Care Models and Care Management Work Group Meeting Agenda 8-12-14

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

Tuesday, August 12th, 2014; 9:00 AM to 12:00 PM
ACCD - 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	Vote To Be Taken
1	9:00 - 9:05	Welcome; Introductions; Approval of Minutes	**Attachment 1:** July meeting minutes	Yes (approval of minutes)
2	9:05 – 9:10	Co-Chair Update (*Nancy Eldridge to serve as meeting facilitator*) ***Public Comment***	**Attachment 2:** Finalized Care Management Problem Statement	
3	9:10 – 9:30	Response to Questions on Integrated Community Learning Collaborative ***Public Comment.***	**Attachment 3:** Memo re Response to Questions on Integrated Community Learning Collaborative	
4	9:30 – 10:00	Summary of Care Management Survey Responses ***Public Comment***	**Attachment 4:** Care Management Survey Responses Presentation	
5	10:00 – 11:30	DLTSS Work Group Presentation: Proposed DLTSS Model of Care ***Public Comment***	**Attachment 5:** DLTSS Model of Care Presentation	
6	11:30 – 11:55	Proposed Process for Developing Care Management Standards ***Public Comment***	**Attachment 6:** Proposed Process for Developing Care Management Standards	
7	11:55 – 12:00	Next Steps, Wrap-Up and Future Meeting Schedule September Meeting Preview: • Further review of CMCM Inventory Survey Results • Obtain feedback on proposed Care Management Standards		

Attachment 1 - Care Models and Care Management Work Group Meeting Minutes 7-08-14

Vermont Health Care Innovation Project

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

Date of meeting: Tuesday, July 8th, 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; Pat Jones, Annie Paumgarten, GMCB; Erin Flynn, Amanda Ciecior, Kara Suter, Eileen Girling, Kelly Gordon, DVHA; Susan Besio, PHPG; Laural Ruggles, Mike Moss, Northeastern Vermont Regional Hospital; Deborah Andrews, Fletcher Allen Health Care; Vicki Loner, Miriam Sheehey, OneCare Vermont; Deborah Lisi-Baker, DLTSS Co-Chair; Marlys Waller, VT Council of Dev. and MH Services; Julie Wasserman, AHS; Michael Bailit, Marge Houy, Bailit Health Purchasing; Nancy Breiden, VLA; Dale Hackett, Consumer; Clare McFadden, Jennifer Woodard, DAIL; Madeleine Mongan, VMS; Mary Moulton, Washington Co. MH Services; Judy Morton, Mountain View Center; Jenney Samuelson, Blueprint; Mary Lou Bolt, Rutland Regional Medical Center CHT; Patrick Clark, CVMC CHT; Dr. Dee Burroughs-Biron, DOC; Sarah Narkewicz, Rutland Regional Medical Center; Patty Launer, Bi-State Primary Care Association & CHAC; Nelson LaMothe, Project Management Team; John Matulis, Dartmouth Hitchcock; Beverly Boget, VNA of Grand Isle and Chittenden Counties; Jill McKenzie, ACCGM.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Bea Grause called the meeting to order at 10:03 and made a motion for approval of the June meeting minutes. Several small edits were suggested to the June meeting minutes by work group members as follows: Agenda Item #3: • Change sentence "in order to better serve all Vermonters (especially those with complex…..)" to "in order to better serve all Vermonters (including those with complex….)" • change sentence "rather than adding these are priorities" to "rather than adding these as priorities" • replace Pamela Fanham with Pamela Farnham Agenda Item #4: • change sentence "a recommendation was made to add 'care management'" to "a recommendation was made to add 'care models'" Nancy Breiden made a motion to approve the June meeting minutes including the suggested edits.	

