VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Thursday, September 24, 2015; 10:00 PM to 12:30 PM
DVHA Large Conference Room
312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from August 20, 2015	Yes
2	10:10 - 11:10	**VHCIP Restructuring and Incorporation of DLTSS Work Plan Activities** Deborah Lisi-Baker	• Attachment 2: DLTSS Year 2 Work Plan – Crosswalk with VHCIP Milestones August 28, 2015	
3	11:10 – 11:30	**DLTSS Feedback on Shared Care Plans** Deborah Lisi-Baker	• Attachment 3a: Shared Care Plans – DLTSS Work Group Comments • Attachment 3b: Self-Sufficiency Matrix	
4	11:30 – 12:15	**Nursing Home Bundled Payments for Care Improvement (BPCI) Initiative** Amanda Ciecior, DVHA, and Judy Morton, VHCA	• Attachment 4: Bundled Payments for Care Improvement 9-24-15	
5	12:15 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker	Next Meeting: Thursday, October 15, 2015 10:00 am – 12:30 pm, Pavilion Building, 4th Floor Conference Room, 109 State Street, Montpelier	

Attachment 1b: Minutes from August 20, 2015

Vermont Health Care Innovation Project

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday, August 20, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:02am. A roll call attendance was taken and a quorum was not present. Deborah noted a few changes in agenda order. A quorum was present following the third agenda item. Deborah Lisi-Baker entertained a motion to approve the June meeting minutes. Peter Cobb moved to approve the minutes by exception. Sue Aranoff seconded. The minutes were approved with no abstentions.	

2. Accountable Communities for Health	Tracy Dolan, Co-Chair of the Population Health Work Group, presented on findings from a report by the Prevention Institute on Accountable Communities for Health (ACHs – also known as Accountable Health Communities). The Prevention Institute reviewed national examples of communities working toward ACHs; identified and studied a selection of Vermont communities where some elements of the model are in place; and discussed next steps.
	• The Prevention Institute's report was finalized in July. Major recommendations included:
	    o Foster an overarching statewide approach to support ACH effectiveness;
	    o Provide guidance to enable regions to effectively establish ACHs;
	    o Build capacity and create an environment for ongoing learning; and
	    o Explore sustainable financing models for ACHs.
	• CMMI is likely to release an RFP to test the ACH model later this year; Vermont's prep work could position us well to apply.
	
	The group discussed the following:
	• To what extent is a peer-directed model emphasized in this framework? How will the target population be involved in planning and execution? The researchers were looking at the structure of the ACH model, not looking in-depth at all programs within communities – however, many aspects of the communities presented in the report are based on community priorities.	

Agenda Item	Discussion	Next Steps
	Community engagement was a weakness in this model nationally – how do the Vermont communities compare? This wasn't included in the report summary, though the researchers noted that community resident engagement was not high at this point. The full report is online: Accountable Communities for Health: Opportunities and Recommendations. • Was any thought given to how underserved populations could be addressed within this model? The report doesn't speak specifically to this in many areas, but many initiatives are in early stages. • The health care bill that came out of the Senate this year originally included language for a State-supported pilot of the ACH concept in the Northeast Kingdom; though this language was dropped from the final bill, there is currently a SIM-supported effort to explore pieces of this concept in the St. Johnsbury area. The planning group for this initiative includes staff from the Population Health Work Group who worked closely with the Prevention Institute in the development of their report. • Short pilot periods may be too brief to expect changes. • Continued work on this should reflect current efforts to integrate care and community supports.	
3. Direct Care Workforce Report Presentation	Brendan Hogan (currently of Optum, previously of Bailit Health Purchasing and DAIL) presented findings from the Direct Care Workforce Report. This report was presented to the Workforce Work Group in October 2014. The full report is online: Direct Care Workforce Report. (Sarah, can you make sure this link is "live".) The group discussed the following: • Many direct care workers (DCWs) are privately hired (over 8,000 in the state, including mental health), rather than through VNAs or other entities. • Standardized training opportunities vary significantly by setting. • How are DCWs connected to the Attendant Services Program with regard to training and other issues? They are part of the spectrum of providers that provide direct care; Brendan is not clear on current Attendant Services Program training requirements. • DCWs come from varied backgrounds and education. Some agencies that employ DCWs have instituted skills trainings. • Turnover is extremely high for DCWs who work at agencies. This likely results in part from low pay (~$10/hour), though in focus groups many DCWs not employed by agencies identified lack of adequate training as a top concern and reason for turnover. • The group was unclear on whether the Fair Labor Standards Act rule was final or still in draft form; the group will receive an update at the next meeting. • Where is this issue going in the future, and how best to resolve it? There is no easy answer – we must continue to push to come up with answers, see how health care and long-term care can be connected, and look at data (for example, micro-simulation demand model contract in process through SIM). • Many types of workers provide support for individuals, including community health teams, SASH, case managers, DCWs – coordination across these is critical. • Have we considered using a core competency model to train DCWs? The group discussed a variety of	

