

Care Models and Care Management Work Group Meeting Agenda 6-10-14

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

Tuesday, June 10th, 2014; 10:00 AM to 12:00 PM

Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT

Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00 - 10:05	Welcome; Introductions; Approval of Minutes	<u>Attachment 1:</u> CMCM Minutes April 2014	Yes
2	10:05 – 10:10	Co-Chair Update <i>Public Comment</i>		
3	10:10 – 10:30	Recommendations for Criteria for Second Round of Provider Grant Program <i>Public Comment</i>	<u>Attachment 3:</u> VHCIP Round Two Grant Award Background	Yes
4	10:30 - 11:00	Work Plan and Problem Statement <i>Public Comment</i>	<u>Attachment 4a:</u> Draft CMCM Work Plan <u>Attachment 4b:</u> CMCM WG Problem Statement	Yes
5	11:00 - 11:40	Continued Discussion of Care Management Standards for ACOs <i>Public Comment</i>	<u>Attachment 5a:</u> Summary of NCQA ACO Care Management Standards <u>Attachment 5b:</u> Additional Considerations for Care Management Standards	Yes
6	11:40 – 11:55	Care Management Inventory <i>Public Comment</i>	<u>Attachment 6:</u> Final Care Management Inventory Survey	
7	11:55 - 12:00	Next Steps, Wrap-Up and Future Meeting Schedule Upcoming Webinar (6/25): OneCare Medicare Shared Savings Program Quality Results		

Attachment 1 - Care Models and Care
Management Work Group Meeting
Minutes 5-13-14



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

Date of meeting: Tuesday, May 13, 2014; 10:00 AM to 12:00 PM, Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT.

Attendees: Bea Grause, Nancy Eldridge, Co-Chairs; Georgia Maheras, AoA; Trinka Kerr, HCA; Dana DeMartino, CVMC; Dale Hackett, Consumer; Clare McFadden, Jennifer Woodard, Steve Dickens, Suzanne Leavitt, DAIL;; Nancy Breiden, VLA; Lisa Viles, Area on Aging for NE VT; Erin Flynn, Amy Coonradt, Kelly Gordon, Heather Bollman, DVHA; Diane Leach, NMC; Kirsten Murphy, Julie Wasserman, Melissa Bailey, AHS; Pat Jones, GMCB; Susan Besio, PHPG; Dr. Dee Burroughs-Biron, DOC; Nick Carter, Planned Parenthood; Michael Bailit, Marge Houy, Bailit Health Purchasing; Patty Launer, Bi-State Primary Care Association; Laural Ruggles, NVRH; Julie Tessler, Marlys Waller, VT Council of Dev. and MH Services; Jenney Samuelson, Blueprint for Health; Madeleine Mongan, Vermont Medical Society; Pamela Farnham, Fletcher Allen Health Care; Maura Crandall, VT Managed Care; Breena Holmes, Barbara Cimaglio, VDH; Vicki Loner, OneCare; Deborah Lisi-Baker, DLTSS Co-Chair; Audrey Spence, BCBS; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Bea Grause called the meeting to order at 10:01 am. Bea asked for a motion to approve the minutes. Trinka Kerr moved to approve, Nancy Breiden seconded and the motion passed unanimously without edits to the minutes.	
2. Co-Chairs Update	<p>The DLTSS work group has developed a presentation on a model of care for people with disabilities and long-term services and supports needs that they would like to present to the CMCM work group in one of our upcoming meetings.</p> <p>Georgia Maheras gave the following update on the VHCIP Provider Grant Program: the Core Team awarded eight grants totaling \$2.6 million, and added \$1.9 million at the last meeting. \$2.7 million will be available for the second round. Starting Monday, May 19th the Core Team will look at criteria to see if there should be any</p>	

Agenda Item	Discussion	Next Steps
	<p>changes. They anticipate soliciting proposals in late July/early August with funds flowing on or around Nov. 1st. If applicants received awards in the first round they can apply again, as can those who applied but did not receive an award. Contracts for grantees will be publically available soon.</p> <p>There were ten proposals that were not funded that the core team thought might relate to the efforts of the CMCM work group. The work group will have a chance to provide feedback to the Core Team regarding potential criteria for Round Two of the Provider Grant Program. Georgia noted that successful proposals can't be shared until the contracts are executed as per the State process. The charge to the work group is not to review proposals for acceptance but to give more guidance to the applicants and the Core Team about the grant program.</p>	
3. Staff Report	<p>Pat Jones gave the following update:</p> <ul style="list-style-type: none"> • On May 20th there will be a webinar to review the survey monkey tool “Inventory of Care Coordination/Care Management/Case Management Programs”. All group members are strongly encouraged to attend. The tool was developed in collaboration with work group staff and consultants, and several work group participants tested the tool. • The group had a presentation a couple of months ago regarding one proposal for a learning collaborative focused on care coordination. The learning collaborative subgroup has met since that presentation, and hopes to have a more refined proposal for the group to consider in the near future. 	<p>Participants should contact Pat if there are groups not currently represented in the work group who should be completing the survey.</p>
4. Debrief from April Meeting	<p><u>Summary of Break Out Sessions:</u></p> <ul style="list-style-type: none"> • The notes were sent out to the group prior to this meeting. • Erin Flynn briefly summarized the notes (Attachment 4a). <p><u>State Health Improvement Plan (SHIP) Presentation- Deb Wilcox, Vermont Department of Health (Attachment 4b):</u> The Performance Dashboard presented by Deb is available on the VDH website; the current data (2012) is available electronically. Key points from the discussion included:</p> <ul style="list-style-type: none"> • 60% of the population (adults ages 18 and older) has more than one disease. • This information in the presentation is from survey data. It would be interesting to compare the survey data with health plan data collected by DFR. • Often times, unhealthy choices are easier to access and/or less expensive than healthier choices. Better access to healthy food and physical activity can positively impact health. • 60% of the population is either overweight or obese. • Evidence based strategies in the SHIP were selected specifically for Vermont; they are believed to work well in a rural area. 	<p>If participants have changes or additions please contact Erin.</p> <p>Participants can email remaining questions to staff and co-chairs.</p>

