Attachment 1a - DLTSS Meeting Agenda 9-11-14

VT Health Care Innovation Project

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

Thursday, September 11, 2014; 10:00 AM to 12:30 PM

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

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

Item	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00 – 10:10	**Welcome; Introductions; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from July 24, 2014 meeting	
2	10:10 – 10:50	**Updates:** • **DLTSS Model of Care presentation to Care Models/Care Management Work Group on August 12, 2014** Erin Flynn, DVHA • **DLTSS Quality and Performance Measures** Final QPM Recommendations for Year 2 of the Medicaid and Commercial ACO Performance Measures; Public Comments; Steering Committee Recommendations Alicia Cooper, DVHA; Pat Jones, GMCB • **Provider Training: Available Resources and Funding** Georgia Maheras	• Attachment 2a: DLTSS Model of Care 6-16-14 final • Attachment 2b: SSP Proposed Year 2 Measure Changes 8-18-14 FINAL (PowerPoint) • Attachment 2c: Memo on VHCIP Funding for Provider Training	
3	10:50 - 12:00	**DAIL Long Term Care Consumer Survey: Choices for Care, Attendant Services** Bard Hill, DAIL	• Attachment 3a: DAIL Long Term Care Consumer Survey Presentation • Attachment 3b: DAIL Long Term Care Consumer Survey Tool	

4	12:00 – 12:20	**Next Steps for Updating the DLTSS Work Plan** Deborah Lisi-Baker and Judy Peterson	• Attachment 4: DLTSS Work Plan	
5	12:20 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: October 9th 10:00 am - 12:30 pm Williston	

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

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

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

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

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

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

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

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

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

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

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

VHCIP DLTSS Work Group Attendence Sheet 7-24-14

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

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

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

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

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

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

Attachment 2a - DLTSS Model of Care 6-16-14 final

MODEL OF CARE FOR PEOPLE WITH DISABILITIES AND LONG-TERM SERVICES AND SUPPORTS (DLTSS) NEEDS

June 16, 2014

Description of DLTSS Population

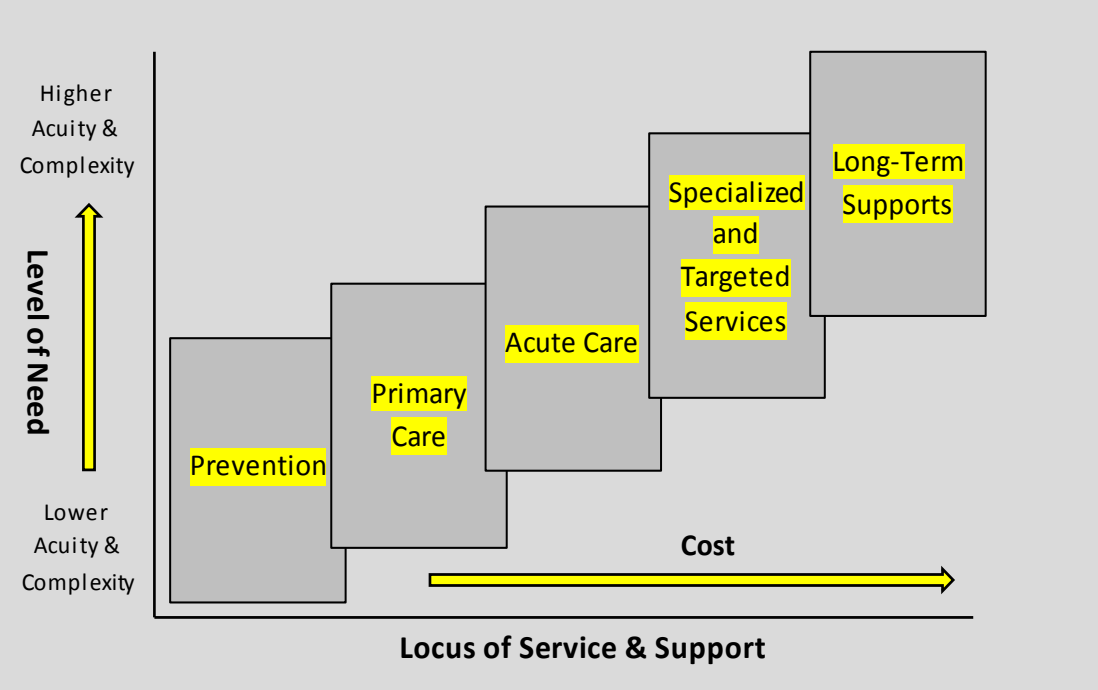
- People with disability and long-term services and supports (DLTSS) needs are..
  - Individuals of all ages who have a physical, cognitive or mental condition who need services and supports to assist with the limitations related to their condition
    - An individual's DLTSS support needs may be simple or complex
    - Effective services and supports must be provided within the context of self-determination, self-direction and understanding of the individual's unique needs
- Total number of all Vermonters with DLTSS needs is undetermined
  - Approximately 40,000 are **Medicaid** enrollees (some of whom also are enrolled in Medicare):
    - Defined as Medicaid enrollees who receive DLTSS-related specialized services and programs [i.e., Choices for Care (CfC); Personal Care; Traumatic Brain Injury (TBI) Program; Developmental Services (DS); Community Rehabilitation Treatment (CRT), Children and Adolescents with Serious Emotional Disturbances (SED), and other Mental Health Treatment; Substance Abuse Treatment; Department for Children and Families (DCF) Case Management; School-Based Health Services; and Success Beyond Six]
    - These individuals represent approximately **25% of total Medicaid enrollees**, but coverage of services to meet their **DLTSS needs represents 55% of the Medicaid budget** and **more than 70% of the Medicaid budget when traditional medical services are included** *(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to DLTSS Work Group, April 24, 2014)*
  - Others are enrolled in **Medicare only** (people over 65 who have DLTSS needs but do not qualify for Medicaid)
  - Others have **private / commercial insurance**

Why are DLTSS Fundamental to Health Care Reform?

- For at least a decade, there has been consensus that older people and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports. *(Sources: Kaiser, Robert Wood Johnson, Center for Health Care Strategies, CMS)*
- Evidence suggests that integration of care (primary care, acute care, chronic care, mental health, substance abuse services, and disability and long-term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care, and lower costs. (*Sources: Commonwealth Care Alliance, SNPs)*
- DLTSS helps prevent the need for care in more expensive, acute care settings - thus improving a person's well-being, improving quality of care, and controlling health care costs.
- Research has shown that environmental and socio-economic factors are crucial to people's overall health. DLTSS provide assistance related to these factors on an individualized basis.
  - For example, people that are employed tend to be healthier and therefore have lower utilization of health care services. Other social determinants of health include financial resources, housing, education, safety, nutrition, and access to transportation. *(Source: IBM Cúram Research Institute, 2013)*

DLTSS Needs Vary by Individual and Situation

- The full continuum of care must be available for people with DLTSS needs:
  - From prevention through lifelong supports
  - Including a diverse range of medical, mental health, substance abuse, developmental disability, personal care, employment, housing and social services and supports
  - Specific needs can vary at any given time



DLTSS-Related Services Covered by Medicaid

- DLTSS-related specialized services funded by Medicaid include, but are not limited to:
  - Assistance with activities of daily living (e.g. personal care, eating, grocery shopping, food preparation, money management)
  - Mental health counseling
  - Crisis services
  - Medication management
  - Substance abuse treatment
  - Assistive Technologies
  - Employment and Housing Supports
  - Residential Services
  - Nursing Home Care
  - Support during medical services (primarily DS)
  - Assistance to make connections in the community
  - Case Management & Coordination
- Some individuals who meet stringent clinical/level of care and/or funding priority criteria receive DLTSS through Medicaid-funded specialized programs (CfC, DS, CRT, TBI, and SED)
- Any Medicaid enrollee can receive some of these DLTSS on an as-needed basis through Medicaid fee-for-service benefits

DLTSS Providers

- Specialized mental health, developmental disability, and substance abuse treatment services and supports are provided by:
  - 11 Designated Agencies and 6 Specialized Service Agencies
- Other long term services and supports are provided by diverse groups:
  - 112 Residential Care Homes
  - 36 Therapeutic Community Residences
  - 40 Nursing Homes
  - 12 Home Health Agencies
  - 5 Area Agencies on Aging
  - 14 Adult Day Providers
  - Substance Abuse Providers
  - Traumatic Brain Injury Providers
  - Durable Medical Equipment Providers
  - Vocational Rehabilitation
  - 6 Designated Regional Housing Organizations and 16 Housing Authorities and Land Trusts
  - Vermont Center for Independent Living and other peer support and advocacy providers and organizations
  - Guardians
  - Thousands of direct care/personal care workers who work directly for elderly and disabled individuals or their family
  - Other independent practitioners and providers (e.g., mental health, rehabilitation, physical and occupation therapy)

Traditional Medical Services Covered by Medicaid

- Individuals who receive DLTSS-related Medicaid specialized services and programs (see definition on Slide 2) *also* utilize approximately $180 million annually in traditional medical services funded by Medicaid
  - This $180 million represents 37% of the total $488 million in Medicaid expenditures for traditional medical services across all Medicaid enrollees
  - Traditional Medical Services include but are not limited to):
    - Inpatient and Outpatient Hospital
    - Primary Care Physicians
    - Specialists
    - Federally Qualified Health Centers (FQHCs)
    - Pharmacy
    - Dental
    - Laboratory Tests
    - Medical supplies
    - Occupational, Physical, Speech Therapy
    - Home Care
    - Hospice
    - Ambulance

(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to DLTSS Work Group, April 24, 2014)

Interactions with Other Programs and Providers

- People with DLTSS needs also may receive other support and case management services from:
  - **Blueprint Community Health Teams (CHTs)**
    - Provide care coordination, education and support as needed to patients of Hospital Owned Primary Care Practices, Independent Single Site Primary Care Practices, Independent Multi-Site Primary Care Practices and Federally Qualified Health Centers (FQHCs)
      - These practices served 514,385 Vermonters (82%) as of December, 2014 *(Blueprint 2013 Annual report)*
    - Focused on medical issues / needs for people with chronic conditions
    - Time limited (due to focus and staffing)
  - **Hub and Spoke Health Home for Opioid Addiction**
    - Provides targeted services for people with Opioid addictions
    - Services include:
      - An established medical home, including comprehensive care management/care coordination
      - A single medication-assisted treatment prescriber and pharmacy home
      - Access to CHT resources
      - Access to Hub and Spoke nurses and clinicians
  - **Federally Qualified Health Centers (FQHCs)**
    - Provide comprehensive services for underserved areas or populations
      - Must provide primary care services and the following services on site or by arrangement with another provider: preventive care, dental, mental health and substance abuse, transportation necessary for adequate patient care, hospital and specialty care
    - Not time limited (intensity of services adapted as needed)

Interactions with Other Programs and Providers, cont.