Agenda Item	Discussion	Next Steps
	possible training models and current programs that could support this.	
4. Disability Awareness Briefs	Deborah Lisi-Baker provided an update on the Disability Awareness Briefs, previously discussed at the June meeting. The briefs are now posted here on the VHCIP website. Deborah thanked members of the Work Group for their feedback and input, and noted that OneCare and CHAC also brought the briefs to their clinical advisory bodies. Green Mountain Care Board members Allan Ramsay and Betty Rambur provided feedback as well. In their current form, the briefs are intended as reference materials, not training materials, though they could guide the development of training tools and materials.	
5. Shared Care Plans from the Learning Collaborative – Review and Input	Deborah Lisi-Baker introduced examples of shared care plans produced by communities participating in the SIM-supported Integrated Communities Care Management Learning Collaborative. Deborah noted that these materials come out of discussions and work by teams of health care, mental health, community service, and other providers at the community level. These shared care plan examples may also support future development and use of a statewide shared care plan, or future pilots. This group's recommendations can inform future efforts in this area. Pat Jones noted that the Learning Collaborative uses a Plan-Do-Study-Act model to test ideas in a continuous quality improvement model. The group discussed the following: • Concerns were expressed about 10-year medical records review, particularly for people with mental health and substance abuse issues. Record review is intended to support a fuller understanding of a person and their history. Some people expressed concern about too much information sharing, and others about not enough. • There were several questions about releases of medical information: When do individuals sign a release? How is information shared? How much information is shared? Are the releases HIPAA compliant? • Mary Alice Bisbee asked if consent needs to be all or nothing; can there be a middle ground in what is shared? • Joy Chilton noted that HIPAA requires providers to give notice of privacy practices, and that people have the right to restrict information sharing. • Martita Giard asked if there has been discussion of a uniform format for use across the state. To date, discussions have centered on common elements in shared care plan templates. • Julie Tessler thinks there might not be enough focus on strengths in the shared care plans. • Kirsten Murphy commented on cognitive accessibility of shared care plans. • Shared care planning is already happening; the goal of the Learning Collaborative is to see if there are ways to better integrate care. • Mike Hall stated that the communities are trying to evaluate and implement small tests of change, and use what is learned from that to develop a more standardized and systematized approach to care coordination. Please send any comments on the shared care plans to Julie Wasserman by September 4th.	**Please send comments on care plans to Julie Wasserman (Julie.wasserman@vermont.gov) by September 4, 2015.**

Agenda Item	Discussion	Next Steps
6. Public Comment/Next Steps	Deborah Lisi-Baker announced proposed changes to VHCIP governance, described in a presentation included in VHCIP Steering Committee materials (available here – see Attachment 2a). Sarah Kinsler further described the proposal and the reasoning behind it. The proposed changes would consolidate six existing VHCIP work groups (Care Models, DLTSS, HIE/HIT, Payment Models, Population Health, and Quality and Performance Measures) into three (Payment Models, Health Data Infrastructure, and Provider Transformation), streamlining our decision-making process and ensuring our governance is reflective of the major streams of work we've agreed to under the SIM grant. If the proposal is approved by the Core Team, members of current work groups will be asked to join one of the new work groups; the DLTSS and Population Health Work Groups will continue to meet quarterly for discussion purposes. The Workforce Work Group, established by Executive Order with appointed membership, will continue to meet bi-monthly and continue to work on workforce-related efforts under the grant. This proposal will be discussed further at the August 26th VHCIP Steering Committee meeting, and will be voted on at the August 31st Core Team meeting. Project leadership is asking for written feedback from the Steering Committee and other interested parties from 8/19-8/30. Please provide comment to Sarah Kinsler at sarah.kinsler@vermont.gov. **Next Meeting:** Thursday, July 30, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	**Provide written comment on VHCIP governance changes to Sarah Kinsler (sarah.kinsler@vermont.gov) by 8/30.**

Motion to approve minutes by exception
Peter Cobb 1°
Sue Aranoff 2°
Motion Carried Unanimously

VHCIP DLTSS Work Group Member List

Roll Call: 8/20/2015

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

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VHCIP DLTSS Work Group Participant List

Attendance: 8/20/2015

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

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

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

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

Cecelia	Wu		AHS - DVHA	S
Marie	Zura		DA - HowardCenter for Mental Health	X
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Suzanne Santarchangelo ~ PHPG
Brendan Hogan - Optum ~ here

Attachment 2: DLTSS Year 2 Work Plan – Crosswalk with VHCIP Milestones August 28, 2015

DLTSS Work Group Work Plan - Year 2
Crosswalk with VHCIP Milestones
August 28, 2015

