

Vermont Health and Long-Term Care Integration Project
Joint Community Advisory Committee and Core Planning Team Meeting
August 8, 2006
Final Minutes – Revised September 6, 2006

Present:

CAC Members: Betsy Davis for Janice Clements, Peter Cobb, Janet Cramer, Larry Goetschius, Scott Goyette, Sarah C. Littlefeather, Jackie Majoros, Maureen Mayo, Dennis McCullough, Harold Nadeau, Jill Olson, Lila Richardson, Darlene Saler, Mary Shriver, Beth Stern, Lynn Whalen, Rebecca Worth
CPT Members: Catherine Collins, Dody Fisher, Deborah Lisi-Baker, Julie Trottier, Scott Wittman, Lynn Whalen
DAIL Staff: Patrick Flood, Joan Haslett, Joan Senecal, Cecile Sherburn
Consultants: Michael Bailit, Erica Garfin, and Marge Houy

Absent:

CAC: Susan Abdo, Peter Coutu, Jeanne Crowley, Debbie Evans, Ken Gordon, Susan Gordon, Jeanne Hutchins, Judith Kantorowski, Martha Miller, Madeleine Mongan, Lorrie Raymond, Liz Tabor, Julie Bushey Trevor, Alicia J. Weiss.
CPT: Heather Shlosser

1. Presentation and Discussion of Community Feedback Partner Input on Covered Services and the Interdisciplinary Care Team

Erica Garfin, Project Evaluation Consultant, presented the key messages from the Community Feedback Partners (CFPs):

- The CFPs were very enthusiastic about the concept of a centralized, comprehensive record and the concept of flexible services.
- Key areas of concern included:
 - lack of clarify regarding the relationship between the ICT and existing core teams, which if not clear could create redundancy and confusion;
 - concern about the medicalization of the model by using MSWs instead of existing case managers;
 - adequacy of funding to support social service coordinators, centralized record development and provision of flexible services;
 - need for the person receiving services to be an active participant in all decision-making;
 - creating quality standards for contracted services;
 - feasibility of team members having adequate time to participate to the extent described, and
 - maintaining confidentiality, privacy and security of centralized record.
- Several CFPs commented on the importance of allowing regional variations in the model and not requiring a one-size-fits-all formula.

Erica noted that there was a fairly high degree of confusion and lack of understanding about the intended scope of services, the concept of Extra Services and some of the concepts regarding additional financial considerations.

During a lengthy discussion, attendees expressed the following key points or concerns:

- that existing providers be involved in the program such that participants would not be required to give up an existing PCP and a full range of services could be provided;
- whether case workers would be MSWs or AAA case managers;
- whether MSWs qualified to assist persons with disabilities and qualified to bill Medicare were available. It was noted that the PACE program is required by Federal law to have MSWs, but the PACE program wants a contract with AAA for intake and social services;
- that there was a lack of clarity regarding the role of MSWs on the Interdisciplinary Care Team (ICT): would they be providing counseling services, be part of the ICT, or both?
- that the model not be medicalized, and that social issues also be documented.
- that benefits must be standard across the state and that the flexibility needs to be around the structure of the ICT;
- that Extra Services need to be specified because they will be an important reason for joining program;
- that the program acknowledge that for some participants there will be a medical component to the services needed;
- how additional members of the ICT will be added. Mental health issues and pharmacy needs are likely to be frequent issues for the team;
- that the team and the participants' representatives will need training to be effective, and
- that some functional case examples be added to program descriptions to clarify the role of the ICT.

The facilitator (Michael Bailit) assigned the CPT the following issues to address:

- Revisit the definition and role of a non-medical member of the ICT.
- Revisit the question of involvement of the existing network: should the involvement be specified by the state or left up to the program contractor (should it not be the state itself).
- How will additional members be added to the ICT.
- Why were specific waiver populations (i.e., TBI, CRT, DS) excluded from the target population?

2. Review of Upcoming Work Plan Steps

Michael Bailit explained that a formal mechanism was needed to obtain feedback from professional associations, such as the Vermont Medical Society, as well as other organizations identified by DAIL. A “white paper” was developed as a synthesis of the work done to date and is to be shared with the associations after it is revised using the input from this meeting. Feedback from the associations will be obtained at a stakeholder meeting, scheduled for September 29, 2006.