- People with DLTSS needs also may receive other support and case management services from:
  - **Support and Services at Home (SASH)**
    - Focused on Medicare beneficiaries of all ages and low income residents of affordable housing regardless of payer
    - Provides a care coordinator and wellness nurse who work in partnership with a team of community providers to assist SASH participants to access the care and support they need to stay healthy while living comfortably and safely at home.
    - Not time limited (intensity of services adapted as needed)
  - **Vermont Chronic Care Initiative (VCCI)**
    - Provides care coordination for Medicaid beneficiaries who have chronic health conditions and/or high utilization of medical services to access clinically appropriate health care information and services and educates and empowers them to eventually self-manage their conditions.
    - Time limited (3 months)
    - Excludes:
      - Children
      - Individuals who are dually eligible for Medicare and Medicaid
      - People enrolled in Medicaid-funded specialized programs (CfC, DS, CRT, TBI)
  - **Commercial Insurance case management for special cases**
  - **Commercial Long Term Care Insurance programs**
  - **Veterans Administration and other Military benefit programs**

What is Working Well for People with DLTSS Needs

- For those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - Receive services and supports based in the values of self-determination and community integration
  - Each program specializes in unique needs
    - Service and supports are provided by staff who understand the complexities and subtleties of the individual's issues and needs, such as:
      - Communication barriers
      - Intellectual / cognitive barriers
      - Physical barriers
      - Symptoms and coping mechanisms related to severe mental illness
      - Medical needs related to their disability or functional limitations
      - Isolation due to the individual's functional limitations

Gaps, Barriers and Disincentives in Receiving Services

- The traditional medical system has not been designed to meet the diverse needs of people with DLTSS needs
  - Lack of understanding regarding how to address disability or functional issues
  - Lack of understanding about availability and effectiveness of specialized services and supports
  - Private health insurance typically does not cover some DLTSS-related services or non-medical expenses beyond short-term, rehabilitation-oriented care (e.g., PT/OT, DME, assistive technology, hearing aids, supplies, personal care)
  - Medicare which covers people over 65 and those with a disability under 65, does not cover long-term services and supports
  - When the need for LTSS arises in the wake of a medical event – a hospitalization for an accident or illness, or a transition from a post-acute stay to long-term care – the planning and organization of LTSS for an individual is often handled separately from the health care planning, and there are few incentives for health care providers to integrate LTSS with medical care planning or service delivery.
    (*Excerpted from Commission on Long-Term Care, September 2013 Report to Congress*)

Gaps, Barriers and Disincentives in Receiving Services

- For most people, DLTSS for individuals with more than one condition are managed by different state agencies and community providers
- Many individuals (and their families) must navigate through different provider systems (e.g., Medical, Mental Health, Developmental Disability, Home Health, DME, Area Agencies on Aging, Centers for Independent Living, Vocational Rehabilitation, Housing Providers) to try to get all their needs met
- The network of DLTSS providers is complex, multifaceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in the DLTSS network evaluate a person's overall situation in order to arrange for the right combination of services based on one's actual needs. Instead, access to services is often organized in relationship to their funding streams. (*Commission on Long-Term Care, September 2013 Report to Congress*)
- Many people with DLTSS needs do not have case management or other DLTSS:
  - *They do not meet clinical and/or financial criteria for Medicaid Specialized Program eligibility (i.e., people who are not able to get developmental services due to the increasing restrictions on Funding Priorities in the State System of Care Plan, or are not eligible for CfC, CRT, TBI or SED services due to strict clinical criteria)*
  - There may be limitations on the availability of Medicaid resources for case management or other services related to health and well-being (e.g., employment supports, adult dental care)
  - Medicare and Commercial insurance do not typically cover case management or DLTSS
- Those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - May have multiple case managers and treatment plans that do not inform each other (e.g., medical care vs DLTSS needs)

PROPOSED MODEL OF CARE and CASE MANAGEMENT for VERMONTERS with DLTSS NEEDS

Basis for Design of Proposed DLTSS Model of Care

- Person-Centeredness and Person-Direction as the Foundation
  - Builds on Vermont's DLTSS current emphasis on self-determination and that people have a right to live meaningful lives in their communities
- Builds on Strengths of Existing Vermont System of Care and Health Care Reform Elements (e.g., Blueprint, Community Health Teams, SASH, Medicaid Health Home "Hub and Spoke" model; DLTSS system of care)
  - Utilizes existing Vermont Waiver population care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations (i.e., CFC, DS, TBI, CRT and Substance Abuse)
  - Augments and develops additional mechanisms to address identified barriers, using national evidence-based strategies
- Vermont Dual Eligible Demonstration Work Group Discussions and Products:
  - Person-Centered Care Work Group, Person-Directed Work Group and Essential Components of Person-Directed Approach Report
  - Service Delivery Model Workgroup
  - Individual Assessment & Comprehensive Care Plan Workgroup
- DVHA Medicare-Medicaid Plan Model of Care Submission to CMS (as part of DE Demonstration)
  - DVHA Model of Care approved by CMS and NCQA (March, 2013) for three years (highest approval range) with a score of 96%

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered **and Directed** Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓

Possible Over-arching Framework: Integrated Health Home

- Medicaid Health Home as possible model
  - Purpose of Medicaid health homes: To provide whole-person care coordination and facilitate access to, and collaboration with, primary care and long-term services and supports
    - Health Homes complement but do not supplant traditional healthcare treatment services
    - Health Homes are not the same as “medical homes” that focus on PCP practices as the locus of care
    - Health homes are responsible for all of the person’s care management and care coordination
      - Presents an opportunity to rationally organize and integrate multiple parallel case/care management programs for special needs populations
      - Supports community providers to provide services in an integrated manner, across special needs and primary care
      - Must include six core services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Support Services
  - States have flexibility to designate health home providers
    - May include community mental health organizations, addiction treatment providers, home health agencies, and other provider groups
  - In the Medicaid health home program, states can draw down enhanced (90%) federal match for these services for two years – this might provide a mechanism to fund the more enhanced single point of contact/care coordination role that is being proposed, and to gain support from other payers where applicable
  - Caution: Health homes must be designed to provide better care for all individuals with diverse DLTSS needs, not just special populations

Description of Core Elements in Proposed DLTSS Model of Care

Person-Centered and Person-Directed Services and Supports

- Definition: Care that is life-affirming, comprehensive, continuous and respectful in its focus on health needs (medical, behavioral, long term care) as well as social needs (housing, employment), while promoting empowerment and shared decision-making through enduring relationships.

- Key Principles of Delivering DLTSS Person-Centered and Person-Directed Services and Supports
  - Individuals feel welcome and heard and their choices are supported;
  - Individuals have access to independent supports for Informed decision-making and rights protection;
  - Availability of stable well-trained workforce and contractor network, including access to alternative providers and peer run services;
  - Commitment & capacity to promote self--help and person-directed services for individuals with diverse and multiple disabilities, over time, and across service settings;
  - "One size does not fit all": organizational/systemic capacity to effectively respond to a range of preferences regarding service information & assistance and service coordination;
  - Individuals have access to services and supports when needed;
  - Assessment, planning, coordination and service delivery practices are shaped by the interests, needs and preferences of individuals rather than agencies;
  - Written, verbal and/or other forms of communication about treatment and services is provided in a manner that is accessible and understandable for the individual;
  - Services are coordinated across all the individual's needs; and
  - Supports are provided, as needed, to assist individuals with DLTSS to participate in all aspects of society and have a high quality of life.

(Primary Source: Dual Eligible Demonstration Person-Directed Work Group)

Person-Centered and Person-Directed Services and Supports: Care Management Roles

- Ensure that the individual is at the center of all planning and decision-making regarding their services and supports.
- Educate, empower and facilitate the individual to exercise his or her rights and responsibilities on an ongoing basis
- Provide information and support to the individual in making choices, including connections with options counseling, peer-support
- Involve the individual as an active team member and stress person-centered collaborative goal setting
- Ensure that all needed accommodations for planning participation and access to services are identified and provided when needed
- As appropriate, represent the individual's point of view when the individual is unable to participate in discussions
- Adhere to and respect all policies regarding individual rights, anonymity, and confidentiality

Access to Independent Options Counseling & Peer Support

- Provide independent, easy-to-access information and assistance to assist individuals and families/caregivers to:
  - Understand insurance options, eligibility rules and benefits
  - Understand specialized program eligibility rules
  - Choose services
  - Choose providers
  - Navigate the delivery system
  - Obtain information and on-going peer support regarding self-management of services and supports
  - Make decisions about appropriate long-term care choices
- Examples:
  - Aging and Disability Resource Connections (ADRCs) Member Organizations, such as:
    - Area Agencies on Aging
    - Vermont Center for Independent Living
    - Green Mountain Self Advocacy
    - Vermont Family Network
    - Brain Injury Association of Vermont
  - Peer-run Mental Health Programs
  - Health Care Advocate Office, Long-term Care and Mental Health Ombudsmen

Involved Primary Care Physician (PCP)

- Ensure that all people with DLTSS needs have an identified PCP that is actively involved in their care
  - Provide routine medical care
  - As medical needs change
  - Who has knowledge about DLTSS service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options
- Encourage individuals to choose Blueprint practices via Health Plan enrollment process and web-site information
  - Provides access to:
    - Blueprint Community Health Teams for short-term interventions and support regarding medical needs
    - PCP practices that utilize technology (e.g., EHRs, care management tools, information exchange) to support patients and improve care
    - Blueprint Leadership and Community Service Networks (which enhances PCP knowledge and networking to support patient care)

Single Point of Contact (Case Manager)

- Role of Single Point of Contact (Case Manager within Health Home):
  - Ensures Individual Self-Direction and Self-Management, as desired
  - Coordination across *all* of the individual's medical, mental health, substance abuse, developmental, and long-term care service needs
  - Assure that all relevant assessments are completed
  - Develop and maintain the Individual Comprehensive Care Plan
  - Communicate with and convene the Individual's Care Team as needed
  - Provide Routine Individual Support, as requested
  - Ensure Support during Transitions in Care and Settings

Single Point of Contact (Case Manager)

- Identification of Single Point of Contact
  - If individual mainly has primary or acute health care needs, their single point of contact (and health home) would be their PCP and CHT (if involved)
  - For individuals with more complex DLTSS needs, their single point of contact (and health home) should have knowledge about the individual's DLTSS needs, such as:
    - Designated Agencies for Mental Health
    - Designated Agencies for Developmental Services
    - Home Health Agencies
    - Area Agencies on Aging
    - Traumatic Brain Injury providers
    - Preferred Providers for Substance Abuse Treatment
    - SASH
    - Others with specialized DLTSS expertise
  - For individuals enrolled in Vermont state specialized programs(i.e., CFC, CRT, DS, and TBI), their single point of contact should be someone who has experience with the care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations
  - For individuals without an existing case manager, the individual's PCP should be responsible for identifying the need for a DLTSS case manager (via a brief DLTSS screening tool) and work with the individual to identify and refer to an appropriate health home organization
    - May need payers to include this as PCP requirement
    - Will require ACO / PCP education regarding DLTSS Provider network and triage protocols
    - Referrals could also occur via other sources, such as VCCI

Medical Assessments and DLTSS Screening by PCPs, Medical Specialists

- PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits
  - CHTs may conduct additional assessments regarding medical needs, if warranted
- If person has functional or cognitive impairments, PCP should be informed about DLTSS services, use a brief DLTSS screening tool (if necessary) and refer to DLTSS providers for more in depth assessments as necessary to determine if there are unmet DLTSS needs
  - VHCIP DLTSS Work Group should review the existing inventory of screening tools that could help inform the VHCIP Care Models & Care Management Work Group
  - If screening indicates need, PCP works with the individual to identify and then make referral to appropriate provider in DLTSS network

DLTSS-specific Assessments

- DLTSS needs-specific assessments already exist:
  - DAIL Independent Living Assessment (used for CfC)
  - Developmental Services Assessment
  - Community Rehabilitation and Treatment Assessment
  - SASH Assessment
- Consistent elements should be assessed for all individuals with DLTSS needs
  - An analysis and listing of questions that would need to be added to these assessments has been developed via planning for the Dual Eligible Demonstration Project.
  - Some initial DLTSS intake screening will lead to the above comprehensive assessments, as needed
- The Individual’s Single Point of Contact (Case manager) is responsible for assuring that:
  - All screening and assessment results (medical and DLTSS-related) should be included in and inform the individual's Comprehensive Care Plan and be shared with the Individual's Care Team members
  - Necessary assessments are updated when a significant change occurs in the beneficiary’s medical, DLTSS, or life situation

Comprehensive Care Plan

- Current Situation
  - PCPs currently develop and maintain an individual's Care Plan related to their medical needs
    - The CHT may re-evaluate the patient Care Plan and initiate appropriate modifications in collaboration with the individual and members of the healthcare team
  - DLTSS providers develop and maintain an individual's Care Plan related to their DLTSS needs
  - An individual may have multiple Care Plans:
    - For medical and for DLTSS services and supports
    - If individual receives multiple DLTSS services
    - If individual is transitioning across care settings

Comprehensive Care Plan

- Proposed Model
  - PCPs and CHTS continue to develop and maintain an individual's Care Plan related to their ***medical*** needs
  - DLTSS providers develop and maintain an individual's Care Plan related to their ***DLTSS*** needs
  - For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
    - Developing and maintaining a single Comprehensive Care Plan that includes ***all*** identified needs, goals, preferences, services and supports
      - Requires communication and coordination with the Individual's PCP
    - Identifying the individual's informal support systems/networks in relationship to his or her functional and safety needs, and including this information in the Comprehensive Care Plan as appropriate
    - Reviewing the effectiveness of the care plan with the individual, and implementing modifications as needed in collaboration with other providers as appropriate
    - Revising the Care Plan during and after Care Transitions
    - Ensuring that all key members of the Individual's Care Team have the most current Comprehensive Care Plan

