Attachment 1a - DLTSS Meeting Agenda 7-24-14

VT Health Care Innovation Project

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

Thursday, July 24th 2014; 10:00 AM to 12:30 PM

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

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

Item	Time Frame	Topic	Relevant Attachments	Action
1	10:00 – 10:10	**Welcome; Introductions; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from June 19, 2014 meeting	
2	10:10 – 11:05	**DLTSS Quality and Performance Measures** • Update on QPM Recommendations from the June 23 QPM Work Group Deborah Lisi-Baker, Judy Peterson, Catherine Fulton, Alicia Cooper	• Attachment 2a: Memo from QPM Co-Chairs, Staff and Consultant dated 6-20-14 "Recommendations for Year 2 Reporting Measures" • Attachment 2b: Y2 Measure Decision Guide for QPM 7-2-14 Final • Attachment 2c: QPM Measure Review Tool-Reporting 2014-7-10 FINAL • Attachment 2d: QPM Measure Review Tool-Payment 2014-7-10 FINAL	
3	11:05 – 11:15	**AHS Survey Results** • **Common Format for Presentations to DLTSS Work Group** Deborah Lisi-Baker and Judy Peterson	• Attachment 3: AHS Survey Presentations – Common Format draft 7-8-14	
4	11:15 – 11:25	**DLTSS Recommendation for Criteria for Second Round of Provider Grant Program** Deborah Lisi-Baker and Judy Peterson	• Attachment 4: DLTSS WG Recommendation to Core Team re Provider Grants Round 2	

5	11:25 – 12:15	**Provider Training Discussion** Deborah Lisi-Baker and Judy Peterson	• Attachment 5: Provider Training Discussion Guide	
6	12:15 - 12:20	**DLTSS Consultant Support Contract — RFP Process** Georgia Maheras		
7	12:20 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: August 14th 10:00 am - 12:30 pm, Williston	

Attachment 1b - DLTSS Meeting Minutes 6.19.14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday June 19th, 2014, 10am – 12:30 pm, AHS Training Room, 208 Hurricane Lane, Williston, VT

Attendees: Deborah Lisi-Baker and Judy Peterson, Co-Chairs; Georgia Maheras, AoA; Julie Wasserman, AHS; Sam Liss, Statewide Independent Living Council; Dion LaShay, Consumer; Pat Jones and Annie Paumgarten, GMCB; Dale Hackett, Consumer; Ed Paquin, Disability Rights Vermont; Joy Chilton, CVHHH; Erin Flynn, Alicia Cooper, Cecelia Wu, Mandy Ciecior, Amy Coonradt, Kara Suter, Jenney Samuelson, Craig Jones, Tony Kramer, DVHA; Marlys Waller, Julie Tessler, VT Council of Developmental and Mental Health Services; Brendan Hogan, Bailit Health Purchasing; Susan Besio and Scott Whitman, PHPG; Kirsten Murphy, VT Developmental Disabilities Council; Jeanne Hutchins, UVM Center on Aging; Ed Paquin, Disability Rights VT; Carol Maroni, Community Health Services of Lamoille County; Madeline Mongan, VMS; Rachel Seelig, VT Legal Aid; Jason Williams, FAHC; Jen Woodard and MaryBeth McCaffrey, DAIL; Jackie Majoros, LTC Ombudsman; Larry Goetschius, Addison County Home Health & Hospice; Marie Zura, Howard Center; Todd Moore, OCVT; Molly Dugan, SASH; Nelson LaMothe, Project Management Team; Anya Wallack, VHCIP Core Team.

Agenda Item	Discussion	Next Steps
1 Welcome; Introductions; Approval of Minutes	Deborah Lisi Baker called the meeting to order at 10:05 and announced that the agenda would be modified as follows: the recommendations for criteria for Round Two of the Provider Grant Program will move in front of the Medicaid Expenditure Analysis. Approval of May 2nd and May 22nd meeting minutes: Carol Maroni made a motion for approval without edit and Madeline Mongan seconded. The motion passed unanimously.	
2 Recommendations for Criteria for Second	Georgia Maheras presented this agenda item. The first round of the provider grant program awards was approved on April 2nd, and the Core Team is currently preparing for Round 2 of	

