

# Care Models and Care Management Work Group Meeting Agenda 7-08-14

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

Tuesday, July 8<sup>th</sup>, 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	<b><u>Attachment 1:</u></b> CMCM June 10 <sup>th</sup> Meeting Minutes	Yes
2	10:05 – 10:10	Co-Chair Update <b><i>Public Comment</i></b>		
3	10:10 – 10:30	Final Review and Approval of Problem Statement <b><i>Public Comment</i></b>	<b><u>Attachment 3:</u></b> Revised CMCM Problem Statement	Yes
4	10:30 – 11:25	Continued Discussion of Care Management Standards for ACOs <b><i>Public Comment</i></b>	<b><u>Attachment 4a:</u></b> Memo re Goals and Implementation of Care Management Standards <b><u>Attachment 4b:</u></b> Care Management Standards by Category	Yes
5	11:25 – 11:55	Vermont’s Multi-Organization “Integrated Community” Care Management Learning Collaborative <b><i>Public Comment</i></b>	<b><u>Attachment 5:</u></b> Integrated Community Learning Collaborative Power Point Presentation	Yes
6	11:55 – 12:00	Next Steps, Wrap-Up and Future Meeting Schedule August Presentation: DLTSS Work Group “DLTSS Model of Care” Extended time for August Meeting?		Yes

Attachment 1 - Care Models and Care  
Management Work Group Meeting  
Minutes 6-10-14



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

**Date of meeting:** Tuesday, June 10, 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; Pat Jones, GMCB; Erin Flynn, Amanda Ciecior, Cecilia Wu, Kara Suter, DVHA; Susan Besio, PHPG; Pamela Farnham, Fletcher Allen Health Care; Deborah Lisi-Baker, DLTSS Co-Chair; Lisa Viles, Area Agency on Aging NE VT; Marlys Waller, Nick Emlen, Julie Tessler, VT Council of Dev. and MH Services; Julie Wasserman, Kirsten Murphy AHS; Michael Bailit, Bailit Health Purchasing; Nancy Breiden, VLA; Dale Hackett, Consumer; Clare McFadden, Jennifer Woodard, Steve Dickens, Suzanne Leavitt, DAIL; Madeleine Mongan, VMS; Barbara Cimaglio, Breena Holmes, VDH; Mary Moulton, Washington Co. MH Services; Beth Tanzman, Blueprint; Trinka Kerr, HCA; Julie Riffon, North Country Hospital; Patty Launer, Bi-State Primary Care Association; Catherine Simonson, Howard Center; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

<b>Agenda Item</b>	<b>Discussion</b>	<b>Next Steps</b>
<b>1. Welcome and Introductions, Approval of meeting minutes</b>	Nancy Eldridge called the meeting to order at 10:05 am. Trinka Kerr moved to approve the minutes and Pam Farnham seconded. The motion passed unanimously.	
<b>2. Co-Chairs Update</b>	<p>The group discussed goals of the Care Management Learning Collaborative:</p> <ul style="list-style-type: none"> <li>• 1. Reduce fragmentation in the care management system, and 2. Provide tools and offer opportunities for care management staff to build core competencies. For example: provide data resources and communication tools; provide training on how to use data for population management.</li> <li>• Three geographic areas have been identified (Burlington, St. Johnsbury, Rutland); these areas were chosen because OneCare, CHAC and Blueprint have a significant presence in these areas.</li> <li>• The Learning Collaborative members are leaning toward developing one approach in the three areas to insure that we end up with one care management system rather than having one region work with IHI and another with ECHO.</li> <li>• No formal decisions have been made regarding the learning collaborative at this time, but the subgroup will continue to report back to the full work group on its progress.</li> </ul>	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> <li>Once a proposal is finalized, it is possible that it will be presented to the CMCM work group and the full SIM governance structure for proposed funding.</li> </ul> <p>The group will continue to discuss the learning collaborative in more detail at future meetings.</p>	
<b>3. Recommendations for Criteria for Second Round of Provider Grant Program</b>	<p>In Round One of the Provider Grant Program the Core Team made awards to eight entities (attachment 3). They added an additional \$1.9 million to the Grant Program for a total of \$5.2 million. \$2.6 million has been awarded thus far.</p> <p>The Core Team is reviewing the application instructions and will approve a revised version for release at their July meeting. They have asked work groups to provide recommendations on the Grant Program criteria. Applications will most likely be due in September and the award year will begin in October.</p> <p>The Care Models and Care Management Work Group has identified the following as its top two priorities, and recommended that they be considered as criteria when reviewing Round Two Provider Grant proposals:</p> <ul style="list-style-type: none"> <li>In order to better serve all Vermonters (including those with complex physical and/or mental health needs), reduce fragmentation with better coordination of provider/CHT/health plan and other care management activities (e.g., medication management, mental health and substance abuse transitions). 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. <ul style="list-style-type: none"> <li>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.</li> </ul> </li> </ul> <p>2. Additionally, the work group recommended that consideration be given to proposals for provider training that supports the above two criteria.</p> <p>3. Some work group members suggested priorities that are already core assumptions of the SIM grant. Rather than adding these as priorities, the work group suggested that these foundational assumptions be highlighted for potential applicants.</p> <p>Pamela Farnham moved to accept these recommendations and Dale Hackett seconded the motion. The motion passed unanimously.</p>	
<b>4. Work Plan and Problem Statement</b>	<p>Nancy reviewed the Problem Statement (attachment 4b). The group discussed and suggested the following changes to the language:</p>	<b>Any additional recommendations should</b>