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> ○ Data shows there is a problem with binge drinking (5 or more drinks in a certain time period); the data isn't as strong for opiate abuse. There was a question about whether VDH is linking to the database for prescription drug monitoring. ● There was also a question about whether the Dashboard can drill down to income levels. That information could help identify target populations. ● Slide 12 indicated that the rates of some screenings appear to have declined. <ul style="list-style-type: none"> ○ Deb noted that the change is not statistically significant. ○ Nancy commented that "no significant change" is still not good news; she asked how people can be reached. ○ Can CMCM support care models or care management activities to help improve those rates? ○ VDH is working with DHVA and the Blueprint to connect with clinical practices. VDH and the Blueprint have developed a cancer screening learning collaborative to improve rates. ○ Screening guidelines have also changed. ● The data can be broken down by age but not by populations receiving certain supports (e.g., LTSS). People who meet eligibility criteria for LTSS and actually receive services may have better health outcomes than those who meet the criteria but don't receive services. 	
5. Discussion of Care Management Standards for ACOs	<p>Michael Bailit presented Potential Topics for Care Management Standards (Attachment 5a). He asked the group to think about groupings of standards as they relate to Care Models.</p> <p>Four proposed domains for care management standards were:</p> <ul style="list-style-type: none"> ● ACO Care Management Program Structure: relates to how the program is organized (e.g., the number of care managers relative to the population). ● ACO Care Managers' Relationships with other Organizations: e.g., communication and coordination when there is more than one care manager. ● ACO Care Management Activities: the actual work that's being done on behalf of people needing services (e.g., engagement of the person needing services, design and use of care plans). ● ACO Care Management Program Evaluation: protocol evaluation and evaluation of the impact of care management on the recipient of care. <p>Group members expressed concern that assumptions were being made that ACOs would develop care management programs when care management infrastructure to meet local needs may already be in place. Pat stated that no assumptions were made when developing the domains. The following points were made during the discussion:</p> <ul style="list-style-type: none"> ● The domains are not actual standards, they are categories under which standards will be developed. ● Contracts between the ACOs and payers were signed without detail on care management standards; 	<p>Per Vicki Loner's suggestion, work group staff and consultants will review the ACO standards from NCQA.</p> <p>Staff and consultants will work together to better define domains and topics for standards.</p> <p>Within the next week participants should look at the list of 11 proposed standards topics and e-mail Pat or Erin with recommended changes.</p>

Agenda Item	Discussion	Next Steps
	<p>the plan is that standards will be added to the contracts once they are approved.</p> <ul style="list-style-type: none"> • Susan Besio suggested that the group start by thinking about what should be in place for people needing care management services, rather than starting with domains. Consider the individual’s perspective first: ask what people need; what are the relationships required to meet their needs; what regulations need to be in place meet their needs; and how success would be evaluated. • Michael Bailit observed that there is interest in clarifying what ACOs can do to help or hinder care management. • A recommendation was made to add a domain related to ACO values and approaches to care management. • The DLTSS work group has developed a list of elements that should be included in care models; the elements represent a set of values or an approach. The DLTSS draft model of care, which includes these elements, will be the subject of an upcoming presentation to the CMCM work group. • Due to time restrictions the group did not move into breakout sessions. 	<p>Staff will send an updated crosswalk with topics and domains to the work group.</p> <p>Staff and Co-Chairs will propose a definition for Care Management and send it to the group (the definition should include panel management and not just working with populations who are high risk).</p>
<p>7 Next Steps, Wrap-Up and Future Meeting Schedule</p>	<p>Next Meeting: Tuesday June 10th, 10 am – 12:00 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier</p> <p>Topics for upcoming meetings:</p> <ul style="list-style-type: none"> • Continued discussion of ACO Care Management Standards. • Review of the Inventory Survey results. • There will be a webinar on Wednesday, June 25th at 10:00 AM to share OneCare Vermont’s preliminary results on its Medicare Shared Savings Program quality measures. Other work groups will be invited. 	