Agenda Item	Discussion	Next Steps
	Madeleine Mongan seconded the motion and it passed unanimously. Edited June meeting minutes will be posted to the VHCIP public website. **Public Comment:** Madeleine Mongan provided a general comment requesting that the work group staff ensures that meeting materials go out at least one week in advance, and that anticipated work group votes be indicated on the meeting agenda. Dale Hackett agreed with this request.	
2. Co-Chairs Update	No co-chair report was provided in order to allow more time for discussion of other agenda items.	
3. Final Review and Approval of Problem Statement	Bea Grause reviewed **Attachment 3: Revised problem statement,** and opened the floor for discussion of the most recent revisions. The following comments were made: • Madeleine Mongan suggested that a link or citation be provided to support the statement "Vermont has high absolute rates of obesity, smoking, substance abuse, mental illness and non-immunized children". She also noted that we don't discuss care models in the problem statement, but rather focus on care management. The work group discussed this point, and agreed that this specific problem statement is focused on the care management problem, but that there may be a subsequent problem statement for care models. • Clare McFadden asked for clarification regarding the meaning of "best practices". The work group discussed that the definition of best practices is an ongoing discussion that the work group will continue to explore. For example, the work group has been reviewing literature and trying to understand what elements of effective care management can apply to a state-wide context in Vermont. • Dale Hackett noted his concern that standardized best practices may not apply in the same way in communities across the state. • Eileen Girling suggested that given that the work group has adapted the definition of care management, we remove the reference to the office of quality and care management. Nancy Breiden made a motion to approve the problem statement as amended, and Madeleine Mongan seconded. The motion passed unanimously.	
4. Continued Discussion of Care Management Standards for ACOs	Michael Bailit began by providing an overview of Attachment 4a, **Memo re Goals and Implementation of Care Management Standards,** and subsequently opened the floor to questions and comments. The following comments were made: • Dale Hackett requested clarification of a comment claiming that care management standards are not meant to stifle innovation. Michael Bailit responded that the challenge is to find the right balance of	

Agenda Item	Discussion	Next Steps
	detail in the standards so that they are meaningful without being overly restrictive. Bea Grause added that an important threshold is that the process for enforcing standards not be overly administratively burdensome. • Vicki Loner commented that she would like to have further conversation with the payers regarding how these standards will be enforced. She also echoed that it would take away from the ACOs' ability to implement best practices if they are spending too much time focused on standards compliance. Vicki also commented that it may be helpful to see what results come out of the care management learning collaborative, and use those results and lessons learned to better understand what appropriate standards may be. Vicki also suggested that a subcommittee could be formed, or that the topic of care management standards could be added to the charge of the existing subgroup, and that this subgroup would make recommendations to the larger group. • Bea asked the group for feedback on this idea and the following comments were made: • Jenney Samuelson suggested that it would be helpful for the subgroup to explore how these standards would be implemented, in order to better understand the level of administrative burden. • Eileen Girling commented that there are many instances where these standards (or variations of NCQA standards) are already being implemented, and that it would be helpful to better understand the baseline. • Patty Launer agreed and suggested that the subgroup look at what is already being done on the ground that could support the standards. • Kara Suter suggested that it would be helpful to put a reasonable timeline on this work so that all parties involved could plan accordingly. Jenney Samuelson asked for clarification on what is a reasonable time frame, and Kara responded that as a first step the subgroup could review what is already in place in order to get a better understanding of how long the subgroup needs, and report back to the full work group regarding a time frame at its next meeting. • Julie Wasserman commented that NCQA standards are largely focused on acute care, and reminded the group that we also need to consider disability and long term services and supports. • Nancy Breiden asked for clarification about what the subgroup would be doing; would they be developing standards, or studying implementation? Bea responded by suggesting that the full work group will continue to review and adapt the NCQA standards as a full work group, and the subgroup will review how those standards will be implemented. She also commented that the subgroup would have the ability to give the full work group feedback regarding the feasibility of its recommendations. • Jenney Samuelson commented that the subgroup would focus on an operational plan for the standards. • Bea commented that it is important that the standards are operationally feasible, and that clinicians are able to implement them. • A question was asked about how to form the subgroup. Bea Grause suggested that work group	

