VHCIP DLTSS

Work Group Meeting

Agenda 8-20-15

VT Health Care Innovation Project

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

Thursday, August 20, 2015; 10:00 PM to 12:30 PM

4th Floor Conference Room, Pavilion Building

109 State Street, Montpelier

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 June 18, 2015	Yes

2	10:10 - 10:25	**Disability Awareness Briefs**
		Deborah Lisi-Baker
			• **Links to:** Disability Awareness Briefs – Final
			  • Introduction to Disability Awareness
			  • Disability Competency for Providers
			  • Disability Competency for Care Management Practitioners
			  • Cultural Competency
			  • Accessibility
			  • Universal Design	

3	10:25 – 10:45	**Shared Care Plans from the Learning Collaborative – Review and provide input** Deborah Lisi-Baker	• Attachment 3a: Shared Care Plan Cover Memo • Attachment 3b: Shared Care Plan A • Attachment 3c: Shared Care Plan B	
4	10:45 – 11:30	**Direct Care Workforce Report Presentation** Brendan Hogan, Optum Executive Client Manager	• Attachment 4a: Direct Care Workforce Report ppt • **Link to:** Direct Care Workforce Report • Attachment 4b: Direct Care Workforce Acronym List	

5	11:30 – 12:15	**Accountable Communities for Health** Tracy Dolan, VDH Deputy Commissioner	• Attachment 5a: Accountable Communities for Health Report – Prevention Institute • **Link to:** Accountable Communities for Health: Opportunities and Recommendations. Prevention Institute. 2015 • Attachment 5b: Accountable Communities for Health – Recommendations 8-5-15	
6	12:15 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker	Next Meeting: Thursday, September 24, 2015 10:00 am – 12:30 pm, DVHA Large Conference Room 312 Hurricane Lane, Williston	

Attachment 1b

June Minutes

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, June 18, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:00am. A roll call attendance was taken and a quorum was not present. A quorum was present after the second agenda item. Deborah Lisi-Baker entertained a motion to approve the May 28, 2015, meeting minutes by exception. Sam Liss moved to approve the minutes by exception. Sue Aranoff seconded. The minutes were approved with two abstentions.	
2. Learning Collaborative Curriculum Development and Training	Deborah Lisi-Baker provided an update on work to develop a curriculum for DLTSS-specific core competency as a component of a larger care management training being developed in collaboration with the Integrated Communities Care Management Learning Collaborative. The State is in the process of developing an RFP to solicit one or more contractors to support this work. The DLTSS-specific training will draw on a series of foundational briefs on various disability competency topics drafted by Susan Besio of Pacific Health Policy Group (PHPG) earlier this spring; these were presented to the DLTSS Work Group in May. A key component of the RFP and resulting work will be to support capacity building within the state through education of local organizations and providers so that these activities can be sustained in the future. The group discussed the following: • Sustainability planning is challenging at this point – it is unclear what the landscape will look like after the grant ends. Bidders will be asked to address sustainability in their applications; however, this could also mean creating a library of resources that includes disability-related training tools or embedding trainings with other organizations in the state that provide training to providers. • This curriculum could include the transition from pediatric to adult care for people with intellectual disabilities as part of an examination of care coordination. This relates to an existing planning grant Kirsten Murphy is working on with Carl Cooley. Young adults with special health care needs and/or disabilities are	

Agenda Item	Discussion	Next Steps
	particularly at risk for uncoordinated care. Dr. Cooley has developed a set of core competencies for supporting the transition from pediatric to adult care (Deborah will share these core competencies with Susan Besio). Erin Flynn mentioned that the Integrated Communities Learning Collaborative leadership has been collaborating with a pediatric care coordination collaborative out of VCHIP, with Dr. Jill Rinehardt of Burlington serving as expert faculty. Susan Besio is retiring this month. PHPG will continue to support the DLTSS Work Group, and to work on the Disability-Specific Core Competency Briefs. Suzanne Santarcangelo of PHPG will be taking on primary support for the DLTSS Work Group, with support from Scott Whitman.	
3. LTSS Information Technology Assessment Findings Report	Beth Waldman of Bailit Health Purchasing presented findings from the LTSS Information Technology Assessment Report prepared by Elise Ames of HIS Professionals with revisions from Beth and various State of Vermont staff. Attachment 3 provides an overview of information technology (IT) capacity across various types of long-term services and supports (LTSS) providers and summarizes other findings of the report. The group discussed the following. • The numbers of total IT systems used is sometimes more than the total organizations/facilities of that type. • This report will feed into the State's Health Information Technology Strategic Plan, which is currently being updated. This document has historically underrepresented the needs of providers not eligible for federal Meaningful Use incentive payments. This plan is required by State statute, and is updated periodically; however, the State hopes for the plan to be a continually updated, living document in the future. • This report focuses on providers for whom we have less information otherwise available – we have ongoing activity to track connectivity capacity for acute providers, for example, so they are not covered here. There will be additional work in SFY 2016 to provide a detailed look at connectivity capacity across various provider types. • In most sectors, about 10% of budgets go to supportive technology. In the health care sector, approximately 1% of total spending goes to technology. In particular, we need investments in health care infrastructure geared at supporting clinical care. Health care claims, utilization, and spending data should not drive clinical decisions directly, though we need this data as well. Investments are currently very dependent on State and federal budget decisions, a concern. • Compliance with HIPAA and other information security laws and regulations is the highest priority. This is an information sharing challenge. • Current systems may not identify people with disabilities adequately in their medical records; in particular, people with developmental or disability services needs that do not meet eligibility requirements for Vermont's Medicaid waiver services may fall through the cracks. People in this situation often have poorer health and use more emergency department services. Beth noted that this is outside the scope of this report.	**Joelle Judge will send the full LTSS Information Technology Assessment Reporting to the Work Group after this meeting.**
4. SCÜP Project	Erin Flynn and Larry Sandage provided an update on the Shared Care Planning/Universal Transfer Protocol (SCÜP)	

Agenda Item	Discussion	Next Steps
Update	Project. To better understand the information that is contained within a Shared Care Plan and Universal Transfer Protocol, Erin shared a draft shared care plan being piloted in the Integrated Communities Care Management Learning Collaborative. The form includes elements such as demographic information, a person-created and -directed "About Me" section, person-directed goals and progress, negotiated actions, and more. Georgia clarified that historically, providers have struggled to share this information across a multi-organization, multi-sector care team, which is one of the key goals of this project The group discussed the following. • This project is building on work previously completed under the Universal Transfer Protocol project, as well as Shared Care Plans being developed in the Integrated Communities Care Management Learning Collaborative. Both are tools to facilitate coordination or care across multiple settings, and to facilitate communication and team based care across a multi organizational team. • The group commended the Learning Collaborative teams for creating shared care plans and identified many ways in which the example is person-centered. The group also discussed some ways that the draft care plan developed could be more responsive to the specific needs of people with disabilities, including universal design, pre-loaded goals specific to the needs of people with disabilities, and inclusion of care team members often critical to people with disabilities including personal care attendants and other residential supports. • This project includes an extensive requirements gathering phase which will investigate existing solutions and projects in process to ensure that projects are coordinated and any solution meets the needs of providers in communities across the state. • The group suggested that individual receiving care be consulted in the development of the shared care plan form to further support person-centeredness. Georgia clarified that this solution will be a provider support tool, not a tool that individuals receiving services can access or edit electronically. Erin and Susan Aranoff noted that shared care plans will be completed in collaboration with the individual receiving services and that the individual will be given the option to sign the care plan if they chose. Several group members noted that the signature of a document does not always indicate that the individual understands and supports everything in the plan, especially in the case of individuals with developmental disabilities. • Deborah asked if it would be possible to have a list of the elements of the draft form so that DLTSS Work Group members can provide suggestions on content without delaying work activities. Erin said this would be fine. A list will be created and sent to the DLTSS Work Group.	
5. Public Comment/Next Steps	There was no additional public comment. **Next Meeting:** Thursday, July 30, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Member List