Agenda Item	Discussion	Next Steps
Round of Provider Grant Program	application process. Georgia walked through attachment 3 including review of a timeline, existing criteria, the goals of the grant program and the Core Team request for ideas from the work groups on how to evaluate Round 2 applications. Work groups are able to make recommendations to the Core Team in June and July. The Core Team has added additional money, and up to $2.8 million will now be available. The following comments/suggestions regarding recommendations to the Core Team regarding Round 2 of provider grants were offered: • Julie Tessler suggested including populations that don't always meet certain eligibility criteria (i.e. - traumatic brain injury, people coming out of corrections, etc.). • MaryBeth McCaffrey agreed and added a suggestion that care giver respite funds and flexible family funds be added. Georgia responded that there may be some limits to how federal funds can be used, and suggested further exploring this possibility offline. • Deborah Lisi-Baker suggested a criterion of reaching out to underserved populations. • Julie Tessler suggested criteria regarding full assessments, care coordination and access to care to promote better health. • Carol Maroni suggested criteria focusing on institutionalized elders in nursing homes and facilitation of needed services (i.e. – dental care) in nursing homes. • Joy Chilton suggested criteria focusing on underserved populations who are not currently receiving services that they have a need for. • Anya Radar-Wallack reminded the group that the overarching framework is that recommendations need to fit into the goals of the SIM grant (innovation in health care payment and delivery reform). • Jackie Majoros suggested that regarding the first bullet point on page 6 of attachment 3, there should be an opportunity to capture the consumer voice and recommended adding consumer and consumer preferences and needs to this bullet point. • Dale Hackett recommended that quality measurement should not exclude any subpopulations when considering the general population. He also supports the recommendations that underserved populations should be included and wants to identify those populations in advance, not once the problem is already occurring.	

Agenda Item	Discussion	Next Steps
	• Dion LaShay agreed and also supports measuring all people. • Molly Dugan recommended supporting existing partnerships that are already in place. Jackie Majoros responded to this recommendation saying that this shouldn't limit innovation that could come via new partnerships. • Sam Liss recommended an allowance for special populations and appropriate exceptions to cost saving measures when needed. • Ed Paquin also supports Sam's comment and recommends doing what makes sense for each individual, not necessarily the outcomes of the entire population	
3 DLTSS Medicaid Expenditure Overview Discussion and Final Draft	Susan Besio kicked off the conversation and provided a summary of this conversation to date, noting that edits were made to the analysis and presentation based on the work group's questions and feedback (reference attachments 2a and 2b). Susan reviewed the following points regarding attachment 2a: • Based on slide 11 the specialized population is about 25% of Medicaid's population, and accounts for about 70% of the expenditures. • The second approach of looking at aid codes accounts for about 60% of the Medicaid budget. • Either way you look at it, DLTSS spend is the majority of the Medicaid budget. Scott Wittman reviewed the following points regarding attachment 2b and then walked the group through all of the questions and answers in this attachment: • Analyses are categorized according to the two different views. On the section related to disability aid codes, additional information was added regarding Medicaid aid codes to provide an overview, and finally a list of all aid codes is attached to the end of the document. • The goal is to identify folks who have DLTSS needs, and use the claims data to identify those folks. Susan Besio wrapped up the conversation by saying that this is not an exact science, and that	

Agenda Item	Discussion	Next Steps
	decisions needed to be made. At a high level, the purpose was to identify the amount of Medicaid spending on people with DLTSS needs.	
4 DLTSS Quality and Performance Measures • Process and Methodology for defining and analyzing the DLTSS Population	Pat Jones presented the next agenda item on DLTSS quality and performance measures. And reviewed the following points: • In total the quality and performance measures work group received recommendations on 22 measures, 21 of which are included in attachment 4a. The 22nd measure, breast cancer screening, was recommended for removal by Betty Rambur of the Green Mountain Care Board as recent studies have called into question the efficacy of breast cancer screening. • 12 represent new measures added to the Reporting measures set and many came from the Year One Pending list. • The first measure in the table: Developmental screening in the first year of life is already in Medicaid, and was recommended for inclusion in the Commercial ACO program as well. • As a next step co-chairs, staff and consultants are meeting to refine the recommendations and will bring them to the full Quality and Performance Measures work group for consideration. The work group is meeting on Monday and hopes to have recommendations on Year 2 ACO Reporting and Payment measures by July 31st. Those recommendations will then go through the VHCIP approval process and a final decision is expected by September 30thwith specifications out by October 31st. <u>Two Options to Identify the DLTSS Population for ACO Performance Measures Analyses</u> Susan Besio reviewed the status of this agenda item and reminded the work group that the discussion is still ongoing. Attachment 4b provides some pros and cons for potential ways to define the DLTSS population. Deborah Lisi-Baker asked for clarification regarding the deadline to complete this work in order to still meet the deadline for the state's performance measurement analysis. Kara Suter commented that we have time, and that the analyses would not be done until about one year from now.	

