

***VT Health Care Innovation Project
Care Models and Care Management Work Group (CMCM) Meeting Agenda***

**Tuesday, November 12, 2013; 10:00 AM to 12 Noon
DFR Third Floor Large Conference Room, City Center, 89 Main Street, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454**

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:10	Welcome and Introductions		
2	10:10-10:30	Report from Joint Insurers Group (Goals and Activities)		
3	10:30-11:30	Presentations from Work Group Members on Care Management Activities: VCCI (Eileen Girling and Kathy Shuster) and DAIL (Marybeth McCaffrey and Kathy Rainville)		
4	11:30-11:45	Draft Charter and Work Plan	1.Care_Models_and_Care_Management_Charter_DRAFT_20131108_EB 2.Work_Plan_Care_Management_Draft_20131011	Yes
5	11:45-11:55	Revised Inventory Template/Glossary Revisions	1.Care_Management_Inventory_Template_v2_20131029 2.Care_Management_Activity_by_Organization_20130910 3. Care Management Glossary 8-26-2013	Yes
6	11:55-12:00	Next Steps, Wrap-Up, Future Meeting Schedule, Webinars	1. Proposed CMCM Meeting Schedule 20130811	Yes (meeting schedule)

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes

Tuesday, November 12, 2013; 10:00 AM to 12 Noon
 DFR Third Floor Large Conference Room, City Center, 89 Main Street, Montpelier, VT
 Call-In Number: 1-866-951-1151; Passcode 7865626

Attendees: Susan Barrett, Renee Kilroy, Pat Jones, Madeleine Mongon, Kelly Champney, Kathy Schuster, Ena Backus, Erin Flynn, Georgia Maheras, Steve Dickens, Nancy Breiden, Nelson LaMothe, Eileen Girling, Marybeth McCaffrey, Kathy Rainville, Jenney Samuelson, Aaron French, Catherine Simonson, Audrey-Ann Spence, Suzanne Leavitt, Peter Albert, Trish King, Julie Wasserman, Judy Morton, Nancy Eldredge, Ann Furnam, Steve Broer, Eileen Girling, Linda Johnson,

Agenda Item	Discussion	Next Steps
1 Welcome & Introductions	Co-Chairs Susan Barrett and Rene Kilroy opened the meeting.	
2 Report from Joint Insurers Group	<p>Pat Jones briefed the group on the Joint Insurers' Group which was created to support the ACO implementation on Jan 1, 2014 with a focus on care management for high risk patients. The goals of the Joint Insurers Group included</p> <ul style="list-style-type: none"> - coordination of care without duplication, and avoiding confusing he patient - "Who does what?" Pat and staff develop an inventory template - Developed a draft Glossary of terms and distributed same - Studied the PCMH oriented best practices of Network Health (MA) to tackle duplication of services issue - Developed a draft model for CMCM. <p>The Joint Insurer's Group will meet again on Nov 13, 2013 Madeleine Mongon proposed that the work product be posted on Project Reporter, all agreed.</p>	
3a &b Presentations from members on Care Management	Kelly Gordon, framed the next 2 presentations with the metric that the top 5% of MCAID (non-Duals) beneficiaries account for 39%.of total MCAID cost. The top 5% group exhibit high complexities of medical needs resulting from socio-economic and behavioral issues. This segmented population also exhibit multiple complex medical conditions and co-morbidities	