Agenda Item	Discussion	Next Steps
	participants contact staff to indicate their desire to participate in the subgroup. Vicki Loner suggested that at least members of the learning collaborative subgroup (at a minimum ACOs and payers) would participate. Bea recommended that we keep the group to a reasonable number. • Jenney suggested that the standards subgroup be merged with the learning collaborative subgroup schedule, and that both topics would be covered at meetings going forward. Michael Bailit continued the discussion and moved on to a review of **Attachment 4b: Care Management Standards by Categories**. Discussion ensued and the following comments were made: • Patty Launer suggested that the standards could be consolidated into groupings, or that the DLTSS elements could be incorporated into the NCQA standards to make them more person centered. • Deborah Lisi-Baker commented that effective communication is important, especially for people with cognitive disabilities. She also noted that it is not only about the communication that occurs when transferring from one setting to another, but also about communication amongst providers in the same setting. Finally, she noted that coordination of financing is also important. • Madeleine Mongan commented that the NCQA standards are phrased in a way that says the ACO or the practice will be responsible for implementing the standards and asked who will be responsible for implementing the DLTSS standards? Michael Bailit suggested that it is better to define the standards as the ACOs' responsibility, and that we allow the ACO to delegate the execution of the standard as they see fit, but that the ACO itself will be ultimately held responsible. • Laural Ruggles asked a question about what the final product would look like. Are we hoping to consolidate several standards into one statement? Michael responded that one option is that it be an NCQA based, Vermont modified set of standards. For example, the next version incorporates the work group input and DLTSS elements and merges them with NCQA. We may also remove certain NCQA standards, or add additional standards that the work group develops internally. For example, we may supplement with things we think are missing, such as alignment. • Bea commented that once we get to a final draft, the subgroup will be able to review the operational feasibility of implementing the standards. • Re Standard #13: Nancy Eldridge asked if we can assume that this information would be exchanged via VITL. Bea responded that it depends on the type of data. • Madeleine commented that she thinks the HIE infrastructure should be in place before we review these standards. Bea responded that we can continue planning assuming that the functionality will be in place in the future. • Nancy Eldridge asked if we will still be using DocSite to feed in this data. Kara responded that the HIE workgroup is focusing on these issues; we can be aspirational in developing standards and then assess whether or not it is feasible at a future date. Bea added that we will solicit input from the HIE	

Agenda Item	Discussion	Next Steps
	workgroup as needed throughout this process. Michael Bailit agreed and said that we have to build standards based on how we hope the future will look. • Re the topic "Data": Michael noted that we have to consider the right level of detail in these standards and that some have to do with patient specific information and some speaks to integration and analysis of complex multiple streams of data. • Dale commented on standard #5 saying that it is too general. Bea noted that staff will follow up with the work group to solicit further comments after today's meeting.	
5. Vermont's Multi-Organization "Integrated Community" Care Management Learning Collaborative	Pat Jones began the conversation by summarizing the activity of the work group to date, and beginning the review of **Attachment 5: Integrated Community Learning Collaborative PowerPoint**. She noted that this is a proposal for a learning collaborative for an amount not to exceed $300k, and that the subgroup is seeking a decision from the full work group on whether or not they will recommend the proposal for funding. Patty Launer and Miriam Sheehey presented the proposal. The following comments were made: • Michael Bailit commented that it seems to rely on learning by doing and suggests that there are a couple of areas where expert knowledge and experience could inform the group. Pat responded that we envision that the expert faculty would address this, as would our existing consulting resources to support the goals of the work plan. Miriam Sheehey also commented that part of the proposal is to look at all the tools that are out there and potentially test out different tools. Jenney Samuelson commented that facilitators could help in meeting this goal. Laural Ruggles also agreed that learning collaborative participants bring a certain level of existing knowledge and expertise to the table. • Nancy Breiden asked how long the group envisions the learning sessions to be, and the subgroup responded that they will be one day. She also asked what the commitment between learning sessions will be. Pat Jones responded that at the community level there are integrated teams who would be working together under the model of plan-do-study-act to structure the process. The facilitator ensures that those activities continue and that the process is fluid. Bea requested a motion. Nancy Breiden made a motion to approve the budget as proposed for recommendation to the Steering Committee and Core Team. Madeleine Mongan seconded and the motion passed unanimously.	

Agenda Item	Discussion	Next Steps
6. Next Steps, Wrap-Up and Future Meeting Schedule	The following next steps were identified for the August in-person meeting: • Continue to discuss care management standards • Present edited care management problem statement to work group • Update on various steps of approval of learning collaborative proposal • Presentation re DLTSS Model of Care • Results of care management inventory survey It was also noted that the July webinar has been cancelled, and a request was made to extend the time of the August meeting to allow adequate time to get through the packed agenda. The work group members indicated that they support meeting from 9-12 in August. **Next Meeting:** *Tuesday August 12th, 9:00 am – 12:00 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier*	

Attachment 2 - Finalized Care Management 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 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[1] 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-

[1] Vermont State Health Improvement Plan, http://healthvermont.gov/hv2020/ship.aspx

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;
- Recommendations regarding payment reform support optimal care management.