Agenda Item	Discussion	Next Steps
• Plan for presentation of AHS Survey Results to DLTSS Work Group	Susan Besio offered clarification regarding the notion that with the Duals being carved out, there wouldn't be a big enough population to do this sub-analysis. On page two of this document, it shows that there are about 10,000 dual eligible individuals who are in specialized services. That still leaves 20,000 people who would be attributed to an ACO. According to the disability aid code analysis, there are roughly 17,500 Duals. These are rough numbers, but there will still be a significant number of DLTSS individuals that may be attributed to ACOs. Susan Besio reviewed attachment 4c and indicated that the work group has shown interest in the AHS surveys and how they fit into the performance measurement picture. Current surveys are done for specific populations. The recommendation of this work group was to have the results of all of these surveys presented to the work group. Julie Wasserman commented that these surveys address quality of life and quality of care issues, which cannot always be captured in other measurement activities. Jackie Majoros asked a question about "MyInnerView". How accessible are those results? Are they proprietary to the Nursing Home Association? Marybeth McCaffrey responded that historically it has been a problem. They are working on it and Marybeth can report back to this group. Marybeth McCaffrey made a motion that we adopt the recommendation. Kirsten Murphy added an amendment that this be pending developing a template for the common format that will be used to present the AHS Survey results to the DLTSS Work Group. Ed Paquin seconded the motion. The motion passed unanimously.	
5 Provider Training – Define Issues, Goals and Next Steps	Deborah Lisi-Baker kicked off this agenda item referencing attachment 5 and the questions contained within. The following points were raised throughout the discussion: • The DLTSS Work Group Charter includes building capacity across different systems to work effectively with people with different disabilities and cultural backgrounds. One	

Agenda Item	Discussion	Next Steps
	approach to addressing this goal is cross-disciplinary training including beneficiaries and providers. • Brendan Hogan provided some history on this topic as it was addressed under the Duals project through the care planning effort and comprehensive assessment work. He also suggested that the work group weigh in on considerations such as the level of training, the most effective approach, what should be included, how to effectively build cross-disciplinary teams, etc. • Marie Zura commented that in developmental services, there is an expectation that all providers have pre-service training which has traditionally been facilitated by the DA. The numbers are large and it is difficult for the DA to address the capacity. They developed an online training that is provider-friendly, and allows them to complete the training at their own pace. The curriculum focuses on values. This may be a way to standardize that value training and allow it to cross populations in a real usable way. • Brendan also noted that this discussion is beginning in the direct care worker subgroup of the Workforce Work Group. DAIL has provided data to the Work Group; currently the subgroup is collecting information re cost and training programs and the expense associated with this training. • Marie commented that the beauty of online training is that it is cost effective. • Jackie Majoris suggested that the Workforce subgroup make regular recommendations to the DLTSS WG re their progress. • Marybeth McCaffrey commented that Maine has done an evidence-based program to help direct service workers be cross-trained for multiple areas. She also recommended that we take a short term approach while we continue to work on the long term goals. She suggested building a library of FAQs related to DLTSS and other resources that the work group has created. • Sam Liss asked if this training is only related to medical models, or if it would include socio-economic and wellness factors. Brendan responded that it is intended to be broader. This training would help facilitate communication, for example, among providers in ACOs. • Carol Maroni suggested that it is important to have a shared vision and understanding so that practitioners are using the resources that are available to them. • Deborah summarized the work of the Duals Person-directed Work Group. On a	

Agenda Item	Discussion	Next Steps
	separate grant, she conducted medical rounds with providers who commented that they don't get as much training on working with people with disabilities as they used to. • Judy Peterson commented that training related to cultural competency and working with Vermont's refugee population is important. Providers need training to ensure that they are truly addressing people's needs and this should be a topic of consideration. • Marie Zura commented that as providers, we all need to start to learn each other's specialty so that we can provide a much more comprehensive approach to a person's care. • Kara Suter commented that it is important to understand how to both collect and describe interests from other provider groups in provider training. Susan Besio asked if people think that this topic is important enough to be recommended as a criterion for consideration under the Provider Grant Program, and potentially for additional funding sources under the VHCIP. Carol Maroni made a motion that the DLTSS work group recommend to the Core Team that they include criteria for specific provider grants including cross-disciplinary and culturally sensitive training inclusive of acute health care and DLTSS with a consumer voice that could be applicable state-wide. Jackie Majoros seconded. Ed Paquin requested the recommendation focus on the specific needs of individuals with disabilities and long term care service and support needs. Madeline added a clarifying point that this is just one of many criteria, and that a provider training component does not need to be included in every proposal, but rather that proposals for provider training should be considered. The motion passed unanimously.	