Agenda Item	Discussion	Next Steps
	<p>Care Management Definition:</p> <ul style="list-style-type: none"> <li>• Change the word "consumers" to "individuals"</li> <li>• Add "evidence-based" after "cost effective"</li> <li>• In place of "medical practice" use "health care services and clinical outcomes"</li> </ul> <p>Regarding data:</p> <ul style="list-style-type: none"> <li>• Change "high rate" to "high absolute rate" or "prevalence"</li> <li>• Possibly state that Vermont has "more work to do"</li> </ul> <p>The group reviewed a current draft of the Work Plan (attachment 4a) which was updated to reflect progress made to date, adjustments to timelines, and additional details for existing tasks.</p> <p>A recommendation was made to add "care models" to the third bullet in the first row under supporting activities (page 2).</p> <p>Trinka Kerr moved to approve the work plan and Dale Hackett seconded. The motion passed unanimously.</p>	<p><b>be directed to Pat.</b></p> <p><b>Marlys gave a specific recommendation and will email it to Pat.</b></p>
<p><b>5. Continued Discussion of Care Management Standards for ACOs</b></p>	<p>The group reviewed attachments 5a &amp; 5b relating to the development of care management standards for the Medicaid and Commercial ACO Program Standards. Examples of topics that the standards could address include:</p> <ol style="list-style-type: none"> <li>1. Identification of people needing care management services;</li> <li>2. What care management services people currently receive or should receive;</li> <li>3. Who provides those services;</li> <li>4. What data and information systems are needed and what information must be captured.</li> </ol> <p>Attachment 5a provides a summary of existing National Committee for Quality Assurance (NCQA) standards related to care management that could help inform the process.</p> <p>The group discussed the following points:</p> <ul style="list-style-type: none"> <li>• Attachment 5a, Section I includes ACO-level standards and Section II includes practice-level standards.</li> <li>• A question was asked regarding the attribution of lives in the shared savings programs and how the opt-out provision might affect attribution. Because the contract is between payers and providers, beneficiaries do not opt in or out of the program. In this case, the term "opt out" refers to the</li> </ul>	

Agenda Item	Discussion	Next Steps
	<p>beneficiary’s ability to request that the payer not share their claims data with the ACO.</p> <ul style="list-style-type: none"> <li>• Trinka Kerr stated her support for broader Care Management approaches that consider life circumstances, not only conditions, such as #4 under Population Health Management.</li> <li>• Items 14, 18, 20 relate to what services are included. A recommendation was made to include social determinants.</li> <li>• Transitions between settings relate more to how services will be delivered. “How” will be added as a category.</li> <li>• A suggestion was made for “Team” to replace the word “practice”. A suggestion was made that the “who” should be driven largely by the client/patient.</li> </ul> <p><b>The group will review the topic “Data” at the July meeting and notes from today’s meeting will be circulated. A “How” category will be created and it is possible that by the end of July the group will have an initial draft of standards to share with the larger VHCIP stakeholder group.</b></p> <p><b>Participants can email Pat any remaining ideas that were not discussed.</b></p>	
<p><b>6. Care Management Inventory</b></p>	<p>The Care Management Inventory (attachment 6) was sent out and 25 responses have been received to date. Organizations that hadn’t yet completed the survey were asked to do so.</p> <p>Only one representative from each organization should respond to the survey.</p>	
<p><b>7. Next Steps, Wrap-Up and Future Meeting Schedule</b></p>	<p><b>Public Comment:</b> Kirsten Murphy stated that Care Management Teams should include consumer advocates.</p> <p><b>Next Meeting:</b> Tuesday July 8<sup>th</sup>, 10 am – 12:00 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier</p>	