Agenda Item	Discussion	Next Steps
Activity	<p>including substance abuse. This complex dynamic results in a high utilization of the emergency dept, pharmacy, hospital admissions and re-admissions.</p> <p>VCCI proactively deploys approximately 25 medical professional FTE's (RN's, LicSW's and Substance Abuse Counselors) across the state to un-cover gaps in care for this complex and high-utilizer group. Some staff are embedded at hospitals working with discharge planners, others engaged at the community level partnering with Blueprint. In 2012, this effort is credited with saving approximately \$11.5 million, 2013 savings will be reported in January.</p> <p><u>Documents:</u> - "Vermont Chronic Care Initiative: Case Management/Care Coordination Services"</p> <ul style="list-style-type: none"> - "Integration of Blueprint and DVHA VCCI" <p>Kathy Shuster & Eileen Girling presented a case in point: Sue, a 54 year old discharged from a hospital with congestive heart disease, on oxygen 100% of the day, resided in a converted hotel room, and had no source of income. An assessment was completed, and case managers were assigned to work with care providers. This involved meeting with providers, visiting nurses, and transporting Sue to FQHC's for care. Sue was re-admitted 28 days later with severe upper respiratory infection. Case managers worked to get Sue admitted to a post-discharge facility, obtained a Social Security disability assessment and incremental housing funding, encouraged Sue to join a pool therapy 3 days per week, connect with new people, and old work colleagues. Sue is now off oxygen, and returned to work 4 hours a week. Developing and nurturing the relationship between the primary care physician and Sue were also key to this successful outcome.</p> <p>Kelly Gordon asked Kathy what her suggestions are to facilitate successful care management. Kathy responded: engage with the patient at discharge; meet with discharge planners and utilization review staff; network with care management colleagues, building those relationships is critical for the patient. Marybeth McCaffrey and Kathy Rainville (DAIL) Kathy Rainville asked about caseload. Kathy Schuster suggests the caseload is approximately 25-30 cases per field care management worker. Contrasting field work to Hospitals, Kathy Rainville suggests the caseload for Hospital care management workers is approx. 50 cases. That work incorporates many activities: assessing patient's needs including pharmacy, transportation, accompanying patient at provider visits, identifying and coordinating with other care management partners, and health-life coaching. The top 5% comprises approximately 7500 citizens of Vermont. Goal is to work with patients through the most challenging issues over the 90 day term, and transition the patient to</p>	

Agenda Item	Discussion	Next Steps
	<p>an advanced medical home setting.</p> <p>Madeleine Mongon asked about Blueprint's access to hospital data. Jenny Samuelson advises some have access, some do not. Sue Barrett indicated that the top 5% dataset is a focus of the HIE Work Group, with the intent to provide data to clinics and small providers.</p>	
3c " " " "	<p><u>Document</u>: "Care Models and care Management: a Long Term Services and Supports Perspective"</p> <p>Marybeth McCaffrey presented on the topic above. Noteworthy is that patients with the greatest and most complex need require the most comprehensive support system, and that private insurance does not cover these services. The focus on how multi-disciplinary approaches to a "person centered process" can be successful desired outcomes.</p> <p>A vignette of "Clara" offered a case study of the Choices for Care Model. A 2nd vignette of "Tricia" offered a case study of the Dual Eligible Care Model.</p>	
4a Draft Charter and 4b Draft Work Plan	<p><u>Document</u>: Care Models & Care Management Charter DRAFT 11.08.2013</p> <p>Ena Backus and Pat Jones presented the draft charter to the group. Several suggestions from the attendees included:</p> <p>Purpose section: add a definition of care models; edit in the concept of "improving care for patients"; edit in "integration of care and support"; edit in "person and family centered"; replace "inconsistent" with "mis-aligned".</p> <p>Scope section: Madeleine Mongon suggests that "care models" be defined by the Workforce Work Group. Georgia Maheras suggested that the SIM definition would be most appropriate. Kathy Rainville suggested adding best "evidenced based" practices in bullet #4. Georgia Maheras indicated that the goal was to find innovative methods for bullet #5. Nancy Eldredge suggested the CMCM purpose was to identify "one system". Georgia clarified that one system is the SIM goal, and that the nature of care models/care management would definitively recognize the variables required.</p> <p>Deliverables section: no comments</p> <p>Member requirements section: no comments. A request for contact info of all CMCM</p>	<p>Syaff to make edits based upon Participants contributions and present at next meeting.</p>

Agenda Item	Discussion	Next Steps
	<p>participants was requested.</p> <p><u>Document:</u> Work Plan, Care Management DRAFT 10.11.2013 (for FYI only as a Work in process, and not discussed.)</p>	
<p>5a Revised Inventory 5b Care by Org 5c Glossary revisions</p>	<p><u>Document:</u> Management Inventory template 10.29.2013</p> <p><u>Document:</u> Care Management Activity by Organization</p> <p><u>Document:</u> Care Management Glossary</p> <p>Documents distributed as a work in progress and FYI... Pat Jones asked the CMCM Work Group to allow the staff to edit comments and supporting activities to the above drafts and review at the next meeting. Any comments or suggestions should be forwarded to staff: Pat Jones, Ena Backus, and Erin Flynn.</p>	
<p>6 Next steps, Wrap up, Future meeting schedule, Webinars</p>	<p>Proposed CMCM Meeting Schedule 08.11.2013</p> <p>Next steps : Pat suggests there's a lot of work ahead and to facilitate that work, a conf call and/or taped webinar twice per month could be very helpful. The webinar option was favored by the group and Susan Barrett will get back to the group about the outcome.</p>	