Roll Call: 6/18/2015

Sam Liss 1° Sue Aranoff 2°
Motion to approve the minutes by exception
Motion carried; 2 abstentions

Member		Member Alternate		April 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 ✓	Joined late - no vote			The Gathering Place
Joyce	Gallimore				Bi-State Primary Care
Martita	Giard ✓	Susan	Shane ✓		OneCare Vermont
Larry	Goetschius ✓	~~Joy~~ Peter	~~Chilton~~ Cobb	A	Home Health and Hospice
Dale	Hackett ✓				None
Mike	Hall	Angela	Smith-Dieng ✓		Champlain Valley Area Agency on Aging
Jeanne	Hutchins ✓	Joined late - no vote			UVM Center on Aging
Pat	Jones ✓	Richard	Slusky		GMCB
Dion	LaShay ✓				Consumer Representative
Deborah	Lisi-Baker ✓				SOV - Consultant
Sam	Liss ✓				Statewide Independent Living Council
Jackie	Majoros ✓	Barbara	Prine		VLA/Disability Law Project
Carol	Maroni				Community Health Services of Lamoille Valley
Madeleine	Mongan ✓				Vermont Medical Society
Kirsten	Murphy ✓			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 ✓				UVM Medical Center
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VHCIP DLTSS Work Group Participant List

Attendance: 6/18/2015

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		Consumer Representative	M
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		DA - HowardCenter for Mental Health	X
Joy	Chilton		Home Health and Hospice	MA
Amanda	Ciecior		AHS - DVHA	S
Peter	Cobb	here	VNAs of Vermont	X
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper		AHS - DVHA	S
Molly	Dugan		Cathedral Square and SASH Program	M

Gabe	Epstein	here	AHS - DAIL	S
Patrick	Flood		CHAC	M
Erin	Flynn	here	AHS - DVHA	S
Mary	Fredette	Phone	The Gathering Place	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard	Phone	OneCare Vermont	M
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett	here	None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M/MA
Bryan	Hallett		GMCB	S
Carolynn	Hatin		AHS - Central Office - IFS	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Jeanne	Hutchins	phone	UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones	Phone	GMCB	S/M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Sarah	Kinsler	here		S
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay	Phone	Consumer Representative	M
Nicole	LeBlanc	here	Green Mountain Self Advocates	X
Deborah	Lisi-Baker	here	SOV - Consultant	C/M
Sam	Liss	here	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
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	phone	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		GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
~~Judy~~	~~Peterson~~		Visiting Nurse Association of Chittenden and Grand Isle Counties	C/M
John	Pierce			X
Luann	Poirer		AHS - DVHA	S
Barbara	Prine		VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Rachel	Seelig	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
Angela	Smith-Dieng	here	Area Agency on Aging	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	here	SOV Consultant - Bailit-Health Purchasing	S
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	MA
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/M
Kendall	West			X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S

Jason	Williams	here	UVM Medical Center	M
Cecelia	Wu		AHS - DVHA	S
Marie	Zura		DA - HowardCenter for Mental Health	X
				88

Suzanne Santarchangelo - PHPG

Lamy Sandage

Attachments 3a – 3c

Shared Care Plan Materials

August 11, 2015

DLTSS Work Group Members,

Attached please find two examples of draft shared care plans that have been tested as tools to facilitate integrated care management across a multi-disciplinary team in the "Integrated Communities Care Management Learning Collaborative" that the DLTSS Work Group has been receiving updates on.

We welcome your input and ask you to keep a couple of things in mind when you review and offer comment:

1) The shared care plan does not replace or include all of the details contained in a clinical treatment plan. Rather, it is a tool to facilitate communication about the individual, and progress towards the individual's goals across a multi-organizational team. Therefore, communities have been testing different variations of the tool in order to get a sense of what information is most relevant, while seeking to keep the tool short enough so that it is easy to use.
2) The goal of a learning collaborative utilizing the PDSA (Plan-Do-Study-Act) model for Quality Improvement is to allow communities the ability to test, observe, and make modifications to the various interventions. At this time it is important to allow communities the ability to freely implement the quality improvement model in order to bring forth learnings that can be applied more broadly in the future.
3) Please keep these concepts in mind when considering any comments you might offer on a shared care plan tool.

Please send your comments to Julie Wasserman by Friday September 4 at Julie.Wasserman@Vermont.gov

Thank you.

COMMUNITY CARE PLAN

Date:		Lead Care Coordinator:				
PATIENT INFORMATION						
Patient Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Phone Number: ( )	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Address:		Social Security no.:			Marital Status: Single / Mar / Div / Wid / Sep	
City:	State:	Zip:			Advanced Directive: ❑ Yes ❑ No	
Diagnosis:		PCP Care Coordinator:			10 Year Medical Record Review Done: ❑ Yes ❑ No	
PCP: Care Team:						

CARE PLAN			
		PERSON RESPONSIBLE	**DUE DATE**
Treatment Goals:			
Patient Goals:			
Shared Strengths:			
Potential Barriers:			
Action / Self-management Plan:			

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Rev. 2/6/15

Last Update:		Shared Plan of Care				
Days Since Update:		Lead Care Coordinator (LCC):				
		LCC Phone:				
PATIENT INFORMATION						
First Name:	Last Name:	Middle:	Sex:	Birthdate:	Age:	
Alerts:						
ABOUT ME						
[INSERT PICTURE, while image is still selected, type CTRL+q to resize]	Strengths & preferred activities:					
	How I Learn:					
	Interaction tips:					
	Communication style:					
	Tips to avoid triggers/behaviors:					
	Mobility:					

DEMOGRAPHIC INFORMATION		
Primary/Emergency contact last name:	First Name:	Relationship to patient:
Street Address:	City:	State:
Mailing Address:	City:	State:
Email (Preferred? ☐Y ☐):	Phone (Preferred? ☐ ☐):	Secondary Phone (Preferred ☐Y ☐N):
Legal Decision Maker Information:		

PROFESSIONALS & SERVICES				
Primary care clinician:		**Phone:**		**Fax:**
Street Address:	**City:**	**State:**	**Zip:**	**Practice:**
Preferred pharmacy:		**Phone:**		**Fax:**
Preferred hospital:		**Phone:**		**Fax:**