# Attachment 3 - Revised CMCM Problem Statement

**DRAFT**

**Care Models and Care Management Work Group Problem Statement  
July 2, 2014**

***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 services and outcomes in order to assist individuals 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, evidence-based or promising innovative, and non-duplicative services.” (Office of Quality and Care Management, adapted by the Care Models and Care Management Work Group)*

***The Care Management Problem:***

The State of Vermont, payers and consumers spend millions of dollars each year on care management through Community Health Teams, the SASH Program, the Vermont Chronic Care Initiative, programs sponsored by Blue Cross and Blue Shield of Vermont and MVP, disability and long term supports and services providers, and initiatives of individual provider organizations. Additional care coordination investments will also be needed as providers assume greater accountability for the cost and outcomes of health care service delivery under new payment models.

Effective and coordinated care management programs could improve health without increasing health spending. Care management efforts are not targeted or coordinated, Vermonters have difficulty navigating through disconnected providers and we have little agreement on “best practices” in care management activities across providers, payers and programs. Available data from the Vermont Department of Health and other organizations bear this out:

- **Health:** Vermont has high absolute rates of obesity, smoking, substance abuse, mental illness and non-immunized children.
- **Fragmentation and waste:** Vermont’s rates of avoidable hospitalization and re-hospitalization are comparatively low but could improve, particularly with focus on managing chronic diseases such as diabetes.

- **Lack of agreement on best practices:** Statewide, multi-payer and cross-provider protocols, best practices and policies on key aspects of care management do not exist. Broad-based guidance is needed on who should receive care management services, 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 while allowing for innovation.

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 groups 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 care models reflect the needs of the DLTSS community;  
and
- Recommendations regarding payment reform support optimal care management.

Attachment 4a - Memo re  
Goals and Implementation of  
Care Management Standards

**State Innovation Model**

109 State Street  
Montpelier, VT 05609  
<http://healthcareinnovation.vermont.gov>

**TO:** Care Models and Care Management Work Group

**FROM:** Work Group Co-Chairs (Bea Grause and Nancy Eldridge), Staff (Erin Flynn and Pat Jones) and Consultants (Michael Bailit and Marge Houy)

**RE:** Goals and Implementation of ACO Care Management Standards

**DATE:** July 2, 2014

**I. Background on Standards Development**

The DVHA/GMxCB ACO pilot standards development process began with the initial meeting of the ACO Standards Work Group on 12-11-12. The participants agreed that the resulting standards would serve as the parameters for a multi-year pilot, and that the standards would be set using a consensus process. They reviewed a candidate list of potential topics, including care management, and prioritized them for development.

Care management was among the higher-prioritized topics for standards development. Actual progress was slow, however. For multiple reasons, the work started and stopped in the spring of 2013 and again in the fall of 2013. The payers were especially interested in developing standards, for fear of duplicative and confusing communications with their members receiving payer-based care management services. In addition, providers and state agencies were concerned about the implications for their existing case and care management services.

The care management standards development work was not completed by late 2013 when the GMxCB and VHCIP Core Team reviewed and approved the standards. As a result, the approved standards document defines the care management standards as “under development”.

The members of the former ACO Standards Work Group envisioned that care management standards would be treated in the same fashion as other standards – incorporated into payer/ACO contracts and subject to oversight by the GMxCB and the contracting payers. The approach to standards development to date has been to capture in the standards that which is judged to be essential to ACO success, but to neither replicate a certification or accreditation process, nor limit opportunity for ACO experimentation and innovation

**II. Goals of Care Management Standards**

The goals of care management standards are to:

- Support the implementation of evidence-based and innovative care management practices and care management tools, and
- Ensure processes that support integration and collaboration among existing participants in the care management infrastructure.

