DAIL Advisory Board Meeting Minutes
October 13, 2016
Sally Fox Conference Center, Waterbury

ATTENDEES:

Board Members: Linda Berger, Robert Borden, Nancy Breiden, Terry Collins, James Dean, Kim Fitzgerald, Mary Fredette, Joseph Greenwald, Jeanne Hutchins, Nancy Lang, Laura MacDonald, Nancy Metz, Gini Milkey, Diane Novak, Steve Pouliot, Martha Richardson, Christine Scott, Beth Stern, Lorraine Wargo, Judy Peterson.

Thanks to Beth Stern who chaired the meeting while Robert Borden participated by phone.

Guests: Sherry Callahan, Matt McMahon, Kirsten Murphy, Jill Olson, Marlys Waller

State Employees: Joanne Fleurrey, Camille George, Monica Hutt, Pamela Cota, Roy Gerstenberger

Motion to Approve Minutes: 09/08/16 minutes: Approved: Steve Pouliot
Seconded: Martha Richardson

Kim Fitzgerald emailed some changes to her bio to Joanne Fleurrey. Nancy Metz abstained from last month's meeting, not Nancy Lang. Changes will be made.

Review and Approval of Meeting Minutes

I. **5 Star Quality Rating for Nursing Homes**
Pam Cota, Licensing Chief, Division of Licensing and Protection, Survey and Certification

Pam shared two websites that have relevant information on this topic and that provide useful information:

Nursing Home Compare website: https://www.medicare.gov/nursinghomecompare/search.html?

Reference website for further detail: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html

The Five Star Quality Rating System for Nursing Homes only applies to Centers for Medicare and Medicaid Services (CMS) certified nursing homes. Nursing homes with 5 stars are considered to have "much above average" quality and nursing homes with 1 star are considered to have quality "much

below average". There is an Overall Rating for each nursing home and a separate rating for Health Inspections, Staffing and Quality Measures (QM's).

Health inspections are done on a rolling basis, with the most recent inspections are weighted much heavier that older inspections. These inspections are very broad inspections – meaning that everything is taken into consideration from physical care of the patient to kitchen cleanliness. The inspections are performed by trained, objective surveyors who go onsite to the nursing home and follow a specific process to determine the extent to which a nursing home has met Medicaid and Medicare's minimum quality requirements. Deficiency findings are weighted by scope and severity. Any findings are rated per the Scope and Severity Matrix. The higher the letter assigned to the finding, the higher the harm/jeopardy to the residents. This measure also considers the number of revisits required to ensure that deficiencies previously identified during the health inspection survey have been corrected.

CMS' 5 Star Quality Rating ratings for the health inspection domain are based on the relative performance of facilities within a state. This approach helps to control for variation between states. Facility ratings are determined using these criteria, which are recalibrated every month:

- The lowest 10 percent (in terms of health inspection deficiency score) in each state receive a 5-star rating.
- The middle 70 percent of facilities receive a rating of two, three or four stars, with an equal number (approx. 23.33%) in each category.
- The bottom 20 percent receive a one-star rating.

Vermont has 37 CMS certified nursing homes which is one of lowest number of homes nationally. The way that CMS determines if a nursing home has met the 5-star rating is by survey. This survey makes sure that they are meeting the minimum requirements. It is not the norm to have no regulatory findings at a facility. If you meet the minimum qualifications with no findings, you usually receive a 5-star rating.

On site surveys are unannounced inspections. CMS requires that variables are added in to try to make them unpredictable. The survey window/year is anywhere between every 9 months to 15.9 months. This way the facility cannot narrow down at what point during that "year" or survey window, they may expect a survey to occur. There are "Staggered Surveys" that occur on weekends or at odd hours. During the inspection, the surveyors try to talk to ask staff questions about staffing. For example, "Does everyone come out during meal times all the time?" or they may notice staff wearing a name tag from another facility. This is not uncommon as many facilities are owned by the same owners, and they reach out to staff to help on some days or did that person get called in because of the survey?

Staffing is a once a year, self-reported measure. Once a year the facility fills out a form to report the amount of staff, hours, and resident care needs. The measure does consider the differences in the level of care, the acuity of needs. For example, a nursing home with residents who had more severe needs would be expected to have more nursing staff than a nursing home where the residents' needs were not as high.

Facility ratings on the staffing domain are based on two measures: 1) Registered nurse (RN) hours per resident day; and 2) total staffing hours (RN + licensed practical nurse (LPN) + licensed nursing assistant (LNA) and/or nurse's aide hours) per resident day. To receive an overall staffing rating of 5-stars, facilities must achieve a rating of 5-stars for both RN and total staffing. To receive a 4-star staffing rating, facilities must receive at least a 3-star rating on one (either RN or total nurse staffing) and a rating of four or five stars on the other.