OTHER PROVIDERS		NAME/TYPE/LOCATION	LAST VISIT	REASON FOR SERVICE	CONTACT INFORMATION

Insurance Information							
Primary insurance:				ID number:			
Policy holder:				Employer:		Policy holder birthdate:	
Secondary insurance:				ID number:			
Policy holder:				Employer:		Policy holder birthdate:	
Waiver	Type:		☐Waiting List	Date applied:			
Medicaid redetermination date:							

Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Target (Date)	Resolved (Date)
Family Personal Goals & Priorities				
Collaboration with/request from primary care and community				
Clinical Goals & Priorities				

Collaboration with/request from primary care and community				
Parking Lot/Future Goals				
Barriers (Existing or Potential)				

Participant Signature:	Care Coordinator Signature:
Date:	Date:
	Care Coordinator Name:
	Phone:
	Email:

Attachments 4a – 4c

Direct Care Workforce Materials

Vermont Health Care Innovation Project

Health Care Workforce Workgroup

Subcommittee on Long Term Care

Direct Care Workforce

October 22, 2014

Stuart Schurr, VT DAIL and
Brendan Hogan, Bailit Health Purchasing

Subcommittee on Long Term Care

Direct Care Workforce

Importance of Direct Care Workforce (DCW) to Health Care Reform

DCWs work in various settings

History of previous DCW efforts

State and key stakeholders make recommendations

Questions

Importance of Direct Care Workforce (DCW) to Health Care Reform

- Vermonters age 75-79 will increase by 156% from 15,960 Vermonters in 2010 to 40,910 by 2030

- 13% of Vermont's population, 83,148 Vermonters had disabilities in 2010

- Demand for DCWs will increase

Importance of Direct Care Workforce (DCW) to Health Care Reform

- Definition of DCW from H-301

An individual who is reimbursed by the State to assist adults residing in community settings not licensed by the State with activities of daily living and instrumental activities of daily living

Importance of Direct Care Workforce (DCW) to Health Care Reform

- Since 2005 when Choices for Care LTC waiver started, Vermonters continue to receive more health care and long term care services in community based settings. In fact, enrollment in community-based settings and enhanced residential care exceeded enrollment in nursing homes for the first time in March 2013.

- Health Care Reform efforts in Vermont will likely expand to include long term services and supports and Direct Care Workers are critical for this expansion.

DCWs work in various settings

Examples of DCW settings/employers

Home Health Agencies, Designated Agencies,

Residential Care Homes and working directly for consumers or their family members or surrogates

History of previous DCW efforts

Report of LTC DCW from the Vermont Department of Disabilities, Aging and Independent Living- 2008

Robert Wood Johnson Foundation funded Better Jobs Better Care project

Vermont Association of Professional Care Providers

History of previous DCW efforts

Alliance for Health Reform Direct Care Worker Report – 2012

Consumer Perspectives on Quality Home Care – National Consumer Voice for Quality Long Term Care – 2012

State and key stakeholders make recommendations

Explore licensure and/or certification for DCWs as a way to create minimum, standard training requirements for DCWs.

State and key stakeholders make recommendations

Explore options to pay for training, such as Medicaid billing or WET funds from the Department of Labor or other funding sources

State and key stakeholders make recommendations

Develop a comprehensive, standardized direct care worker training curriculum that reflects the preferences of the people receiving the services from direct care workers, meets the needs of specialized populations, and work toward statewide implementation. If possible, resolve any Fair Labor Standard Act implementation challenges when planning for direct care worker training.

State and key stakeholders make recommendations

Identify existing promising practices in DCW training and ways to expand those practices

State and key stakeholders make recommendations

Include DCWs in any workforce demand micro-simulation model developed by the State and have this subcommittee work with state staff and the micro-simulation contractor to provide context and content to help the vendor better understand the current and future demand for DCWs in Vermont.

Disability and Long Term Services and Supports Workgroup

Direct Care Workforce Presentation Acronym List

August 20, 2015

ADL = Activities of Daily Living

AFSCME = American Federation of State, County and Municipal Employees

ARIS = A non-profit fiscal intermediary based in White River Junction VT known as "ARIS Solutions"