### **III. Compliance Assessment**

To date, DVHA and the GMCB have envisioned compliance assessment being performed through periodic reporting using standard report templates. It is possible that these could be complemented with occasional meetings and dialogue. As with all ACO pilot activity, this assessment will be designed and conducted with a spirit of partnership and collaboration.

# Attachment 4b - Care Management Standards by Categories

Broad Category	Supporting NCQA Standard/DLTSS Work Group Element/IOM Principle	Work Group Member Comments
<p><b>Identification of people needing care management services</b></p> <p>(Who gets care management and who does not?)</p>	<p><u>NCQA Standard #2</u> 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.</p> <p><u>NCQA Standard #4</u> The ACO systematically identifies and provides services to attributed people who are eligible for:</p> <ul style="list-style-type: none"> <li>• Wellness and health promotion programs</li> <li>• Chronic disease management programs</li> <li>• Complex care management</li> </ul>	<ul style="list-style-type: none"> <li>• Trinka Kerr supported a broader approach. For example, supports using NCQA standard #4 rather than focusing too narrowly and listing out conditions.</li> <li>• Kristin Murphy agreed with Trinka.</li> <li>• Catherine Simonson also supported a broader approach which uses early intervention to impact population health and improve outcomes for children and families.</li> <li>• Deborah Lisi-Baker agreed that individuals and families should be included and standards should reflect a commitment to quality of services across the life span (childhood-adult life) and encompass social as well as health indicators/needs. She also commented that care management should include the capacity to support planning for and providing disability specific accommodations in health care, both within medical settings and when care transitions to other settings. For some individuals, DLTSS providers will be essential parts of this care coordination but it also needs to include practitioners with relevant medical expertise.</li> </ul>

<p><b>Services</b></p> <p>(What are the care management services people currently receive or should receive?)</p>	<p><u>NCQA Standard #3</u> The ACO makes patient decision aids available to participating providers to promote patient engagement</p> <p><u>NCQA Standard #11</u> 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.</p> <p><u>NCQA Standard #20</u> The practice performs the following for people identified as having important selected conditions:</p> <ul style="list-style-type: none"> <li>• Conducts pre-visit preparations to assure that all paperwork, lab tests, imaging tests, or referral visits are completed and reviewed prior to the visit</li> <li>• Collaborates with the person/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit</li> <li>• Gives the person/family a written plan of care</li> <li>• Assesses and addresses barriers when the person has not met treatment goals</li> <li>• Gives the person/family a clinical summary at each relevant visit</li> <li>• 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</li> <li>• Follows up with people/families who have not kept important appointments.</li> </ul> <p><u>NCQA Standard #21</u> 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.</p>	<ul style="list-style-type: none"> <li>• Catherine Simonson pointed out that there is no mention of social determinant issues.</li> <li>• Deborah Lisi-Baker commented that the scope of work needs to be broadened to include social support/services as well as medical care.</li> </ul>
-------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

	<p><u>NCQA Standard #22</u> 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 EHR to identify and provide people-specific education resources.</p> <p><u>NCQA Standard #23</u> 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.</p> <p><u>DLTSS WG Element #2</u> Access to independent options counseling and peer support</p> <p><u>DLTSS WG Element #8</u> Comprehensive individualized care plan inclusive of all needs, supports and services</p> <p><u>DLTSS WG Element #9</u> Care coordination and care management</p>	
<p><b>Who provides those services</b> (Characteristics of providers – are they practices, or teams?)</p>	<p><u>NCQA Standard #1</u> For primary care practice within the ACO, the ACO evaluates practice capacity to meet patient-centered medical home requirements</p> <p><u>DLTSS WG Element #3</u> Actively involved Primary Care Physician</p> <p><u>DLTSS WG Element #4</u> Provider network with specialized DLTSS expertise</p>	<ul style="list-style-type: none"> <li>• Nancy Eldridge noted that the reference to “practice” could potentially imply that it is just the medical practice that does/leads the care management process.</li> <li>• Beth Tanzman commented that there is concern that the ACOs will create an additional layer of care management on top of what already exists. Therefore we should include a standard that says we want to use what already exists.</li> <li>• Lisa Viles agrees with Beth’s comment.</li> </ul>