Individual Care Team (ICT)

- For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
  - Ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP.
  - Establishing a routine working relationship with the individual's PCP / CHT member(s), and with other ICT providers as appropriate
  - Convening the ICT (in person or by phone) when needed to integrate and coordinate care, especially during care transitions
  - Provide links/coordination/integration with care providers across settings
  - Reporting new information to ICT members and other appropriate providers as needed

Interdisciplinary Care Team- Working Principles

- Mutual respect for the expertise of all members of the team, including the individual with DLTSS needs
- Knowledge and trust among all parties establishes quality working relationships
- Shared responsibility which leads to joint decision-making
- Equal participation and responsibility on the part of team members to ensure the beneficiary's needs and goals are met, with "shifting" responsibility determined by the nature of the problem to be solved.
- Communication that is not hierarchical, but rather multi-directional - facilitating sharing of information and knowledge
- Cooperation and coordination which promote the use of the skills of all team members, prevent duplication, and enhance productivity
- Emphasis by the team on "health care, environmental determinants of health and public health" rather than the more narrow focus of "medical care"
- Optimism that the ICT process is the most effective method to achieve quality care and improved outcomes

Support During Care Transitions

- For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
  - Initiating and maintaining contact at the care transition point of service
    - At the beginning, during, and at the end of the care transition
  - Identifying barriers to follow-up treatment, services, supports, and medication adherence and working with the individual, family and providers to overcome barriers
  - Ensuring the individual has the relevant information specific to their new condition
  - Coordinating linkages and follow-up with targeted services
    - Assuring that PCP, specialty care, home health, community mental health center, or other appointments are scheduled within 7 days of discharge, or more quickly if clinically indicated
  - Changing the Individual Care Plan to reflect any new needs
  - Communicating changes in Individual Care Plan with the individual's care team

Use of Technology for Information-Sharing

- Ultimate goal: A technological infrastructure that would:
  - House a common case management database/system
  - Enable integration between the case management database and electronic medical records and between all providers of an Individual's ICT
  - Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options
  - Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent

- The Population-Based Collaborative (ACO) Proposal is designed to "effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients."

- The ACTT Proposal for the DLTSS Network "builds on the ACO work to broaden responsive, integrated, person-centered services across additional parts of the full continuum of care" to:
  - Ensure high quality clinical data for population health and quality/outcome improvement and reporting from ACTT providers
  - Enable ACTT to securely transmit, exchange and store health information
  - Enable a 42 CFR Part 2 compliant database system/repository for designated and specialized service agencies
  - Develop a uniform and efficient EHR infrastructure for 4 Developmental Disability Specialized Service Agencies (SSAs) and 1 Designated Agency
  - Develop and implement an ACTT transitions of care/uniform care transfer protocol

What should improve under this MOC?

- Beneficiary experience:
  - Increased involvement in decision-making
  - Decreased frustration regarding care coordination and access to services and supports due to integrated service delivery
  - Routine and timely primary care visits
  - Support during care transitions
  - Increased overall satisfaction with services and supports
  - Decreased out-of-pocket costs (e.g., fewer co-pays for ER, other services)
- Staff experience:
  - Increased efficiency regarding assisting consumers
  - Improved collaboration and communication between the medical and DLTSS systems of care
- Improved Consumer Outcomes:
  - Decreased emergency room utilization
  - Decreased avoidable hospital admissions / re-admissions
  - Decreased nursing home utilization
  - Increased appropriate use of medication
- Decreased Provider Cost-shifting across Payers
  - Due to more service oversight and coordination across all of the individual's medical and DLTSS needs via a single point of contact, comprehensive care plan, and integrated care team
- Decreased Overall Costs for Health Care System

Case Study

Peter is 50. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He sees a mental health counselor and receives medication management by a psychiatrist at his local designated mental health agency. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy.

Under the proposed DLTSS MOC, Peter's designated mental health agency case manager is Peter's single point of contact for coordinating his care and ensuring that all his care and treatment planning is integrated.

Peter's Case Manager finds a PCP that is taking new patients and assists him to get to the appointment. The PCP, who is part of a Blueprint Advanced Primary Care Practice, conducts a thorough physical and discovers Peter has diabetes, which has compromised his immune system and is causing the repeated pneumonia. The PCP prescribes an antibiotic for the pneumonia, and schedules routine visits for evidenced-based diabetes care, including blood work and foot exams. The PCP gives Peter some information about diabetes and how to control it, but also suggests that Peter could access the practice-affiliated Blueprint Community Health Team (CHT) if he would like additional information and support in managing his diabetes. Peter agrees, and the PCP office sets up appointments for that afternoon. Peter meets with the CHT Nurse who further explains diabetes symptoms and management, and with the CHT Nutritionist who provides information about nutrition related to diabetes.

In the meantime, Peter's Case Manager has notified the PCP office of her role (providing a signed agreement from Peter to release information to her on his behalf). As such, Peter's diagnosis of diabetes and other CHT action steps are entered into his Individual Care Plan.

With Peter's permission, Peter's Case Manager arranges for Peter and his mental health counselor to talk with the CHT staff regarding how to integrate diabetes management with the management of his depression. In addition, Peter' Case Manager ensures that Peter's PCP and DA psychiatrist are both aware of all of Peter's medications and that Peter understands the side effects and potential interactions for all of them. Peter and his Case manager then meet to update his Individual Care Plan to reflect the new goals and action steps related to his diabetes, and the revised Plan is shared with all the members of his care team.

Glossary of Acronyms

- ACCT: Advancing Care through Technology
- ACO: Accountable Care Organization
- ADRC: Aging and Disability Resource Connections
- BP: Blueprint for Health
- CfC: Choices for Care
- CHT: Community Health Teams
- CMS: Centers for Medicare and Medicaid Services
- CRT: Community Rehabilitation and Treatment Program
- DA: Designated Agency
- DAIL: Department of Disabilities, Aging and Independent Living
- DCF: Department for Children and Families
- DLTSS: Disability and Long-Term Services and Supports
- DOH: Department of Health
- DME: Durable Medical Equipment
- DMH: Department of Mental Health
- DS: Developmental Services
- DVHA: Department of Vermont Health Access
- EHR: Electronic Health Record
- ER: Emergency Room
- FQHC: Federally Qualified Health Center
- HHA: Home Health Agency
- ICT: Interdisciplinary Care Team
- IT: Information Technology
- MOC: Model of Care
- NCQA: National Committee for Quality Assurance
- OT: Occupational Therapy
- PCP: Primary Care Physician
- PT: Physical Therapy
- SASH: Support and Services at Home
- SSA: Specialized Services Agency
- SED: Serious Emotional Disturbance
- TBI: Traumatic Brain Injury
- VCCI: Vermont Chronic Care Initiative
- VHCIP: Vermont Health Care Innovation Project

Attachment 2b - SSP Proposed Year 2 Measure Changes 8-18-14 FINAL

Vermont ACO Shared Savings Program Quality Measures: Recommendations for Year 2 Measures from the VHCIP Quality and Performance Measures (QPM) Work Group

August 18, 2014

ACO SSP Measure Categories

PAYMENT

Payment measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs influences amount of shared savings.

REPORTING

Reporting measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How the ACO performs does NOT influence the amount of shared savings.

MONITORING & EVAL

Monitoring measures are collected at the State or Health Plan levels; cost/ utilization measures at the ACO level. ACO not responsible for collecting these measures. How the ACO performs does NOT influence the amount of shared savings.

PENDING

Pending measures are considered to be of interest, but are not currently collected.

QPM WG Year 2 Measure Review Process

- **Goals were to adhere to transparent process and obtain ongoing input from WG members and other interested parties**
- **March-June**
  - Interested parties and other VHCIP Work Groups presented Year 2 measure changes for consideration
  - WG reviewed and finalized criteria to be used in evaluating overall measure set and payment measures
  - WG reviewed and discussed proposed measure changes
- **June-July**
  - Co-Chairs/Staff/Consultant scored each recommended measure against approved criteria on 0-1-2 point scale and developed proposals for Year 2 measure changes for the WG's consideration
  - WG reviewed and discussed proposals
- **July**
  - WG voted on measures during July 29th meeting

Summary of Year 2 Recommended Changes

- QPM Work Group voted to:
  - Re-classify **9 existing** measures
    - 3 to Payment
    - 4 to Reporting
    - 2 to M&E
  - Add **2 new** measures
    - 1 to Reporting (Patient Experience Survey)
    - 1 to M&E