ASP = Attendant Services Program

BJBC= Better Jobs Better Care

CBA = Collective Bargaining Agreement

CCV = Community College of Vermont

CE = Continuing Education

CMS = Centers for Medicare and Medicaid Services

COVE = Community of Vermont Elders

CPR = Cardio Pulmonary Resuscitation

CVAA = Champlain Valley Agency on Aging

DAIL = Department of Disabilities, Aging and Independent Living

DCW = Direct Care Workers

EE = Employees

EMR = Electronic Medical Record

FLSA = Fair Labor Standards Act

FPL = Federal Poverty Level

HCWW = Health Care Workforce Workgroup

HIPAA = Health Information Portability and Accountability Act

HITECH = Health Information Technology for Economic and Clinical Health

IADL = Instrumental Activities of Daily Living

LNA = Licensed Nursing Assistant

LTC = Long Term Care

LTSS = Long Term Services and Supports

NCCNHR = National Citizens Coalition for Nursing Home Reform

OSHA = Occupational Safety and Health Administration

PAS = Personal Assistance Services

PCA = Personal Care Attendant

RWJF = Robert Wood Johnson Foundation

SCAN = A foundation in California that works on aging issues

SLTCDCW = Subcommittee on Long Term Care Direct Care Workforce

USDOL = United States Department of Labor

VAPCP = Vermont Association of Professional Care Providers

VATD = Vermont Associates for Training and Development

VCIL = Vermont Center for Independent Living

VHCIP = Vermont Health Care Innovation Project

VNA = Visiting Nurse Association

WET = Workforce Education and Training

WETF = Workforce Education and Training Fund

Attachments 5a – 5c

Accountable Community Health Materials

Accountable Communities for Health Research

Vermont Population Health Work Group
June 16, 2015

Leslie Mikkelsen, MPH, RD
Managing Director, Prevention Institute

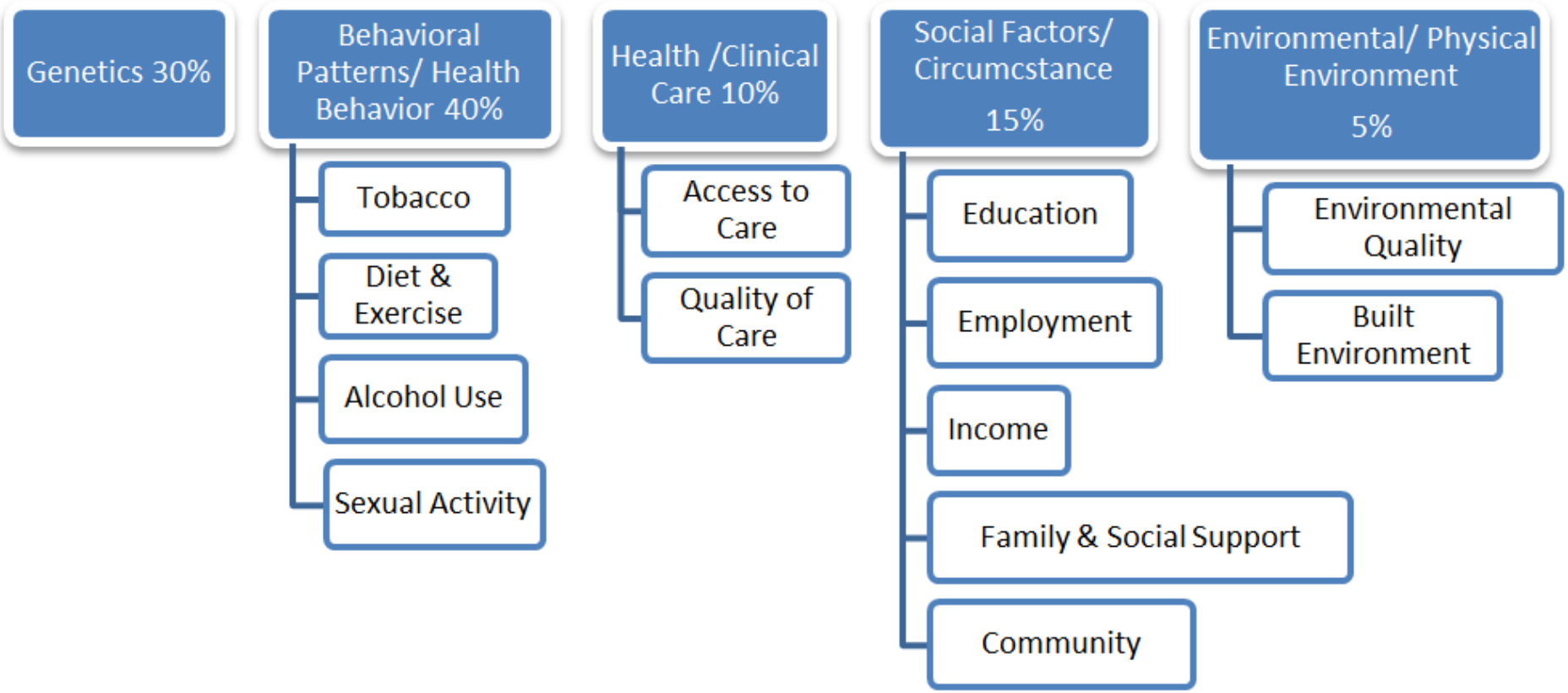
William L. Haar, MPH, MSW
Program Coordinator, Prevention Institute

Lisa Dulsky Watkins, MD
Principal, Granite Shore Consulting, LLC

Kalahn Taylor-Clark, PhD, MPH
Senior Advisor, Center for Health Policy Research & Ethics

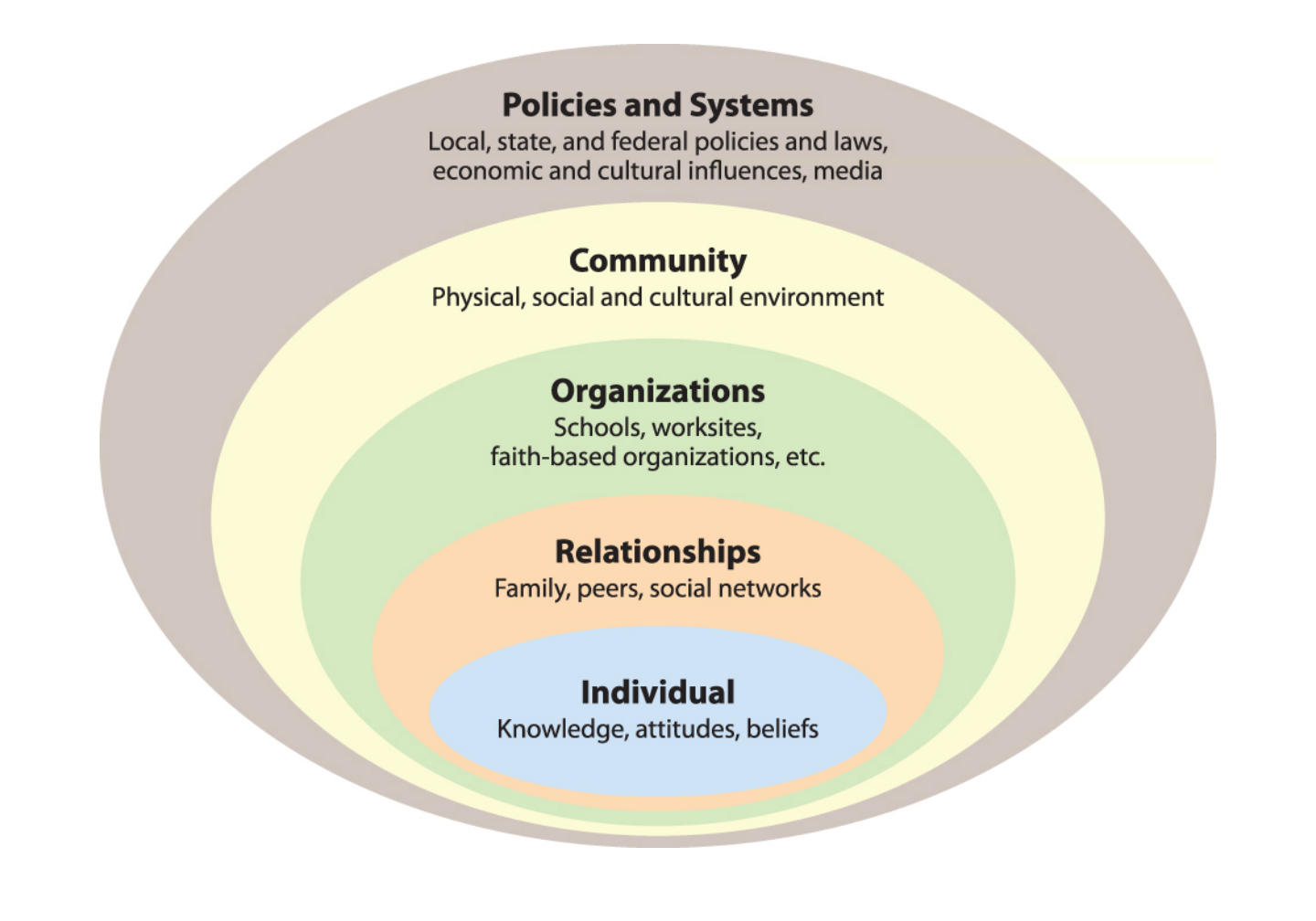
Prevention Institute
Prevention and equity | at the center of community well-being