	<p><u>Concept from IOM Report, “Core Principles &amp; Values of Effective Team-Based Health Care” (October 2012):</u></p> <p>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.</p> <p><u>DLTSS WG Element #6</u> Single point of contact for person with DLTSS needs across all services</p> <p><u>DLTSS WG Element #10</u> Interdisciplinary care team</p>	<ul style="list-style-type: none"> <li>• Trinka suggests that we use the word team instead of practice.</li> <li>• General discussion followed regarding who would be on a team; consensus was that it cannot be solely medical.</li> <li>• Mary Moulton commented that care management services should be driven by the client and it is important to make sure the client’s voice is heard.</li> </ul> <p>From Georgia’s Notes:</p> <ul style="list-style-type: none"> <li>• Use of existing Care management workforce</li> <li>• Team-collaborative, those dealing with the individual</li> <li>• Don’t create a whole new care management system</li> <li>• Leverage high quality infrastructure; improve where we can</li> <li>• Driven by the person</li> </ul>
<p><b>How are services provided</b> (what is the delivery system setting for care management services and how are transitions amongst settings managed)</p>	<p><u>NCQA Standard #13</u> 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.</p> <p><u>NCQA Standard #14</u> To facilitate transitions, the ACO has a documented process to:</p> <ul style="list-style-type: none"> <li>• identify attributed people who transition between settings,</li> <li>• share clinical information received from the first setting with the second setting and primary care practitioner,</li> </ul>	<ul style="list-style-type: none"> <li>• Deborah Lisi-Baker commented that #14 is too narrow and medical based. We need to include social services. Additionally, people may be transitioning to different funding/service settings, such as early childhood, school, adult services, senior programs or particular disability related services. If these transitions are not planned for the individual and family, they often experience gaps or delays in services.</li> </ul>

	<ul style="list-style-type: none"> <li>• communicate with hospitals to exchange information about patients during hospitalization,</li> <li>• obtain patient discharge summaries from hospitals, emergency departments and other facilities,</li> <li>• contact patients or families following transitions within an appropriate time frame for appropriate follow-up care,</li> <li>• electronically exchange key clinical information with facilities,</li> <li>• provide an electronic summary of care record to other care settings, and</li> <li>• track the status of transitions, including the timing of information exchange</li> </ul> <p><u>NCQA Standard #15</u> The ACO demonstrates that the transitioning or referring practitioner provides a summary of care record for transitions of care and referrals.</p> <p><u>NCQA Standard #16</u> The ACO has a process to determine whether timely information exchange occurred between providers for care coordination and care transitions.</p> <p><u>NCQA Standard #17</u> At least quarterly, the ACO monitors transitions to determine if they were performed safely and efficiently, by reviewing if:</p> <ul style="list-style-type: none"> <li>• The sending setting’s care plan was shared with the receiving setting within a specified time frame.</li> <li>• The patient’s usual practitioner was notified of the transition within a specified time frame</li> <li>• Communication with the patient or the patient’s family about the care transition process occurred within a specified time frame</li> <li>• 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.</li> </ul>	<p>From Georgia’s notes:</p> <ul style="list-style-type: none"> <li>• Parking lot: data</li> <li>• Cross-training</li> <li>• Regional relationships</li> <li>• Impact on payment model</li> </ul>
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

NCQA Standard #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.

NCQA Standard #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).

NCQA Standard #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.

DLTSS WG Element #1

Person Centered and Directed Process for Planning and Service Delivery

DLTSS WG Element #5

Integration between medical and DLTSS care

DLTSS WG Element #7

Standardized assessment tool

DLTSS WG Element #11

Coordinated support during care transitions

	<p><b><u>IOM Core Principles and Values of Effective Team-Based Health Care</u></b></p> <ol style="list-style-type: none"> <li>1. Shared goals</li> <li>2. Clear roles</li> <li>3. Mutual trust</li> <li>4. Effective communication</li> <li>5. Measureable processes and outcomes</li> </ol>	
<p><b>Data</b> (What are the information systems needed and what information must be captured in those systems?)</p>	<p><b><u>NCQA Standard #5</u></b> The ACO uses an electronic system that records the following as structured (searchable) data:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p><b><u>NCQA Standard #6</u></b> 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.</p> <p><b><u>NCQA Standard #7</u></b> The ACO works with external entities to exchange clinical information.</p> <p><b><u>NCQA Standard #8</u></b> 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,</p>	