Agenda Item	Discussion	Next Steps
6 Public Comment/Updates/Next Steps	The meeting adjourned without further comment.	

Attachment 2a - QPM Recommendations for Year 2 Reporting Measures from Co-Chairs, Staff and Consultant

TO: Members/Interested Parties of VHCIP Quality and Performance Measures Work Group

FROM: Laura Pelosi and Catherine Fulton, Co-Chairs; Alicia Cooper, DVHA; Pat Jones, GMCB; Michael Bailit, Bailit Health Purchasing

DATE: June 20, 2014

RE: Year 2 Reporting Measures: Preliminary Recommendations for Discussion

As part of the measure review and modification process conducted by the VHCIP Quality and Performance Measures (QPM) Work Group, a total of thirteen measures have been recommended for addition to the Reporting Measure Set for Year 2 of Vermont's Commercial and Medicaid Shared Savings Program. Organizations recommending measures included the DLTSS Work Group, the Howard Center, the Population Health Work Group, and Vermont Legal Aid/Office of Health Care Advocate. At the May 29, 2014 Meeting of the QPM Work Group, the Co-Chairs recommended that they, in conjunction with the Work Group's staff and consultants, review the list and make recommendations to the full Work Group for further discussion as the group seeks to develop a recommendation for the VHCIP Steering Committee and Core Team and the Green Mountain Care Board. Work Group members agreed to this initial step.

The Co-chairs, Staff and Consultant had two working sessions to review and score the measures against most of the criteria that were adopted by the QPM Work Group for measure selection. Those criteria included whether the measures are:

- Valid and reliable,
- Representative of the array of services provided and beneficiaries served,
- Consistent with state's goals for improved health systems performance,
- Not administratively burdensome/feasible to collect,
- Aligned with other measure sets,
- Have a relevant benchmark,
- Focused on outcomes, and
- Population-based/focused.[i]

The review against these criteria resulted in a ranking of the measures. The following were considered strong candidates for inclusion in the Year 2 Reporting Measure Set:

1. Cervical Cancer Screening
2. Tobacco Use Screening and Cessation Intervention
3. Prenatal and Postpartum Care
4. Developmental Screening in the First Three Years of Life (Commercial SSP)
5. Influenza Immunization

An additional measure, Controlling High Blood Pressure, was ranked highly. However, because of recent changes in national guidelines, the measure is not recommended for inclusion in the Year 2 Reporting Measure Set. We do, however, suggest the measure be revisited for the Year 3 Reporting Measure Set.

We respectfully offer these recommendations to the work group. Thank you for your participation in this process and for proposing measures for consideration. We look forward to the discussion at our June 23 meeting.

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[i] The criteria that were not included and the reasons for not considering them were:

- Uninfluenced by Differences in Patient Case Mix – this is captured in the Valid and Reliable criterion
- Not Prone to Random Variation/Sufficient Denominator Size – information not yet available on this criterion (i.e., test calculations or other estimating techniques will need to be applied)
- Limited in Number – pertains to complete measure set as opposed to individual measures
- Includes a Mix of Measure Types – pertains to complete measure set as opposed to individual measures

Attachment 2b - Y2 Measure Decision Guide for QPM

Quality and Performance Measures for Year 2 of Vermont's ACO Shared Savings Programs

1. Measure Changes Recommended by QPM Work Group Co-Chairs, Staff and Consultant

Y1 Measure Category	Co-Chair/Staff/Consultant Recommendation for Y2 Measure Category	Proposed Measure	Decisions: Questions to be Resolved	Considerations
Reporting (except Develop-mental Screening)	Payment	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Leave as Reporting or promote to Payment?	• When considered against QPM payment measure criteria, these measures scored most highly, having clear benchmarks and focusing on outcomes or prevention.
		Pediatric Weight Assessment and Counseling	Leave as Reporting or promote to Payment?	
		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite	Leave as Reporting or promote to Payment?	• Claims-based measure; seeking guidance from CMS on benchmarking options • CMS has recommended that this measure be promoted to payment.
		Developmental Screening in First Three Years of Life (Commercial SSP)	Promote to Payment, promote to Reporting, or promote to M&E?	• Awaiting information on data collection from commercial insurers.
	M&E*	Breast Cancer Screening	Leave as Reporting, move to Monitoring and Evaluation, or remove?	• Recent studies have raised questions about effectiveness of breast cancer screening • Moving the measure to Monitoring and Evaluation would allow monitoring of health plan level results.
Pending	Reporting	Cervical Cancer Screening	Resolved on 6/23	• ***QPM WG voted to promote to Reporting on 06/23***
		Tobacco Use: Screening & Cessation Intervention	Resolved on 6/23	• ***QPM WG voted to promote to Reporting on 06/23***
		Prenatal & Postpartum Care	Leave as Pending, promote to Reporting, or promote to M&E?	• Concerns about using the combined measure because of timing guidelines for postpartum care • Could use only the prenatal care portion of the measure
		Influenza Immunization	Leave as Pending, promote to Reporting, or promote to M&E?	• Concerns about feasibility of collecting valid information; multiple settings for obtaining immunization