Factors Affecting Health Outcomes



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

Vermont Prevention Model



Accountable Communities for Health (ACH) Definition

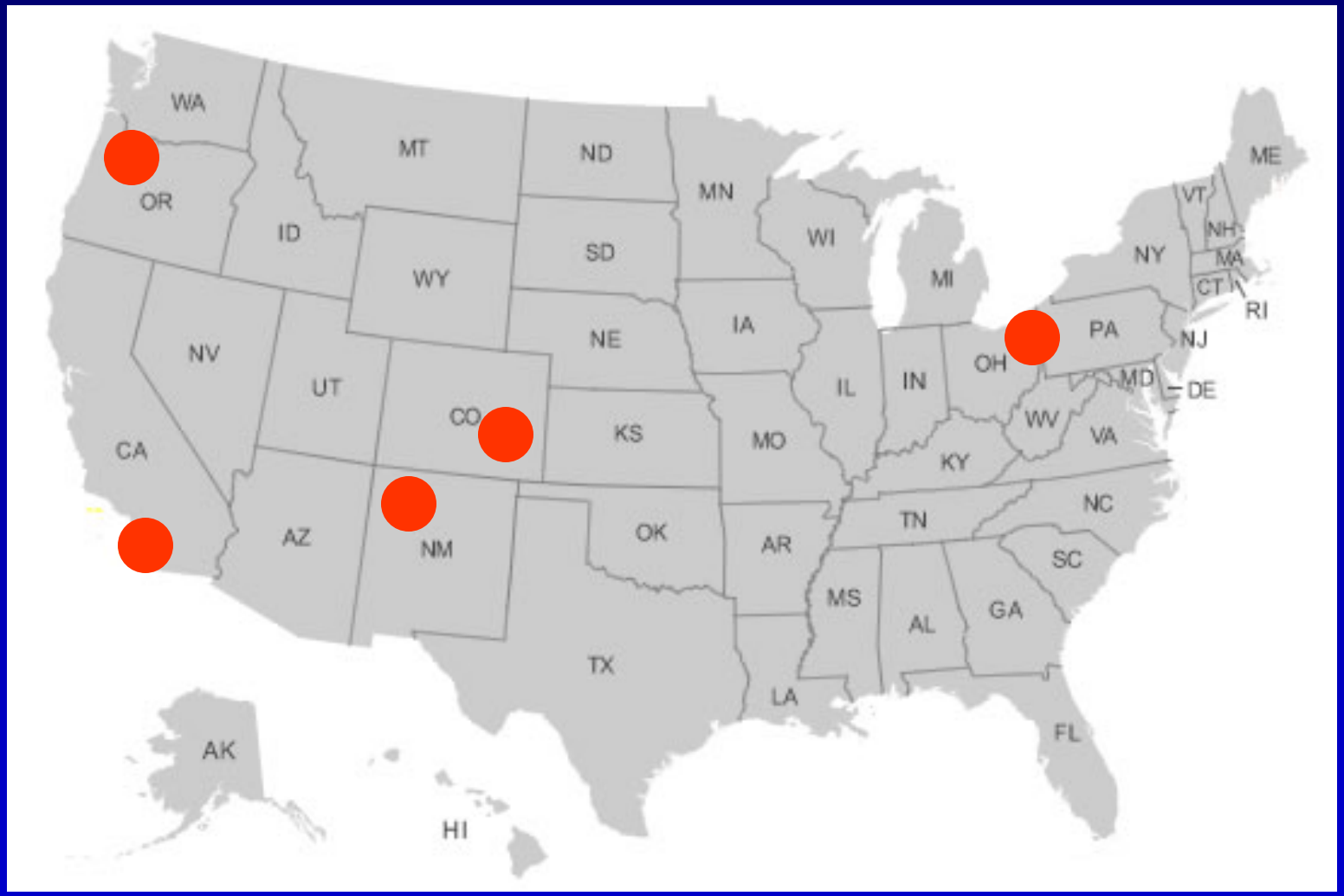
An ACH works across the entire population of its defined geographic area to support the integration of:

- Medical Care
- Mental and Behavioral Health Services
- Social and Community Services
- Community-Wide Prevention Efforts

National Sites

- Live Healthy Summit County, Ohio
- Pueblo Triple Aim Coalition, Colorado
- Trillium Community Health Plan, Oregon
- Live Well San Diego, California
- Pathways to a Healthy Bernalillo County, New Mexico

National Sites



Prevention Institute

Elements of Accountable Communities for Health

- Integrator
- Partnership
- Assessment, Planning, and Comprehensive Strategies
- Data, Metrics, and Accountability
- Community Resident Engagement
- Funding and Sustainability

Prevention Institute

Integrator

- Facilitated by an internal or external integrator that coordinates the roles and capacities of the partners within the ACH according to its governance structure

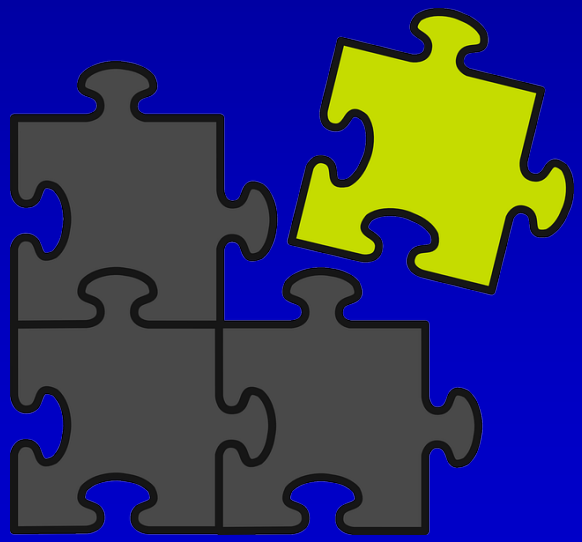
Prevention Institute

Integrator

- San Diego/Summit: HHSA/public health is integrator
- Lane: Health plan is integrator
- Bernalillo/Pueblo: External integrators
- No significant difference observed between internal and external integrators

Partnership

- Structured, integrated partnership of healthcare delivery systems, social service agencies, public health departments, government, and community organizations



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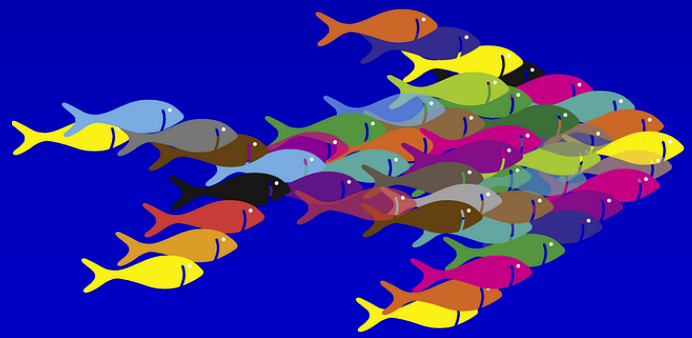
Partnership

- Hospitals and public health always included (except Bernalillo)
- Pueblo: Signed commitments to a work plan
- Lane: CHIP assigns responsibility to specific organizations for work
- Pueblo: External integrator's board requires C-Suite participation from partners

Assessment, Planning, and Comprehensive Strategies

- Engages all partners in a process for assessing and planning health improvement approaches, as well as implementing a comprehensive set of strategies that span the Spectrum of Prevention



Spectrum of Prevention

- Influencing Policy and Legislation
- Changing Organizational Practices
- Fostering Coalitions and Networks
- Educating Providers
- Promoting Community Education
- Strengthening Individual Knowledge and Skills

