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Think Tank – Day Two

LISTENING TOUR THEMES AND VISION STATEMENTS WITH SUPPORTING STRATEGIES

COMMUNITY BASED LEVEL OF CARE: *QUALITY*

LISTENING TOUR THEME	**VISION STATEMENT WITH SUPPORTING STRATEGIES IDENTIFIED**		
WORKFORCE/QUALITY OF CARE ***QUALITY IS ALSO BASED IN TRAUMA INFORMED CARE, GENDER INFORMED CARE, CULTURAL AND LINGUISTIC APPROPRIATENESS.*** ***WOULD LIKE TO SEE QUALITY APPROACHES THAT SPEAK TO MORE VULNERABLE POPULATIONS- MINORITIES, GENDERS, AGES***	There are optimal and appropriate levels of workforce resources to fully support all levels of care.		
	Short-Term	Mid-Term	Long-Term
	Strategy: **Steps:** • Gap and SWOT analysis- identify barriers (rural nature of VT), look at roles in the SOC, maximize them appropriately • Review EBPs • Assess need • Evaluate what is the right staffing mix	**Strategy:** **Steps:** • Deliver identified core competencies and trainings • Develop funding ability to pay for tuition, loan forgiveness, pay, benefits • Enact identified EBPs • Provide identified trainings and connect with colleges/universities	**Strategy:** **The right number of people with the right skill set to deliver services** **Steps:** • We have the right number of people, • Diversity in the workforce • Able to support entry level staff • Support professional development • Evaluate impact of EBP • Determine consistent trainings (WRAP, IPS etc.)

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LISTENING TOUR THEME	VISION STATEMENT WITH SUPPORTING STRATEGIES IDENTIFIED		
PUBLIC HEALTH DATA IS REDACTED RELATED TO SPECIAL POPULATIONS. THIS COULD BE DONE BETTER WITHIN ORGANIZATIONS RATHER THAN STATEWIDE. ***WHERE IS THE SUPPORT FOR ORGANIZATIONS IN STAYING CURRENT WITH QUALITY. HOW DO YOU RESOURCE THE SUPPORT? THINK ABOUT VBP MODELS THAT SUPPORT QUALITY.***	• Identify trainings and educational requirements that are needed • Right skill set, identify core competencies Have provider, consumer, state perspective at the table.		
WORKFORCE/QUALITY OF CARE	All Vermonters with mental health needs feel effectively supported on their path to recovery through a community culture that promotes dignity and respect.		

Commented [KA1]: Draft end state based on discussion of our wish to have something targeting the person's experience in care. Please weigh in.

Commented [KA2R1]: Short term, Mid-term, & Long-term goals were taken from our flip chart notes and matched with statements from the think tank. Please review to ensure they feel accurate with the tenor and details of our discussion.

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	Short-Term	Mid-Term	Long-Term
	Strategy: **Review existing patient/consumer/client experience measures** **Steps:** Identify existing practices for soliciting feedback in treatment and evaluate whether they should be expanded (ie: FIT – Feedback Informed Treatment) UVMMC- inpatient- have a weekly group that meets to discuss quality and provide input- gets response more immediately. How do you address the power dynamic of the person asking about quality of services. Push for independence in review. FIT model changes the culture and create a model of partnership. Identify essential elements that should be shared across providers –	**Strategy:** **All providers (private/peer/DA/SSA) have a process in place to receive input from the people they serve** **Steps:** Expand oversight beyond just DA/SSA system, bring private practice and other partners into the fold. Identify what types of oversight and accountability improve quality of care and what exists because it always has but is never utilized. Streamline paperwork! Both a reduction in documentation requirements AND Training on documentation. How to	**Strategy: Ensure patient/consumer/client experience is continually solicited and utilized** **Steps:** A level and scope of oversight and accountability that assures quality without overburdening organizations. Quality measures that are meaningful and uniform across organizations. Feedback from persons served incorporated at every level of the system (individual/ program/agency/state)

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	improves collaboration and communication – clarifies HIPAA requirements Identify areas where we are "blanketing" compliance policy procedures/documentation across community care when it is only necessary for certain programs or populations. Identify existing means for fostering person-centered care (ie: tx plan) and determine barriers to utilizing these means as such.	efficiently and clearly document service provision. Smarter use of technology – Ex: auto-population, carrying information forward so a person only has to tell their story once. Simplification of quality metrics across disciplines – streamlines the provider and consumer experience Update policies/procedures and documentation standards based on initial work to identify where they are being over extended.	

FEEDBACK FROM STRATEGY PREVIEW

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Review from previous:

- Discussing the placeholder. P. 22-23: community-based approach – consumer experience – making sure peers/people with loved experience have input in all levels of the process.