AGENDA ITEM # 3A

Vermont Chronic Care Initiative: Case Management/Care Coordination Services

Indicators for Referring to DVHA VCCI:

- Intensive Case Management and Care Coordination (home visits, multiple diagnoses)
- Limited health literacy with respect to condition(s)
- Medical, behavioral, and/or psychosocial instability, leading to gaps in care
- Emerging needs identified that could destabilize future plans for health improvement (e.g. housing or financial insecurity impacting ability to manage health)

Eligibility Criteria:

- Be enrolled in Medicaid program - no dually eligible populations
- Multiple complex health conditions. Individuals who have co-occurring conditions of substance abuse and/or mental health diagnoses may be especially good candidates
- High ER utilization, frequent hospitalizations, poly-pharmacy and/or high predictability of future health care complications
- Not currently receiving other case management services (e.g. CMS covered case management such as CRT, Choices for Care/PACE and/or other waivers)
- Not currently residents of nursing homes or assisted living facilities
- Not have Medicare or other primary insurance coverage; or be incarcerated.

Case Manager/Care Coordinator Role: Overall responsibilities include: Advocacy,

Assessment, Planning, Implementation, Care Coordination, Monitoring, Evaluation, and Outcome analysis. The Case Managers are Registered Nurses, Licensed Clinical Social

Workers or Licensed Alcohol and Drug Abuse Counselors, and Medical Social Workers with direct and relevant experience with holistic care management and community support networks to facilitate sustainability. The case managers/care coordinators:

- Facilitate access to a medical home, specialty care and communication among providers.
- Assess clinical and psychosocial need and develop a plan of care based on priority of the provider and beneficiary, and social factors impacting health outcomes.
- Facilitate communication and coordination among providers to support the treatment plan, minimize contraindicated or redundant treatments, including mental health and substance abuse providers.
- Support development of skill and confidence required for effective self-management of chronic condition via coaching, education, and/or referral to programs and/or services (certified diabetic educators, Healthier Living Workshops); and monitoring progress.
- Refer to appropriate resources to reduce the socioeconomic barriers to health and health care, including access to safe and affordable housing, employment, food stamps, fuel assistance and transportation to health care providers as appropriate.

Integration of Blueprint and DVHA VCCI

AGENDA ITEM 3B

DVHA VCCI

Eligibility Criteria for Referring to VCCI

1. Ages – individuals up to age 64, (assume SSI at 65),
2. Medicaid primary coverage (Dual insured are ineligible), Predictive modeling acuity rating= very high risk, and complex chronic conditions, including those generating high utilization (IP/ED, multiple providers, no PCP, etc...)
3. Intensive case management required (complex need, in-person visits), but are not covered by other case management services
4. Limited health literacy with respect to medical condition(s)
5. Medical, behavioral and/or psychosocial instability adversely impacting health
6. Emerging needs identified that could destabilize future plans for health improvement (housing instability, pharmacy non-adherence)
7. Substance use/abuse history including MAT post induction and stabilized in tx
8. PCP, hospital or AHS referral for high risk factors impacting health
9. High Risk Pregnant women including MAT (pilot Franklin County)
- 10.

Blueprint CHT

CHT Activities

1. Provides ongoing support for general patient population in Patient Centered Medical Homes (PCMHs) across a community
2. Work closely with PCPs to optimize adherence rates with age and gender appropriate health maintenance and prevention
3. Work closely with PCPs to optimize ongoing adherence with individual care plans
4. Work closely with PCPs to monitor and evaluate care plans with modifications as needed
5. Work closely with PCPs to support achievement of self-management goals with reevaluation and modification of self management goals and plans as necessary
6. Linkages to social support and economic services that contribute to health and well being
7. Work closely with PCPs to coordinate care across all domains of the healthcare system
8. Work closely with PCPs to assure that care support is suited by USPSTF recommendations and disease specific guidelines adapted by the Blueprint providers
9. Continuous evaluation of the need to transfer care back to DVHA and/or case closure

DVHA/VCCI Activities

1. Confirm eligibility
2. Outreach to Member and access needs
3. Obtain a PCP if member does not have one.
4. Create POC working collaboratively with member and physician.
5. Secure needed resources (food, shelter etc.) and collaborate with providing agencies
6. Work closely with PCP and member to manage complex chronic conditions.
7. Attend member appointments
8. Frequent visits to evaluate member's progress in managing medical condition, assess for changes that may require additional supports/ or changes to POC.
9. Continuous evaluation to determine need to transition care back to CHT or case closure.