Attachment 3 - VHCIP Round Two Grant Award Background

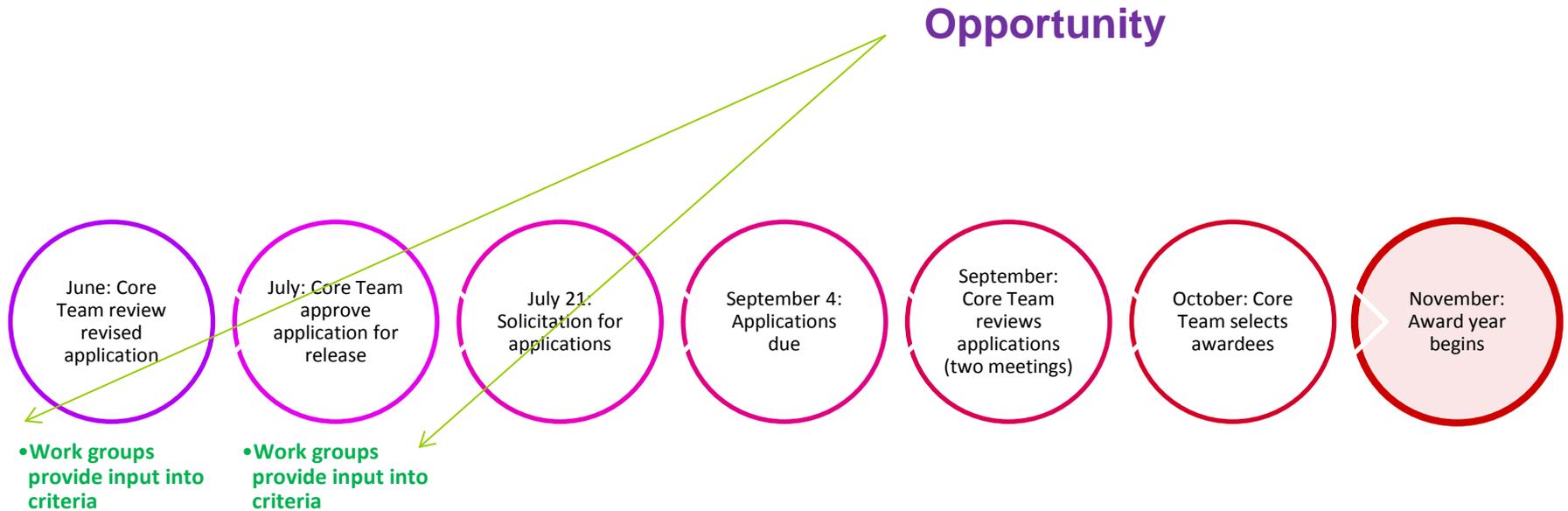
VHCIP Round Two Grant Award Background for Care Models and Care Management Work Group

June 10, 2014

Georgia Maheras, JD

Project Director

Timeline



Request:

The Core Team requested that the CMCM Work Group:

- Provide feedback on criteria used in Round One of the provider grant program, and
- Recommend additional criteria for the next round of grant funding, to support care models and care management activities that will help achieve VHCIP goals.

Grant Program Goals

- Grant Program is intended to foster health care innovation throughout Vermont.
- To maximize the impact of non-governmental entity involvement in this health care reform effort.

Grant Program Criteria

- Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application.
- Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
 - Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
 - Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
 - Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference for:

- 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);
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- 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.

CMCM Work Group Priorities

At its March 2014 meeting, the CMCM Work Group identified the following as its top two priorities:

- In order to better serve all Vermonters (especially those with complex physical and/or mental health needs), reduce fragmentation with better coordination of provider/CHT/health plan and other care management activities. Focus on improving transitions of care and communications between providers and care managers that offer services throughout the various domains of a person's life.
- Better integrate social services (e.g., housing, food, fuel, education, transportation) and health care services in order to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for high-risk Vermonters.

Awardee Summaries:

Grantee
Rutland Area Visiting Nurse Association & Hospice in Collaboration with Rutland Regional Medical Center, Community Health Centers of the Rutland Region and the Rutland Community Health Team
Project Description
This project will support design and implementation of a supportive care program for seriously ill patients with congestive heart failure and /or chronic lung disease. The program will improve communication between the multiple providers and organizations involved in the care of these patients and advance a patient-centered model for care planning and shared decision-making. The project is expected to reduce use of hospital and emergency department care, improve patient quality of life and save money.

Grantee
Northeastern Vermont Regional Hospital in Collaboration with Northern Counties Health Care, Rural Edge Affordable Housing, the Support and Services at Home (SASH) Program, the Northeastern Vermont Area Agency on Aging and Northeast Kingdom Community Services
Project Description
This project will provide flexible funding for goods and services not normally covered by insurance, enabling an integrated multi-disciplinary community care team to better care for clients who are at risk for poor outcomes and high costs of medical care.

Awardee Summaries:

Grantee
White River Family Practice in Collaboration with the Geisel School of Medicine at Dartmouth College
Project Description
This project will continue work at one of the most innovative primary care practices in the state to manage patient care using data systems, team-based care protocols and tools shown to improve patient self-management of their health. The focus will be on patients with chronic conditions who often have high emergency room use and high rates of hospital readmission.

Grantee
InvestEAP in Collaboration with the Burlington Community Health Center and Northern Counties Health Care
Project Description
InvestEAP, Vermont's public/private employee assistance program, and two federally-qualified health centers, will partner to demonstrate the impact of integrating an innovative stress prevention and early intervention program with traditional primary care delivery. The project embodies the core belief that early intervention aimed at the social determinants of health and the root causes of stress will improve health outcomes and reduce medical expenditures.

Awardee Summaries:

Grantee

The Vermont Medical Society Education and Research Foundation in Collaboration with Vermont’s “Hospitalist” Physicians and the Fletcher Allen Health Care Department of Pathology and Laboratory Medicine

Project Description

This project will support an effort to decrease waste and potential harm in the hospital setting based on evidence behind the national “Choosing Wisely” campaign that estimates 30 percent of U.S. health care spending is avoidable and potentially harmful. Physicians from Vermont hospitals and Dartmouth-Hitchcock Medical Center will work together to reduce unnecessary lab testing, and in doing so will create a statewide provider network to lead additional waste reduction and care improvement efforts.

Grantee

Bi-State Primary Care in Collaboration with all Participating Providers and Affiliates of Community Health Accountable Care

Project Description

Seven Federally Qualified Health Centers and Bi-State have formed a primary care centric Accountable Care Organization, Community Health Accountable Care (CHAC), to participate in Shared Savings Programs with all payers. This capacity grant will allow CHAC to further develop their ACO infrastructure to manage patient care. Their specific focus will be to integrate with other community providers, including Behavioral Health Network of VT, the VT Assembly of Home Health and Hospice, Area Agencies on Aging and the Support and Services at Home program.