Re-classify Three Year 1 Reporting Measures to Payment

Year 1

Payment

Reporting

Pending

Monitoring & Evaluation

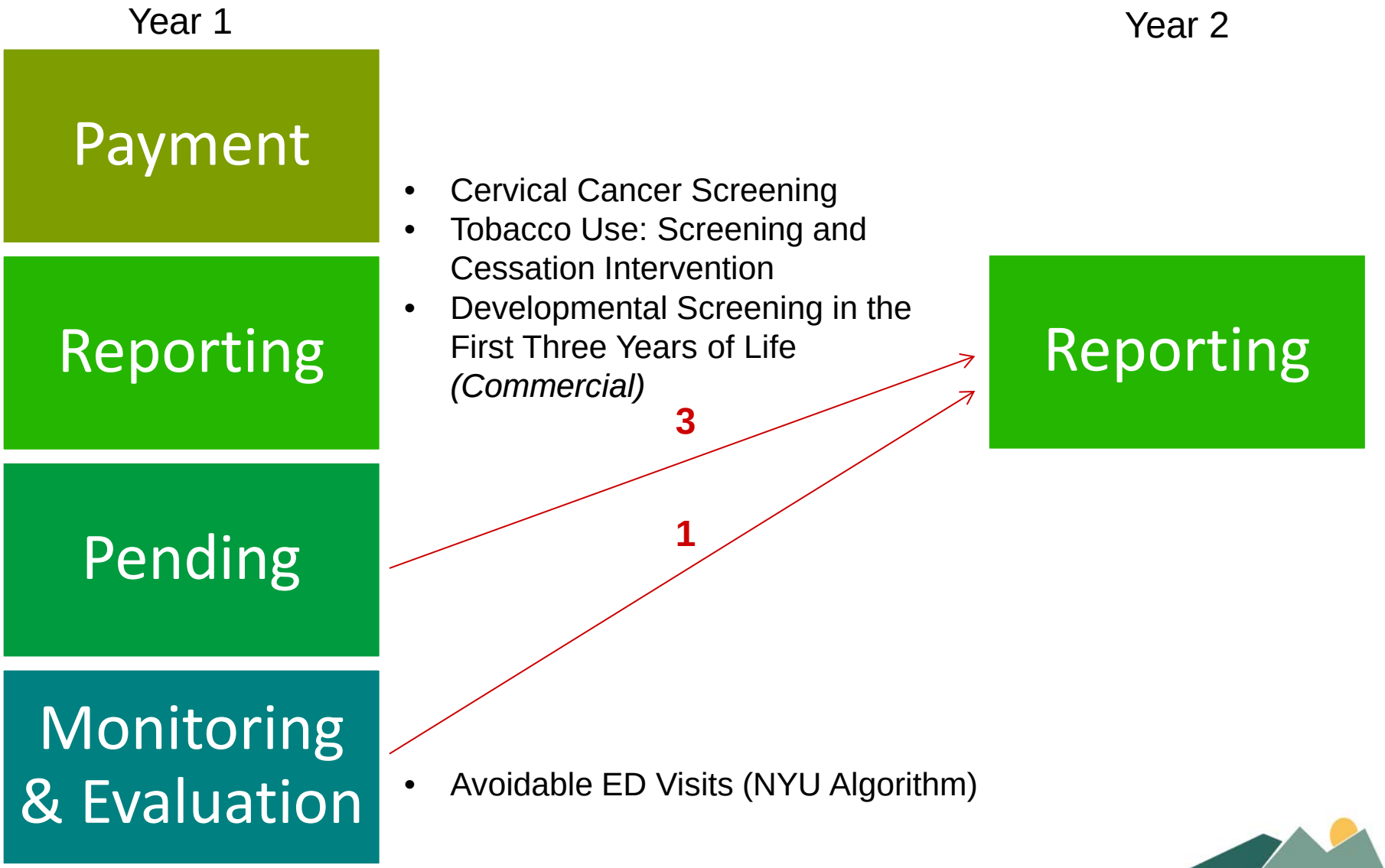
Year 2

Payment

3

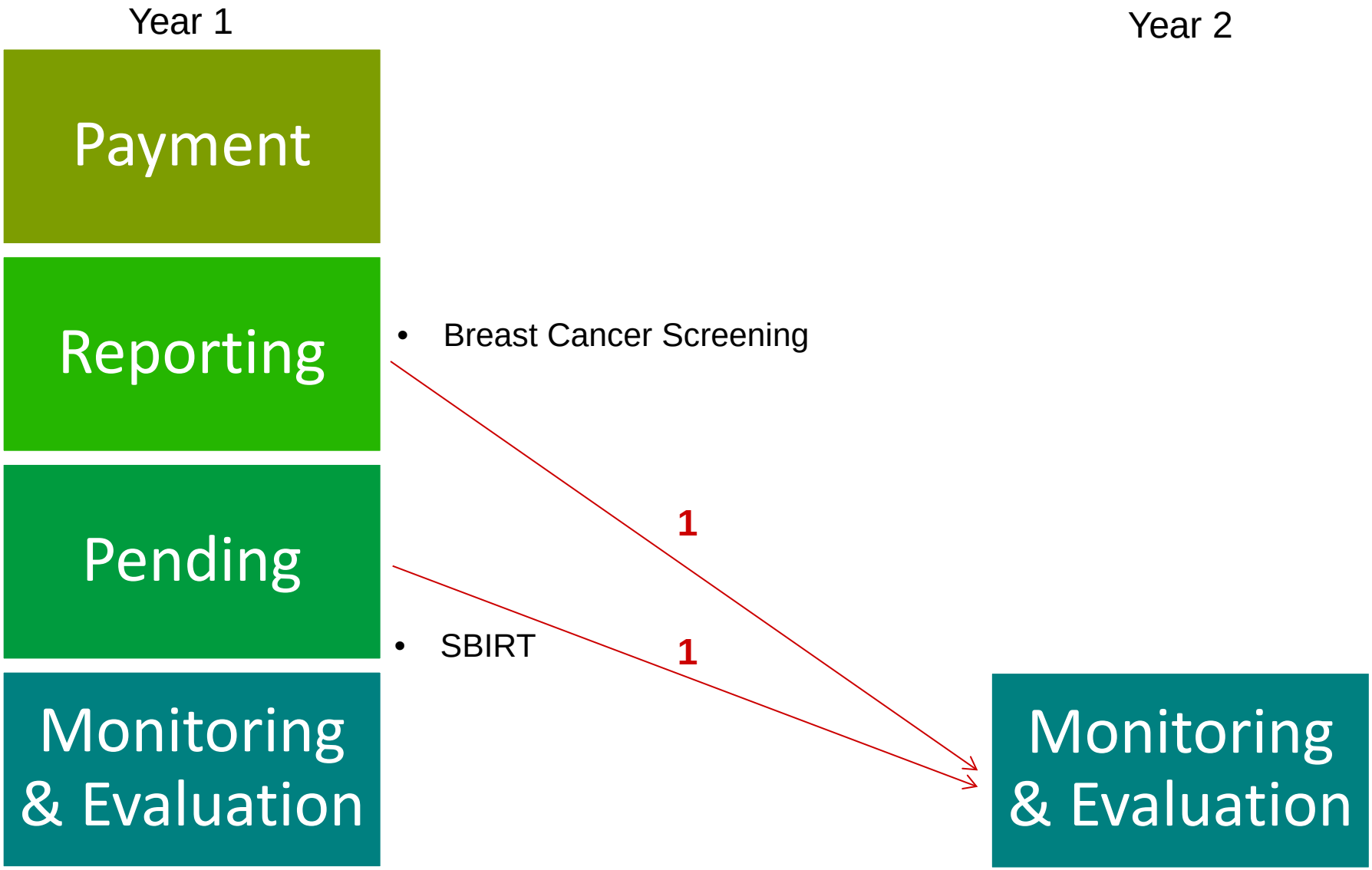
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite
- Diabetes Care: HbA1c Poor Control
- Pediatric Weight Assessment and Counseling

Re-classify Three Year 1 Pending Measures and One Year 1 M&E Measure to Reporting



Vermont Health Care Innovation Project

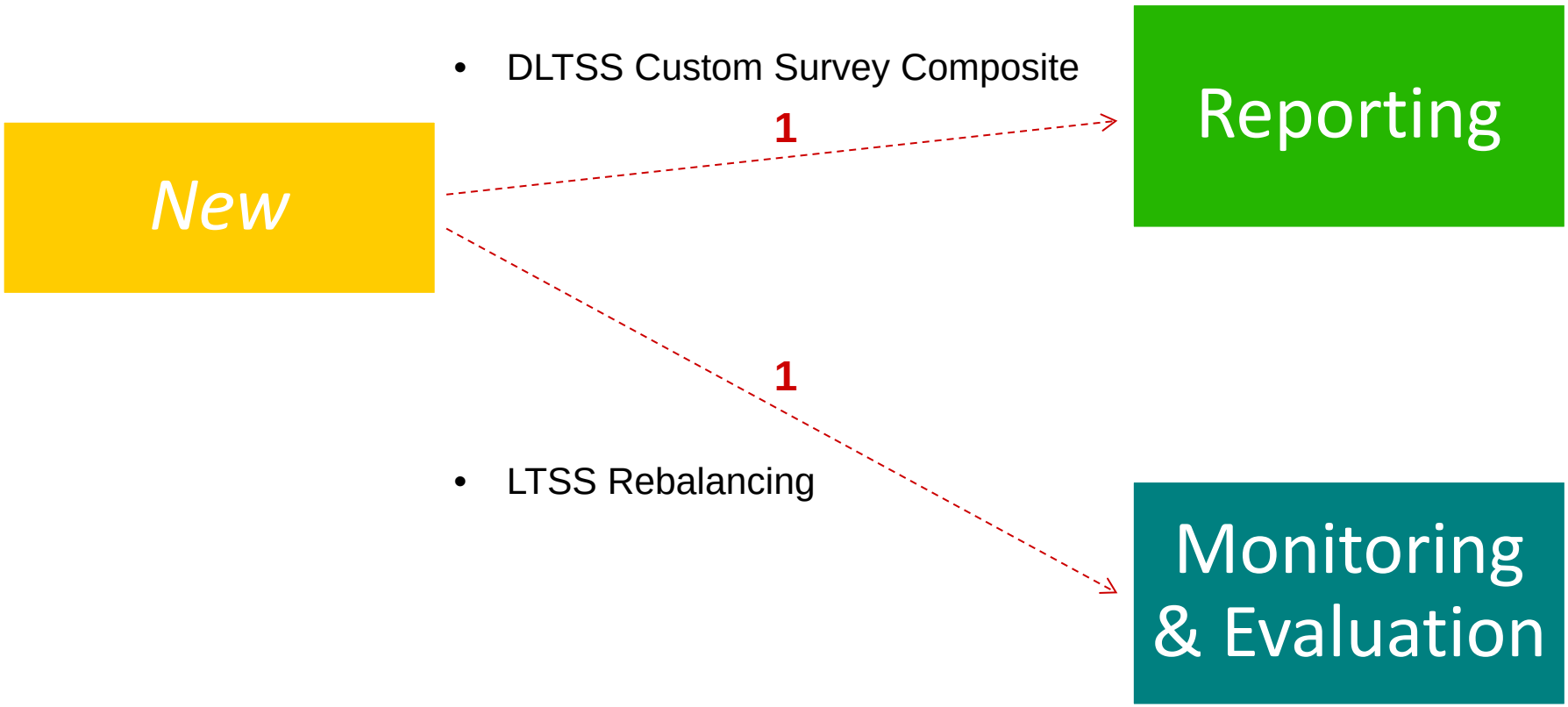
Re-classify One Year 1 Reporting Measure and One Year 1 Pending Measure to M&E



Add Two New Measures (One to Reporting and One to M&E)

Year 1

Year 2



Number of Measures by Category: Year 1 and Proposed Year 2 Measures

Current Year 1	Proposed Year 2
Payment (7 Commercial/ 8 Medicaid)	Payment (10 Commercial/ 11 Medicaid)
Reporting (24)*	Reporting (25 Commercial/ 24 Medicaid)*
Monitoring & Evaluation (22 Commercial/ 23 Medicaid)	Monitoring & Evaluation (24 Commercial/ 25 Medicaid)

***Reporting category counts Diabetes Composite as 5 measures because each sub-measure is counted as 1 measure. If this measure was only counted as 1 measure, the Reporting numbers would decrease by 4 in Y1 and Y2.**

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant recommended considering these measures for promotion
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Reporting	Prenatal and Postpartum Care (Clinical Data)	**5** in favor of promotion **9** opposed to promotion
Pending	Reporting	Influenza Immunization (Clinical Data)	**7** in favor of promotion **7** opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering this measure for promotion
- Work group members requested additional consideration for use as Reporting in Year 2
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Pending	Screening for High Blood Pressure and Follow-Up Plan Documented (Clinical Data)	**2** in favor of promotion to Reporting **11** opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering these measures for promotion
- QPM work group members did not vote on these measures at the July 29, 2014 work group meeting

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure
Reporting	Reporting	Optimal Diabetes Care (D5 – Composite)
Reporting	Reporting	Rate of Hospitalization for ACSCs (COPD/Asthma in Older Adults)
Reporting	Reporting	Screening for Clinical Depression & Follow-Up
Reporting	Reporting	Adult BMI Assessment
Pending	Pending	Controlling High Blood Pressure
Pending	Pending	Care Transition Record Transmitted to Health Care Professional
Pending	Pending	Transition Record with Specified Elements Received by Discharged Patients
Pending	Pending	Percentage of Patients with Self-Management Plans

APPENDIX:

YEAR ONE MEASURE SET WITH RECOMMENDED YEAR 2 CHANGES

Recommended Year 2 Payment Measures – Claims Data

Commercial & Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*
- **Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite** *(10-5 vote of QPM WG; move from Reporting)*

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Recommended Year 2 Payment Measures – Clinical Data

Commercial & Medicaid

- **Diabetes Care: HbA1c Poor Control (>9.0%)*** *(10-5 vote of QPM WG; move from Reporting)*
- **Pediatric Weight Assessment and Counseling** *(10-5 vote of QPM WG; move from Reporting)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Claims Data

Commercial & Medicaid

- Ambulatory Care-Sensitive Conditions Admissions: COPD*
- ~~Breast Cancer Screening*~~
- ~~Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: Composite~~
- Appropriate Testing for Children with Pharyngitis
- **Avoidable ED Visits** *(9-6 vote of QPM WG; move from M&E)*

Commercial-Only

- **Developmental Screening in the First Three Years of Life** *(10-4 vote of QPM WG; already in Y1 Payment Measure Set for Medicaid SSP)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Clinical Data

Commercial & Medicaid

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
  - *HbA1c control**
  - *LDL control**
  - *High blood pressure control**
  - *Tobacco non-use**
  - *Daily aspirin or anti-platelet medication**
- ~~Diabetes HbA1c Poor Control*~~
- Childhood Immunization Status
- ~~Pediatric Weight Assessment and Counseling~~
- **Cervical Cancer Screening** *(Unanimous vote of QPM WG, move from Pending)*
- **Tobacco Use: Screening & Cessation Intervention*** *(Unanimous vote of QPM WG, move from Pending)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Patient Experience Survey Data

Commercial & Medicaid

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care
- **Provider Knowledge of DLTSS Services and Help from Case Manager/Service Coordinator** *(11-3 vote of QPM WG; NEW)*