Shared Tools

1. Evidence-based guidelines
2. Patient Care Plans
 - Action Plans
 - Clinical Data
 - Health Briefs
3. DocSite Clinical Tracking Tool
4. Population reports(NCQA); gaps in care

Transitioning from DVHA VCCI to Blueprint CHT

1. General and at least one disease specific assessments performed
2. Care plan implemented and mutually agreed upon by beneficiary and provider (readiness for change)
3. Initial coaching to evidence-based guidelines performed; action plan(s) initiated
4. Basic knowledge about condition(s) and motivated to change
5. Care plan goals and objectives related to the primary diagnosis met or partially met/in process
6. Medical home established and utilizing
7. Medical, behavioral and psychosocial stability stabilized

Care Models and Care Management: a Long Term Services and Supports Perspective

November 12, 2013
Marybeth McCaffrey, JD, Principal Health Reform Administrator
Department of Disabilities, Aging and Independent Living

1

What is LTSS?

Long term services and supports (LTSS) are a range of medical, personal, and social services that can help people with functional limitations live their lives more independently.

Supports range from daily living (e.g. grocery shopping and food preparation) to 24-hour medical care provided in nursing homes.

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Step One:
Observation



2

Why Are LTSS Care Models Fundamental to Health Reform?

- For at least a decade, there has been consensus that people who are elderly or disabled are **the most complex and expensive populations** that Medicaid supports.

(e.g., Kaiser, Robert Wood Johnson, Center for Health Care Strategies, CMS)

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LTSS Care Models - Guiding Principles

LTSS programs support greater integration of care for people with the most significant needs.

Federal partner (CMS) includes these 5 principals among its areas of review, approval, and oversight of states' LTSS programs:

Goals

1. Person-centered Processes with Stakeholder Engagement
2. Comprehensive and Integrated Service Packages
3. Quality Measures
4. Adequate Planning and Transition of Care Strategies
5. Payment Structures Aligned with LTSS Programmatic Goals

May 2013

<http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topic/Delivery-System/Downloads/MLTSS-Summary-Elements.pdf>

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Person Centered Processes ...

... the people are the center!

Regardless of our myriad models & theories, people just don't fit models of single programs



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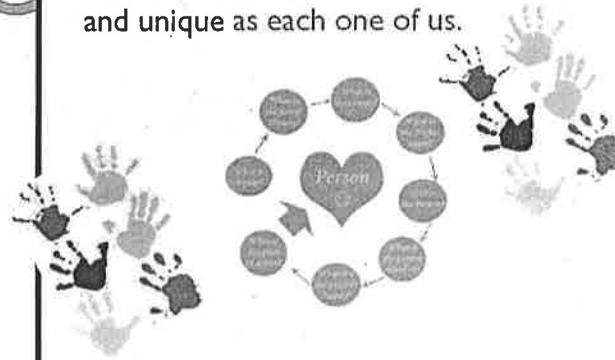
Person Centered Processes a fundamental component to effective LTSS care management



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Person Centered Processes

Reflect that people's lives are as complex and unique as each one of us.

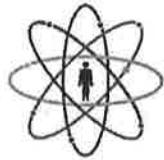


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Person Centered Processes

Necessary:

Broad generalizations can be made about people's preferences and needs...