Y1 Measure Category	Co-Chair/Staff/Consultant Recommendation for Y2 Measure Category	Proposed Measure	Decisions: Questions to be Resolved	Considerations
	M&E*	SBIRT	Leave as Pending, promote to Reporting, or promote to M&E?	• SBIRT program is currently limited to pilot sites; not feasible to collect at ACO level • Could collect existing information for M&E reports (at aggregated pilot site level)
New	Reporting	Custom DLTSS Survey Questions	Add as Reporting, or don't add?	• Questions could be added to state-funded PCMH CAHPS survey at little or no added cost (pending approval from NCQA, if needed) • No benchmarks
	M&E*	LTSS Rebalancing	Add as Reporting, add as M&E, or don't add?	• Claims-based measure • LTSS Rebalancing is already being collected by DAIL for the Choices for Care (CFC) program • Majority of CFC population will not be attributed to VMSSP/XSSP, making it less relevant to Medicaid and Commercial ACOs • Vermont already performs well on this measure, leaving less of an opportunity for improvement • Could collect existing information for all eligible Medicaid beneficiaries for M&E reports (at statewide & county levels)
M&E	Reporting*	Avoidable ED Visits	Leave as M&E, promote to Reporting, or promote to Payment?	• Claims-based measure. • When considered against QPM selection criteria, this measure was not prioritized for Payment because of a lack of available benchmarks; may be candidate for Reporting measure with potential for Payment benchmarking or change-over-time evaluation in the future.

* Recommendation differs from original request

2. Measures Not Recommended for Changes by QPM Work Group Co-Chairs, Staff and Consultant

Y1 Measure Category	CC/S/C Recommendation for Y2 Measure Category	Proposed Measure	Questions to be Resolved	Considerations
Reporting	Maintain as Reporting *(Not Recommended for Y2 Promotion)*	Optimal Diabetes Care (D5)	Leave as Reporting or promote to Payment?	• Measure specifications are being revised; lacks clear benchmarks (see memorandum from Minnesota measure steward)
		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma for Older Adults	Leave as Reporting or promote to Payment?	• Claims-based measure; limited benchmarking opportunities • CMS has recommended that this measure be promoted to payment
		Screening for Clinical Depression and Follow-Up	Leave as Reporting or promote to Payment?	• Limited benchmarking opportunities make it less attractive for Payment
		Adult BMI Assessment	Leave as Reporting or promote to Payment?	• Limited benchmarking opportunities make it less attractive for Payment
Pending	Maintain as Pending *(Not Recommended for Y2 Promotion)*	Controlling High Blood Pressure	Leave as Pending, promote to Reporting, or promote to M&E?	• Scored high during evaluation, but guideline and specification changes impacted recommendation • Should be considered in future years
		Care Transition Record Transmitted to Health Care Professional	Leave as Pending, promote to Reporting, or promote to M&E?	• Limited benchmarking opportunities • Feasibility challenges
		Screening for High Blood Pressure and Follow-up Plan Documented	Leave as Pending, promote to Reporting, or promote to M&E?	• Limited benchmarking opportunities
		Transition Record with Specified Elements Received by Discharged Patients	Leave as Pending, promote to Reporting, or promote to M&E?	• Limited benchmarking opportunities • Administrative burden impacts feasibility of collecting
		Percentage of Patients with Self-Management Plans	Leave as Pending, promote to Reporting, or promote to M&E?	• Lacks specifications • Limited benchmarking opportunities