	DLTSS ACTIVITY	CROSSWALK with VHCIP MILESTONES
	Payment Models	
1	Recommend a process and methodology for the DLTSS sub-analyses of Year 1 Medicaid and Commercial ACO SSP quality and performance measures, following a presentation on possible approaches.	Payment Model Milestone: ACO Shared Savings Programs quality metrics analysis
2	Review and recommend possible new payment models that reimburse for DLTSS-specific population outcomes.	Payment Model Milestones: Prospective Payment System for Home Health, Prospective Payment System for DAs, Episodes of Care, All-Payer Model, State Activities to Support Model Design and Implementation, Blueprint
3	Recommend payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long-term services and supports.	Payment Model Milestones: Prospective Payment System for Home Health, Prospective Payment System for DAs, Episodes of Care, All-Payer Model, State Activities to Support Model Design and Implementation, Blueprint
4	Collaborate with Population Health efforts to develop policy, plans, and strategies to create a viable financial model that supports the broader goals of population health, including DLTSS populations and providers.	Payment Model Milestones: Accountable Health Communities
5	Collaborate with Payment Models Work Group on Nursing Home Initiatives, including Bundled Payments for Care Improvement (BPCI) Initiative.	Payment Model Milestones: All-Payer Model, State Activities to Support Model Design and Implementation

	DLTSS ACTIVITY	CROSSWALK with VHCIP MILESTONES
6	Research and discuss the emerging body of HCBS quality and performance measures to provide input for VHCIP payment reform efforts.	Payment Model Milestones: Prospective Payment System for Home Health, Prospective Payment System for DAs, Episodes of Care, All-Payer Model, State Activities to Support Model Design and Implementation
7	Identify barriers and develop strategies to address them in Medicare, Medicaid, and commercial coverage and payment policies for people needing DLTSS services (e.g., DME approval process and coverage; curative and hospice benefits; commercial coverage for attendant care; coverage of medical and mental health services in nursing homes to reduce hospital admissions and improve outcomes).	Payment Model Milestones: All-Payer Model, State Activities to Support Model Design and Implementation
8	Make recommendations on current and possible future use of flexible funds within Medicaid to prevent unnecessary hospitalizations, ER visits, and nursing home admissions, and to promote appropriate use of medications, as well as funding other social safety net services.	Payment Model Milestones: All-Payer Model, State Activities to Support Model Design and Implementation
	Care Delivery and Practice Transformation	
9	Provider Training initiative for disability-specific core competency trainings.	Practice Transformation Milestones: Learning Collaborative, Ongoing Development of Core Competency Trainings regarding Disability and Long Term Services and Supports
10	Recommend and advise on best practices for disability-specific care management and models of care.	Practice Transformation Milestones: Learning Collaborative, Shared Care Plans, Universal Transfer Protocol, ACO Care Management Standards

	DLTSS ACTIVITY	CROSSWALK with VHCIP MILESTONES
11	Ensure DLTSS principles (person-centered, disability-related, person-directed, cultural competency) are incorporated into VHCIP Work Group activities.	This is relevant to Payment Model Milestones, Practice Transformation Milestones, and Health Data Infrastructure Milestones
12	Gather input on building workforce capacity; obtain update from Workforce Work Group and Workforce Sub-Committee on Long-Term Care.	Practice Transformation Milestones: Workforce Care Management Inventory, Workforce Demand and Supply Data Collection and Analysis
	Health Data Infrastructure	
13	Provide recommendations on technical and IT needs to support payment and care models that meet the needs of DLTSS populations and providers including beneficiary portals, accessibility, and universal design in collaboration with HIE/HIT and Payment Models Work Groups.	Health Data Infrastructure Milestones: Expand Connectivity to the HIE, Improve quality of data flowing into the HIE; EMR Expansion; Data Warehousing, registries and repositories; Care management tools
14	Provide recommendations on informed consent and confidentiality issues, including 42 CFR Part 2 to the HIE/HIT Work Group.	Health Data Infrastructure Milestones: Integration of 42 CFR Part 2 data; Data Warehousing, registries and repositories
15	Work with HIE/HIT Work Group to perform data quality, technical assessment, and development and implementation of care management protocols.	Health Data Infrastructure Milestones: Expand Connectivity to HIE, Improve quality of data flowing into the HIE, EMR Expansion, provide project management and SME to non-meaningful use providers, Gap Remediation, Develop Shared Care Plans and Uniform Transfer Protocol.

Attachment 3a: Shared Care Plans – DLTSS Work Group Comments

DLTSS Work Group Comments on Draft "Shared Care Plans"

September 16, 2015

1. Joy Chilton RN, Central VT Home Health & Hospice: "There should be space devoted to signs that indicate that the client needs intervention and what actions to take. One of the benefits of a shared care plan is more people being able to pick up on early indications of a problem and taking action to prevent bigger problems, including hospitalizations, ER use and increased suffering. In physical health terms it could be something like listing a threshold symptom (cough for a patient with lung problems) or a reading (blood sugar over 150) that anyone helping the patient could notice and respond to with specific actions. I'm sure that there are signs that could indicate an impending exacerbation of a mental health problem as well. Having such things in the care plan would allow all care providers to be of greater assistance to the client, regardless of their area of expertise."