Awardee Summaries:

Grantee

HealthFirst in Collaboration with all Participating Providers and Affiliates of their ACOs: Accountable Care Coalition of the Green Mountains and Vermont Collaborative Physicians

Project Description

HealthFirst is an Independent Practice Association that includes 120 physicians in 58 independent practices in Vermont. HealthFirst has formed ACOs to participate in both the Medicare and commercial shared savings programs. This capacity grant will allow HealthFirst to further develop their ACO infrastructure to manage patient care. Their specific focus will be increasing coordination between physical and mental health providers and increasing communication between primary care and specialty physicians.

Grantee

The Vermont Program for Quality in Health Care in Collaboration with the Vermont Association of Hospitals and Health Systems, all Vermont hospitals and the Vermont chapter of the American College of Surgeons

Project Description

This grant will provide partial funding for a statewide surgical quality improvement program. The program will gather clinical data to feed into a national database maintained by the American College of Surgeons, allowing Vermont surgeons to benchmark their practices and outcomes against peers nationally and target improvement efforts. The program is expected to improve surgical outcomes, enhance patient safety and reduce costs from surgical complications.

Attachment 4a - Draft CMCM Work Plan

DRAFT 06/04/2014 – Work Plan for Care Models and Care Management Work Group

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Group logistics: charter, membership, meeting schedule, 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	Staff; co-chairs; work group members	<ul style="list-style-type: none"> • Finalized charter available on VHCIP website • Membership list finalized • 2013 – 2014 meetings scheduled 	<ul style="list-style-type: none"> • Final Charter • Comprehensive membership list • 2013-14 meeting schedule • Resources are adequate to accomplish objectives
Obtain consultants to assist with selected work group activities	<ul style="list-style-type: none"> • Identify activities that could benefit from consultant expertise • Develop scope of work and RFP for consultant resources • Issue RFP • Review bids • Select vendor • Execute contract 	March 2014	Staff; co-chairs; work group members; Core Team	<ul style="list-style-type: none"> • Executed contract with Bailit Health Purchasing 	<ul style="list-style-type: none"> • Contract in place
Coordinate and collaborate with other work groups	<ul style="list-style-type: none"> • Identify activities led by other work groups that relate to activities of the Care Models and Care Management Work Group • Develop mechanisms for reporting about related activities to other work groups, and for obtaining information about related activities from other work groups 	Ongoing	Staff; co-chairs; work group members; other work groups	<ul style="list-style-type: none"> • Mechanisms established for monthly co-chair meetings and work group reports to steering committee • Presentation from Population Health Work Group completed • Presentation from DLTSS Work Group scheduled • Presentation from Payment Models Work Group scheduled 	<ul style="list-style-type: none"> • Well-coordinated and aligned activities among work groups

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
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) • Develop an inventory survey tool to facilitate collection of structured data related to care management activities • Analyze results of Care Management Inventory Survey and present pertinent findings to work group • As requested by work group, ask selected entities to attend work group meetings to describe their activities in greater detail 	July 2014	Staff; co-chairs; work group members; organizations engaging in care management	<ul style="list-style-type: none"> • Presentations completed from organizations performing care management (additional presentations to be scheduled upon request) • Inventory Survey tool created and distributed to care management organizations throughout the state 	<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.	<ul style="list-style-type: none"> • Based on written and verbal information and inventory survey results, identify gaps • Based on written and verbal information and survey results, identify redundancies • Based on written and verbal information and survey results, identify opportunities for coordination 	August 2014	Staff; co-chairs; work group members; organizations engaging in care management		<ul style="list-style-type: none"> • Written description of gaps, redundancies, opportunities for coordination
Research, summarize, and review best practices in care management.	<ul style="list-style-type: none"> • Review literature • Review best practices in other states • Review best practices in Vermont • Obtain recommendations from other work groups 	September 2014	Consultant; possibly CMMI Technical Assistance Staff		<ul style="list-style-type: none"> • Description of promising best practices
Identify characteristics and goals of ideal care models/care management activities for Vermont.	<ul style="list-style-type: none"> • Based on review of best practices, discuss and identify Vermont's care model/care management goals • Based on review of best practices, discuss and identify characteristics of ideal model(s) 	October 2014	Work group members		<ul style="list-style-type: none"> • Description of characteristics and goals for Vermont
Develop strategic plan with recommendations on characteristics of ideal care models/care management activities; ACO care management	<ul style="list-style-type: none"> • Discuss and develop strategic plan to support achievement of Vermont's goals, including proposed: <ul style="list-style-type: none"> ○ Characteristics of ideal care models/care management activities ○ ACO care management standards 	November 2014	Staff; co-chairs; work group members		<ul style="list-style-type: none"> • Written strategic plan adopted by work group

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
standards; mechanisms to reduce fragmentation and duplication; reinforcement, extension and/or adaptation of existing care models; and/or criteria to be considered in the adoption of additional care management activities, to support achievement of Vermont's goals.	<ul style="list-style-type: none"> ○ Mechanisms to reduce fragmentation and duplication ○ Recommendations to reinforce, extend or adapt existing models ○ Criteria to be considered in the adoption of new models 				
Identify Additional implementation needs (e.g., care management standard development, learning collaboratives, electronic and other information, communication, provider engagement) and potential resources to meet those needs.	<ul style="list-style-type: none"> ● Develop care management standards ● Recommend whether and to what extent to support proposed learning collaboratives related to care management ● Address other implementation needs as they arise, on an ad hoc basis ● Review strategic plan to identify additional implementation needs not previously identified ● Identify mechanisms and resources to meet implementation needs 	<p>September 2014 (care management standards)</p> <p>December 2014 (initial learning collaboratives)</p> <p>January 2015 (review strategic plan)</p> <p>Ongoing (ad hoc implementation needs, identification of mechanisms and resources to meet those needs)</p>	Staff; co-chairs; work group members	<ul style="list-style-type: none"> ● Care management learning collaborative subgroup meeting to refine proposal ● ACO care management standards under development 	<ul style="list-style-type: none"> ● Written implementation plan, including proposed care management standards, proposed learning collaboratives, HIE needs, communication mechanisms, provider engagement activities, implementation resources