Recommended Year 2 Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- **Breast Cancer Screening** *(Unanimous vote of QPM WG; moved from Reporting)*

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate
- **LTSS Rebalancing** *(Medicaid-only; state and county level; unanimous vote of QPM WG; NEW)*
- **SBIRT** *(for pilot sites; unanimous vote of QPM WG; move from Pending)*

UTILIZATION & COST

- Total Cost of Care
- Resource Utilization Index
- Ambulatory surgery/1000
- Average # of prescriptions PMPM
- ~~Avoidable ED visits- NYU algorithm~~
- Ambulatory Care (ED rate only)
- ED Utilization for Ambulatory Care-Sensitive Conditions
- Generic dispensing rate
- High-end imaging/1000
- Inpatient Utilization - General Hospital/Acute Care
- Primary care visits/1000
- SNF Days/1000
- Specialty visits/1000

- Annual Dental Visit

Recommended Year 2 Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
- Influenza Immunization*
- ~~Tobacco Use Assessment and Tobacco Cessation Intervention*~~
- Coronary Artery Disease (CAD) Composite*
- Hypertension (HTN): Controlling High Blood Pressure*
- Screening for High Blood Pressure and Follow-up Plan*
- ~~Cervical Cancer Screening~~
- Care Transition-Transition Record Transmittal to Health Care Professional
- Percentage of Patients with Self-Management Plans

- How's Your Health?
- Patient Activation Measure
- Frequency of Ongoing Prenatal Care
- Elective delivery before 39 weeks
- Prenatal and Postpartum Care
- ~~Screening, Brief Intervention, and Referral to Treatment~~
- Trauma Screen Measure
- Falls: Screening for Future Fall Risk*
- Pneumococcal Vaccination for Patients 65 Years and Older*
- Use of High Risk Medications in the Elderly
- Persistent Indicators of Dementia without a Diagnosis
- Proportion not admitted to hospice (cancer patients)
- ~~Developmental Screening in the First Three Years of Life (commercial)~~

**Medicare Shared Savings Program measure*

Attachment 2c - Memo on VHCIP Funding for Provider Training

109 State Street

Montpelier, VT 05609

www.healthcareinnovation.vermont.gov

To: Deborah Lisi-Baker and Judy Peterson, Co-Chairs DLTSS Work Group
Fr: Georgia Maheras, Project Director
Date: August 28, 2014
Re: VHCIP funding for provider training

VHCIP provides certain financial resources to support delivery system transformation. The VHCIP Core Team approved a funding allocation process that allows the Workforce Work Group to make recommendations regarding spending of certain SIM funds. The Core Team approved the following line items as within the joint purview of the DLTSS and CMCM Work Groups:

Budget Line Item Title	Year one	Year two	Year three	Total for three years
Model Testing: Service delivery to support enhancement and maintenance of best practice as payment models evolve for LTSS, MH, SA, Children	$ 0	$ 700,000	$ 700,000	$ 1,400,000
Model Testing: Integration of MH/SA into patient centered medical home		$ 75,000	$ 75,000	$ 150,000
Learning Collaboratives		$ 80,000	$ 270,000 -	$ 350,000

Approved text from the federally-approved budget[1]:

Model Testing: Integration of mental health into patient centered medical home	
Organizational Affiliation	DVHA
Scope of Project/Services to be Rendered	Conduct independent assessment to develop a strategic plan options to better integrate LTSS and/or MH/SA into the overall learning health system. This could include conducting market research with providers and stakeholders, benchmarking to other states who have HIT systems in place for these providers, reviewing current state of the art solutions that may be appropriate. The deliverable is a detailed description of options and their advantages and disadvantages for supporting how best to ensure LTSS and MH/SA providers are best plugged into the learning health systems.
Relevance of Project/Service to SIM Grant implementation	The SIM grant supports testing of several large-scale payment system reforms. Ensuring all providers across the continuum of medical and social care can leverage and participate in the learning health system. Depending on findings of assessment, resources could be used for technical assistance, infrastructure development or related needs.
Name of Consultants	The State of Vermont will issue an RFP for these services.

Model Testing: Service delivery to support enhancement and maintenance of best practice as payment models evolve	
Organizational Affiliation	DVHA
Scope of Project/Services	An objective of our SIM grant is ensuring that Vermont's models

[1] Note that CMMI has only approved the Year One funding, not subsequent years.

to be Rendered	address the divide between the medical community and traditionally Medicaid-only specialty and social support services. This contract will support enhancement and maintenance of best practice as payment models evolve to support integration of physical health care with each of the following: • Mental health and substance abuse • Dementia • Long term care support services • Child and family programs Deliverables include: • Conducting independent assessments to develop strategic plan options to better integrate these services with physical health within our proposed testing models. • Conducting market research with providers and stakeholders about their needs and feasibility of alternative solutions, • Benchmarking to other states who have HIT systems in place for these providers, reviewing current state-of-the-art solutions that may be appropriate. • Development of a detailed description of options and their advantages and disadvantages for supporting how best to ensure these providers are supported in their participation of testing models and the Learning Health System. • Technical support and facilitation in implementation of options across providers and/or Investment in tools and resources which would facilitate rapid adaption of these options across providers
Relevance of Project/Service to SIM Grant implementation	The SIM grant application contemplates a fully integrated health care system that allows patients to seamlessly move from acute care to community and home based services. Connecting the system in this manner will require identification of opportunities with providers who are not currently integrated into the system.
Name of Consultants	The State of Vermont will issue an RFP for these services.

Technical Assistance: Learning Collaboratives	
Organizational Affiliation	DVHA
Scope of Project/Services to be Rendered	The State will host 5 learning collaborative each year to share knowledge and integrate lessons learned into clinical practice. These collaborative will be formal convenings with technical experts and the availability of continuing education credits.
Relevance of Project/Service to SIM Grant implementation	Shifting to alternative payment systems requires collaboration among providers, payers and government. It also requires a willingness to continually learn and build towards a high performing health system. The State of Vermont will pull all of these entities together throughout the grant period to encourage discussion and shared learning. The State has also participated in similar initiatives across States convened by vendors like the Center for Health Care Strategies (CHCS) and found the approach useful in advancing collaboration and knowledge in the content underlying the models. Potential subjects of the learning collaboratives could be, but would not be limited to: • Participation in the LHS: using predictive models and data analytics to improve patient care • Participation in P4P: support and technical assistance in adapting value-based approaches into clinical practice • Participation in Payment Pilots: support and technical assistance in developing, implementing and evaluation of payment pilots • Best practices in ACOs: supporting collaboration and technical assistance in entities launching ACOs in the State • Expanding PCMH to medical neighborhoods: supporting collaboration and dissemination of best practices among medical home participants

Attachment 3a - DAIL Long Term Care Consumer Survey Presentation

Presentation of AHS Survey Information to DLTSS Work Group
DAIL LTC Consumer Survey: Choices for Care, Attendant Services Program
8.26.14

Link to most recent survey report:
http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/ltc-consumer-satisfaction-survey-2013-1
Note: DAIL has worked with the CFC independent evaluator and the VT Health Care Association to improve access to and use of survey results for residents of nursing homes, residential care homes, and assisted living facilities.

1. Brief Background of Survey Implementation in Vermont (maximum 5 – 10 minutes)

a. Survey Purpose:

To assess consumer experience in Choices for Care HCBS and Attendant Services Program.

DAIL Core Principles

• Person-Centered: The individual will be at the core of all plans and services.
• Respect: Individuals, families, providers and staff are treated with respect.
• Independence: The individual's personal and economic independence will be promoted.
• Choice: Individuals will have options for services and supports.
• Self-Determination: Individuals will direct their own lives.
• Living Well: The individual's services and supports will promote health and well-being.
• Contributing to the Community: Individuals are able to work, volunteer, and participate in local communities.
• Flexibility: Individual needs will guide our actions.
• Effective and Efficient: Individual needs will be met in a timely and cost effective way.
• Collaboration: Individuals will benefit from our partnerships with families, communities, providers, and other federal, state and local organizations.

Choices for Care Core Objectives:

1. Support individual choice
2. Serve more people
3. 'Shift the balance': reduce the number and percentage of people who are served in nursing homes; increase the number and percentage of people who are served in alternative settings
4. Expand the range of service options
5. Eliminate or reduce waiting lists
6. Manage spending to available funding
7. Ensure an adequate supply of nursing home beds
8. Ensure that services are of high quality and support individual outcomes
9. Support the independent evaluation, including associated measures and documents

b. Source of Survey Instrument (e.g., national instrument, Vermont developed instrument, other)

Survey instrument is developed collaboratively by state staff, CFC independent evaluator (UMass Medical School) and the survey contractor.

c. History of Vermont Implementation (when first started, frequency of implementation)

Annually since 2006- see
http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys

Surveys also done intermittently before 2006.

d. Who conducts survey (e.g., state staff, state contractor, other)?

The survey contractor (procured via RFP; currently Thoroughbred) fields survey, creates summary data, and prepares survey report. State reviews/comments on report outline and draft report before final report is produced.

e. How is survey funded (e.g., department budget, federal grant, other)?

DAIL funds including Medicaid admin.

f. Format and Process for Presenting Survey Findings (e.g., written report, power point presentation at specific meetings)

Survey reports are posted online (see above). Survey results are also used in CFC evaluation reports, completed by independent evaluator and posted online:
http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-report-yrs-1-8
http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys
and in CFC data reports posted online:
http://www.ddas.vermont.gov/ddas-publications/publications-cfc/cfc-qrtrly-data-rprts

2. Brief Overview of Survey Methodology (maximum 5 – 10 minutes)

a. Survey construction (e.g., categories of questions, number of questions, format of questions)

2013: SURVEY POPULATION AND SAMPLE

The Vermont LTC survey population consists of all consumers using one or more of the following DAIL-funded services: Choices for Care home and community based services, Adult Day services, Homemaker services, the Attendant Services Program, and the Traumatic Brain Injury Program.

Thoroughbred worked with DAIL to develop a sampling plan that meets statistical confidence levels of 5% standard error with a 95% confidence interval for each program/service. We anticipated obtaining approximately 1,000 completes among the various programs/services. For the 2013 data collection, we created 17 sample strata. Sixteen of these strata included a census of all consumers, and one stratum included a random sample of consumers. We drew the random sample of this stratum (CFC Case Management, Homemaker Services) assuming a 35% response rate (due to past response rates). All out-of-state consumers were excluded from sampling. The table below shows the sample for the 2013 survey administration cycle.

i. Please provide a handout of the actual survey instrument

See appendix 2 (page 196):
http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/ltc-consumer-satisfaction-survey-2013-1

b. 2013 Survey instrument reliability and validity metrics:

A total of 1,268 surveys were completed by consumers by mail (630) and telephone (638), for a total response rate of 58.54%. Response rates were calculated using the AAPOR Response Rate 1 formula. Table 3 summarizes the response rates and sampling errors by program.

Response Rate and Sampling Errors by Survey Population

Program	Number of Consumers	Completed Surveys	Response Rate	Precision @ 95% Confidence
CFC Case Management	2,319	1,149	58.71%*	1.86%
Personal Care Services	1,336	653	58.62%*	2.47%
Consumer-Directed	*301*	*164*	*64.31%**	*4.58%*
Surrogate-Directed	*466*	*212*	*54.50%**	*4.55%*
Agency-Directed	*705*	*354*	*60.20%**	*3.29%*
Flexible Choices	108	45	47.87%	10.60%
Adult Day Centers	446	209	56.18%*	4.49%
Homemaker Services	848	428	59.03%*	3.03%
Attendant Services Program	111	64	68.82%	6.88%
Traumatic Brain Injury Program	49	11	47.83%	21.82%
Total	2,586	1,268	58.54%*	1.77%

*Response rate meets 5% margin of error at 95% Confidence Interval threshold

c. Specific Population Focus

Participants in Choices for Care HCBS and Attendant Services Program. Age range 18-100+.

d. 2013 Sample Selection Process:

The Vermont LTC survey population consists of all consumers using one or more of the following DAIL-funded services: Choices for Care home and community based services, Adult Day services, Homemaker services, the Attendant Services Program, and the Traumatic Brain Injury Program.
Thoroughbred worked with DAIL to develop a sampling plan that meets statistical confidence levels of 5% standard error with a 95% confidence interval for each program/service. We anticipated obtaining approximately 1,000 completes among the various programs/services. For the 2013 data collection, we created 17 sample strata. Sixteen of these strata included a census of all consumers, and one stratum included a random sample of consumers. We drew the random sample of this stratum (CFC Case Management, Homemaker Services) assuming a 35% response rate (due to past response rates). All out-of-state consumers were excluded from sampling. The table below shows the sample for the 2013 survey administration cycle.