   "HIPAA – There should be a Notice of Privacy Practices explained and given to clients when they sign on to this program. There should be space on the care plan to indicate if the client has requested restrictions on the sharing of Protected Health Information that have been agreed to by the program (via the lead care coordinator, perhaps)."

2. Mary Alice Bisbee felt an individual should be able to restrict the release of information. It should not be "all or nothing"; people should be able to specify which information can be released and which information cannot be released.

3. Comments included concerns about the 10-year "look-back" for medical records review, stating it may be overly intrusive and has great potential for stigmatization, especially where mental health and substance abuse issues are concerned. Also, a concern about the 10-year window not being long enough.

4. Multiple comments and questions about how information is shared; how much information is shared; how many releases are required (e.g. Notice of Privacy release, consent to participate in the "coordinated care" program release); when are releases signed; and whether the releases are HIPAA compliant.

5. The Gathering Place (an Adult Day Center in Brattleboro) stated they preferred Shared Care Plan B (multi-page form) because they liked the layout and the

requested information. “It combines a number of forms, and addresses family/caregiver goals as well.”

6. Annie Paumgarten, Director of VHCIP Evaluation asks, “Has there been any consideration of including a quantitative assessment tool that would measure progress in some of the areas that drive the social determines of health? Please see attached for a free tool (the Self-Sufficiency Matrix) that has been used by housing and other programs in Vermont (not necessarily this exact version) for that purpose. It is generally completed at set intervals of time as a means to identify areas of risk, measure individual progress over time for the individual, and also build summary statistics that point to areas where systems-level change or investment is warranted.” (See September 24, 2015 DLTSS Work Group Materials Attachment 3b for the Self-Sufficiency Matrix.)

7. Dale Hackett: “The challenge is information being allowed to be shared, what is asked for by person, what is possible. H.I.P.P.A could be a problem and ten years of records, diagnosis and clinical alignment to goals???? They must have ability to explore new process or model of care, getting data that validates effectiveness??? Payment reform needs to enhance this model...I am worried the system will prevent this model from reaching its full potential, or fail to recognize how it is successful... communities could tweak it in ways that limits its potential...it is very cost sensitive.”

8. Lisa Maynes, Vermont Family Network: “In general, I preferred the (Shared Care Plan B) version, however, I do think it’s too long (to your point about keeping it short!). Here’s some points for your consideration:
   - Section titled: Professionals and Services, I would think that the primary care information does not need to be here. The primary care office would be working with the patient to create the plan, correct?
   - Section titled: Insurance Information, again not feeling like this is necessary in a plan of care. With the overlying goal of creating a document that is focused on facilitating patient understanding, and embracing them in the process of creation – this seems the wrong place to put this information. Too business-y.
   - Section titled: Plan of Care: Negotiated Actions, I believe this is the most important section of the document. It should be simple, and clear. I would not separate Family from Clinical, but rather, just word/order/present things as “What is important to you?” (the patient). “What matters to you?” “What worries you?” I’m a supporter of basic, simple, clear language and even using these questions is a nice idea to me. Perhaps asking a few things like that, then leading into GOALS.

These kinds of simple questions would be aids to patients making important goal decisions.

In general, I say to simplify as much as possible. This is not a clinical piece in my opinion, it is a patient voice, sensitive to emotions. It is meant to facilitate patient understanding at least as much as provider."

9. Comments questioned whether these forms are "patient-centered", and wondered how they can be patient-centered when the patient is not part of the process?

10. Julie Tessler pointed out that Shared Care Plan B documents the patient's "Strengths" but only includes "Barriers" in the Plan of Care. (Please note that both "Strengths" and "Barriers" are included in the Care Plan for Shared Care Plan A.)

11. Kirsten Murphy noted the importance of cognitive accessibility of the shared care plans.

12. Will these Shared Care Plans be standardized across the state? Participants made a plea for moving toward consistency among Shared Care Plans; or at a minimum, having 10-15 core elements.