Attachment 4b - CMCM WG Problem Statement

Care Models and Care Management Work Group Problem Statement

The Care Models and Care Management (CMCM) Work Group has adopted the following definition of Care Management:

“Care Management programs apply systems, science, incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.” (Office of Quality and Care Management)

What is the problem we are addressing through the CMCM work group?

We spend an estimated \$XXX on care management in Vermont through Community Health Teams, the SASH Program, the Vermont Chronic Care Initiative, programs sponsored by Blue Cross and Blue Shield of Vermont and MVP and initiatives of individual provider organizations. We are slated to invest even more resources in care management as providers assume greater accountability for the cost and outcomes of health care service delivery under new payment models.

We are not getting optimal results from our current investments. The health of Vermont’s population is not as good as it could be, care management efforts are not targeted or coordinated as effectively as they could be, Vermonters’ experience of care is not the best it could be, and we have little agreement on “best practices” in care management activities across providers, payers and programs. Available data bear this out:

- **Health:** Vermont has high rates of obesity, smoking, substance abuse, mental illness and non-immunized children.
- **Fragmentation and waste:** Vermont has high rates of avoidable hospitalization and rehospitalization and, despite much attention to better managing chronic diseases such as diabetes, still falls short on indicators of the quality of care for managing these diseases.
- **Lack of agreement on best practices:** We do not have statewide, multi-payer and cross-provider agreement on key aspects of care management, including how to target efforts, how to assign lead accountability for outcomes, how best to involve non-medical service providers in care management and how best to coordinate across acute care and long-term services and supports, across mental and physical health services and across other key zones of care management.

The vision of the CMCM Work Group is to provide care management to all Vermonters who could benefit from these supports through a coordinated system, with the goal of improving the health and wellness of Vermonters.

What is the role of the CMCM work group in addressing this problem?

The CMCM Work Group will recommend mechanisms for assuring greater consistency and/or coordination across Vermont care management activities to improve the effectiveness of these efforts in terms of the extent to which they:

- Improve the health of Vermonters;
- Reduce waste;
- Improve Vermonters experience of care;
- Appropriately link individuals and populations to services managed by interdisciplinary teams well-suited to meet an individual's lifelong holistic needs;
- Reduce duplication of effort and inconsistencies between care management approaches and programs, and adhere to proven best practices.

Toward this end, the Work Group will produce several work products. These include:

- An inventory of care management and care models currently in use in Vermont;
- Care Management Standards for the Commercial and Medicaid Shared Savings Programs;
- Learning Collaboratives to support coordination of care management programs;
- A Literature Review of evidence-based care models and care management activities;
- An inventory of electronic and other information and communication tools to support care models and care management activities; and
- A strategic plan with recommendations on reinforcement, extension and/or adaptation of existing care models, and/or adoption of additional care management activities, to support Vermont's goals.

In addition, the CMCM Work Group will coordinate with other VHCIP work group to assure that:

- Vermont health information systems collect, analyze and continuously update data that are most needed for effective care management and population health improvement;
- Recommendations regarding work force development reflect the needs for optimal care management;
- Recommendations regarding payment reform support optimal care management.

Attachment 5a - Summary of
NCQA ACO Care
Management Standards

Summary of NCQA ACO Standards Related to Care Management

I. ACO-Level Standards

A. Patient-Centered Primary Care Oversight (based on PC2, Element A)

#1: For primary care practices within the ACO, the ACO evaluates practice capacity to meet patient-centered medical home requirements (see practice-level standards on pages 4 and 5 below).

B. Guidelines and Decision Aids (based on PO2, Elements A and B)

#2: The ACO adopts evidence-based guidelines and disseminates decision support tools to participating providers for at least one important chronic condition, at least one high-risk or complex condition, and at least one condition related to unhealthy behaviors or mental health or substance abuse.

#3: The ACO makes patient decision aids available to participating providers to promote patient engagement.

C. Population Health Management (based on CM3, Elements A and B)

#4: The ACO systematically identifies and provides services to attributed people who are eligible for:

- Wellness and health promotion programs
- Chronic disease management programs
- Complex care management

D. Data Collection, Integration and Use (based on CM1, Elements A, B, C, D, E, F and G)

#5: The ACO uses an electronic system that records the following as structured (searchable) data:

- Information about attributed people: date of birth, gender, race, ethnicity, preferred language, contact information, dates of previous clinical visits, legal guardian/health care proxy, primary caregiver, presence of advance directives, and health insurance information.
- Clinical information: current problem list, allergies, blood pressure with date of update, height, weight, status of tobacco use for patient 13 years and older, list of prescription medications with date of updates, clinical lab test results.

#6: The ACO has an electronic system that provides participating providers with access to information about attributed people, outpatient practitioners with access to patient information clinical data recorded by other outpatient practitioners and by inpatient facilities, and inpatient facilities with access to patient information and clinical data recorded by other inpatient facilities and by outpatient practitioners.

#7: The ACO works with external entities to exchange clinical information.