Sampling Plan for 2013 Survey

Sampling Strata	Total Consumers Within	Sample Pull
CFC Case Management	31	31
CFC Case Management, Personal Care Services		
Consumer-Directed	229	229
Surrogate-Directed	288	288
Agency-Directed	425	425
Agency-Directed, Consumer-Directed	49	49
Agency-Directed, Surrogate-Directed	58	58
CFC Case Management, Personal Care Services, Adult Day Centers		
Consumer-Directed	15	15
Surrogate-Directed	97	97
Agency-Directed	139	139
Multiple Personal Care Services (Agency + 1 other)	27	27
CFC Case Management, Homemaker Services	964	786
CFC Case Management, Adult Day Centers	112	112
CFC Case Management, Homemaker Services, Adult Day Centers	53	53
Flexible Choices	107	107
Attendant Services Program	111	111
Other Multiple Services	10	10
Total	2,769	2,586

e. Data Collection Methodology (i.e., is survey administered by mail, phone, in person) and protocol (i.e., how are prospective respondents contacted, can individuals have proxy respondents)

POPULATION

The Vermont Department of Disabilities, Aging and Independent Living Long-Term Care Services and Programs Customer Survey is based on mail surveys and telephone interviews conducted among current customers receiving services. The target population for the 2013 DAIL Long-Term Care Services and Programs Customer Survey consisted of all Vermont residents receiving services.

A random sample of customers was selected within each program to participate in the survey.

The survey used an instrument developed by DAIL and Thoroughbred in 2013. Many of the items in the survey included questions that were asked in prior surveys. The 2013 survey instrument added additional questions to those from prior years to address other topic areas and to assess recommendation of programs/services and competency of staff. A copy of the survey is included in Appendix 2.

PROTOCOL

The 2013 Vermont LTC Consumer survey protocol used the following methodology protocol. 100% received the survey in the mail. Those who did not respond received a second mailing. People who did not respond to either mailing were contacted up to six times by phone. Individuals can have proxy respondents.
A detailed description of the survey methodology is provided in Appendix 1 of the survey report.

f. Historical Response Rates

A total of 1,268 surveys were completed by consumers by mail (630) and telephone (638), for a total response rate of 58.54%. Response rates were calculated using the AAPOR Response Rate 1 formula.App. 60% (see above).

3. Key Findings - From Most Recent Survey Year and Trends Over Time, if available

Improving and Maintaining Performance

Thoroughbred Research Group conducted a key driver analysis called "attributable effects analysis" to determine what attributes drive overall satisfaction and recommendation of the various long-term care services and programs provided by DAIL. This analysis identifies two types of drivers. Potential drivers are attributes where the greatest benefit can be realized through improvements in quality. Maintenance drivers are those that would result in the greatest loss of satisfaction/recommendation if quality declined in these attributes.

The Provision of Services is among the strongest Potential and Maintenance drivers. Staff Attributes are also important, with ensuring competency of staff as a top Potential and Maintenance driver, and having courteous and respectful caregivers as a top Maintenance driver. Consumer Choice is another important driver of satisfaction with services provided and recommendation of the programs/services to others.

DAIL should focus on improving the quality of services received, the competency of staff, the receipt of all services that consumers need, when and where needed, and the choice and control consumers have in their care in order to improve its overall rating. DAIL should focus on maintaining the quality of services received, the courtesy and respect of caregivers, staff competency, the receipt of all services that consumers need, and the choice and control consumers have in their care.

Top Potential Drivers	Top Maintenance Drivers
Quality of Services Received	Quality of Services Received
Staff Competency	Courteous and Respectful Caregivers
Consumers Receive Services That Meet Needs	Staff Competency
Receive Services When and How Needed	Consumers Receive Services that Meet Needs
Consumers Have Choice/Play Role in Care	Consumer Have Choice/Play Role in Care

a. Prominent Positive Findings

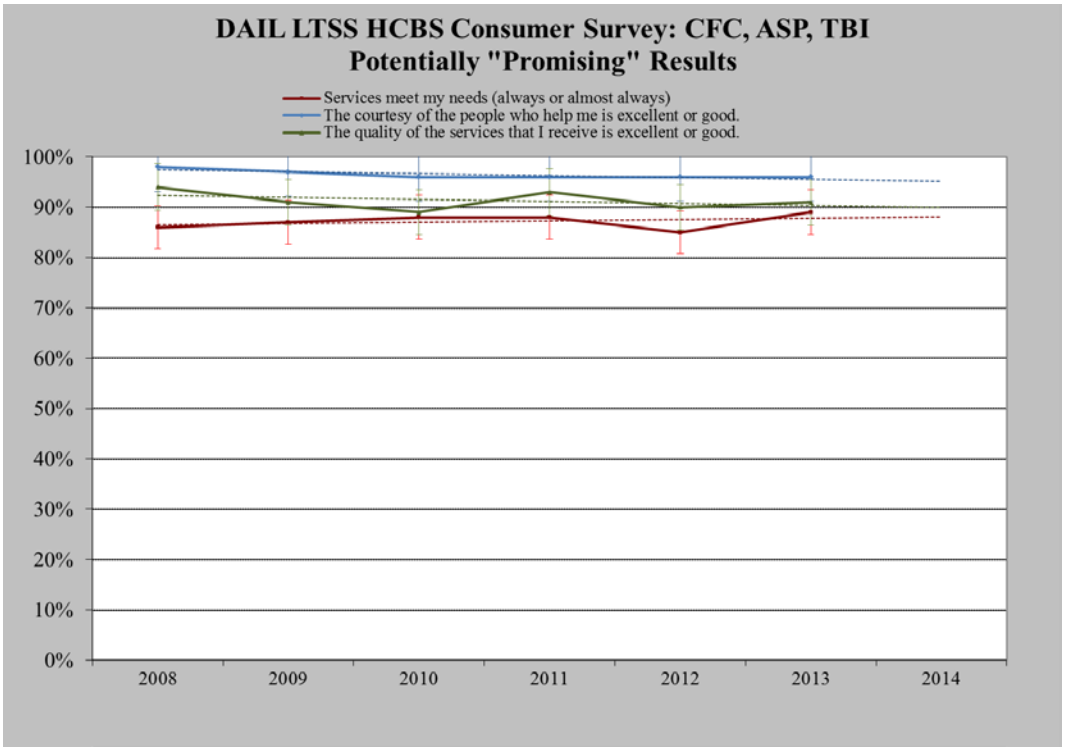


Table 12a. Percentage of respondents' rating General Services "Excellent" or "Good" b Program

	Amount of Choice and Control		Overall Quality of Help		Timeliness of Services	
	% Excellent or Good		% Excellent or Good		% Excellent or Good	
	n	%	n	%	n	%
Total	**1,268**	**84%**	**1,268**	**91%**	**1,268**	**85%**
CFC Case Mgmt	1,149	83%	1,149	90%	1,149	85%
Personal Care Services	653	85%	653	92%	653	88%
Consumer-Directed	164	83%	164	93%	164	87%
Surrogate-Directed	212	91% ⇧	212	96% ⇧	212	90% ⇧
Agency-Directed	354	81%	354	90%	354	87%
Flexible Choices*	45	88%	45	92%	45	89%
Adult Day Services	209	84%	209	91%	209	86%
Homemaker Services	428	81%	428	87%	428	81%
Attendant Services Program*	64	94% ⇧	64	98% ⇧	64	87%
Traumatic Brain Injury Program*	11	90%	11	92%	11	83%

⇧ Statistically higher than the total at 95% Confidence Level

⇩ Statistically lower than the total at 95% Confidence Level

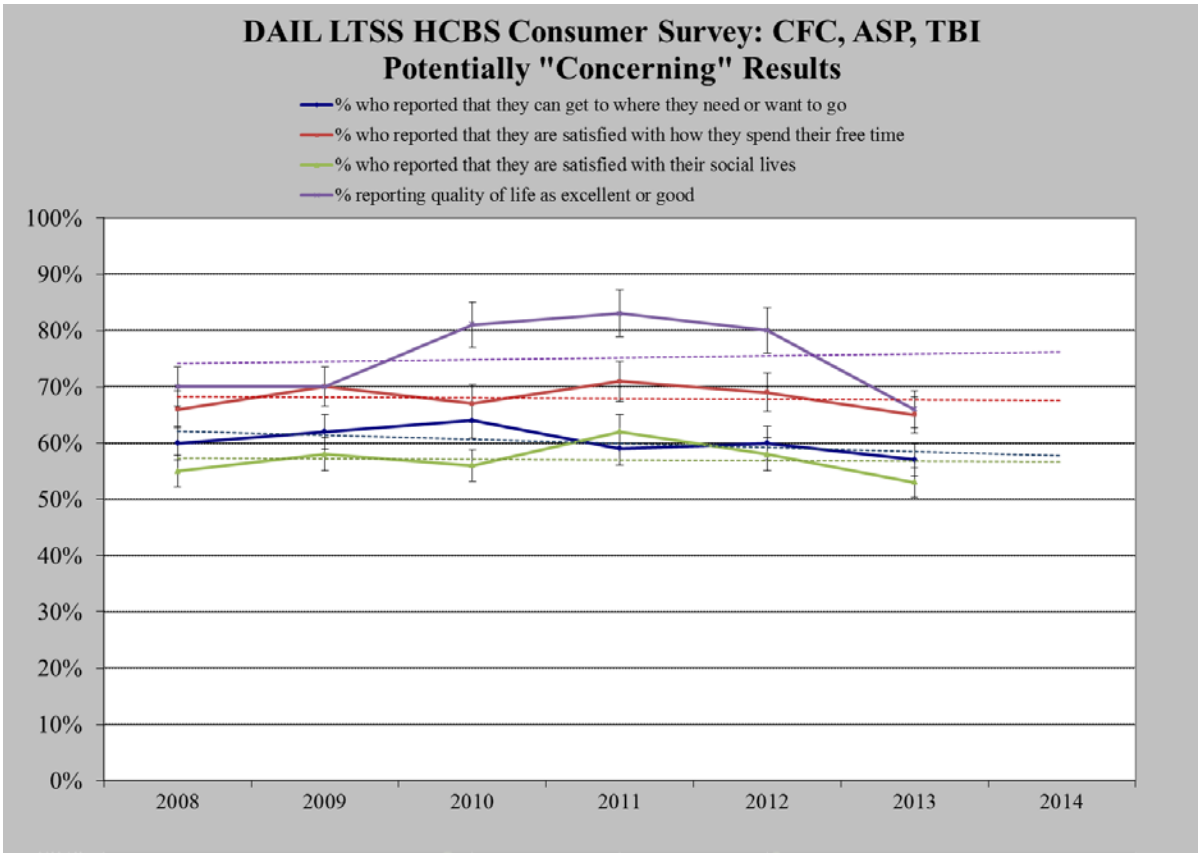
* Program did not meet 95/5 statistical criteria and should be interpreted with caution

b. Prominent Findings re: Areas Needing Improvement

Relatively low performance measures for MNG Homemaker services.