The Quality Measure (QM's) rating is recalculated quarterly, so you can get a bigger picture than a "moment in time". The rating is submitted quarterly, annually and as residents change. This rating is based on data that the nursing homes submit for the residents. The facility ratings for the QM's are based on performance on 16 of the 24 QM's that are currently posted on the Nursing Home Compare website, and that are based on Minimum Data Sheet (MDS) 3.0 assessments as well as hospital and emergency department claims. These include nine long-stay measures and seven short-stay measures. Long-stays are considered anything over 100 days. Points are awarded for each measure. Thresholds are set so that the overall proportion of nursing homes would be approximately 25% five-star, 20% each for two, three and four-star and 15% one-star.

It is a self-reported measure so it is not 100% accurate. An added level of reliability is by using Emergency Room and hospital claims. Nursing homes have a responsibility to help improve a person's ability to function and must prove that they are doing everything that can be done. Aging is a natural process, so if all that can be provided has been, it does not reduce the rating. The goal is to have a "successful discharge" – which is defined as the patient being discharged back into the community and not being readmitted within 30 days. This includes having a discharge plan with community supports and care plans in place at time of discharge.

A Board member asked about a Physician review and why patients must choose from the doctor's that are at the facility. This is only the case if a physician chooses not to follow their patient to the facility. The nursing home must let the residents have a choice of their physician, but only if there is a choice. Those that choose not to follow their patients cannot be reflected in the nursing home's rating. Physicians are regulated by the Medical Board, DAIL has no authority over their choices. Vermont Health Care Association does organized education – meetings, trainings, conferences – all year long and there is a national organization that provides education to the facilitates. DAIL has several ways that they meet with and share with materials and information to the facilities. The nursing homes know what the expectations are for these surveys.

Overall Nursing Home Rating – Composite Measure. Based on the star ratings for the health inspection domain, the staffing domain and the MDS quality measure domain, CMS assigns the overall 5-star rating in three steps:

1. Start with the health inspection rating.
2. Add one star to the Step 1 result if the staffing result is four or five stars and greater than the health inspection rating; subtract one star if the staffing rating is one star. The overall rating cannot be more than five stars or less that one star.
3. Add one star to the Step 2 result if the quality measure rating is five stars; subtract one star if the quality measure rating is one star. The overall rating cannot be more than five stars or less that one star.

Note: If the health inspection rating is one star, then the overall rating cannot be upgraded by more than one star based on the staffing and quality measure ratings.

If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum overall rating is three stars. These facilities are typically a one-star rated facility that because of deficiencies are monitored more closely, but they can be up to a maximum of 3-stars. SFF's can "graduate" from this category after having no deficiencies above a certain scope and severity for more than two surveys.

Change in Nursing Home Rating – Facilities may see a change in their overall rating for several reasons. Since the overall rating is based on three individual domains, a change in any one of the domains can affect the overall rating. Examples of events that could change the rating are:

- A new health inspection
- New complaint deficiencies
- A second, third or fourth revisit
- Resolution of an informal Dispute Resolution (IDR) or Independent Informal Dispute Resolution (IIDR) resulting in changes to the scope or severity of deficiencies
- The "aging" of complaint deficiencies
- New staffing data submitted
- Changes in QM data/claims

Below are the answers to some questions that came up during the 5-Star Rating presentation:

- Facilities that do not respond to reviews are terminated from CMS – meaning that there is no Medicaid or Medicare funding.
- Nursing homes are the most heavily regulated part of the health care world.
- The staffing thresholds are the same nationally.
- Vermont's Nursing Home rating in the United Health Foundation (UHF) ranking is based on beds. Vermont range from 23-153 beds, most of our nursing homes are small and 60% have under 99 beds. That is what is lowering our rating on that scale.

- There are 5 Quality Incentive Awards that are given out each year. Even if we have more than 5 facilities that have met all the measures, only 5 can receive the award. This year Mayo Healthcare met all the measures but did not receive the award. They were presented with an Honorable Mention for all the great work that they do.