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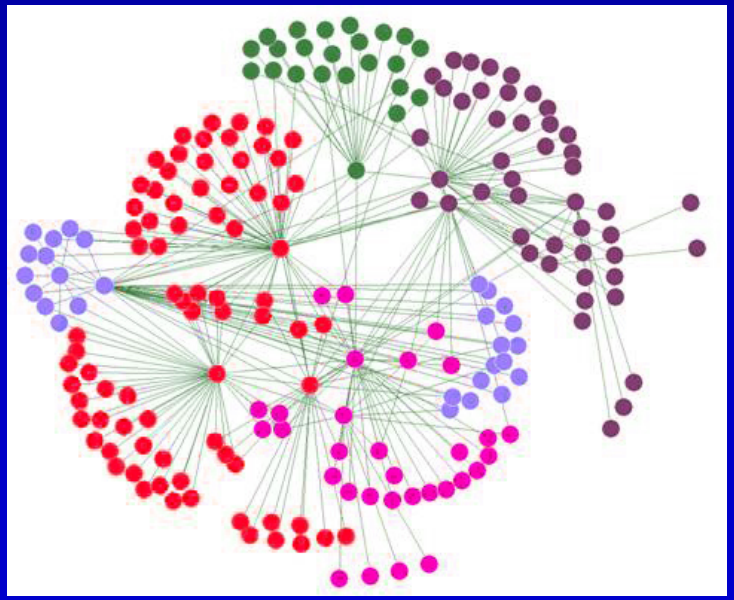
Assessment, Planning, and Comprehensive Strategies

- Lane/Pueblo: Metrics span the entire spectrum of prevention
- All CHIPs include a broad spectrum of strategies
- Health education and services are emphasized, while community prevention is less well represented
- San Diego: Partnership structure allows coalition to pursue policy work even though county government is at the center of the effort

Data, Metrics, and Accountability

- Includes the exchange of health and community data useful for assessing and developing strategies to improve population health. Measures of quality and performance ensure accountability in planning and implementation



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Data, Metrics, and Accountability

- San Diego: Data central to planning, evaluation, and communications. Public annual reports on progress.
- Pueblo: Hospitals share proprietary data with other sectors to measure success
- Lane: Health plan receives incentivized awards if it meets metrics
- Bernalillo: Evaluation determines pay. Lack of health outcome data self-identified as limitation

Community Resident Engagement

- Prioritizes authentic community participation throughout assessment, planning, implementation, and evaluation processes

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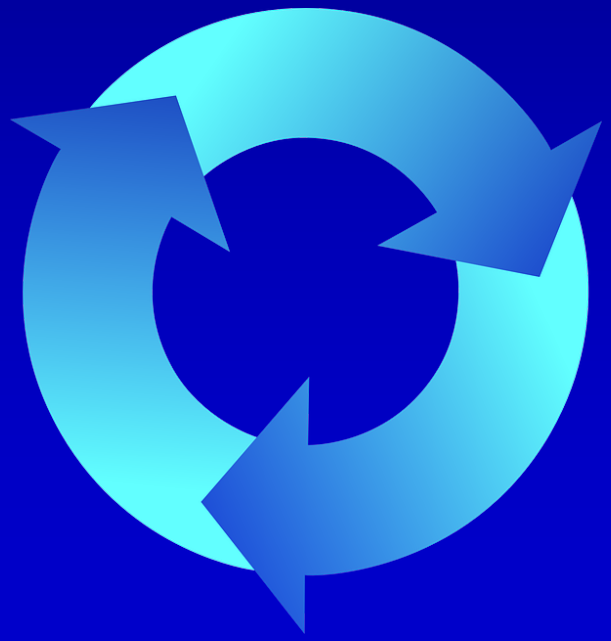
Community Resident Engagement

- Lane: Community Advisory Council has representation on executive board
- Overall, community participation is far more likely to involve “grass tops” than grassroots.

Funding and Sustainability

- Fosters sustainable and generalizable delivery and financing models that support and reward improvements in population health



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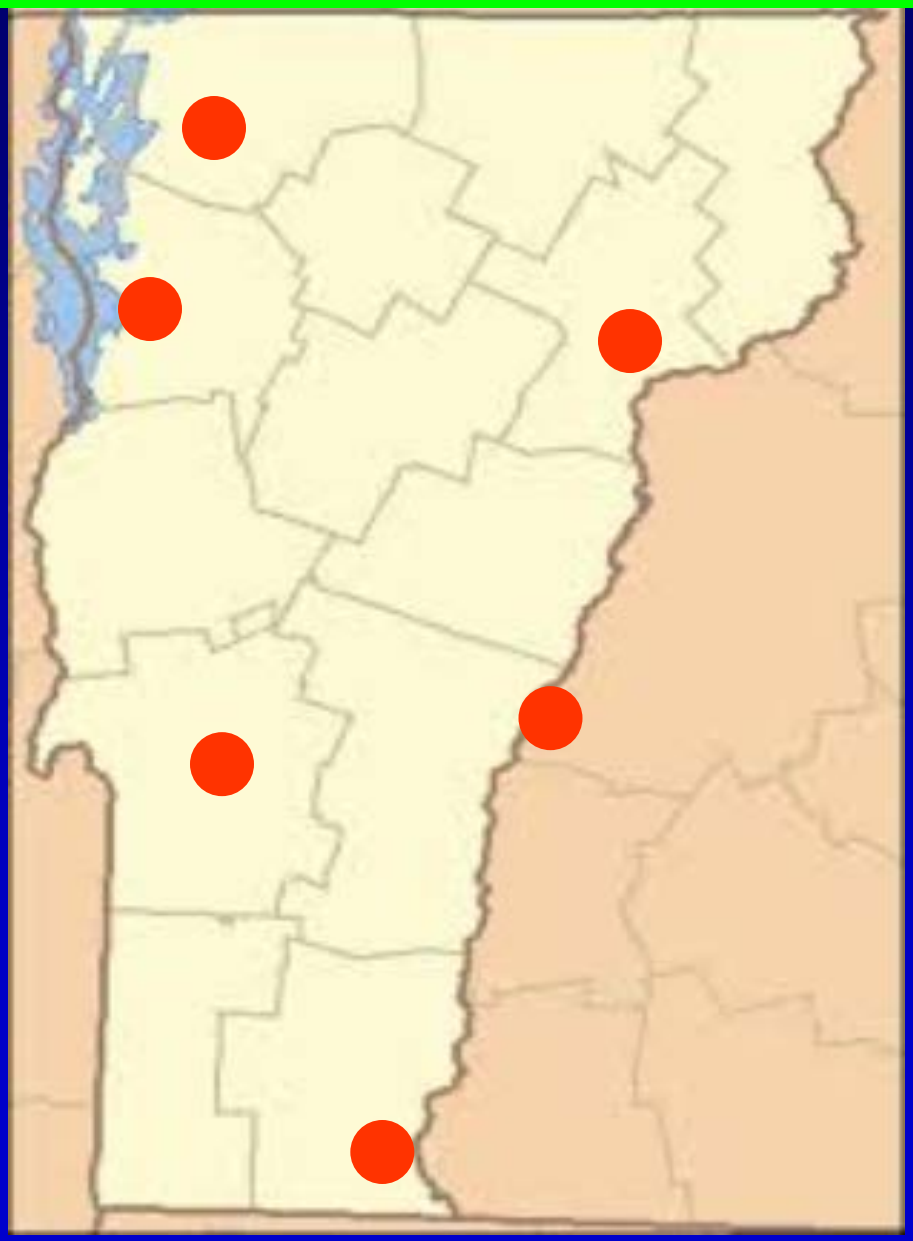
Funding and Sustainability