... No one single program or combination of programs accommodates everyone

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LTSS Person Centered Care Management The Present

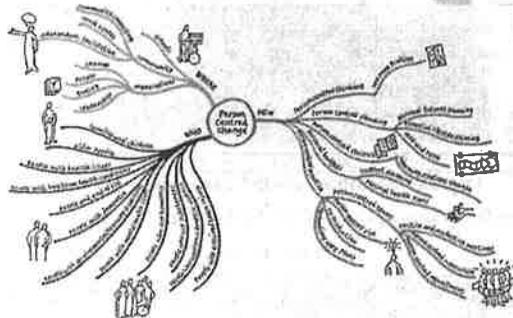
Here today because we believe it is possible to improve a necessarily reactive system by proactively designing structures – across the whole health continuum – that better meets the triple aim:

- To give best care
- With best quality
- At lower costs



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LTSS: Person Centered Care Management (who needs support? how do they need to be supported? where are supports needed?)



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LTSS Person Centered Care Management Our Charge

- Examine current and planned care management approaches across the whole continuum:
 - How can we be more responsive to a person's actual needs, improve the quality of their care, and deliver it more efficiently?

Our challenge is to proactively develop "systems" that meet our **fundamental principles** of care management.

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LTSS Person Centered Care Management Broad Goals

- Integrate full continuum of care: prevention, primary, complex, chronic, long term
- Provide responsive person-centered services

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LTSS Person Centered Care Management Desired Outcomes

- People are healthy
- People have good quality of life
- People have stable, affordable housing
- People living in the setting of their choice
- People are engaged with their families, friends and communities
- People who want jobs have jobs
- People feel safe, respected and valued
- People are able to pursue their individual goals and preferences
- People's choices are supported
- People find it easy to access the services they need
- People are satisfied with services

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LTSS Person Centered Care Management Our LTSS Principles

A person-directed support system is:

- Life-affirming
- Strength-based
- Satisfying
- Humane
- Meaningful

Core values include:

- Choice
- Dignity
- Respect
- Self-determination
- Purposeful living

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2 Case Examples

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Model 1: Choices for Care
Moderate Needs

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Choices for Care – Moderate Needs
Tricia's Challenges

- Complexity medical conditions (hemiplegia, strokes, frequent seizures)
- Single parent of 3 children, two with special needs
- Recent loss of voluntary natural support (retired case manager)

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Choices for Care –
"Tricia"
Moderate Needs

Single mother, 41 years old
Receives services because of many strokes, seizures, and memory problems
3 children under age 18
Receives SSI, Medicaid, no transportation
Receives 12 hours/year case management per year
Requesting 6 more hours to help with paying bills



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Choices for Care – Moderate Needs
Tricia's Team

1. Joanne Jones - Primary Care clinical coordinator – brings team together every 6 weeks, and manages medications and care in between.
2. Susan Minor - Chronic Care Initiative case manager – allocated 2 hours per month to manage eligibility, medical appointments coordination
3. Mary Ellen Riley - CFC case manager (MNG) – 1 hour/month historically has picked up the areas that are beyond what Joanne and Susan could support (mental health counseling, utilities, rep payee, home upkeep/modifications)
4. Primary care physician
5. Designated agency counselor
6. Voc Rehab counselor for help with assistive technology and learning to drive
7. Speech Therapy for help using assistive technology
8. Occupational Therapy for assistance with cooking
9. Caring Citizens – community organization willing to assist with bills
10. Lawyer – Maria Delmar, Esq.

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**Choices for Care – Moderate Needs
Gaps in Care Model**

- Despite large service team, no support for keeping household bills organized and paid
- Granted a "variance" to permit 6 more hours year for this support.

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**Choices for Care: Clara
Transition through Program**

(special thank you to CVAA, Care Manager, Meg Burmelster)

75 years old Isolated and homebound in 2007

Husband died 8 years ago

Diabetes, angina, memory loss, incontinence, depression and fatigues easily.

Cluttered subsidized apartment,
Needed help with transportation, insurance, cleaning, and meal preparation.



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Model 2: Choices for Care High Needs

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2007 -2009	
<ul style="list-style-type: none"> • Referred by primary care doctor to CVAA due to poor <u>nutrition</u> • <u>Counseling</u> thru the elder care clinician program at WCMH • Intermittent <u>home care</u> through the local Visiting Nurse Association. • Placed Clara on the moderate needs wait list • <u>Homemaker</u> services in 2008 • Developed close relationship with <u>Senior Companion</u> • <u>Outcome:</u> with noted improvement in housing, she invited friends over 	<ul style="list-style-type: none"> • She is steadfast in her desire to remain in the community. • Family did not feel she should be living alone, however. Numerous family problems arose including one of her children manipulating her money. • Adult Protective Services (APS) became involved and made visits. Daughter was found to be exploiting her and rep payee was put in place to aid with financial resources and to eliminate the exploitation. • Clara gained some ability to put limits and boundaries in place with her family grew thru the work of the Area Agency on Aging Case Manager, Home Health staff, and Elder care clinician.
Choices for Care: Clara 2007-2013	