Attachment 3 - Memo re Response to Questions on Integrated Community Learning Collaborative

VERMONT

Vermont Health Care Innovation Project

State Innovation Model

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

TO: Care Models and Care Management Work Group

FROM: Integrated Community Care Management Learning Collaborative Planning Group

RE: Responses to Questions on Integrated Community Learning Collaborative

DATE: August 4, 2014

At the July 8th 2014 meeting of the Care Models and Care Management Work Group, a team of participants in the Integrated Community Care Management Learning Collaborative planning group presented a proposal[1] for a one year Learning Collaborative, including a budget not to exceed $300,000. The Care Models and Care Management Work Group voted unanimously to recommend funding in support of this proposal, and the funding request will next go before the Steering Committee on August 6th and the Core Team on August 13th for further consideration. Since the July 8th meeting the Care Models and Care Management Work Group staff have received a number of follow up questions regarding the Integrated Community Learning Collaborative proposal, and the planning group discussed these questions at its July 11th and July 25th meetings. Following are summaries of the questions that were received, and answers from the planning group.

1. Questions were received regarding whether or not any funds were available to offset the financial impact on pilot community organizations for the time and resources needed if they choose to participate in the Learning Collaborative. The planning group discussed this topic at length and ultimately agreed that this type of expense was not built into the proposed Learning Collaborative budget, could greatly increase the overall budget, and would probably not be sustainable. The planning group discussed the potential to use existing pilot community meetings for the Learning Collaborative and offer benefits, such as continuing education credits, to help offset the resources needed to participate in the Learning Collaborative. Even though the Collaborative would probably not be able to offer financial remuneration, it could provide participating organizations with an opportunity to be part of a health care reform activity that has the potential to inform and shape the way that care management activities are delivered in the future, and impact future referral patterns.

[1] Please see Attachment 5 of the July 8th, 2014 meeting materials found at http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/CMCM.7.08.14.Merged.Meeting.Materials.v2.pdf

2. Questions were received seeking clarification of the population focus of the Learning Collaborative, such as: How is at-risk defined? Will each pilot community focus on the same population? How many people will each pilot community focus on? What is a panel? These types of design elements will be refined by participating organizations as the Learning Collaborative is implemented, but the planning group believes that there are benefits to be gained by focusing on similar populations in each area, such that shared learning can occur. While the pilots may initially focus on a common definition of at-risk people in need of care management services, the goal over time (as noted in the presentation to the CMCM Work Group) is to build a foundation that will be scalable to broader populations. Questions such as how to define the at-risk population will be explored as part of the pre-work phase of the Learning Collaborative. Because we are seeking to test integration of care management activities, the at-risk population will likely consist of people who receive services from more than one organization.

3. Questions were received regarding what organizations and individuals (patients) will be included in the collaborative to meet the goals of an integrated community such as: How is integrated and collaborative care management defined? Will designated developmental services agencies be included? Will there be patient involvement? A list of potential team members was included in the July 8th presentation. Generally speaking, the planning group believes that Integrated Community care management refers to a team-based approach characterized by functional integration of multiple organizations serving – and including - the person and their family. The planning group anticipates that a wide variety of organizations (including designated developmental services agencies) will be included in the Integrated Community teams. The planning group has obtained a list of developmental services agencies so that they can be sure the pilot communities are aware of them.

4. Finally, questions were received regarding the tools, supports, and core competency training opportunities for team members engaged in care management, such as: Is the intention for these teams to learn about specialized needs; for example, communication with people who have limited or no verbal skills? Will there be field support for initiatives? How are core competencies determined and what methods are planned for determining the learning needs and the value and impact of participation on providers and panel members/others? The planning group is discussing some of these details as part of the pre-work phase and they will be further refined during implementation of the Learning Collaborative. Training related to working with populations with specialized needs could be an area of skills development highlighted by Learning Collaborative participants. The planning group anticipates that team members in the field will work together to better define the specific training, supports and tools that will be most beneficial to their

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communities. The community facilitators will also provide field support to participants in the pilot communities.

Attachment 4 - Care Management Survey Responses Presentation

Initial CMCM Survey Analysis

August 12, 2014

Christine Hughes

Senior Consultant, Bailit Health Purchasing

Number and Type of Responding Organizations

Type of Organization	Number of Respondents
ACO	2
Blueprint Community Health Team	11
Health Plan	3
State Agency	3
Community Service Provider	14
Health Care Provider	9
Other	0
Total	42

Note: All who responded “Other” were re-categorized as shown on slides that follow.