Attachment 2c - QPM Measure Review Tool-Reporting

QPM "Reporting" Measures Review Tool - July 10, 2014

VT Measure ID	Y1 Pending/New Measure	TOTAL SCORE	Representative of the array of services provided and beneficiaries served	Has a relevant benchmark	Aligned with other measure sets	Valid and Reliable	Feasible to collect	Focused on Outcomes	Opportunity for Improvement	Consistent with State Objective for Health Improvement
Core-30	Cervical Cancer Screening (CCS)	10	2	2	1	2	1	0	2	0
Core-36	Tobacco Use: Screening and Cessation Intervention	9	2	0	2	2	1	0	?	2
Core-39	Controlling High Blood Pressure	8	2	0	1	0	1	2	0	2
Core-8*	Developmental Screening In the First Three Years of Life	8	2	1	1	2	1	0	1	0
Core-34	Prenatal & Postpartum Care (PPC)	8	2	2	1	2	1	0	0	0
Core-35	Influenza Immunization	7	2	0	2	2	1	0	?	0
M&E-14*	Avoidable ED Visits (NYU Algorithm)	7	2	0	0	1	2	2	?	0
new	3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management	6	2	0	0	1	2	1	?	0
Core-37	Care Transition Record Transmitted to Health Care Professional	6	2	0	1	2	1	0	?	0
Core-40	Screening for High Blood Pressure and Follow-up Plan Documented	6	2	0	1	0	1	0	?	2
Core-45	Screening, Brief Intervention, and Referral to Treatment	6	2	0	0	0	1	1	?	2
Core-44 (ALT)	Transition Record with Specified Elements Received by Discharged Patients	5	2	0	1	2	0	0	?	0
new	LTSS Rebalancing	4	2	0	0	1	1	0	0	0
Core-44	Percentage of Patients with Self-Management Plans	3	2	0	0	0	1	0	?	0

*Recommended for Payment, but since these were not previously Reporting measures, they were assessed against overall Measure Selection criteria. They were also assessed separately against Payment measure criteria.

	Recommended by:
recommended by >1 entity	PH, DLTSS, VLA
	PH, DLTSS, HC
	PH, DLTSS
	DLTSS
	PH

Attachment 2d - QPM Measure Review Tool-Payment

QPM "Payment" Measures Review Tool - July 10, 2014

VT Measure ID	Y1 Reporting Measure	TOTAL SCORE	Has a relevant benchmark	Opportunity for Improvement	Focused on Outcomes	Focused on Prevention, Wellness, or Risk/Protective Factors	Comments
Core-17	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	6	2	2	2	0	
Core-15	Pediatric Weight Assessment and Counseling (WCC)	5	2	1	0	2	
Core 8	Developmental Screening In the First Three Years of Life	4	1	1	0	2	
Core-16	Optimal Diabetes Care (D5)	4	1	?	2	1	Changing specifications
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: Composite	3	1	?	2	0	CMS recommended that this to be added to payment
Core-10	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: Chronic Obstructive Pulmonary Disease	3	1	?	2	0	CMS recommended that this to be added to payment
Core-10	Screening for Clinical Depression and Follow-Up Plan	3	1	?	0	2	
Core-20	Adult Body Mass Index (BMI) Assessment	3	1	?	0	2	
M&E-14	Avoidable ED Visits (NYU Algorithm)	2	0	?	2	0	

	Recommended by:
recommended by >1 entity	CMS, DVHA, DLTSS
	CMS, DVHA
	DLTSS
	DLTSS, VLA/HCA, Population Health

Attachment 3 - AHS Survey Presentations - Common Format

Common Format for
Presentation of AHS Survey Information to DLTSS Work Group

Draft – July 8, 2014

1. Brief Background of Survey Implementation in Vermont (maximum 5 – 10 minutes)
    a. Survey Purpose (general statement of survey goal and use)
    b. Source of Survey Instrument (e.g., national instrument, Vermont developed instrument, other)
    c. History of Vermont Implementation (when first started, frequency of implementation)
    d. Who conducts survey (e.g., state staff, state contractor, other)?
    e. How is survey funded (e.g., department budget, federal grant, other)?
    f. Format and Process for Presenting Survey Findings (e.g., written report, power point presentation at specific meetings)

2. Brief Overview of Survey Methodology (maximum 5 – 10 minutes)
    a. Survey construction (e.g., categories of questions, number of questions, format of questions)
        i. Please provide a handout of the actual survey instrument
    b. Specific Population Focus
    c. Sample Selection Process
    d. Data Collection Methodology (i.e., is survey administered by mail, phone, in person) and protocol (i.e., how are prospective respondents contacted)
    e. Historical Response Rates

3. Key Findings - From Most Recent Survey Year and Trends Over Time, if available
    a. Prominent Positive Findings
    b. Prominent Findings re: Areas Needing Improvement

4. Use of Survey Findings (i.e., who does what with them)

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

Attachment 4 - DLTSS WG Recommendation to Core Team re: Provider Grants Round 2

DLTSS Work Group Recommendation to the Core Team for the VHCIP Provider Grant Program, Round Two

June 26, 2014

At the June DLTSS Work Group meeting, Georgia Maheras requested input regarding the criteria for Round Two of the VHCIP Provider Grant Program. As a result, the DLTSS Work Group had a lengthy discussion about the need to bridge the knowledge gap among providers between acute/medical care and disability and long term services and supports (DLTSS).

