/ Program Length	January 1st, 2012/ 3 performance years with 2 optional 1-year extensions	Multiple start dates in 2012-2014/ 5 yr with a 2 yr extension	Jan 1, 2016 and Jan 1, 2017/ 5 performance years (3 or 2 performance years with 2 optional 1-year extensions in 2019 and 2020).	January 1st, 2014/ 3 performance years	January 1st, 2014/ 3 performance years

Monitoring Year 1 Payments

- SIM staff at DVHA produce monthly financial reports for each ACO's TCOC spend during the Performance Year (PY)
- Updates continue after the end of each PY to account for claims runout (~6 months)
- Final Actual TCOC calculation and final reconciliation for PY1 will be completed in summer of 2015
- Payment of any shared savings to ACOs will be distributed in August, 2015

In the Coming Months…

- May meeting was not held, next meeting: June 22nd
- Update on Year 3 Total Cost of Care Research
- VT Bundled Payment for Care Improvement (BPCI) Nursing Home Bundled Payment Presentation
- Value Based Purchasing Report from PHPG
- Episodes Initiative Reboot
- Ensuring we are aligning PMWG plans with All Payer initiative

Attachment 4b

ACO Comparison

	Pioneer	Medicare Shared Savings Program	Next Generation	Vermont Medicaid Shared Savings Program	Vermont Commerical Shared Savings Program
Attribution methodology	Prospective alignment with year-end reconciliation: Beneficiaries will first be aligned with the group of primary care providers (same as MSSP, but including NPs and PAs) who billed for the plurality of primary care allowed charges during combined 3 year period. If a beneficiary had less than 10% of E&M allowed charges billed by primary care physicians (in or out of the ACO), alignment will be with the group of eligible specialistswho billed for the plurality of allowed charges	Retrospective alignment in two steps: 1.) Assign a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. 2.) For beneficiaries who have not received primary care services from PCPs within the ACO, assign beneficiaries if they receive the plurality of primary care services from other ACO professionals within the ACO.	Prospective beneficiary alignment using Pioneer claims-based model and voluntary affiliation.	Retrospective alignment in two steps: 1) attributed through claims with qualifying CPT codes in performance year with Medicaid-enrolled primary care providers 2) eligible beneficiaries not assigned through claims, assign them to PCP they selected or were auto-assigned to in PY.	Retrospective alignment in two steps: 1) attribute to PCP if beneficiary selects one 2) if not assigned, look at claims in most recent 24 months for qualifying CPT codes of providers with internal medicine subspecialties 3) assign members to practice where they had greatest # of qualifying claims
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