#8: The ACO has a documented process and collects and integrates data from multiple sources, including: outpatient claims/encounter data from participating/non-participating providers; inpatient claims/encounter data from participating/non-participating providers, EHRs, pharmacy data, laboratory results, health appraisal results, cost data

#9: The ACO uses the data for identifying needs of attributed people, care management services and performance measurement.

E. Support for Participating Providers (based on CM4, Elements A, C and D)

#10: The ACO uses patient information and clinical data to maintain registries that can be retrieved by participating providers at the practice site for preventive care services and chronic or acute services.

#11: The ACO provides educational resources to assist in self-management, provides self-management tools that enable attributed people/families to record self-care results, and provides or connects attributed people/families to self-management support programs and resources.

#12: The ACO provides the following information and services to attributed people through a secure electronic system:

- Electronic copies of health information within three business days
- Electronic access to current health information within four business days of when the information is available to the ACO
- Clinical summaries within three business days of office visits
- Two-way communication between attributed people/families and participating providers
- Requests for appointments or prescription refills
- Requests for referrals or test results

E. Information Exchange for Care Coordination and Transitions (based on CT 1, Elements A, B, C, D, and E)

#13: To promote care coordination, the ACO has a documented process for exchanging health information across care settings, which includes an agreement with care providers about exchanging information, the types of information to be exchanged, time frames for exchanging information, and how the organization facilitates referrals.

#14: To facilitate transitions, the ACO has a documented process to:

- identify attributed people who transition between settings,
- share clinical information received from the first setting with the second setting and primary care practitioner,
- communicate with hospitals to exchange information about patients during hospitalization,
- obtain patient discharge summaries from hospitals, emergency departments and other facilities,
- contact patients or families following transitions within an appropriate time frame for appropriate follow-up care,
- electronically exchange key clinical information with facilities,
- provide an electronic summary of care record to other care settings, and
- track the status of transitions, including the timing of information exchange

#15: The ACO demonstrates that the transitioning or referring practitioner provides a summary of care record for transitions of care and referrals.

#16: The ACO has a process to determine whether timely information exchange occurred between providers for care coordination and care transitions.

#17: At least quarterly, the ACO monitors transitions to determine if they were performed safely and efficiently, by reviewing if:

- The sending setting's care plan was shared with the receiving setting within a specified time frame.
- The patient's usual practitioner was notified of the transition within a specified time frame
- Communication with the patient or the patient's family about the care transition process occurred within a specified time frame
- Communication with the patient or the patient's family about changes to the patient's health status and plan of care occurred within a specified time frame.

II. **Practice-Level Standards** (these standards mirror the NCQA standards that primary care practices in Vermont must meet to participate in the Blueprint for Health)

A. **Care Management Services** (based on PC1, Elements C, D, E, F, G, H, and I)

#18. The practice provides a range of services by:

- Defining roles for clinical and nonclinical team members
- Having regular team meetings and structured communication processes
- Using standing orders for services
- Training and assigning care teams to coordinate care for individual people.

#19. The practice implements evidence-based guidelines through point-of-care reminders for people identified as having selected important conditions (including high-risk or complex conditions, and conditions related to unhealthy behaviors, mental health or substance abuse).

#20. The practice performs the following for people identified as having important selected conditions:

- Conducts pre-visit preparations to assure that all paperwork, lab tests, imaging tests, or referral visits are completed and reviewed prior to the visit
- Collaborates with the person/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
- Gives the person/family a written plan of care
- Assesses and addresses barriers when the person has not met treatment goals
- Gives the person/family a clinical summary at each relevant visit
- Identifies people/families who might benefit from additional care management support and refers the patient/family to other internal or external resources for such support
- Follows up with people/families who have not kept important appointments.

#21. The practice manages medication by reviewing and reconciling medications for people/families during care transitions, providing information about new prescriptions, and assessing patient response to medications and barriers to adherence.

#22. The practice conducts activities to support people/families in self-management, including documenting self-management abilities, developing/documenting self-management plans and goals, providing or referring people/families to educational resources, and using an HER to identify and provide people-specific education resources.

#23. The practice demonstrates that it tracks lab and imaging tests, flagging and following up on overdue results; flags abnormal lab and imaging results, bringing them to the attention of the clinician; and notifies people/families of normal and abnormal and abnormal lab and imaging results.

#24. The practice coordinates referrals by giving the consultant or specialist the clinical reason for the referral and pertinent clinical information; tracking the status of referrals, including requiring timing for receiving a specialist's report, and following up to obtain a specialist's report.

Attachment 5b - Additional
Considerations for Care
Management Standards

Additional Considerations for Care Management Standards

Standards could relate to the following:

- **Identification of people needing care management services** (Who gets care management and who does not?)
- **Services** (What are the care management services people currently receive or should receive?)
- **Who provides those services** (Characteristics of providers – are they practices, or teams?)
- **Data** (What are the information systems needed and what information must be captured in those systems?)

The DLSS Work Group has identified the following evidence-based model of care elements that might help inform our standards work:

- **Person Centered and Directed Process for Planning and Service Delivery**
- **Access to Independent Options Counseling and Peer Support**
- **Actively Involved Primary Care Physician**
- **Provider Network with Specialized DLSS Expertise**
- **Integration Between Medical and DLSS Care**
- **Single Point of Contact for Person with DLSS Needs Across All Services**
- **Standardized Assessment Tool**
- **Comprehensive Individualized Care Plan Inclusive of All Needs, Supports and Services**
- **Care Coordination and Care Management**
- **Interdisciplinary Care Team**
- **Coordinated Support During Care Transitions**
- **Use of Technology for Sharing Information**

In addition, the Institute of Medicine discussion paper that we reviewed (“Core Principles & Values of Effective Team-Based Health Care”)¹ identified the following principles of effective health care teams:

- **Shared Goals**
- **Clear Roles**
- **Mutual Trust**
- **Effective Communication**
- **Measureable Processes and Outcomes**

¹ Definition of Team-Based Care: “Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated, high-quality care.” Naylor MD, Coburn KD, Kurtzman ET, et al. from paper presented at ABIM Foundation meeting in Philadelphia, PA, March 24-25, 2010. Cited in October 2012 Institute of Medicine Discussion Paper, “Core Principles & Values of Effective Team-Based Health Care.”