13. See below for Vermont Legal Aid letter.

VERMONT LEGAL AID, INC.
264 NORTH WINOOSKI AVE. - P.O. BOX 1367
BURLINGTON, VERMONT 05402
(802) 863-5620 (VOICE AND TTY)
FAX (802) 863-7152
(800) 747-5022

OFFICES: BURLINGTON, RUTLAND, ST. JOHNSBURY

OFFICES: MONTPELIER, SPRINGFIELD

September 3, 2015

SENT VIA EMAIL

Deborah Lisi-Baker
Chair, DLTSS Workgroup
Vermont Health Care Innovation Project
109 State Street
Montpelier, VT 05620

Re: Concerns Regarding Releases of Information
Integrated Communities Care Management Learning Collaborative / Shared Care Plan

Dear Deb,

We are writing to express our concerns about the release following discussion of the Shared Care Plan at the August 20 meeting the DLTSS workgroup of the VHCIP. We support the overall purpose and goal of the Shared Care Plan, however we think that consumer understanding of the nature of the shared information is critical, and needs more attention.

1. Before moving forward with Shared Care Plans, standards, or a uniform HIPAA-compliant release agreeing to information-sharing should be established.

We believe that some of the release forms used in learning collaboratives or pilot projects were not compliant with the HIPAA, and clearer requirements for release of information in new learning collaboratives or Accountable Communities for Health should be in place before Shared Care Plans are adopted.

In addition to these specific HIPAA concerns, release of information related to HIV status and substance abuse, as well as mental health records, should not be included in a general release. This information is subject to additional protections.

The HIPAA requirements for a release form include core elements, required statements, and a plain language requirement. 45 C.F.R. § 164.508(c). Considering these requirements, we have several concerns with the compliance of some of the forms used in pilot projects. Because the Shared Care Plans have been discussed as a next step to some of the pilot projects, we believe it is appropriate to raise these concerns here

A. A release form must provide the consumer with information on the purpose of disclosure. 45 C.F.R. § 164.508(c)(1)(iv). This information should be provided in plain language so that the consumer understands what he or she is authorizing. Not all of the forms employed by pilot projects/learning collaboratives provide a clear, comprehensible description of purpose.

B. A release form must have an expiration date or event relating to the purpose of the use or disclosure. 45 C.F.R. § 164.508(c)(1)(v). While the expiration could be "none" in a research project not all of the forms employed by pilot projects/learning collaboratives contain this core element. We recommend as a best practice that releases have a one-year expiration date, which provides an opportunity to annually review and reaffirm or modify the consumer's agreement to share information. At a maximum, however, releases should expire with the completion of the research – the end of the pilot project or learning collaborative in which the consumer is a participant.

C. A valid release form must give notice of the individual's right to revoke authorization in writing, exceptions to the right to revoke, and a description of how to revoke authorization. 45 C.F.R. § 164.508(c)(2)(i). Again, not all of the forms employed by pilot projects/learning collaboratives contain this core element.

D. A valid release form must give notice of the ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization. 45 C.F.R. § 164.508(c)(2)(ii). This can be stating either that the entity cannot condition treatment on signing the authorization when the prohibition of such conditioning applies, or the consequences of refusing to sign the authorization when conditioning is allowed. *Id.* Not all of the forms employed by pilot projects/learning collaboratives contain this core element. Although an entity can condition treatment on whether an individual signs a release form for purposes of a research study, we believe that the release forms for the pilot projects and learning collaboratives must be clear that patients have the right to receive their regular health care from their providers regardless of whether or not they sign the release. Only participation in the pilot project can be conditioned on signing the release.

E. A valid release form must describe the potential for information disclosed to be subject to re-disclosure by a recipient that is not covered by HIPAA. 45 C.F.R. § 164.508(c)(2)(iii). In the context of agreeing to share information across medical

and non-medical service providers, understanding the potential for private information to be shared (and re-shared) with individuals or organizations is particularly important. Not all of the forms employed by pilot projects/learning collaboratives contain this core element.

F. HIPAA also requires that releases are written in plain language. 45 C.F.R. §164.508(c)(3). Not all of the forms employed by pilot projects/learning collaboratives are written in plain language or are understandable to people with intellectual disabilities.

2. We support the overall purpose and goal of the Shared Care Plan, and think it is important to more clearly emphasize the person-centered nature of such plans, including both the document and the services provided through it.

Care coordination is an area with great potential for improvement, and we support the goals of the learning collaboratives and Shared Care Plan project to provide better coordinated services.

However, we are concerned that some of the ways the Shared Care Plan document has been described are in tension with person-centered care, and may facilitate the development and execution of Shared Care Plans that are not person-centered. Specifically, the Shared Care Plan, as a document, has been referred to as something the consumer would never touch, and is purely for the providers involved in caring for or providing services to, him or her.

We believe the Shared Care Plan must be person-centered in all its components. It is antithetical to the concept of person-centeredness to obfuscate when it comes to securing a release of information from a consumer. Thus far, we believe inadequate attention has been paid to the issue of ensuring informed decision making, and the potential consequences of sharing otherwise protected information.