	<p>laboratory results, health appraisal results, cost data</p> <p><u>NCQA Standard #9</u> The ACO uses the data for identifying needs of attributed people, care management services and performance measurement.</p> <p><u>NCQA Standard #10</u> 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.</p> <p><u>NCQA Standard #12</u> The ACO provides the following information and services to attributed people through a secure electronic system:</p> <ul style="list-style-type: none"><li>• Electronic copies of health information within three business days</li><li>• Electronic access to current health information within four business days of when the information is available to the ACO</li><li>• Clinical summaries within three business days of office visits</li><li>• Two-way communication between attributed people/families and participating providers</li><li>• Requests for appointments or prescription refills</li><li>• Requests for referrals or test results</li></ul> <p><b><u>DLTSS WG Element #12</u></b> Use of technology for sharing information</p>	
--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

# Attachment 5 - Integrated Community Learning Collaborative PowerPoint

**Proposal for Vermont's  
Multi-Organization  
“Integrated Community”  
Care Management  
Learning Collaborative**

Building Capacity for Population-Wide Care Management,  
Beginning With Effective Care Management for At-Risk  
Populations

# Working Concepts

- Care management should be:
  - Integrated and person centered/directed
  - Ensure that individuals have a coordinated plan of care that optimizes health, wellness, and quality of life.
- Each panel of people receiving care management services should have an Integrated Community Team
- Each person receiving care management services should have a designated lead contact, based on the person's needs at a given point in time. The lead contact (with the person, their caregivers and the Integrated Community Team) should:
  - Partner with the person and their caregivers,
  - Develop a shared plan of care,
  - Ensure that services are appropriate and coordinated,
  - Identify who is responsible for providing services, and
  - Ensure accountability for implementing the care plan

# Aim

To develop and/or enhance integrated and collaborative care management, beginning with at-risk populations in the near term and expanding to the broader population over the longer term.

# Goals

Learning collaborative sites will demonstrate that integrated and collaborative care management services can:

a) Improve quality of care, patient and family experience, health and wellness

and

b) Reduce unnecessary utilization and cost

Provide tools and core competency training opportunities for team members engaged in care management

Improve coordination, support integration, and decrease fragmentation among different organizations that provide care management services

Reduce unnecessary ER and inpatient utilization

Reduce gaps in care for at-risk people with complex health conditions

Establish efficient, financially sustainable care management system as we consider changes in investments in care management

# Objectives

Demonstration sites will form Learning Collaborative Pilot Planning Teams to identify:

Existing care management services and resources

Gaps in services

Needed care management tools and training resources

Care management protocols that would systematize referrals, transitions, and co-management

Measures of success and accountability

# Learning Collaborative Process

**Pre-Work**

## Learning Session I

(Teams gather for a face-to-face meeting)

### Action Period

(approximately 3 months – community teams working together to implement change)



## Learning Session II

(Teams gather for a face-to-face meeting)

### Action Period

(approximately 3 months – community teams working together to implement change)



## Learning Session III

(Teams gather for a face-to-face meeting)

**Spreading the Change**

# Potential Team Members include\*:

\*(but are not limited to, and not necessarily all on every team)

People in need of care management services and their families

Primary Care Practices participating in ACOs (practice team includes care coordinator)

Designated Mental Health Agencies

Visiting Nurse Associations and Home Health Agencies

Hospitals and Skilled Nursing Facilities (including their case managers)

Area Agencies on Aging

Community Health Teams and Practice Facilitators (Vermont Blueprint for Health)

Support and Services at Home (including SASH coordinators and wellness nurses)

ACOs (OneCare, CHAC, ACCGM/VCP)

Medicaid: Vermont Chronic Care Initiative (including care coordinators)

Commercial Insurers (BCBSVT, MVP, Cigna)

# Integrated Community Team Members' Charge:

1. Form new (or enhance existing) Integrated Community Teams in each health service area to meet about specific at-risk people on a regular basis.
2. Identify current care management services and needs (includes a gap analysis).
3. Define current care management systems and tools.
4. Review existing reports and tools for identification of at-risk populations (e.g., Blueprint practice reports, VCCI high risk patient reports, NNEACC prospective at-risk patients, DocSite reports, Medicare portal reports).
5. Agree on criteria to define at-risk person using one or more of the systems above.

# Integrated Community Team Members' Charge (cont'd):

6. Define which at-risk people and how many or what proportion will initially receive outreach for care management services. Consider asking each team member to provide a list of at-risk people that they think could benefit from an Integrated Community approach.