Attachment 6 - Final Care Management Inventory Survey

Introduction

The Care Models and Care Management Working Group of the Vermont Health Care Innovation Project is conducting a survey to gather information that will help create a better understanding of current care management activities in Vermont.

For the purposes of this survey Care Management is described as follows:

“Care Management programs apply systems, science, incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.” (Office of Quality and Care Management)

We thank you for your participation in this survey.

Questions 1-5 are about your organization

1. Organization Name

2. Contact Person Name

3. E-mail Address

4. Type of Organization (please check one):

- ACO
- Blueprint Community Health Team
- Community Service Provider
- Health Care Provider
- Health Plan
- State Agency
- Other

Other (please specify)

5. Where does your organization provide services? (check all that apply)

- Statewide (if selected, no need to check individual counties)
- Addison County
- Bennington County
- Caledonia County
- Chittenden County
- Essex County
- Franklin County
- Grand Isle County
- Lamoille County
- Orange County
- Orleans County
- Rutland County
- Washington County
- Windham County
- Windsor County

Questions 6-10 are about the type and amount of services provided

6. Please indicate whether your organization engages in care management activities in the following categories (check yes for all that apply, leave blank if no)

Note: Your responses to the remainder of this survey will be dependent on your response to this question. Please read the following definitions carefully before responding. An organization can offer programs in high risk management, special services management, episodic pathways, disease management, and/or post-discharge follow-up. When completing this survey, the organization should serve unique people in each of those categories that it checks off; it should not check off multiple categories for the same people.

If the same people receive services in multiple categories, the organization should select the category that best characterizes the services those people receive.

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Does your organization provide this service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Categories (please specify)

DEFINITIONS

High Risk Management is the deliberate organization of care activities for high risk individuals, designed to improve their health status and reduce the need for expensive services. High risk people may include individuals experiencing serious illness, high utilization of health care services and/or transitions in care (e.g., changes in setting, service, practitioner, or level of care).

Special Services Management is the deliberate organization of care activities for a specified population requiring ongoing management (other than high risk individuals and those receiving disease management services), for an undetermined time frame. Examples of specified populations include people with mental health or substance abuse needs, and children with special health needs.

Episodic Pathways are standardized care processes used to promote organized and efficient care based on evidence-based practice for a specific group of individuals with a condition that is characterized by a predictable clinical course with a limited time frame (e.g. pregnancy, joint replacements). The interventions involved in the evidence-based practice are defined, optimized and sequenced; they are also known as clinical pathways, care pathways, critical pathways, integrated care pathways, or care maps.

Disease Management is a system of coordinated interventions and communications for specific groups of people with chronic conditions for which self-care efforts can have significant impact. Disease management supports the practitioner/person relationship, development of a plan of care, and prevention of exacerbations and complications. It is characterized by evidence-based practice guidelines and strategies that empower people.

Post-Discharge Follow-Up consists of a phone call or visit to discharged individuals within 48 to 72 hours of their departure from a care facility. The purpose is to ask about the individual's condition, adherence to and understanding of medication orders and other treatment orders, general understanding of his or her condition, and intent to attend follow-up appointments. Post-discharge follow-up is for individuals other than those served by High Risk Care Coordination, Special Services Care Coordination, Episodic Pathways, or Disease Management.

Short-Term Case Management Programs are targeted and short term (30-60 days maximum) interventions with the goals of empowering individuals to better understand their illnesses and manage their own conditions, and coordinating care between individuals, providers and the community.

Utilization Management is the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures to ensure appropriate access to and management of the quality and cost of health care services provided to health plan members or other populations.

Prevention/Wellness Engagement activities are interventions designed to increase engagement and activation and promote positive behavior across populations, such as obtaining preventive care, exercising regularly, and modifying dietary habits. These activities may draw on the principles of positive psychology and the practices of motivational interviewing and goal setting (e.g., health coaching).

Life Resource Management involves providing resources and counseling to help mitigate acute and chronic life stressors; and may include health care as well as social and/or community services.

7. Please indicate population(s) served by each category (check all that apply)

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
People with multiple comorbidities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with rare complex and high cost conditions (e.g. lupus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with chronic conditions (e.g. diabetes, asthma, CHF, COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with mental health & substance abuse needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elders needing support with ADL and/or other functional status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People needing prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with multiple admissions to facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with multiple admissions to outpatient programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with multiple ED visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People at risk re: social determinants of health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People discharged from acute inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People discharged from SNF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People discharged from inpatient rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People discharged from mental health/substance abuse facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People discharged from home health agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other

Other (please specify)

8. Please indicate the eligibility criteria your organization use for each category (check all that apply)

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Meets predictive modeling criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meets high cost criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meets high utilization criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meets state-defined clinical or functional criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meets state-defined financial criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referred by physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has multiple comorbidities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Key clinical indicators outside of benchmarks (e.g. HbA1c>9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual has specific diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual at high risk due to social determinants of health (e.g. homeless, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual has specific payer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

9. Estimated number of people receiving this service annually

	<50	51 to 250	251 to 500	501 to 750	751 to 1000	1001 to 1500	>1500
High Risk Management	<input type="radio"/>						
Special Services Management	<input type="radio"/>						
Episodic Pathways	<input type="radio"/>						
Disease Management	<input type="radio"/>						
Post-Discharge Follow-Up	<input type="radio"/>						
Short-Term Case Management	<input type="radio"/>						
Utilization Management	<input type="radio"/>						
Prevention/Wellness Engagement	<input type="radio"/>						
Life Resource Management	<input type="radio"/>						

10. Please indicate the care management functions that your organization engages in for each of these categories (check all that apply)

Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient to accomplish shared goals within and across settings to achieve coordinated, high-quality care.