Before a Shared Care Plan is developed or put into action, the consumer should understand that this plan and document mean that treating professionals and other service providers will be freely sharing information about the individual. A consumer should be able to make an informed choice to share or decline to share information, to be able to choose if some subset of information is not shared, and to choose which providers the consumer will allow access to shared information. To ensure true patient-centeredness in the Shared Care Plan, there must be respect for informed choice about information sharing, which will require more than simply the disclosures required to be HIPAA compliant. We suggest that there be some draft protocol or script developed to explain this to patients.

Once a consumer does agree to a Shared Care Plan, the development of the Plan must include the consumer. The Shared Care Plan document should be accessible to the consumer. The consumer should have the ability to make changes to its various elements, both on paper and in practice.
We support the sentiments expressed at the most recent meeting that a universal format will be ideal once learning collaboratives have had the opportunity to test different formats.

Thank you for your consideration of our comments.

Sincerely,

/s/ Barb Prine, Staff Attorney, Disability Law Project

/s/ Rachel Seelig, Staff Attorney, Elder Law Project / Disability Law Project

Cc: Trinka Kerr, Chief Health Care Advocate
Jackie Majoros, Vermont Long Term Care Ombudsman

Attachment 3b: Self-Sufficiency Matrix

Self-Sufficiency Matrix Participant Name ____________________ DOB __/__/____ Assessment Date __/__/____ Initial Interim Exit

(If using ServicePoint) Program Name ______________________ HMIS ID ___________

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.		
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.		
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		
Child Care	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.		
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.		
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.		
Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) have medical coverage.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.		
Family /Social Relations	Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable and communication is consistently open.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.		
Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.		
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.	Parenting skills are well developed.		
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more that 12 months and/or no felony criminal history.		
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.		
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.		
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Disabilities	In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity – asymptomatic – condition controlled by services or medication	Thriving – no identified disability.		
Other: (Optional)	In Crisis	Vulnerable	Safe	Building Capacity	Empowered		

Attachment 4: Bundled Payments for Care Improvement 9-24-15

Bundled Payments for Care Improvement (BPCI) Initiative

VHCIP DLTSS Work Group

September 24th, 2015

Vermont Health Care Innovation Project

BPCI

- CMMI initiative
  - Medicare fee-for-service
- Initial pilots began in January 2013
- Three year payment reform pilot
- Includes 4 model options
- Goals include:
  - Improve care transitions
  - Improve coordination of care
  - Collaboration on best practices
  - Improve efficiency and seamlessness of care across care continuum

Key Phrases

- **Skilled nursing facilities -** SNFs
- **Inpatient rehabilitation facilities -** IRFs
- **Long-term care hospitals -** LTCHs
- **Home health agencies -** HHAs
- **Diagnosis Related Group -** DRG
- **Prospective payment bundling** – pre-determined payment made for the bundle of services to be provided
- **Retrospective payment bundling** – payments are made at the usual fee-for-service rates (actual cost) then aggregated and compared to the target price

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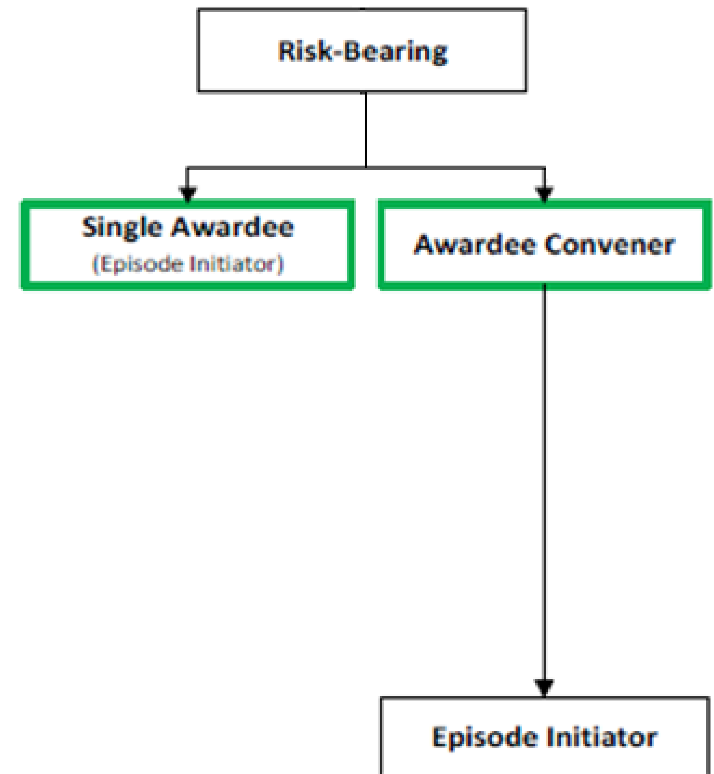
Key Roles

- **Episode Initiator –** Program participants that begin the actual care of the patient
  - An episode initiator can be a physician group practice, an acute care hospital or a SNF, IRF, LTCH, HHA
- **Convener –** Helps facilitate participation in the program by providing services such as data analytics and CMS compliance.
- **Awardees** – Medicare providers that bear risk for episodes they initiate