Level and scope of oversight- discussion with Dan- not enough accountability and oversight from client. Staff feel there is too much oversight. Try to make it meaningful without making it just 'more'. Providers frustrated with the overlapping documentation, need to be clear with public about this burden. People don't know about the provider perspective. Quality and transparency is the goal. Quality of services. Communication and collaboration- not just identifying elements. Overburdening organizations feels one-sided. Need accountability that is perceived as such by all people within the system of care. Want to make sure dignity and respect is included in action steps. Feedback should be in real time, not after the fact. As often as possible in real time.

Group D

Discussed vision statements. How to communicate what oversight is done. How to do quality oversight and not just quantity in oversight. At micro level this is FIT. How to do this timely feedback in real time. Integrating perspective of people being served. Theme of dignity and respect need to go through all of these visions. Specifics about ongoing training in MH- not just a one-off. In schools there is PBIS across all levels in the system- need to do this with MH in hospitals, DAs, etc. Why are grievances able to be resolved in 90 days? Need to be faster. How do you file a grievance with the healthcare system? There are ways to do this for physical healthcare too. Reality is that DAs deal with grievance within 48 hours. The documents have the time frame- are we creating a culture of legal process or the human interaction. The 90 days is standard. Treatment is all about relationships- working with teenagers- there is no feedback loop to tailor services to what service recipients want. Need open communication procedure then we don't need a grievance procedure. We don't have anything yet to appeal the current grievance procedure. Most people say I really like services there aren't enough of them. Need long term study of coercion- what happens after 5 years of data of impact of EE, involuntary medication and ONHs. Curious- quality across DAs comparability from DA to DA- are there standards of care. DMH has a formalized review process for this. That is not to say quality does not vary across DAs. Part of this is the array of services that are able to be provided. How do we evaluate quality and capacity across the system? How do we map out what services are available in each catchment area? It is suspicious we don't know what is available in each catchment area? Spent years trying to map

it out. Does every DA have the same crisis response? What about the economy of scale- 64 superintendents for 80,000 kids in VT? Why only 10 designated agencies? There are cities in other states that have more people in Vermont- should have less agencies in Vermont to do this work. You won't get money out of the system by collapsing them. Need to develop strong communities- when you pull towns apart you don't have a strong community. Promoting a culture of dignity and respect- beyond grievances- please share with this committee.

Group 1: Broad umbrella of gap analysis and SWOT- how well versed providers are in EBP. How do we define quality- not wanting this to be an add on for agencies. Quality in perspective of client and FIT. Concern/suggestion: pay attention to special populations – how to measure quality for geriatric, bilingual, refugees. Workforce development- are young people being training in quality across programs or just in one practice such as CBT. If we agree on quality- how do we give programs stamps of approval (such as COE work). Through value-based contracting, support for extra training.

Debate- how to do that without punishing those that are struggling with quality. How to be strengths based with the workforce. ADAP has come up with new requirements for their providers- demonstrate cultural competence. How do we evaluate this without supporting the initial training and support. Want best practices. Need to shift towards professional development at tier 1 and away from giving kudos to those already doing it well. Need to incentivize earning additional money? Is there research to support this? Depends on what you are incentivizing. Rewarded for how well instead of how much. Everyone wants to measure different things- all of these over-burden providers. Discussed examples of this. The goal is to have some shared measures across systems (DMH, feds, insurance, etc).

How are we stamping programs? How do clients measure quality?

Group 2/3: Reinforcement for what we have. Validation for workforce. Doing gap analysis. Acknowledge balance between oversight without over-burden. Be more transparent for those using the services. Are there dashboards for oversight? Gave examples of what this would look like. Would like to have public dashboards so that public can see the measures. Could this be a comparison across DAs? Feedback about Grievance and Appeals process. Supporting those that need support. We look at aggregate data. We want to

incentivize good outcomes without stacking people against one another. Strength in the system of people working together. Want innovative practices to share across- lend people to one another. We don't want unhealthy competition between agencies. Competition can be healthy. Legislators are frustrated that core services are the same but additional services can be added regionally. Does this discourage innovation? On medical side you can see the report cards and outcomes to choose where you can get care with a great result. We don't do this on the mental health side. There is no competition between counties in MH in VT. Should we be doing this? Need to be able to talk about what is already in place. How to do it in a way that encourages core services. How to support agencies that are struggling.

Cheryle's Group

Community Profiles, OneCare has a lot of data- how do we look at data sharing.

Increase peer supports

Really use all components of the PDSA: Look at data and determine what information is needed and makes the most impact-how do we accurately study the data and report out on it.

Client satisfaction surveys/ focus groups- evaluation prior to leaving the hospitals – more immediate feedback

VCP has a survey with 6 questions that are universal for all DA's and the DA's have their own quality standards

Focus groups to gain a better understanding.

OneCare – the PRAMS measures, ICHAM- worldwide group that looks at individual groups to identify what is important to them versus what the system thinks is important to them.

We as a system can be better at asking what people value and think is important to them and how do we as a system meet those requests. How do we measure these on a fundamental and elegant level.