IOM Report, “Core Principles & Values of Effective Team-Based Health Care”, October 2012

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Individual Identification and Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develops, Modifies, Monitors Care/Support Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referrals to Specialty Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning and Managing Transitions of Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Connections to Community/Social Service Organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Team-based Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

Questions 11 and 12 are about your organization's staffing

11. Please indicate the licensure and/or credentials of staff performing each of these care management functions. (check all that apply)

	Individual Identification and Outreach	Needs Assessment	Develops, Modifies, Monitors Care/Support Plan	Referrals to Specialty Care	Planning and Managing Transitions of Care	Medication Management	Individual Education	Connections to Community/Social Service Organizations	Team-based Care	Other
Advanced Practice Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Manager/Service Coordinator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Health Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LPN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Clinical Care Coordinator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified Developmental Disabilities Professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Expert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

12. Please indicate the number of currently budgeted FTEs for each type of staff providing care management functions (please round to the closest number) (check all that apply)

Budgeted FTEs

Advanced Practice Registered Nurse	<input type="text"/>
Case Manager/Service Coordinator	<input type="text"/>
Community Health Worker	<input type="text"/>
LPN	<input type="text"/>
MD	<input type="text"/>
Medical Assistant	<input type="text"/>
Mental Health Professional	<input type="text"/>
Non-Clinical Care Coordinator	<input type="text"/>
Peer Counselor	<input type="text"/>
Pharmacist	<input type="text"/>
Physician Assistant	<input type="text"/>
RN	<input type="text"/>
Qualified Developmental Disabilities Professional	<input type="text"/>
Social Worker	<input type="text"/>
Substance Abuse Expert	<input type="text"/>
Other	<input type="text"/>

Other (please specify)

Questions 13 & 14 are about your organization's engagement in team-b...

13. How does your organization interact with other organizations that provide care management services? (check all that apply)

	ACO	Blueprint Community Health Team	Community Service Provider	Health Care Provider	Health Plan	State Agency
We share information with this organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We share resources with this organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We make referrals to this organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We receive referrals from this organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (Please specify activity and/or organization type)

14. Your organization may come together in "functional teams" with other organizations to provide care management services to people who need them. Please list the other organizations that your organization interacts with regularly as part of a functional care management team, and indicate the nature of your organization's relationships with each of those other organizations (check all relationships that apply):

	Legal Relationship (e.g., contract, MOU)	Financial Relationship (funding supports team interaction)	Regular, Structured Interaction (e.g., scheduled meetings)	Ad Hoc Interaction Using Established Communication Mechanisms
ACOs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Day Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Area Agencies on Aging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blueprint Community Health Teams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children with Special Health Needs Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Action Agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Service Providers (Designated Agencies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Service Providers (Other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPSDT Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faith-Based Organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fitness Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Care Provider Offices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Insurers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Health Agencies/VNAs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing Organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrated Family Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid VCCI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Providers (Designated Agencies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Providers (Other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Public Health District Offices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational Rehabilitation Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

Questions 15-17 are about your organization's data systems & measure...

15. Please indicate data systems for implementation, communication, tracking and measuring success (check all that apply)

	Currently Available	Plan to add in the next 3 years	Wish List, but no plans to add
Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Information Exchange	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Registry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Management Software	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Predictive Modeling Software	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrated Health Record with Multiple Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Plan Data Sources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All-Payer Claims Database	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

16. Please indicate the measures that your organization uses to evaluate success (check all that apply)

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Individual Satisfaction Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intervention Process Measures (e.g. call tracking logs, # of contacts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Process & Outcome Measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization Measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost Measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Determinant Outcome Measures (e.g., employment rate, education level, incarceration rate, earnings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

17. Is your care management program accredited? If yes, please identify by what organization(s) (check all that apply).

- None
- CARF
- URAC
- The Joint Commission
- NCQA

Other (please specify)

Questions 18 and 19 are about financial support for your organizatio...

18. Identify the type of payment model(s) that support each category (check all that apply)

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Fee-For-Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pay for Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bundled Payment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shared Savings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Global Payment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administrative Fees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

19. Identify the funding source(s) for this service (check all that apply)

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Commercial Health Plan (including self-insured employer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Grant, Federal Grant, Foundation/Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Pay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization's Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

Question 20 is about challenges your organization experiences

20. Please indicate the challenges you experience in providing these services (check all that apply)

	High Risk Management	Special Services Management	Episodic Pathways	Disease Management	Post-Discharge Follow-Up	Short-Term Case Management Programs	Utilization Management	Prevention/Wellness Engagement	Life Resource Management
Difficulty identifying individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient funding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Challenges in recruiting qualified staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services not currently reimbursed by payer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of communication mechanisms with other organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Challenges to developing relationships between organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technical barriers to sharing information between organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Privacy barriers to sharing information between organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Privacy concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Challenges in engaging individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Challenges in engaging providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)