Responding Organizations: ACOs

Organization Name	Contact Person Name
ACCGM	Jill McKenzie
OneCare Vermont	Vicki Loner

Note: Vermont's third ACO, Community Health Accountable Care (CHAC), elected to have its member providers respond on its behalf, rather than developing one aggregated ACO response. The FQHCs that responded were categorized as Health Care Providers.

Responding Organizations: Blueprint Community Health Teams

Organization Name	Contact Person Name
Barre HSA Community Health Team	Patrick Clark
Brattleboro Memorial Hospital Community Health Team	Wendy Cornwell
CHT for Rutland County HSA	Mary Lou Bolt
Fletcher Allen Health Care	Pam Farnham
Gifford Medical Center	LaRae Francis
Mt. Ascutney Hospital and Health Center	Jill Lord, RN
North Country Hospital Blueprint HSA	Julie Riffon
Springfield Medical Care Systems	Joshua Dufresne
St Albans HSA Blueprint Program	Candace Collins
Bennington Hospital Service Area/United Health Alliance	Dana Noble
VT Blueprint for Health Middlebury HSA	Susan Bruce

Responding Organizations: Community Service Providers

Organization Name	Contact Person Name
Cathedral Square/SASH	Nancy Eldridge
Champlain Community Services	Elizabeth Sightler
Counseling Service of Addison County	Robert Thorn
Families First	Julie Cunningham, LICSW
Healthcare and Rehabilitation Services of Southeastern Vermont (HCRS)	Alice Bradeen
HowardCenter	Catherine Simonson
Lamoille County Mental Health Services	Jennifer Stratton
Lincoln Street Inc.	Cheryl Thrall Executive Director
Northwestern Counseling & Support Services	Amy Putnam
United Counseling Service	Ralph Provenza
Upper Valley Services	William Ashe
Washington County Mental Health Services	Mary Moulton
Clara Martin Center	Melanie Gidney
Community Care Network/Rutland Mental Health Services	Daniel Quinn

Responding Organizations: Health Care Providers

Organization Name	Contact Person Name
Community Health Centers of Burlington	Jonathan Bowley
Community Health Services of Lamoille Valley	Corey Perpall
Invest EAP / VTHealthEngage	Steve Dickens
Little Rivers Health Care, Inc.	Gail Auclair
Mountain Health Center	Martha
Mountain View Center	Judy Morton
Northeastern Vermont Regional Hospital	Laural Ruggles
Northern Tier Centers for Health (NoTCH)	Unknown
Otter Creek Associates and Matrix Health Systems	Melissa Bailey

Responding Organizations: Health Plans

Organization Name	Contact Person Name
BCBSVT	Audrey Spence
DVHA/VCCI	Eileen Girling
MVP Health Care	Linda Johnson, Director Population Health Management

Responding Organizations: State Agencies

Organization Name	Contact Person Name
Vermont Department of Health - Alcohol and Drug Abuse Programs	Kerrie Taylor
Ladies First: Breast and Cervical Cancer and Heart Health Screening Program	Nicole Lukas
Vermont Department of Disabilities, Aging and Independent Living (DAIL)	Jen Woodard

Changes to Categorization of Organization Type (1 of 2)

Organization Name	Contact Name	Identified 'Org Type' by Organizations	Changed 'Org Type' for Consistency in the Analysis
Cathedral Square/SASH	Nancy Eldridge	Other	Community Service Provider
Champlain Community Services	Elizabeth Sightler	Other	Community Service Provider
HowardCenter	Catherine Simonson	Other	Community Service Provider
Northwestern Counseling & Support Services	Amy Putnam	Other	Community Service Provider
Northeastern Vermont Regional Hospital	Laural Ruggles	Other	Health Care Provider

Changes to Categorization of Organization Type (2 of 2)

Organization Name	Contact Name	Identified 'Org Type' by Organizations	Changed 'Org Type' for Consistency in the Analysis
Otter Creek Associates and Matrix Health Systems	Melissa Bailey	Other	Health Care Provider
DVHA/VCCI	Eileen Girling	Community Service Provider	Health Plan
Vermont Department of Health - Alcohol and Drug Abuse Programs	Kerrie Taylor	Community Service Provider	State Agency
Ladies First: Breast and Cervical Cancer and Heart Health Screening Program	Nicole Lukas	Health Plan	State Agency