BPCI - Four Models

BPCI MODELS

	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients, all DRGs	Selected DRGs, hospital plus post-acute period	Selected DRGs, post-acute period only	Selected DRGs, hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions. Up to 48 episodes.	All non-hospice Part A and B services during the post-acute period and readmissions. Up to 48 episodes.	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective
Phase 1 participants		-364 participants -47 conveners -2,038 providers	-240 participants -33 conveners -4,646 providers	-7 participants -1 convener -8 providers
Phase 2 participants	-1 convener -12 providers	-60 awardees -18 conveners -142 providers	-20 awardees -8 conveners -81 providers	-8 awardees -1 convener -8 providers
Total providers	12	2,180	4,727	17
Episode length		30, 60, or 90 days	Services must begin within 30 days of discharge and end 30, 60, or 90 days after the initiation of the episode	Covers inpatient stay and related readmissions for 30 days after the hospital discharge
Episode initiators		-acute care hospitals (ACH) -physician group practices (PGPs)	-skilled nursing facilities (SNFs) -long-term care hospitals (LTCHs) -inpatient rehab facilities (IRFs) -home health agencies (HHAs) -physician group practices (PGPs)	-acute care hospitals (ACH) paid under the Inpatient Prospective Payment System (IPPS)

http://www.paccr.org/wp-content/uploads/2015/04/BPCI_Overview.pdf

Phases in BPCI Models (2,3 and 4)

- Phase I
  - “Preparation” period as CMS and participants prepare for implementation and assumption of financial risk
  - Exploratory for participants
  - Emphasis on data analysis
  - No risk
- Phase II
  - “Risk-bearing” period
  - Optional for participants based on findings from Phase I

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BPCI in VT: Models 2 and 3

Model 2

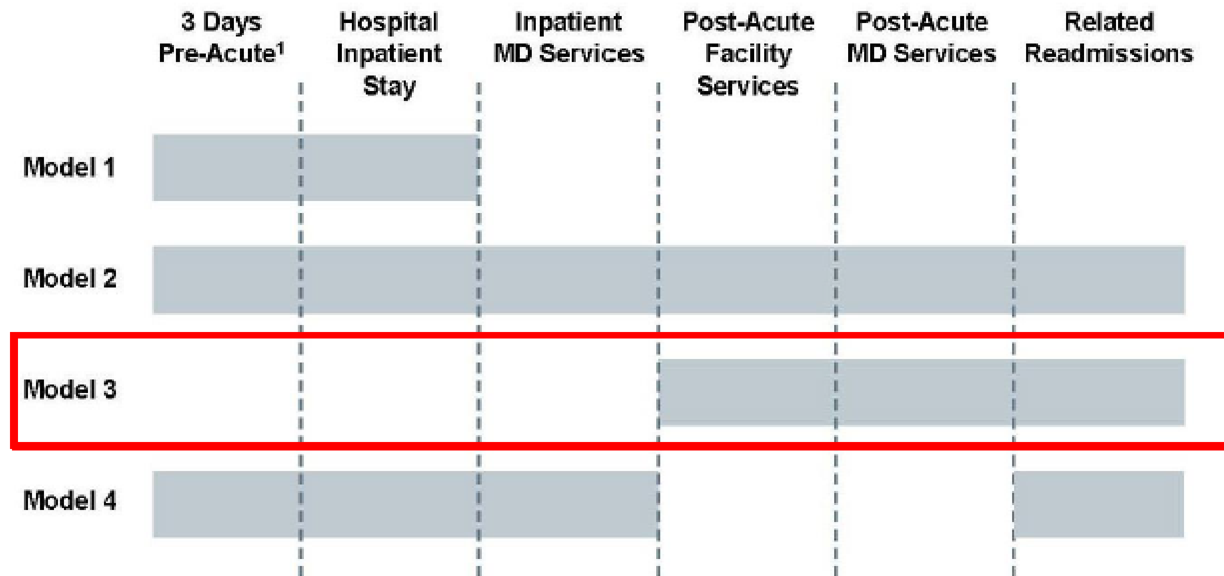
- Episode begins with an inpatient admission at a participating hospital for a DRG designated by the participant
- Length 30, 60, 90 days
- Participant proposes minimum discount dependent on episode length (2-3%)

Model 3

- Episode begins with initiation of care at a SNF, IRF, LTCH or HHA that occurs within 30 days of discharge from a hospital
  - Services provided in the initial hospital stay are not included
  - Services after the hospital discharge but prior to the episode start are not included in the bundle
- 3% discount rate
- Length 30, 60, 90 days
- Readmissions are included