7. Develop and implement protocols that systematize referrals, transition, and co-management between primary care and other team members in the Integrated Community (e.g., accountabilities and triage protocols).

8. Based on care plan and Integrated Community team process (including person in need of services), determine which services will initially be offered to the person.

9. Develop written agreements that include guidelines and expectations for referrals and transitions.

10. Develop a tracking tool to monitor transitions.

# Potential Measures (measures should relate to pilot goals, be limited in number, and have clearly specified numerators and denominators)

1. Number of people each quarter for each health service area who meet at-risk criteria (and/or who are participating in pilot)

2. Percentage of people participating in pilot each quarter who have met in person with lead contact

3. Percentage of people participating in pilot each quarter whose care plans followed the protocols for referrals, transitions, and co-management

4. Percentage of people participating in pilot each quarter who have a shared plan of care

5. Percentage of people participating in pilot each quarter who have an emergency plan of care

# Potential Measures (cont'd):

6. Percentage of people participating in pilot each quarter who have updates to their shared plan of care

7. Percentage of people participating in pilot each quarter with avoidable ED visits, ambulatory care sensitive admissions, and readmissions

8. Patient experience of care survey results for people participating in pilot, pre- and post-shared plan of care development

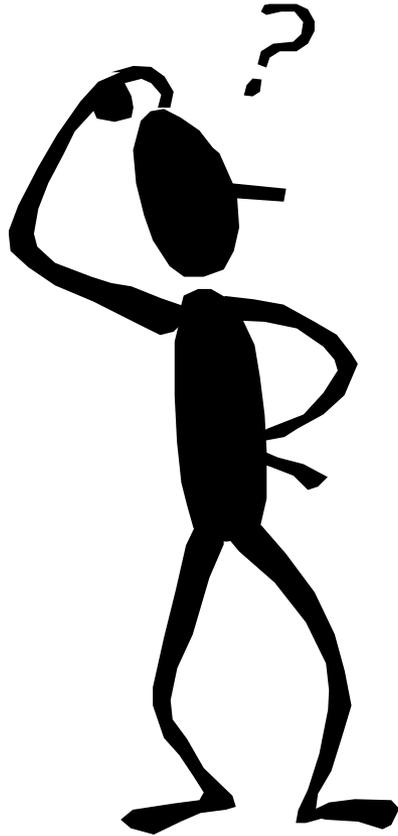
# Proposed Timeline

- Kick-Off Webinar: (September 2014)
- Learning Sessions 1-3: (October-November 2014)
- Action Period: (December 2014-February 2015)
- Learning Sessions 4-5: (March-May 2015)
- Action Period: (June-August 2015)
- Learning Session 6: (September 2015)

# Proposed Budget

- Learning Collaborative Facilitator to coordinate Collaborative design, team member outreach and communications, and logistics: 1 FTE for 1 Year, \$95,000 (contractor, includes travel and training)
- Learning Collaborative Facilitator to work with team members on data resource identification, data analysis, panel management and measurement activities: 1 FTE for 1 Year, \$95,000 (contractor, includes travel and training)
- Expenses for 6 Learning Sessions during the year, including expert faculty and travel expenses, rental of meeting space, meals, materials: estimated \$60,000
- TOTAL ESTIMATED BUDGET FOR YEAR 1 OF THE LEARNING COLLABORATIVE: \$250,000; consider a not-to-exceed amount of \$300,000

# Questions



# Appendix

# Care Management Defined:

*“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.”*

*-- (State of Washington Office of Quality and Care Management; currently under revision by VHCIP Care Models and Care Management Work Group)*

# Sample Learning Session Agenda

Time	Topic	Presenter
8:30-9:00	Registration and breakfast	
9:00-9:15	Welcome and Opening Remarks	
9:15-10:30	Design, implementation and communication of shared plans of care	
10:30-10:45	Break	
10:45-12:00	Care Conference as a Care Planning Strategy	
12:00-12:45	Lunch	
12:45-1:45	Engaging people: how to reach out to people needing care management services and their caregivers	
1:45-2:30	Team Working Time	
2:30-3:00	Report Out and Closing Remarks	

# Ideas for Learning Session Topics:

What is Care Management and Why is it Important?

Establishing Integrated Communities

Creating Effective Team-Based Care

Understanding Data Sources and Using them Effectively

Care Conferences

Care Management Rounds and Other Communication Strategies

Engaging People Needing Care Management Services