Responding Organizations by Geographic Area

County	# of Organizations	% of Responses
Statewide	13	31%
Addison County	6	14%
Bennington County	4	10%
Caledonia County	2	5%
Chittenden County	4	10%
Essex County	2	5%
Franklin County	4	10%
Grand Isle County	2	5%
Lamoille County	2	5%
Orange County	7	17%
Orleans County	1	2%
Rutland County	4	10%
Washington County	6	14%
Windham County	5	12%
Windsor County	6	14%

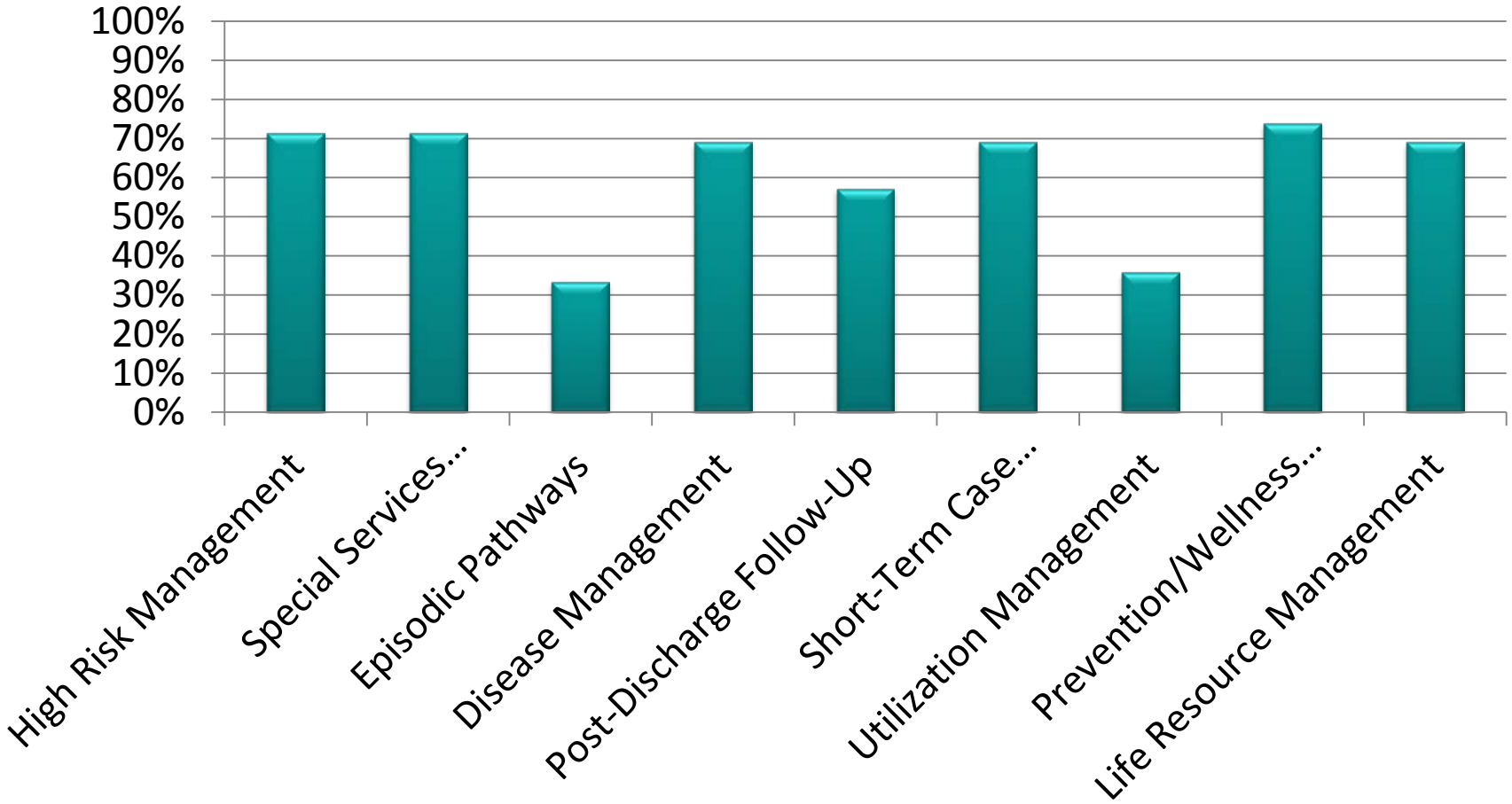
Care Management Services Definitions

- **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.

