



***VT Health Care Innovation Project  
DLTSS Work Group Meeting Minutes***

**Pending Work Group Approval**

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

Agenda Item	Discussion	Next Steps
<p><b>1 Welcome; Introductions; Approval of Minutes</b></p>	<p>Judy Peterson kicked off 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.</p>	
<p><b>2 DLTSS Quality and Performance Measures</b></p>	<p>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.</p> <p>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 28<sup>th</sup>. Catherine requested that comments from DLTSS work group members be submitted in writing.</p> <p>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 30<sup>th</sup> and issue new measure specifications by</p>	

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	<p>October 31<sup>st</sup>. 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.</p> <p>Discussion ensued and the following comments were made:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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</li> </ul>	

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	<p>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.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• Judy Peterson asked if the group had considered any measures around Adverse Child Experience (ACEs). Catherine commented that the population health work group also</li> </ul>	

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	<p>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.</p> <p>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.</p>	
<p><b>3 AHS Survey Results</b></p>	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Julie Tessler also supported this comment and said that the results may be skewed due to missing populations (such as the uninsured).</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• Jackie Majoris suggested that we may want to judge the applicability of the surveys to</li> </ul>	

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	<p>the general population as so many of them are service specific. Susan reminded the group that this framework is for the presenters to use.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>	
<p><b>4 DLTSS Recommendation for Criteria for Second Round of Provider Grant Program</b></p>	<p>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 4<sup>th</sup>. 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.</p> <p>Discussion ensued and the following comments were made:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>	

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	<p>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.</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<p><b>5 Provider Training Discussion</b></p>	<p>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.</p> <p>Discussion ensued and the following comments were made:</p> <ul style="list-style-type: none"> <li>Joy commented that awareness of the importance of effectively populating EHRs and other electronic information sources is important.</li> <li>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.</li> <li>Julie Tessler suggested including case studies to help illustrate this topic.</li> <li>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.</li> <li>Dion LaShay commented that best practices in information sharing across providers should be incorporated.</li> <li>Barbara Prine suggested that we consider mental disability, communication ability, and technological adeptness of the population. Not everyone communicates in the same way.</li> <li>Kirsten suggested a focus on people who use augmentative and alternative forms of communication be included.</li> <li>Judy Peterson suggested that language be included about seeing the person as an individual not as a disability.</li> <li>Deborah summarized Ed Paquin and Sam Liss’s comments (sent to Deborah before</li> </ul>	

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	<p>the meeting) that you must look at the whole person and not let the disability dictate how the person is served.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Barbara Prine commented that when technology is used, people have to understand how to use it.</li> <li>• Madeleine asked if there are models or examples of training that we could learn from to further reach our goals.</li> <li>• 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.</li> </ul>	
<b>6 DLSS Consultant Support Contract – RFP Process</b>	<p>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.</p>	
<b>7 Public Comment/Updates/Next Steps</b>	<p>Deborah Lisi-Baker invited comment from the public, and hearing none thanked the group for participation and called the meeting adjourned.</p>	

# VHCIP DLTSS Work Group Attendance 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	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	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	Health Policy Analyst	AHS - DVHA	X

*Susan Besio*

*X (Phone)*

*car*

*Amy Coonradt*

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 Care	CHAC	M
19	Erin	Flynn		<i>Erin Flynn</i>	Health Policy Analyst	AHS - DVHA	S
20	Mary	Fredette			Executive Director	The Gathering Place	M
21	Joyce	Gallimore			Director, Community Health Payment	Bi-State Primary Care/CHAC	M
22	Lucie	Garand			Senior Government Relations Specialist	Downs Rachlin Martin PLLC	X
23	Christine	Geiler			Grant Manager & Stakeholder Coordinator	GMCB	S
24	Larry	Goetschius			CEO	Addison County Home Health & Hospice	M
25	Bea	Grause			President	Vermont Association of Hospital and Health Care	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	AHS - DAIL	X
31	Churchill	Hindes			COO	OneCare Vermont	X
32	Brendan	Hogan			Consultant	Bailit-Health Purchasing	X
33	Jeanne	Hutchins		<i>Jeanne Hutchins</i>	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 Services	Washington County Mental Health Services	X



59	Miki	Olszewski			Assistant Director of Blueprint for AHS - DVHA - Blueprint	AHS - DVHA - Blueprint		X
60	Jessica	Oski				Sirotkin & Necrason		X
61	Ed	Paquin			Ed Paquin	Disability Rights Vermont		M
62	Annie	Paumgarten		<i>Anne Paumgarten</i>	Evaluation Director	GMCB		X
63	Laura	Pelosi			Executive Director	Vermont Health Care Association		M
64	Eileen	Peltier			Executive Director	Central Vermont Community Land Trust		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		<i>Barbara Prine</i>	Attorney	VLA/Disability Law Project		MA
69	Paul	Reiss			Executive Director,	Accountable Care Coalition of the Green		M
70	Virginia	Renfrew				Zatz & Renfrew Consulting		X
71	Rachel	Seelig		<i>Rachel Seelig</i>	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 AHS - DVHA - Blueprint	AHS - DVHA - Blueprint		X
76	Julie	Tessler		<i>Julie Tessler</i>	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	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