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2009-2012	2012-2013
<ul style="list-style-type: none"> • Clara's memory continued to deteriorate • Eventually moved in with her son. • Son and daughter in law began to experience more challenges with her behaviorally. • Clara was alone during the day as her son and daughter in law needed to work. • Adult Day services were added • Son began to seek another placement as he was feeling burned out and her behaviors were increasingly challenging. 	<ul style="list-style-type: none"> • Just as she was to be placed in a facility, a friend came into the picture and offered to have Clara live with her. • This process revealed more of her impairment: she became incontinent and had challenges caring for herself. • The case manager worked on applying for greater CFC supports this past spring and she is now cared for at the home of her friend and Adult Day on the Choices for Care Program.

Choices for Care: Clara
2007-2013

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Model 3:
~95% Choices for Care
Participants have Dual Eligibility

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Present	Gaps
<ul style="list-style-type: none"> • She began to get out to the senior center and continues in her friend's home. • It took the combined services of many types of support to help her remain independent and in the community. 	<ul style="list-style-type: none"> • Caregiver Support • Natural Supports • Housing

Choices for Care: Clara
2007-2013

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**People with Dual Eligibility
for Medicare and Medicaid**

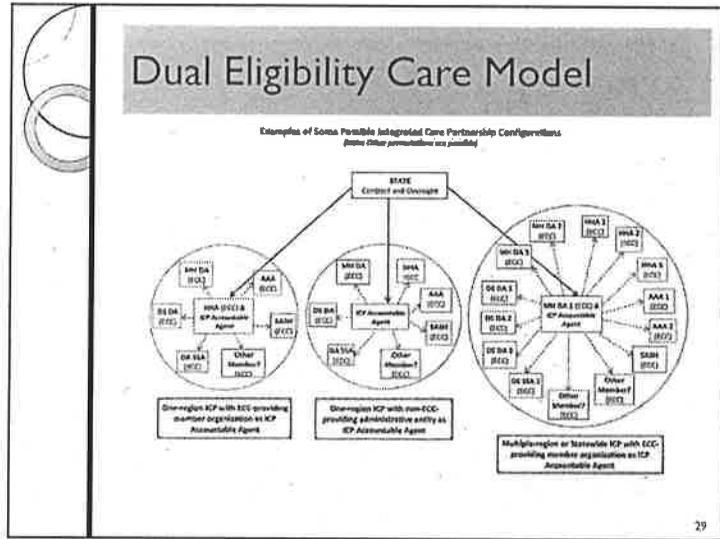
Care model summary (2013)

- Care Coordination
- Assessment and Plans
- Web-based clinical registry

<http://humanservices.vermont.gov/dual-eligibles-project/dual-eligibility-model-of-care-synopsis/view>



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LTSS Care Management Approach Observations

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- ### Dual Eligibility Care Model
- SIM Care Models and Care Management Workgroup**
- *DUALS Person Centered Care Workgroup*
 - *DUALS Service Delivery Models Workgroup*
 - *DUALS Individual Assessment & Comprehensive Care Plan Workgroup*
 - *DUALS Essential Components of Person-Directed Approach Workgroup*
 - *DUALS Pharmacy Program State team*
- Duals CMS/NCQA approved DVHA Model of Care as a "Medicare Advantage" Plan
 - Duals Person-centered Policy
 - Duals Integration of Self-management Services
 - Duals Individual Assessment deliverables*
 - Duals Draft RFP Criteria for ICP/ICP+
 - Duals Integrated Medicare/Medicaid pharmacy benefit*
- Completed deliverable
* In progress
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What do people want?

Information

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LTSS Care Management Approach
Observation: Ready Access to Integrated Multidisciplinary Resources

- Who will help me make choices, provide me with information, help me prepare for the next steps?
- Our task: look at the evidence ... in similar scenarios what is the same, what is different, what works best more often?