II. Developmental Disabilities Services Regulations

Roy Gerstenberger, Director of Developmental Disabilities Services Division

The Developmental Disabilities Services Division (DDSD) was tasked with rewriting the regulations that implement the Developmental Disabilities Act of 1996. This involved taking components of the Developmental Disabilities Services System of Care Plan (SOCP) and moving them into regulations, or, rules. The State Developmental Disabilities Act requires DAIL to develop a new SOCP every three years, with the option to update more frequently if needed. The proposed rules include a number of changes, some that are basic housekeeping, to make things more clear, and some to develop a plan to comply with CMS' Home and Community-Based Rules (HCBS Rules). In completing of crosswalk of the existing SOCP and state rules with the new federal rules we found seven areas that need improvement, but are not significant. Other changes to the rules encompass learning that has occurred over the last several years and items that needed modernization. The proposed rule has been drafted and submitted to ICAR; and we are now into the period of public comment. Below are some areas of the draft regulations that were highlighted:

Part 4.7, G.2.m – Available Programs/Funding Sources – HCBS. Changed language to increase exception limit of maximum Home and Community Based Services (HCBS) funding per person from $250,000 to $300,000. The Designated Agencies (DA's) and Specialized Service Agencies (SSA's) were experiencing problems on putting services in place. Limits were being exceeded and there was no reimbursement for these services. The limits were typically exceeded due to the need for high levels of staffing and/or requiring agency paid staff versus contracted staff. If you go from self-employed to contracting the services out, you cannot regulate the training. This is an area of concern for people with complex needs. A provision was added for the ability to appeal decisions in front of the Human Services Board (HSB).

Part 5 – Self/Family Managed Services. New language to clarify the purpose of self/family management is for individual or family to oversee their services, not purchase services from a non-certified provider who is out-of-network. This is to ensure accountability and oversight by DDSD. The DA's and SSA's that DDSD works closely with go through a comprehensive vetting process, but other organizations may not. There are several areas of concern when using non-certified providers – financial stability, background checks, and training. DDSD has been reaching out to these providers and will try to pull them into the fold.

Part 4.12 – Individualized Support Agreement (ISA). Language was added to clarify new wording in the ISA Guidelines. There are some services that have been developed over time that do not fit into what was traditionally recognized as "medically necessary," but are needed. For example, many

Vermonters benefit from the service of communication supports. The language has been broadened to specifically include these services.

One area that caught a Board member's attention was in Section 9.2.a.4, page 61, of the draft regulations. "…ensure that workers are exposed to best and promising practices in supporting individuals with developmental disabilities." The word "promising" was added because there are practices that are used that look encouraging, but they have not been in place long enough to have been adopted as "best practices" or "evidence-based." This allow for developmental services to be more open to trying new and different ways of doing things.

The Developmental Services State Program Standing Committee (SPSC) has been an essential partner in determining how DS services are provided. They created a workgroup to focus on the regulations and took a broader look at the rules that needed to be changed. They were a large contributor to the new draft. Linda Berger will bring the committees insights to share with the Board at the November meeting.

The draft regulations have been submitted to ICAR, next will be LCAR where they will be recorded. Then they go in front of the legislative rules committee. The public comment period is underway; and advisory board members were encouraged to comment.

III. Introductions of New Board members

Judy Peterson and Terry Collins, newly appointed members to DAIL Advisory Board

Judy Peterson is the CEO of the Visiting Nurse Association (VNA) of Chittenden and Grand Ilse counties. She is a lifelong Vermonter who grew up in the Northeast Kingdom. She was fortunate to grow up on a dairy farm, but where all the children attended college. Judy spent three years in Central America and fell in love with community health. To have that Peace Corps experience was when Judy recognized the importance of the social determinants of health. Most of Judy's career has been in public health. She is very committed to community-based care and helping people live in the least restrictive environment and committed to giving the best quality of care. Judy has worked closely with DAIL for several years. She looks forward to see positive change happen in health care reform and feels that being part of the DAIL Advisory Board is an opportunity for her to both hear from others and share with others.

Terry Collins moved to Vermont from New York in 1988. Terry worked for many years in publishing and thought that she would retire. But, there was still much work to be done. She worked as a contractor with DAIL's Division of Vocational Rehabilitation, before VABIR, in supported employment. Terry was also the chair of the Northeast Kingdom (NEK) Mental Health – now NEK Human Services and had been there for 13 years. Four years ago, Terry became the Executive Director of the NEK Home Health and the Adult Day program. She looks forward to seeing things continue to move forward in health care, especially around Choices for Care (CFC) and giving people more choices.

IV. Conversation with the Commissioner

Monica Caserta Hutt, Commissioner

Vocational Rehabilitation Re-Allotment Funding – DAIL's Division of Vocational Rehabilitation's (VR) work is primarily around supported employment and getting people with disabilities competitive employment. Their funding is mostly federal and for the last 10 years has benefited by re-allotted dollars that have not been spent in other states. This year those re-allotted funds to Vermont were reduced by 76%. Although we knew that these funds were not a guarantee, programs were built around it because we had been receiving it for so many years. We were one of a few states that did not receive their requested re-allotment funding. The Governor, Secretary and our Congressional Staff have been on top of this and have gone all the way to the top in Washington. We are working with the Business Office on how to fill these holes. The impact will mostly be felt in VR, not consumers. The reductions will mainly be in staff training and advertising. We do not anticipate that there will be cuts in programs and services in SFY17, but we are still not sure how this will play out in SFY18. This reduction has made future planning very challenging.