- Bernalillo: Set-aside portion of mill levy funds integrator
- Pueblo: Grant funded, contract work
- Lane: Global Medicaid payments, set-aside for prevention
- San Diego/Summit : County general funds, grants

Vermont Sites

- Franklin and Grand Isle Counties
- Northeast Kingdom
- Chittenden County
- Windsor County
- Upper Connecticut River Valley
- Windham County

Map and List of Vermont Sites



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Integrators

- Franklin and Grand Isle Counties: Northwestern Medical Center
- Northeast Kingdom: Northeastern Vermont Regional Hospital
- Chittenden County: Regional Planning Commission
- Windsor: Mt. Ascutney Hospital and Health Center
- Upper Connecticut River Valley: ReThink Health UCRV
- Brattleboro: Brattleboro Memorial Hospital (planning)

Priorities

- Healthy lifestyles
- Access to mental, behavioral, social, and economic services
- Substance abuse treatment
- Poverty – housing, economic development, jobs
- Aging in Place

Partners

- Hospitals, FQHCs
- Public Health districts
- Social Services, AAA, other service providers
- Regional Planning
- Business community, media

Strategies

- Individual and group health education
- Service referrals – working with CHTs
- Model organizational practices to promote healthy lifestyles
- Regional plans, local tobacco policies, state sugary beverages tax

Funding

- In-kind staff contributions
- Monetary contribution by hospital
- Grants

Building Blocks in Vermont

- Communities organizing around ACH concepts
- The right size for innovation
- Communities taking action to create healthy environments
- Vermont Blueprint for Health
- Hospital system leadership

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Issues for Reflection

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Seeking Balance

Service delivery and integration

Community prevention

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Other Reflections

- How to motivate ACH participation
  - Mission-Driven Participation
  - Funding-Driven Participation
- Power dynamics in the shifting healthcare marketplace
- Accountability mechanisms

Opportunities to Consider

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Seed Funding for ACH Communities

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Ensuring a Strong Role for Community Prevention in the ACH

- Make the co-benefits for multi-sector partnership explicit
- Promulgate a comprehensive framework for population health
- Establish a set of core community level metrics for use by communities
- Cultivating leadership

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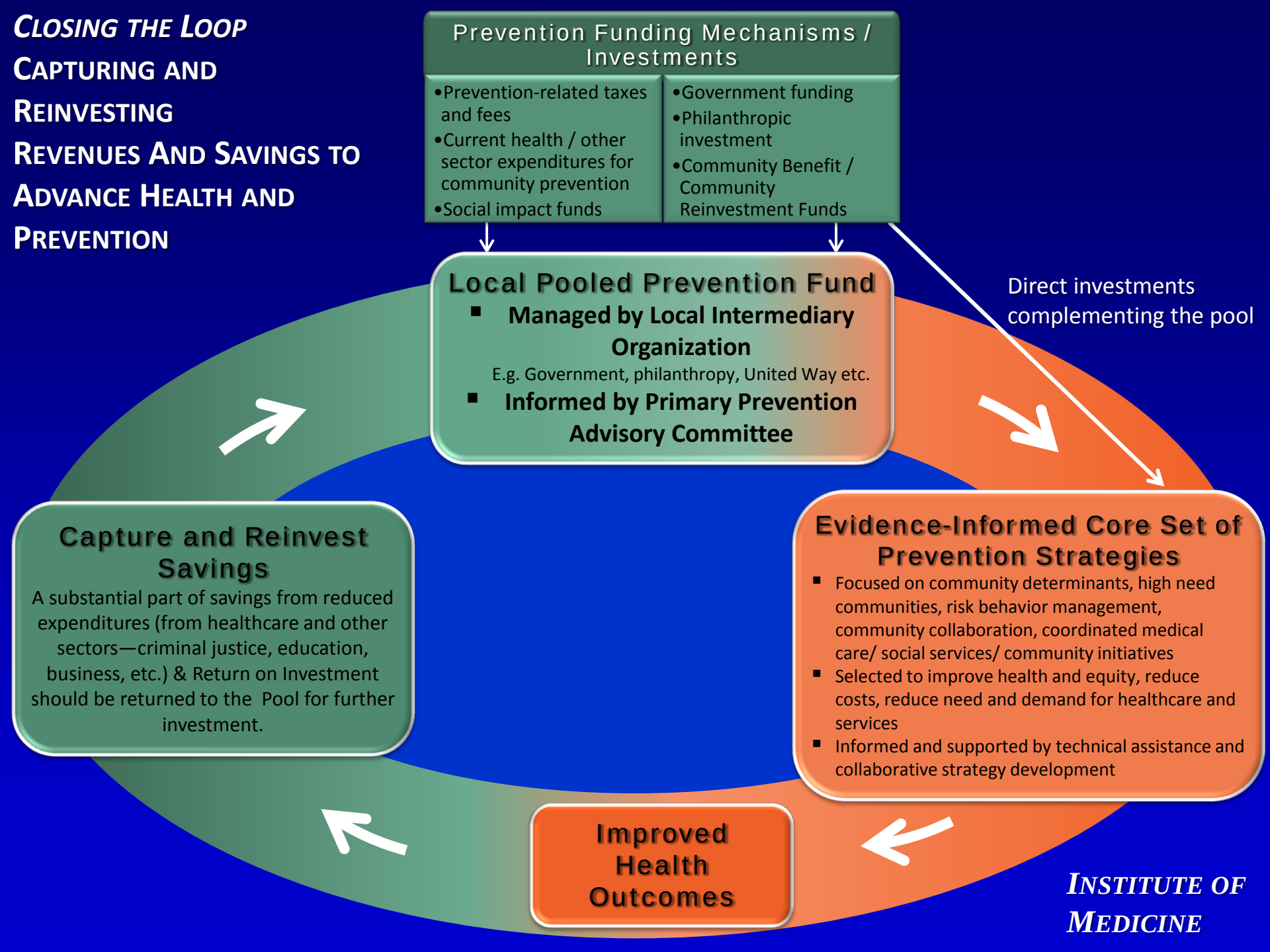
Other Opportunities

- Develop practices to maximize synergy between service integration and community prevention efforts
  - Community-Centered Health Homes
- Create a set-aside for prevention
- Closing the loop

Closing the Loop
Capturing and Reinvesting Revenues And Savings to Advance Health and Prevention



Institute of Medicine

Prevention Institute

Prevention and equity at the center of community well-being

Questions, Comments? Contact us:

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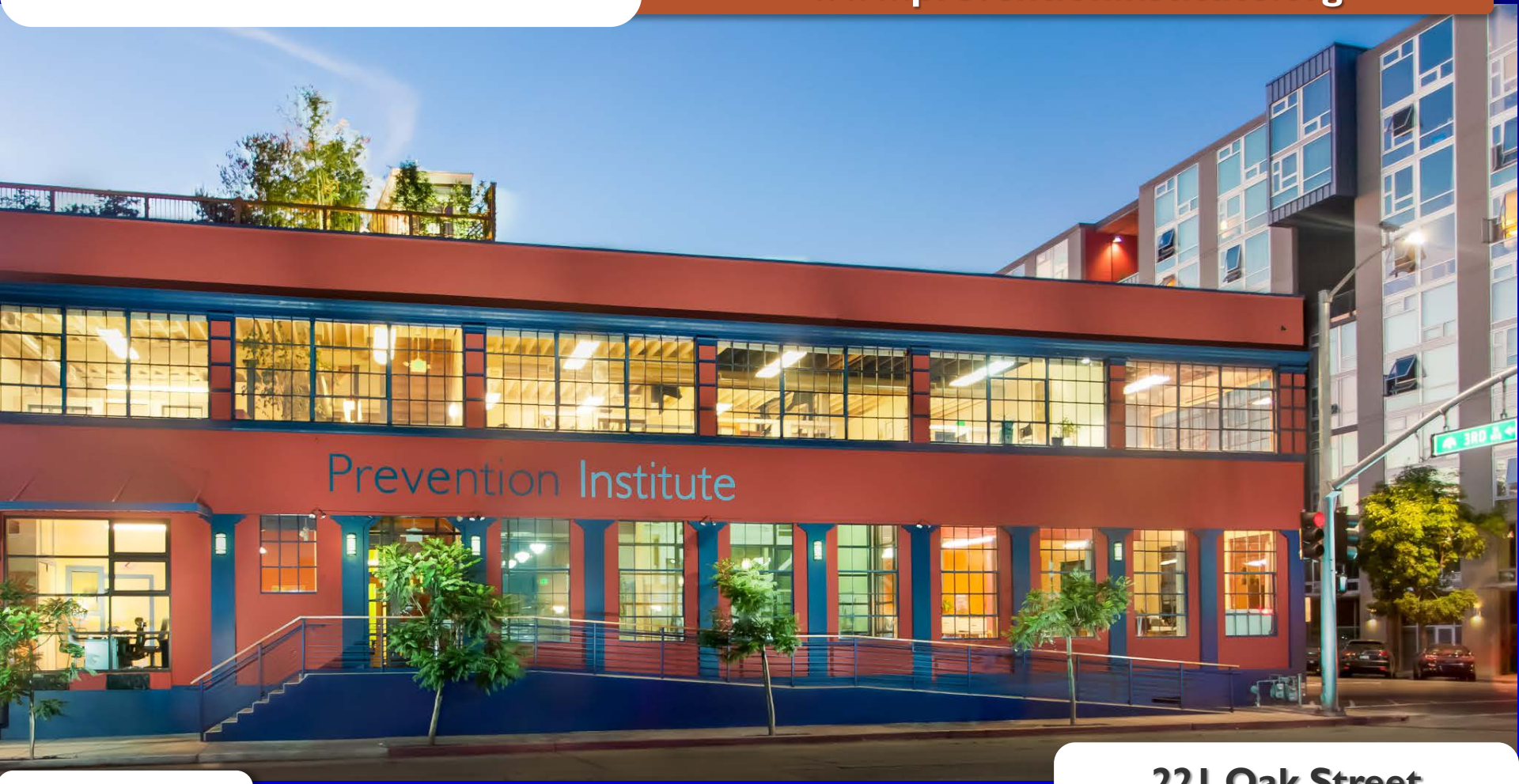

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Questions for Discussion

What strikes you about the Prevention Institute report? Which recommendations do you think are most critical?

Which questions from the CHCS are the most critical for consideration if we want to move forward in the development and support of Accountable Communities for Health?

The PI is not recommending a pilot test. An alternative would be to support a number of communities that are interested in exploring how to move towards an ACH through technical assistance and a peer learning collaborative. What would need to be in place to support this effort?

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From Prevention Institute Report – Core Concepts

Working Definition of Accountable Community for Health:

> "An aspirational model—accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An ACH supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness."

Vermont's working definition of an ACH is notable in that it specifically calls out two important pillars of a system of health:

1) Integrated medical care, mental and behavioral and social services; and
2) Community-wide prevention efforts

As emerging, the ACH concept is unique in that it:

- Brings together major healthcare providers across a geographic area, and requires them to operate as partners rather than competitors;
- Focuses on the health of all residents in a geographic area rather than just a patient panel;
- Engages a broad set of partners outside of healthcare to improve overall population health; and
- Identifies multiple strands of resources that can be applied to ACH-defined objectives that explore the potential for redirecting savings from healthcare costs in order to sustain collaborative efforts

Prevention Institute Recommendations

A. Foster an overarching statewide approach to support ACH effectiveness

Develop a statewide strategic framework for population health improvement to support local ACHs in setting priorities.

Establish a core set of community-level indicators for use by local ACHs to monitor progress in community-wide prevention.

Emphasize accountability mechanisms that are linked to population health improvement.

Phase in the formation of ACHs.

Explore the role of the State Government Department of Health, and other regional offices, in participating in local ACH collaboratives.

B. Provide guidance to enable regions to effectively establish ACHs

Ensure ACHs balance individual service integration and community prevention efforts

Conduct a network analysis of community prevention efforts in each Health Service Area

Encourage ACHs to form around existing regional partnerships and collaborations. *PI recommends the State not designate a specific type of organization to serve as the integrator.*

C. Build capacity and create an environment of ongoing learning

Expand the paradigm of the health system from healthcare to health.

Foster skill development for the emerging cadre of ACH leaders. *Consider establishing and supporting a peer learning collaborative for communities ready to start.*

Promote authentic community engagement in all aspects of the ACHs and their work.

Encourage the creation of robust communications platforms for the ACHs.

D. Explore Sustainable Financing Models for Accountable Communities for Health

Potential options include:

- Dedicating a portion of a new or existing tax to fund ACH activities.
- Specifying that a portion of a global healthcare payment or a per-patient per-month assessment on payers support the ACH upstream effort.
- Establishing a wellness trust to support the ACHs, funded through one or a blend of the sources described previously under core element nine.

CHSC Questions to Consider in Further Development

Scope

- What entities/actors/stakeholders should be involved in the initiatives? What type of collaboration does the state envision between these stakeholders?

- Which of these three domains of population health – Clinical, Clinical-Community Linkages, and the Broader Community Environment – does Vermont think should be the focus of the AHC efforts? A*: Ultimately, Broader Community Environment. Currently, there is innovation through VHCIP and the ACO/BO UCC at the Clinical Community Linkages level.*

- How does the state want to leverage its existing delivery system and payment reform efforts to achieve its population health goals, including Blueprint for Health, ACOs, and Health Homes? *A: These may all be part of a transition towards AHC.*

Structure

- Will AHCs serve a specific geographic area, a defined patient population, or an existing or new patient panel? *A: Geographic area*

- How will AHCs be funded and what type of entity may receive funding for this initiative?

- What type of entities are most likely to succeed in driving the changes and accomplishing the goals that the state has identified? How prescriptive does the state want to be about AHC entities?

- How does the state envision launching its effort? Will the state begin with a pilot approach, provide a competitive bidding/grant opportunity, etc.? *A: Build on existing efforts +?*

- How might the state approach scaling up the AHCs over time and sustaining its initial investments?