Summary of Items Evaluating Individual Programs and Services

	CFC Personal Care Services	CFC Home-maker Services	CFC Adult Day	Attendant Services Program
How satisfied are you with the services you receive? (% very or somewhat satisfied)	95%	90%	94%	90%
How do you rate the quality of the services you receive? (% excellent or good)	95%	88%	94%	97%
What is your recommendation of the services you receive to others? (% excellent or good)	95%	88%	94%	96%
The services I receive meet my needs. (% always or almost always)	92%	83%	92%	95%
My caregivers treat me with respect and courtesy. (% always or almost always)	97%	98%	96%	100%
I know who to contact if I have a complaint or if I need more help. (% always or almost always)	92%	88%	90%	87%
Provides services to me when and where I need them. (% always or almost always)	92%	87%	93%	93%
Please rate the competency of staff. (% excellent or good)	93%	89%	94%	95%
Have you experienced any problems with ……during the past 12 months? (% Yes)	15%	24%	12%	5%
I was able to choose my services (% agree or strongly agree)	87%	67%	--	--
I was able to choose the provider of my services (% agree or strongly agree)	85%	48%	--	--
I was able to choose the scheduling of services that meets my needs (% agree or strongly agree)	85%	70%	--	--
I was able to select my services provider from a variety of providers (% agree or strongly agree)	65%	32%	--	--
Having more providers who offer services would allow me to better meet my needs (% agree or strongly agree)	52%	43%	--	--
There are services that I need that I CAN'T GET (% agree or strongly agree)	24%	24%	--	--



4. **Use of Survey Findings (i.e., who does what with them)**
   - DAIL management uses survey results to inform program design/improvement. Example: Relatively low survey measures for MNG Homemaker services (over several years) directly influenced the development of MNG 'flexible choices' service option in 2014.
   - Choices for Care independent evaluator uses some survey results in the independent evaluation. The independent evaluation assesses Vermont's performance in achieving the objectives of Choices for Care.
   - Survey reports, CFC evaluation reports, and CFC data reports are distributed to the DAIL Advisory Board.
   - Selected survey results have been used in DAIL annual reports and legislative testimony regarding Choices for Care performance.
   - Survey reports are posted online.

5. **Work Group Questions and Answers (please allow minimum of 10 minutes)**

Attachment 3b - DAIL Long Term Care Consumer Survey Tool

Vermont Department of Disabilities, Aging, and Independent Living
Long-Term Care Services and Programs Customer Survey

You can be assured that your responses to this survey will be confidential. Your responses will never be shared with your caregivers or local agencies. Your responses will have no effect on your eligibility for services or the services that you receive. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned the survey so we don't have to send you reminders. For specific information about this study, please call Thoroughbred Research Group at our Toll Free Number, 1-866-714-9948.

Information and Awareness of LTC Programs

1. How did you first learn about the long-term care services you receive?
Mark one or more.

- ○ Vermont 211
- ○ Area Agency on Aging
- ○ Home Health Agency
- ○ Vermont Center for Independent Living
- ○ Brain Injury Association
- ○ Designated Agency
- ○ Green Mountain Self Advocates
- ○ Vermont Family Network
- ○ Doctor or nurse, at office of Health Care Provider
- ○ Hospital
- ○ Person – Friend/Family/Word of Mouth/Other Children
- ○ Health Fair/Community Event
- ○ Community Groups/Advocacy Groups/Church
- ○ Department for Children and Families
- ○ Department of Disabilities, Aging and Independent Living
- ○ Division for the Blind and Visually Impaired
- ○ Division of Vocational Rehabilitation
- ○ Agency of Human Services
- ○ TV/Radio/Newspaper Advertisement
- ○ Website for Department of Disabilities, Aging and Independent Living
- ○ Website - Other
  ➔ *Please Specify:* _____
- ○ Other ➔ *Please Specify:*_____

2. Did someone talk with you about ways of getting the help you needed with daily activities?

- ○ Yes, *Please Specify:*_____
- ○ No

3. How satisfied were you with the information you were given?

- ○ Very Satisfied ➔ *Go to Question 4*
- ○ Somewhat Satisfied ➔ *Go to Question 4*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 4*
- ○ Somewhat Dissatisfied
- ○ Very Dissatisfied

3a. Why are you dissatisfied with the information you were given?

_____

_____

Please let me know how familiar you are with the following:

4a. The Long-Term Care Ombudsman program, which protects the health, welfare and rights of people who live in long-term care facilities in Vermont.

- ○ Very Familiar
- ○ Somewhat Familiar
- ○ Not Very Familiar
- ○ Not at all Familiar

4b. The Adult Protective Services program, which protects adults from abuse, neglect and exploitation?

- ○ Very Familiar
- ○ Somewhat Familiar
- ○ Not Very Familiar
- ○ Not at all Familiar

General Ratings of Services Provided by DAIL

For these next few questions, please think about ALL of the services you receive and ALL programs in which you participated in the past 12 months. For example, if you participated in more than one program, try to think about your experiences with all of the programs as a group.

Please give each statement a letter grade using a letter grade scale where A means Excellent, B means Good, C means Fair, and D means Poor.

5a. The amount of choice and control you had when you planned the services or care you would receive.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5b. The overall quality of the help you receive.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5c. The timeliness of your services. For example, did your services start when you needed them?

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5d. When you receive your services or care. For example, do they fit with your schedule?

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5e. The communication between you and the people who help you.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5f. The reliability of the people who help you. For example, do they show up when they are supposed to be there?

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5g. The degree to which the services meet your daily needs such as bathing, dressing, meals, and housekeeping.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5h. How well problems or concerns you have with your care are taken care of.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5i. The courtesy of those who help you.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

5j. How well people listen to your needs and preferences.

- ○ A means Excellent
- ○ B means Good
- ○ C means Fair
- ○ D means Poor

6. Overall, how do you rate the value of the services you receive? Would you rate the value as…?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

7. What is your recommendation of Choices of Care to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Next, please tell me how strongly you agree or disagree with the following statements.

8a. I receive all the services I need and want exactly when and how I need and want the services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

8b. My services help me to achieve my personal goals.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

8c. My current residence is the setting in which I choose to receive services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

8d. I receive services exactly where I need and want services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

9. Is there anything that could improve the services offered to you and others?

- ○ Yes ➔ *Please specify what could be improved:*

  _____

  _____
- ○ No

10. If you had complete choice, control and flexibility, would your service plan look different?

- ○ Yes ➔ *Please specify how your service plan would look different:*

  _____

  _____
- ○ No

Improvement in Quality of Life

11. Has the help you received made your life…?

- ○ Much Better
- ○ Somewhat Better
- ○ About the Same
- ○ Somewhat Worse
- ○ Much Worse

12. How easy would it be for you to stay in your home if you didn't receive services?

- ○ Very Easy
- ○ Easy
- ○ About the Same
- ○ Difficult
- ○ Very Difficult

13. Please tell me how strongly you agree or disagree with the following statement. My services help me to maintain or improve my health.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

Quality of Life Measures

14. The next questions refer to how you feel about your life now. Please indicate how well the statements describe your life.

	Yes	Somewhat	No
a. I feel safe in the home where I live.	○	○	○
b. I feel safe out in my community.	○	○	○
c. I can get to where I need or want to go.	○	○	○
d. I can get around inside my home as much as I need to.	○	○	○
e. I am satisfied with how I spend my free time.	○	○	○
f. I am satisfied with the amount of contact I have with my family and friends.	○	○	○
g. I have someone I can count on in an emergency.	○	○	○
h. I feel satisfied with my social life.	○	○	○
i. I feel valued and respected.	○	○	○
j. I really feel a part of my community.	○	○	○
k. I have someone I can count on to listen to me when I need to talk.	○	○	○
l. I have someone to do something enjoyable with.	○	○	○
m. In my leisure time, I usually don't like what I am doing, but I don't know what else to do.	○	○	○
n. During my leisure time, I almost always have something to do.	○	○	○

15. Please think about all the help you received during the last week around the house like cooking and cleaning. Do you need more help with things around the house than you are receiving?

- ○ Yes
- ○ No

16. During the last week, did any family member or friends help you with things around the house?

- ○ Yes
- ○ No

17. Are there people who are not paid who help you to stay at home and to get around in the community?

- ○ Yes
- ○ No ➔ *Go to Question 18*

17a. How often do you see that person during a week?

- ○ Less than one time a week
- ○ One time a week
- ○ More than one time a week

18. During the past week, how often would you say you felt sad or blue?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

The next two questions are about emotional support and your satisfaction with life.

19. How often do you get the social and emotional support you need? (Please include support from <u>any source</u>).

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

20. In general, how satisfied are you with your life?

- ○ Very Satisfied
- ○ Satisfied
- ○ Neither Satisfied nor Dissatisfied
- ○ Dissatisfied
- ○ Very Dissatisfied

Health Status

21. In general, compared to other people your age, would you say your health is…?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

22. Compared to one year ago, how would you rate your health in general now?

- ○ Much Better Now than One Year Ago
- ○ Somewhat Better Now than One Year Ago
- ○ About the Same
- ○ Somewhat Worse Now than One Year Ago
- ○ Much Worse Now than One Year Ago

23. Based on his or her knowledge of my health needs, my case manager helps me understand the different service options that would be good for me.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never
- ○ Not applicable/No Case Manager

Case Management

24. These next few questions are about your case management. First, who is your case manager?

_____

- ○ I do not have a case manager
  ➔ *Go to State-Sponsored Programs, page 6*

25. How satisfied are you with your case manager?

- ○ Very Satisfied ➔ *Go to Question 26*
- ○ Somewhat Satisfied ➔ *Go to Question 26*
- ○ Neither Satisfied nor Dissatisfied
  ➔ *Go to Question 26*
- ○ Dissatisfied
- ○ Very Dissatisfied

25a. Why are you dissatisfied with your case manager?

_____

_____

26. What is your recommendation of your case manager to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about your experiences with your case manager.

27a. I feel I have a part in planning my care with my case manager.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

27b. My case manager coordinates my services to meet my needs

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

27c. My case manager understands which services I need to stay in my current living situation.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

27d. I can talk to my case manager when I need to.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

27e. My case manager helps me when I ask for something.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

27f. My case manager asks me what I want.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

27g. My case manager helps me understand the different service options that are available.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

28. Please rate case management services on the competency of staff.

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

STATE SPONSORED PROGRAMS

For the next few questions, please think SPECIFICALLY about the services you receive from each one of the state-sponsored programs in which you participate.

Attendant Services Program

The following series of questions are about your experiences with the Attendant Services Program. The Attendant Services Program provides assistance with personal care for adults with disabilities. Participants hire, train, and supervise their attendants.

29. Are you currently receiving or have you received services through the Attendant Services Program in the past?

- ○ Yes
- ○ No ➔ *Go to Homemaker Services, page 7*

30. How satisfied are you with the services you receive from the Attendant Services Program?

- ○ Very Satisfied ➔ *Go to Question 31*
- ○ Somewhat Satisfied ➔ *Go to Question 31*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 31*
- ○ Dissatisfied
- ○ Very Dissatisfied

30a. Why are you dissatisfied with the services you receive from the Attendant Services Program?

_____

_____

31. How do you rate the quality of the services you receive from the Attendant Services Program?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

32. What is your recommendation of the services you receive from the Attendant Services Program to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about using the Attendant Services Program.

33a. The services I receive from the Attendant Services Program meet my needs.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

33b. My caregivers in the Attendant Services Program treat me with respect and courtesy.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

33c. I know who to contact if I have a complaint about the Attendant Services Program or if I need more help.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

33d. The Attendant Services Program provides services to me when and where I need them.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

34. Please rate the Attendance Services Program on the competency of staff.

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

35. Have you experienced any problems with the Attendant Services Program during the past 12 months?

- ○ Yes
- ○ No ➔ *Go to Question 36*

35a. What problems did you experience?

_____

_____

35b. Did the Attendant Services Program work to resolve these problems?

- ○ Yes
- ○ No

36. Is there anything that could improve services offered to you and others by the Attendant Services Program?

- ○ Yes ➔ *Please specify what could be improved*:

  _____

  _____

- ○ No

Homemaker Services

The following series of questions are about your experiences with Homemaker Services. Homemaker services provide help at home with activities such as cleaning, laundry, shopping, respite care, and limited personal care.

37. Are you currently receiving or have you received services through Homemaker Services in the past?

- ○ Yes
- ○ No ➔ *Go to Personal Care Services, page 9*

38. How satisfied are you with Homemaker Services?

- ○ Very Satisfied ➔ *Go to Question 39*
- ○ Somewhat Satisfied ➔ *Go to Question 39*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 39*
- ○ Dissatisfied
- ○ Very Dissatisfied

38a. Why are you dissatisfied with Homemaker Services?

_____

_____

39. How do you rate the quality of Homemaker Services?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

40. What is your recommendation of Homemaker Services to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about Homemaker Services.