Budget Update – This year's budget development process is very early this year due to the transition of administration. DAIL has recently presented the budget to the Governor's Office. We were instructed to present a level funded budget, which means reductions in some areas. There are caseload pressures in DS and CFC. Stories were used to tell the budget tale because we wanted to articulate where the pressures exist. This budget presentation will be brought to the Governor and then to the Governor-elect. Although the Secretary of Administration is very new, he was very engaged. As has been reported in the media, agencies were instructed to present a program to cut, this is not the first time we have been asked to do this and we have never actually had to cut it.

Receivership Contract Update – There have been two receiverships since the statute has been put into place. Going through these, we recognized that an independent review of the statute was needed. As the statute currently reads, there is no funding source associated with it. The receiver is supposed to use the resources of the facility, but that is not always possible – either there are no funds or they cannot be accessed. DAIL has contracted with Flint Springs Associates, who will be partnering with the Lewin Group's Brendan Hogan. Brendan was Commissioner of DAIL during the first receivership, so he is very close to this topic. The deadline on receiving their recommendations is very short, as we want to have them before the legislative session in case there is a legislative impact.

Health Rankings – Like the Senior Health Rankings from United Health Foundation (UHF) another report recently came out from United Cerebral Palsy – a pre-eminent annual ranking of how well Medicaid dollars are servicing people with intellectual disabilities and their families. Last year, this report ranked Vermont 22nd. This year we are 2nd. This reflects all the work that we do promoting independence, keeping families together and reaching those in need. This report also reported that

as recently as 2014, 15 states report having no institutions – leaving 35 that still actively institutionalize.

Legislative Initiatives – DAIL is considering several areas for possible legislative initiatives to include changes in the receivership statute, the State Long Term Care Ombudsman statute that may be needed due to new federal regulations, Adult Protective Services (APS) and Act 248. All proposals need to be vetted through the Secretary of Human Services and the Governor and then a legislative sponsor will be sought. As with the budget, much will be dependent on the new Governor.

There is a legislative study currently underway looking at adding home delivered meals into Choices for Care, but it is likely that the work will not be completed in time for any legislative initiative, however, the legislature may decide to act itself.

V. Serving on the DAIL Advisory Board – a Board Member's Perspective

Beth Stern, Board Member

Beth Stern is the Executive Director of the Central Vermont Council on Aging (CVCOA) and President of the V4A (Association of Area Agencies on Aging). She started out at CVCOA as the Community Organizer, but felt she needed more structure. Her work at CVCOA gives her the perspective of the aging population. But in her personal life, she has a family member with developmental disabilities, so she is also aware of the challenges that population faces, too.

The aging population is the fastest growing in the state. This population uses the health care most at the end of their life. For the cost of one person in a nursing home, three could be served at home with home and community-based services. The five Area Agencies on Aging (AAA) provide several services – case management, home delivered meals, senior center congregate meals, eldercare (mental health) services, transportation, just to name a few. About ½ of their services are contracted out – examples are transportation and MH services. The direct care that they offer is more about case management and coordinating care and services.

As with most agencies around the state, not enough funding and increased caseloads is always a challenge. They 5 AAA's try to work together to fill in the gaps with obtaining foundation grants and private donations. The Older American's Act was reauthorized this year with recommended funding attached, but receiving the funds is not a guarantee. They look to other states to see how they triage their services, but each states funding varies greatly. Pennsylvania receives funding from their lottery. Ohio's funding is by county and not town. So, comparing how to deliver services is difficult. One way they use their resources well is through education. It not only serves several consumers at once, it educates the partner agencies in that area, too.

The AAA's work together to have specific legislative initiatives and be a presence at the State House. They want to be at the table for health care reform discussions – so when something does happen, home and community based services are part of that.

VI. Board Updates

DAIL Advisory Board members

Linda Berger shared that the DS SPSC unanimously made a request to Commissioner Hutt to increase the rate paid to direct care workers to $15.00/hour.

The Alzheimer's survey has been extended to December 1st. Martha Richardson will send Joanne materials to resend out to DAIL Advisory Board. The survey will now include a form that can be completed and submitted.

Gini Milkey let us know that the Community of Vermont Elders (COVE) has been awarded a grant from the Center for Crime Victim Services to fund COVE to build upon the work it's Senior Medicare Patrol Program – to avoid scams, fraud and exploitation and to refer more elders who are victims to appropriate services to receive help.

Meeting was adjourned