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LTSS Care Management Approach
Observation: These are the reasons research supports that the best design approach is a Person Centered Process

- A fundamental problem for very complex systems like health care is that no one is "in charge," no one has the authority or resources to design and manage the entire system.
- Research supports that the best health outcomes come from person-centered processes

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What else do we want?

Someone there with us

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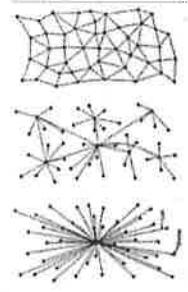
What else do people want?

Well-coordinated Team

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LTSS Care Management Approach

Observation: Behaviors of complex adaptive systems can usually be more easily influenced than controlled.



Complex adaptive systems characteristics:

- *nonlinear and dynamic* system behaviors may appear to be random or chaotic
- composed of *independent agents* whose behavior is based on physical, psychological, or social rules rather than the demands of system dynamics
- agents' needs or desires, reflected in their rules, are not homogeneous, their *goals and behaviors are likely to conflict*.
- Agents are *Intelligent*. As they learn, the overall system behavior inherently changes over time.
- Adaptation and learning tend to result in *self organization*. Behavior patterns emerge rather than being designed into the system.
- There is *no single point(s) of control*. System behaviors are often unpredictable and uncontrollable, and no one is "in charge."

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LTSS Care Models – look past to prepare for the future

LTSS spending in VT Medicaid

GROUP	CASELOAD	EXPENDITURE	PPM
Choices for Care	3,880	\$98,671,065	\$4,239
ABD child	3,720	\$39,276,187	\$1,737
ABD adult	14,141	\$78,931,016	\$930
ABD dual	16,978	\$86,312,782	\$517

through Dec 2012 <http://www.vt.gov/state.vt.us/files/pers/2013/ExternalReports/286790.pdf>

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Trends

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LTSS Care Models – look past to prepare for the future

Vermont has compelling data showing our death rate from falls is statistically higher than the national rate.

- VT Rate per 100,000 21.0
- US Rate per 100,000 7.3

Source: U.S. WICQARS: VT Vital Statistics 2009

In 2007, in VT there were

- 133 deaths
- 2,261 hospital discharges
- 21,526 ED Visits for fall related injuries.

Most patients with hip fractures are hospitalized for one week.

- 1/3 of those hospitalized for a hip fracture cannot return home or live independently after their injury.
- 89% of all hospital discharges for hip fractures were from a fall.

- Up to 1/4 who live independently before the hip fracture has to be placed in a LTC facility for at least a year after injury.
- One in five individuals dies within one year. From 2003-2007 in VT, the majority of death related falls occurred at the same level (59%)
- Inclusion of fall risk management measure could focus attention where needed.

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LTSS Care Management – full continuum ... possible next steps

NEAR TERM (Dec-Jan)

- What other LTSS models do we want to learn about?
 - DUALS?
 - Mental Health and Developmental Disabilities Services

MEDIUM TERM (Jan-Mar)

- What LTSS Quality and Design Features do we want to recommend?
 - Quality – Should we request input on performance measures for improved LTSS coordination and care?
 - HIE – Should we invite support design use cases to consider LTSS delivery model options?

LONGER TERM (April)

- What financial incentives will promote LTSS quality and design improvements



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Discussion



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October 24, 2013 DRAFT

Assess 1/13/14

Vermont Health Care Innovation Project
Care Models and Care Management Work Group Charter

DRAFT

PURPOSE

The purpose of the Care Models and Care Management Work Group is to maximize the effectiveness of care models and care management tools/activities in Vermont's health care delivery system while minimizing duplication of effort and inconsistencies between the models and management tools/activities. The overarching goal is to develop an integrated delivery system that results in coordination, collaboration and the "right care by the right organizations at the right time" for people in need of services and supports.

SCOPE OF WORK

- Develop understanding of current landscape of care management activities, including processes for collaboration.
- Identify programs and models of interest both within the state and across the country.
- Identify redundancies, gaps, and opportunities for coordination.
- Research, summarize, and review best practices in care management.
- Identify characteristics and goals of ideal care models/care management activities for Vermont.
- Make recommendations to the Vermont Health Care Innovation Project Steering Committee on the reinforcement, extension and/or adaptation of existing care models, and/or adoption of additional care management activities, to support Vermont's goals.
- Identify implementation needs (e.g. electronic and other information, communication, provider engagement) and potential resources to meet those needs.