An estimated one in five Vermonters has a disability[1], and people with disabilities are more susceptible to preventable health problems that decrease their overall health and quality of life.[2] To be healthy, people with disabilities require health care that meets their needs as a whole person, not just as a person with a disability. Yet, people with disabilities experience significant barriers to health care and health disparities when compared with persons who do not have disabilities.[3,4] A primary source of this disparity is the lack of knowledge about disabilities among health care providers (e.g., communication and other accessibility needs, socio-economic factors associated with disabilities and health outcomes, resources for services and supports).[5]

The DLTSS Work Group submits that addressing this provider knowledge gap is paramount in order to achieve the VHCIP goals of improving the care and health of all Vermonters, and reducing per capita health care costs. As such, the DLTSS Work Group unanimously recommended that the following be adopted by the Core Team for incorporation into the Provider Grant Program Request for Proposals:

"Amend the Provider Grant Program criteria to support specific provider grant proposals that include provider training activities to achieve person-centered, cross-disciplinary and culturally sensitive care specific to the needs of people with disabilities and long term service and support needs, and which include consumer input/participation and statewide applicability."

Following are proposed changes (underlined) to the language on pages 2-3 of the Vermont Health Care Innovation Project Grant Program Application (released on 1.16.2014) to achieve this recommendation:

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[1] http://www.cdc.gov/ncbddd/documents/Disability%20tip%20sheet%20_PHPa_1.pdf

[2] For example, adults with disabilities are 3 times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities. http://www.cdc.gov/vitalsigns/disabilities/

[3] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a3.htm?s_cid=mm6234a3_w

[4] http://www.cdc.gov/vitalsigns/disabilities/

[5] http://www.cdc.gov/ncbddd/disabilityandhealth/hcp.html

GP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;
    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure and workforce development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
    c. Development of management systems to track costs and/or quality across different types of providers in innovative ways;
    d. Provider training to achieve person-centered, cross-disciplinary and culturally sensitive care specific to the needs of people with disabilities and long term service and support needs.

Preference will be given to applications that demonstrate:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);
- Statewide applicability of the project learnings;
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field and that it is informed by service recipient experience and engagement;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots. The Green Mountain Care Board's specifications can be found here: http://gmcboard.vermont.gov/PaymentReform.

I. What these grants will fund

Grants will fund the following types of activities. Appendix B includes a detailed list of federal guidelines around this funding:

- Data analysis
- Facilitation
- Quality improvement, including provider training
- Evaluation
- Project development

Attachment 5 - Provider Training Discussion Guide

DLTSS Work Group Discussion Guide regarding Provider Training and Education

July 24, 2014

Ultimate Goal: Care by all providers throughout Vermont that is person-centered, disability-competent, cross-disciplinary and culturally sensitive for people with disabilities and long term service and support needs. *See Slides 18 and 19 from the DLTSS Model of Care (attached at the end of this document).*

Background: An estimated one in five Vermonters has a disability[1], and people with disabilities are more susceptible to preventable health problems that decrease their overall health and quality of life.[2] To be healthy, people with disabilities require health care that meets their needs as a whole person, not just as a person with a disability. Yet, people with disabilities experience significant barriers to health care and health disparities when compared with persons who do not have disabilities.[3,4] A primary source of this disparity is the lack of knowledge about disabilities among health care providers (e.g., communication and other accessibility needs, socio-economic factors associated with disabilities and health outcomes, resources for services and supports).[5]

DLTSS Work Group Role to Help Achieve this Goal: The primary purpose of the DLTSS Work Group is to "incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, related chronic conditions and those needing long term services and supports"(from DLTSS Work Group Charter). Addressing the gap in provider knowledge and care delivery is paramount in order to achieve the VHCIP goals of improving the care and health of all Vermonters, and reducing per capita health care costs. While the DLTSS Work Group does not have the resources to actually design, develop and deliver provider education and training, it is incumbent on the DLTSS Work Group to provide guidance on which the broader VHCIP efforts can build to address this gap.

Purpose of July 24th DLTSS Work Group Discussion:

To begin developing this guidance using the diverse perspectives of the DLTSS Work Group members by discussing the following questions:

Please draw from your personal and professional experiences during this discussion!