41a. The Homemaker Services I receive meet my needs.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

41b. My caregivers providing Homemaker Services treat me with respect and courtesy.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

41c. I know who to contact if I have a complaint about Homemaker Services or if I need more help.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

41d. The Homemaker Services are provided to me when and where I need them.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

Please tell me how strongly you agree or disagree with the following statements.

42a. I was able to choose my Homemaker Services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

42b. I was able to choose the provider of my Homemaker Services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

42c. I was able to choose the scheduling of Homemaker Services that meets my needs.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

42d. I was able to select my Homemaker Services provider from a variety of providers.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

42e. Having more providers who offer Homemaker Services would allow me to better meet my needs.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

42f. There are Homemaker Services that I need that I CAN'T GET.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
  ➔ *Go to Question 43*
- ○ Disagree ➔ *Go to Question 43*
- ○ Strongly Disagree ➔ *Go to Question 43*

42f1. What are these Homemaker Services you cannot get?

_____

_____

43. Please rate the Homemaker Services on the competency of staff.

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

44. Have you experienced any problems with Homemaker Services during the past 12 months?

- ○ Yes
- ○ No ➔ *Go to Question 45*

44a. What problems did you experience?

_____

_____

44b. Did Homemaker Services work to resolve these problems?

- ○ Yes
- ○ No

45. Is there anything that could improve the Homemaker Services offered to you and others?

- ○ Yes ➔ *Please specify what could be improved:*

  _____

  _____
- ○ No

46. Vermont is looking at possibly adding new providers of Homemaker Services. Based on your experience, how helpful would adding new providers of Homemaker Services be to you?

- ○ 1 Not at all Helpful
- ○ 2
- ○ 3
- ○ 4
- ○ 5 Very Helpful

How strongly do you agree or disagree with the following statements?

47a. Adding new providers of Homemaker Services would improve my ability to have services where and when I need them.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

47b. Adding new providers of Homemaker Services would improve the cost effectiveness of my services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

47c. Adding new providers of Homemaker Services would improve the quality of my services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

47d. Do you have any other comments about adding new providers?

- ○ Yes ➔ *Please specify:*

  _____

  _____
- ○ No

Personal Care Services

The following series of questions are about your experiences with Choices for Care Personal Care Services. These services provide assistance with personal care for seniors and adults with disabilities.

48. Are you currently receiving or have you received Personal Care Services in the past?

- ○ Yes
- ○ No ➔ *Go to Adult Day Centers, page 12*

49. How satisfied are you with the Personal Care Services you receive?

- ○ Very Satisfied ➔ *Go to Question 50*
- ○ Somewhat Satisfied ➔ *Go to Question 50*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 50*
- ○ Dissatisfied
- ○ Very Dissatisfied

49a. Why are you dissatisfied with the Personal Care services you receive?

_____

_____

50. How do you rate the quality of the Personal Care Services you receive?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

51. What is your recommendation of Personal Care services to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about the Personal Care Services you receive.

52a. The Personal Care Services I receive meet my needs.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

52b. My personal caregiver treats me with respect and courtesy.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

52c. I know who to contact if I have a complaint about Personal Care Services or if I need more help.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

52d. Personal Care Services are provided to me when and where I need them.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

Please tell me how strongly you agree or disagree with the following statements.

53a. I was able to choose my Personal Care Services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

53b. I was able to choose the provider of my Personal Care Services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

53c. I was able to choose the scheduling of Personal Care Services that meets my needs.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

53d. I was able to select my Personal Care Services provider from a variety of providers.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

53e. Having more providers who offer Personal Care Services would allow me to better meet my needs.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

53f. There are Personal Care Services that I need that I CAN'T GET.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree ➔ *Go to Question 54*
- ○ Disagree ➔ *Go to Question 54*
- ○ Strongly Disagree ➔ *Go to Question 54*

53f1. What are these Personal Care Services you cannot get?

_____

_____

54. Please rate the Personal Care Services on the competency of staff.

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

55. Have you experienced any problems with Personal Care Services during the past 12 months?

- ○ Yes
- ○ No ➔ *Go to Question 56*

55a. What problems did you experience?

_____

_____

55b. Did Personal Care Services work to resolve these problems?

- ○ Yes
- ○ No

56. Is there anything that could improve the Personal Care Services offered to you and others?

- ○ Yes ➔ *Please specify what could be improved:*

  _____

  _____
- ○ No

57. Vermont is looking at possibly adding new providers of Personal Care Services. Based on your experience, how helpful would adding new providers of Personal Care Services be to you?

- ○ 1 Not at all Helpful
- ○ 2
- ○ 3
- ○ 4
- ○ 5 Very Helpful

How strongly do you agree or disagree with the following statements?

58a. Adding new providers of Personal Care Services would improve my ability to have services where and when I need them.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

58b. Adding new providers of Personal Care Services would improve the cost effectiveness of my services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

58c. Adding new providers Personal Care Services would improve the quality of my services.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

59. Do you have any other comments about adding new providers?

- ○ Yes ➔ *Please specify:*

  _____

  _____
- ○ No

Adult Day Centers

The following series of questions are about your experiences with Adult Day Centers. Adult Day Centers provide social interaction, meals, personal care, and health services.

60. Are you currently attending or have you attended an Adult Day Center in the past?

- ○ Yes
- ○ No ➔ *Go to Traumatic Brain Injury Program, page 13*

61. How satisfied are you with the Adult Day Center you attend?

- ○ Very Satisfied ➔ *Go to Question 62*
- ○ Somewhat Satisfied ➔ *Go to Question 62*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 62*
- ○ Dissatisfied
- ○ Very Dissatisfied

61a. Why are you dissatisfied with the Adult Day Center you attend?

_____

_____

62. How do you rate the quality of the services provided by the Adult Day Center you attend?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

63. What is your recommendation of the Adult Day Center you attend to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about the Adult Day Center you attend.

64a. The services I receive from the Adult Day Center meet my needs.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

64b. My caregivers at the Adult Day Center treat me with respect and courtesy.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

64c. I know who to contact if I have a complaint about the Adult Day Center or if I need more help.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

64d. The Adult Day Center provides services to me when and where I need them.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

65. Please rate the Adult Day Center you attend on the competency of staff.

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

66. During the past 12 months, have you experienced any problems with the Adult Day Center you attend?

- ○ Yes
- ○ No ➔ *Go to Question 67*

66a. What problems did you experience?

_____

_____

66b. Did the Adult Day Center work to resolve these problems?

- ○ Yes
- ○ No

67. Is there anything that could improve services offered to you and others by the Adult Day Center?

- ○ Yes ➔ *Please specify what could be improved:*

  _____

  _____
- ○ No

Traumatic Brain Injury Program

The following series of questions are about your experiences with the Traumatic Brain Injury Program. The Traumatic Brain Injury Program helps Vermonters, with moderate to severe traumatic brain injuries, move from hospitals and facilities to community-based settings. This is a rehabilitation-based, choice-driven program, intended to support individuals to achieve their optimum independence and help them return to work.

68. Are you currently receiving or have you received services through the Traumatic Brain Injury Program?

- ○ Yes
- ○ No ➔ *Go to Home Delivered Meals Program, page 14*

69. How satisfied are you with the services you receive from the Traumatic Brain Injury Program?

- ○ Very Satisfied ➔ *Go to Question 70*
- ○ Somewhat Satisfied ➔ *Go to Question 70*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 70*
- ○ Dissatisfied
- ○ Very Dissatisfied

69a. Why are you dissatisfied with the services you receive from the Traumatic Brain Injury Program?

_____

_____

70. How do you rate the quality of the services you receive from the Traumatic Brain Injury Program?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

71. What is your recommendation of the Traumatic Brain Injury Program to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about using the Traumatic Brain Injury Program.

72a. The services I receive from the Traumatic Brain Injury Program meet my needs.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

72b. My caregivers in the Traumatic Brain Injury Program treat me with respect and courtesy.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

72c. I know who to contact if I have a complaint about the Traumatic Brain Injury Program or if I need more help.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

72d. The Traumatic Brain Injury Program provides services to me when and where I need them.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

73. Please rate the Traumatic Brain Injury Program on the competency of staff.

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

74. Have you experienced any problems with the Traumatic Brain Injury Program during the past 12 months?

- ○ Yes
- ○ No ➔ *Go to Question 75*

74a. What problems did you experience?

_____

_____

74b. Did the Traumatic Brain Injury Program work to resolve these problems?

- ○ Yes
- ○ No

75. Is there anything that could improve services offered to you and others by the Traumatic Brain Injury Program?

- ○ Yes ➔ *Please specify what could be improved:*

  _____

  _____
- ○ No

Home Delivered Meals Program

The following series of questions are about your experience with the Home Delivered Meals Program, or Meals on Wheels. The Home Delivered Meals Program provides nourishing meals to seniors in their homes who are unable to attend a community meal site.

76. Do you currently receive meals through the Home Delivered Meals Program?

- ○ Yes
- ○ No ➔ *Go to Question 88*

77. How satisfied are you with the Home Delivered Meals Program?

- ○ Very Satisfied ➔ *Go to Question 78*
- ○ Somewhat Satisfied ➔ *Go to Question 78*
- ○ Neither Satisfied nor Dissatisfied ➔ *Go to Question 78*
- ○ Dissatisfied
- ○ Very Dissatisfied

77a. Why are you dissatisfied with the Home Delivered Meals Program?

_____

_____

78. How do you rate the quality of the services provided by the Home Delivered Meals Program?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

79. What is your recommendation of the Home Delivered Meals Program to others?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Please rate each statement about the Home Delivered Meals Program.

80a. The food tastes good.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80b. The food looks good.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80c. The meals provide a variety of foods.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80d. When the meal arrives, the hot food is hot.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80e. When the meal arrives, the cold food is cold.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80f. The meal is delivered on time.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80g. I eat the meals that are delivered.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

80h. I like the meals that are delivered.

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

81. Have you experienced any problems with the Home Delivered Meals Program during the past 12 months?

- ○ Yes
- ○ No ➔ *Go to Question 82*

81a. What problems did you experience?

_____

_____

81b. Did the Home Delivered Meals Program work to resolve these problems?

- ○ Yes
- ○ No

82. Is there anything that could improve services offered to you and others by the Home Delivered Meals Program?

- ○ Yes ➔ *Please specify what could be improved:*

  _____

  _____
- ○ No

83. Think about the amount of food you eat from home-delivered meals. On the days you eat a meal from home-delivered meals, what proportion of all the food you eat in a day does this meal represent?

- ○ Less than one-third
- ○ Between one-third and one-half
- ○ About one-half
- ○ More than one-half

Do services from the home-delivered meals program help you to…

84a. Eat healthier foods

- ○ Yes
- ○ No

84b. Achieve or maintain a healthy weight

- ○ Yes
- ○ No

84c. Improve your health

- ○ Yes
- ○ No

84d. Feel better

- ○ Yes
- ○ No

84e. Continue to live at home

- ○ Yes
- ○ No

85. Special dietary requirements are recommendations made by a health care provider (such as low sodium, low fat, high protein, or low sugar). How often do the meals offered through the Home Delivered Meals Program meet your specific dietary requirements?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

86. To what degree do you feel that the home delivered meals have helped you financially?

- ○ A lot
- ○ Somewhat
- ○ A little
- ○ Not at all

Additional Comments

87. Do you have any comments you would like to make about the help you receive?

- ○ Yes ➔ *Please specify:* _____
  _____
  _____
  _____
- ○ No

Help Completing Survey

88. Did someone help you complete this survey?

- ○ Yes
- ○ No ➔ *Thank you, please return the completed survey in the postage-paid envelope*

88a. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

88b. Is the person who helped you a paid caregiver for you?

- ○ Yes
- ○ No

88c. What is the relationship of the person who helped with the questionnaire to the person receiving services?

- ○ Spouse
- ○ Immediate family (parent, child, or sibling)
- ○ Extended family (such as cousin, aunt, uncle, grandchild)
- ○ Unrelated/Other

Attachment 4 - DLTSS Work Plan

Work Plan for DLTSS Work Group - April 24, 2014

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

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

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

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

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

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