DELIVERABLES

- Glossary of care models and care management terminology.
- Inventory of care models and care management activities in Vermont.
- Literature Review of evidence-based care models and care management activities.
- Inventory of electronic and other information and communication tools to support care models and care management activities.
- Recommendations on consistent, coordinated approaches to care management and models of care, including implementation needs.

MILESTONES

Winter 2013-14:

October 24, 2013 DRAFT

- Completed glossary of care models and care management terminology.
- Completed Inventory of care models and care management activities in Vermont.

Spring 2014:

- Completed Literature Review
- Recommendations on consistent and coordinated approaches and implementation needs.

Fall 2014:

- Completed inventory of electronic and other information and communication tools to support care models and care management.

Winter 2014-15

- Begin testing of consistent, coordinated approaches to care management and models of care.

MEMBERSHIP REQUIREMENTS

The Care Models and Care Management Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the work group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Bea Grause, Vermont Association of Hospitals and Health Systems
Bea@vahhs.org
- Susan Barrett, Bi-State Primary Care
sbarrett@bistatepca.org

Work Group Staff:

- Pat Jones, Green Mountain Care Board
Pat.Jones@state.vt.us
- Ena Backus, Green Mountain Care Board
Ena.Backus@state.vt.us
- Erin Flynn, Department of Vermont Health Access
Erin.Flynn@state.vt.us

Additional resources may be available to support consultation and technical assistance to the work group.

DRAFT 10/11/13 – Work Plan for Care Models and Care Management Work Plan

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Group logistics: charter, membership, meeting schedule, resource needs, etc.	<ul style="list-style-type: none"> Review and refine draft charter Review membership list for gaps Develop 2013-2014 meeting schedule Identify resource needs 	December 2013		<ul style="list-style-type: none"> Draft charter in SIM Operational Plan Membership list developed 	<ul style="list-style-type: none"> Final Charter Comprehensive membership list 2013-14 meeting schedule Resources are adequate to accomplish objectives
Review work of Joint Insurers Care Management discussion.	<ul style="list-style-type: none"> Summarize Joint Insurers Work Determine remaining tasks related to short-term coordination of care management activities 	December 2013		<ul style="list-style-type: none"> Work still in process 	<ul style="list-style-type: none"> Plan for coordination of care management activities
Develop understanding of current landscape of care management activities, including processes for collaboration.	<ul style="list-style-type: none"> Identify entities that conduct care management activities Identify data elements related to those activities (including processes for collaboration) Collect written information on data elements As requested by work group, ask selected entities to attend work group meetings to describe their activities in greater detail Use information collected to develop detailed care management inventory 	January 2014		<ul style="list-style-type: none"> Initial list completed Data collection tool developed; probably needs refinement Data obtained from several organizations 	<ul style="list-style-type: none"> Comprehensive Care Management Inventory Work group members indicate understanding of current care management landscape
Identify redundancies, gaps, and opportunities for coordination.					
Research, summarize, and review best practices in care management.		Should be concurrent with current landscape work			

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Identify characteristics and goals of ideal care models/care management activities for Vermont.					
Recommend reinforcement, extension and/or adaptation of existing care models, and/or adoption of additional care management activities, to support Vermont's goals.					
Identify implementation needs (e.g., electronic and other information, communication, provider engagement) and potential resources to meet those needs.					

AGENDA ITEM #6

PROPOSED Meeting Schedule for Care Models and Care Management Work Group

Second Tuesday of Each Month from 10 AM – 12 PM

Location TBA

- October 29, 2013 10 AM – 12 PM
- November 12, 2013 10 AM – 12 PM
- December 10, 2013 10 AM – 12 PM
- January 14, 2014 10 AM – 12 PM
- February 11, 2014 10 AM – 12 PM
- March 11, 2014 10 AM – 12 PM
- April 8, 2014 10 AM – 12 PM
- May 13, 2014 10 AM – 12 PM
- June 10, 2014 10 AM – 12 PM
- July 8, 2014 10 AM – 12 PM
- August 12, 2014 10 AM – 12 PM
- September 9, 2014 10 AM – 12 PM
- October 14, 2014 10 AM – 12 PM
- November 4, 2014 10 AM – 12 PM