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[1] http://www.cdc.gov/ncbddd/documents/Disability%20tip%20sheet%20_PHPa_1.pdf

[2] For example, adults with disabilities are 3 times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities. http://www.cdc.gov/vitalsigns/disabilities/

[3] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a3.htm?s_cid=mm6234a3_w

[4] http://www.cdc.gov/vitalsigns/disabilities/

[5] http://www.cdc.gov/ncbddd/disabilityandhealth/hcp.html

1. Thinking about the following provider groups

- Emergency Room Staff
- Hospital Staff (e.g., Doctors, Nurses, Admissions, etc.)
- Primary Care Providers & Staff
- Medical Specialists & Staff
- Nursing Homes
- Home Health Agencies
- Area Agencies on Aging
- Designated Agencies – MH
- Designated Agencies – DS
- DLTSS Direct Care Workers
- Substance Abuse Providers
- State staff and Contractors
- Advocacy Organizations
- Others?

…. what training content would be most helpful?

Possible Content Areas:

- Definition and Identification of Disability
- Policy and practices relating to understanding and addressing disability issues across the lifespan, including issues relating to aging with a disability.
- Socio-economic Factors impacting Disability and Health
- Values-based training on effective practices for person centered and directed assessment, planning and service delivery, including information from/by people with disabilities and families on how to provide effective and respectful information and support.
- Making information and services accessible to individuals with specific disabilities:
    - Effective medical and DLTSS communication and decision-making with individuals with different disabilities and their families
    - Planning for and accommodating disability in clinical care
    - Knowledge of Vermont and related national DLTSSS services and supports
- Understanding and implementing linguistically and culturally competent practices relating to Vermonters with DLTSS support needs and their families
- Vermont public health initiatives and inclusive practices for Vermonters with DLTSS needs.
- What is Vermont Healthcare Reform and its implications for me (e.g., VHCIP, SSP and ACO 101)?
- Other – what's missing?

2. What has been your experience with receiving education / training related to the gaps identified above?

- What was the topic(s), audience for training/education, delivery method, your perception of its effectiveness?
- Was the training difficult to take advantage of due to cost, time constraints, or other barriers?

3. What training strategies make the most sense to you/your network? (Recommendations on this may vary by topic…or may not!)

Web-based Training/Education: Education and training modules that are designed for self-paced training via the Internet. This approach provides training that is flexible, interactive and convenient to accommodate busy schedules, and is typically accessible 24 hour a day, seven days a week. The training must be hosted by an entity that also manages administration of the training (e.g., participant registration, training completion, continuing education credits or other sources of recognition).

Webinars: Short for Web-based seminar, it is a presentation, lecture, workshop or seminar that is transmitted over the Web using video conferencing software at specific points in time. Webinars originate from one host (but can have more than one presenter) are available to many receivers across geographically dispersed locations. A key feature of a Webinar is its interactive elements -- the ability to give, receive and discuss information typically using written questions submitted by participants to the presenters.

Learning Collaboratives: Learning Collaboratives are designed to help organizations close gaps by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements. A Learning Collaborative combines subject matter experts in specific clinical areas with application experts who can help organizations select, test and implement changes (IHI, 2003). Learning Collaboratives: 1) are informed by evidence base; 2) include common measurement; 3) focus on actionable knowledge; and 4) strive toward behavior change by identifying clear actionable standards and providing tools for systems changes.

Hospital Medical Grand Rounds: Medical Grand Rounds seek to promote excellence and quality in clinical care; introduce clinicians to recent advances in medical care; provide updates on scientific advances that affect the practice of medicine; help doctors and other healthcare professionals keep up to date in important evolving areas which may be outside of their core practice; and provide a forum for discussion of topics that strengthen the relationship of Medicine to the broader community. Most departments at major teaching hospitals have their own specialized, often weekly, Grand Rounds. Many teaching and research hospitals have started providing streaming video of their Grand Rounds presentations for free over the internet, and/or video-tape them and make them available online at a later date.

Formal Education Courses: Content provided during the formal college / graduate level education process for medical and health care providers.

On-site Presentations: Face-to-face presentations to providers at their office locations.

Statewide Conferences: Multi-hour or multi-day events at a centralized location with multiple presentations organized around a common theme.

Dissemination of Written Materials: This strategy is intended to provide awareness and knowledge of the information being disseminated. It involves one-way communication from the source to the audience (i.e., a message is delivered, but there is little opportunity for an exchange of information with those who receive the message).

Others?

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Person-Centered and Person-Directed Services and Supports

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

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

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

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