Model 3 – Post-Acute Care

- 48 Clinical Episodes based on 179 DRGs
- 17 facilities in Vermont participated in Phase I



http://www.advisory.com/research/health-care-advisory-board/blogs/toward-accountable-payment/2013/01/a-breakdown-of-the-four-bundling-models

Model 3, Phase I – VT Facilities

Berlin Health & Rehabilitation Center	Barre
Rowan Court Health & Rehabilitation	Barre
Bennington Health & Rehabilitation	Bennington
Pine Heights At Brattleboro Center For Nursing & Rehabilitation	Brattleboro
Burlington Health & Rehabilitation	Burlington
Bel-Aire Center	Newport
Thirty Five Bel-Aire Drive SNF Operations LLC	Newport
Forty Six Nichols Street Operations LLC	Rutland
Mountain View Center	Rutland
Nine Haywood Avenue Operations LLC	Rutland
Rutland Healthcare & Rehabilitation Center	Rutland
The Pines At Rutland Center For Nursing & Rehabilitation	Rutland
Five Ninety Six Sheldon Road Operations LLC	Saint Albans
Saint Albans Healthcare & Rehabilitation Center	Saint Albans
St Johnsbury Health & Rehabilitation	Saint Johnsbury
Springfield Health & Rehabilitation	Springfield
Redstone Villa	St Albans

Model 3 - Optional Bundled Services

FORTY-EIGHT CLINICAL EPISODES REPRESENT ABOUT 70 PERCENT OF SPENDING ON EPISODES OF CARE

Acute myocardial infarction	AICD generator or lead	Amputation	Atherosclerosis	Back & neck except spinal fusion	CABG	Cardiac arrhythmia	Cardiac defibrillator
Cardiac valve	Cellulitis	Cervical spinal fusion	Chest pain	Combined anterior posterior spinal fusion	Complex non-cervical spinal fusion	Congestive heart failure	COPD, bronchitis, asthma
Diabetes	Double joint replacement of the lower extremity	Esophagitis, gastroenteritis and other digestive disorders	Fractures femur and hip/pelvis	Gastrointestinal hemorrhage	GI obstruction	Hip & femur procedures except major joint	Lower extremity and humerus procedure except hip, foot, femur
Major bowel	Major cardiovascular procedure	Major joint replacement of the lower extremity	Major joint upper extremity	Medical non-infectious orthopedic	Medical peripheral vascular disorders	Nutritional and metabolic disorders	Other knee procedures
Other respiratory	Other vascular surgery	Pacemaker	Pacemaker device replacement or revision	Percutaneous coronary intervention	Red blood cell disorders	Removal of orthopedic devices	Renal failure
Revision of the hip or knee	Sepsis	Simple pneumonia and respiratory infections	Spinal fusion (non-cervical)	Stroke	Syncope & collapse	Transient ischemia	Urinary tract infection

Convening Organizations

- **Awardee Conveners** may work with BPCI facilities across all 50 States
- In Phase I, conveners:
  - Assist participants with analysis of baseline data for all possible episodes
  - Help participants decide whether to transition to Phase II for any episodes
- In Phase II, conveners:
  - Are eligible to share in savings, and also assume a share of the risk
  - Serve as a "General Contractor" to support Episode Initiators
  - Assist Episode Initiators with administrative work (meeting reporting requirements, etc.)
  - Assist Episode Initiators with patient identification using admission and discharge data
    - SNFs generally do not receive DRG information
    - ICD 9 → DRG predictor
  - Provide resources for post-discharge care coordination (call centers, web-based provider & patient portals, etc.)
- An **Awardee Convener**, *Remedy Partners,* worked with 13/17 VT facilities on Phase I activities

Timeline – Models 2-4

- In January 2015, new Awardees and Episode Initiators may enter **Phase II** by transitioning to risk-bearing for *at least one* clinical episode
- All Awardees and each Episode Initiator must enter *at least one* BPCI clinical episode into **Phase II** by April 2015
- Awardees and EIs may transition *additional* clinical episodes from **Phase I** to **Phase II** in July 2015 and October 2015

Model 3: Phase II

- Few choosing to move onto Phase II
  - As of July 1, 2015, BPCI Model 3 has 1353 participants in Phase 2
  - Model 3 has been the most popular
  - No Vermont facilities have transitioned to Phase II
- Conditions that were most commonly selected and the percentage of organizations that selected that condition
  - Congestive heart failure (66%)
  - Major joint replacement of the lower extremity (53%)
  - Simple Pneumonia and Respiratory Infections (34%)
  - Chronic obstructive pulmonary disease, bronchitis, asthma (32%)
- Average number of episodes per facility in Phase II is 11

Few Transitioning from Phase I to Phase II

- Why not?
  - Administrative burden can be significant if not working with a convening organization
  - Results of baseline data analyses may suggest that assuming risk is not a viable option
- Bundles are being priced against the state average
  - Already high-performing facilities are better positioned to assume risk than average- or poor-performing facilities

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