The attendees suggested that the following organizations be invited to attend the stakeholder meeting:

- Statewide Independent Living Council (SILC)
- Vermont Coalition for Disability Rights (VCDR)
- Transition organizations, e.g. *Mt. Ascutney*
- Disease-specific organizations, e.g., MS Society
- Vermont Psychiatric Survivors
- Mental health organizations, i.e., Community Mental Health Designated Agencies and SSAs.
- The three medical schools (Albany, Hitchcock and UVM)
 - Dr. Steve Contempasis, UVM Medical School
 - People who control the curriculum at the medical schools
- Vermont Medical Society
- Vermont Association of Hospitals and Health Systems
- Vermont Nurse Practitioners Association
- Adult day organizations
- Psychology practices and the psychology professional organizations
- Anderson Parkway
- Vocational rehabilitation organizations
- Senior centers
- Vermont Health Department
- Vermont Agency of Human Services, Field Service Division
- Bi-state Primary Care
- OVHA
- Potential entities or partners interested in managing the program
- PACE
- VT Attendant Services Program (Mike Meunier, Director)
- Hospice providers, other than home health agencies
- UVM Medical School Center for Aging – Grand Rounds
- RAISE

The following feedback was offered to improve the effectiveness of the white paper:

- Begin with a return on investment statement.
- Include other benefits such as efficiency, higher quality.
- Include a schematic to explain how the members of the ICT interrelate.
- Clarify that savings to the state will be reinvested in providing services (not used for any unrelated purposes).
- Include information on the financial arrangements – such as capitation and which entities will assume how much risk.
- Add the concept of Extra Benefits and distinguish them from Flexible Benefits. Specifically include dental and vision as important Extra Benefits.
- Add a separate, one-page summary that will be customized for each constituency by identifying the implications for each constituency. This summary will get the recipient's attention and focus their reading of the white paper.
- Craft two or three vital messages to include in the one-page summaries.

- Add dental and vision issues as possible risk factors.
- Clarify how this new program relates to the “Choices of Care” program. Possibly include a schematic.
- Explain how a consumer may access the ICT and its services.
- Explain how program decisions are made if there is disagreement (CAC works towards a consensus; the CPT votes on issues).
- Add psychosocial concerns to the centralized comprehensive record’s list of data elements.
- Delete the footnote that suggests that Covered Population Group 2 is still under discussion for inclusion.
- Delete the history section.
- Use numbers throughout, not bullets.
- Explain the ICT’s activities/functions/goals, rather than its composition. Clarify that it is intended to be a flexible, living workable model.
- Explain that the ICT is a resource to the consumer, and not a group controlling his or her life.
- Clarify the participant’s role on the team.

Sarah Littlefeather is to identify language in the 3/30 CAC document that she finds particularly clear and will tell Michael Bailit.

The following views were expressed regarding what to consider when identifying an entity to run the program.

- Find an organization that is already doing these services.
- Find an organization that has the ability to set up the centralized electronic record.
- If the state runs the program, it must set up all new infrastructures, but the state will glean more savings.
- A not-for-profit organization is preferred.
- A capitated arrangement is necessary with the contracting entity and with the providers to have all incentives aligned.
- Performance measures are important to allocate incentives. How will the performance of the ICT be measured?
- The ICT needs to be composed of providers who want to grow their practices.
- Mission-driven organizations and providers need to participate.
- Potentially eligible organizations may not have resources to accept risk. The state may need to accept some of the risk during a transitional period.
- The pilot should be in the Northeast Kingdom, which is an under-served area.

The next steps regarding the white paper are to:

- incorporate the comments from today’s meeting into a second draft;
- obtain CPT input at its 8/22/06 meeting on the revised version, and
- distribute the final version to organizations with a request that they survey their membership and attend the 9/29 meeting to provide input in the development process.

3. Brainstorming on Project Name

After much discussion of possible names, and the need for an explanatory tag line, the attendees suggested the following name and tag line:

“My Care Vermont: resources for independence and coordinated healthcare”

4. Discussion of the Grant Home Page

The presentation on the grant home page was delayed until a future meeting.

The attendees offered the following suggestions regarding contents and functionality of the home page:

- include an introduction and committee-specific links for the Community Advisory Committee, Core Planning Team and Community Feedback Partners;
- include a mission statement;
- include meeting schedules;
- include contact information;
- include project updates;
- provide the ability to enlarge the type font, and
- possibly include the meeting minutes; however, one attendee questioned the need if the home page audience is people already involved in the process who get minutes via email.

5. Presentation of Medicaid Only Data

Scott Wittman presented expense data for members of the target population who have Medicaid-only coverage.

- There are approximately 200 Vermonters per month who can be expected have Medicaid-only coverage. This represents approximately 5% of the target population.
- If all Medicaid recipients are included in the calculation, monthly expenses for Medicaid-only recipients are approximately \$200. If only those using services are included in the calculation the average monthly cost is \$4,648. This number is consistent with the PACE monthly combined Medicare/Medicaid rate of \$5000.

6. Date and Agenda of Next Meeting

- The September 11 CAC meeting is cancelled.
- CAC members were asked to hold the October 30 meeting time for possible discussion of the next steps after the September 29, 2006 stakeholder meeting.
- The attendees stated that the meeting was well managed and everyone was heard. The width of the room worked well for wheelchairs.

7. Other

Cecile announced that she will be having breast cancer surgery on Monday, August 14, 2006 and would be out for an undetermined time. All attendees wished her well.