Care Management Services Definitions (Continued)

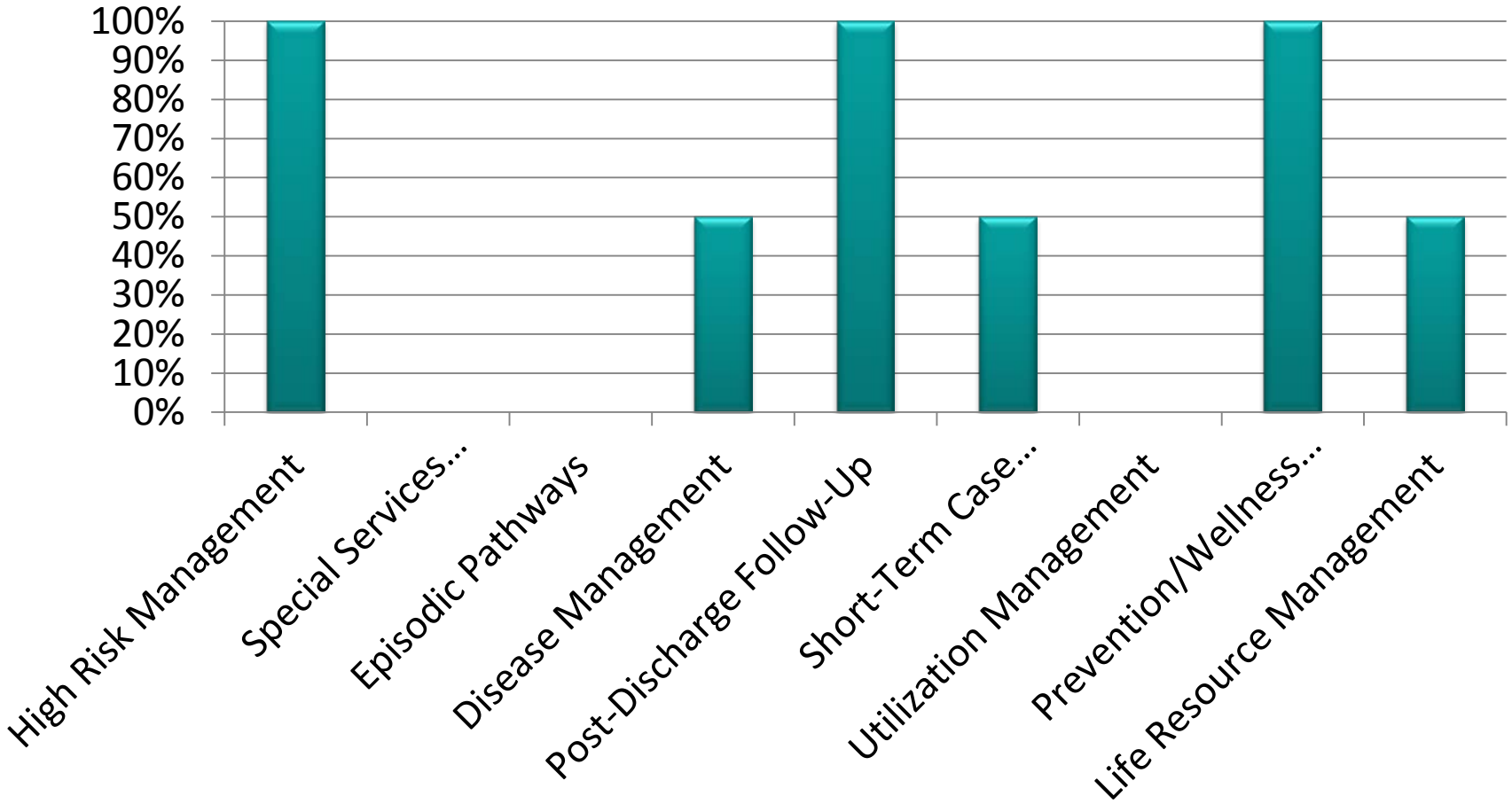
- **Post-Discharge Follow-Up** consists of a phone call or visit to discharged individuals within 48 to 72 hours of their departure from a care facility. The purpose is to ask about the individual's condition, adherence to and understanding of medication orders and other treatment orders, general understanding 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.

Percent of All Responding Organizations Providing Care Management Services By Type of Service



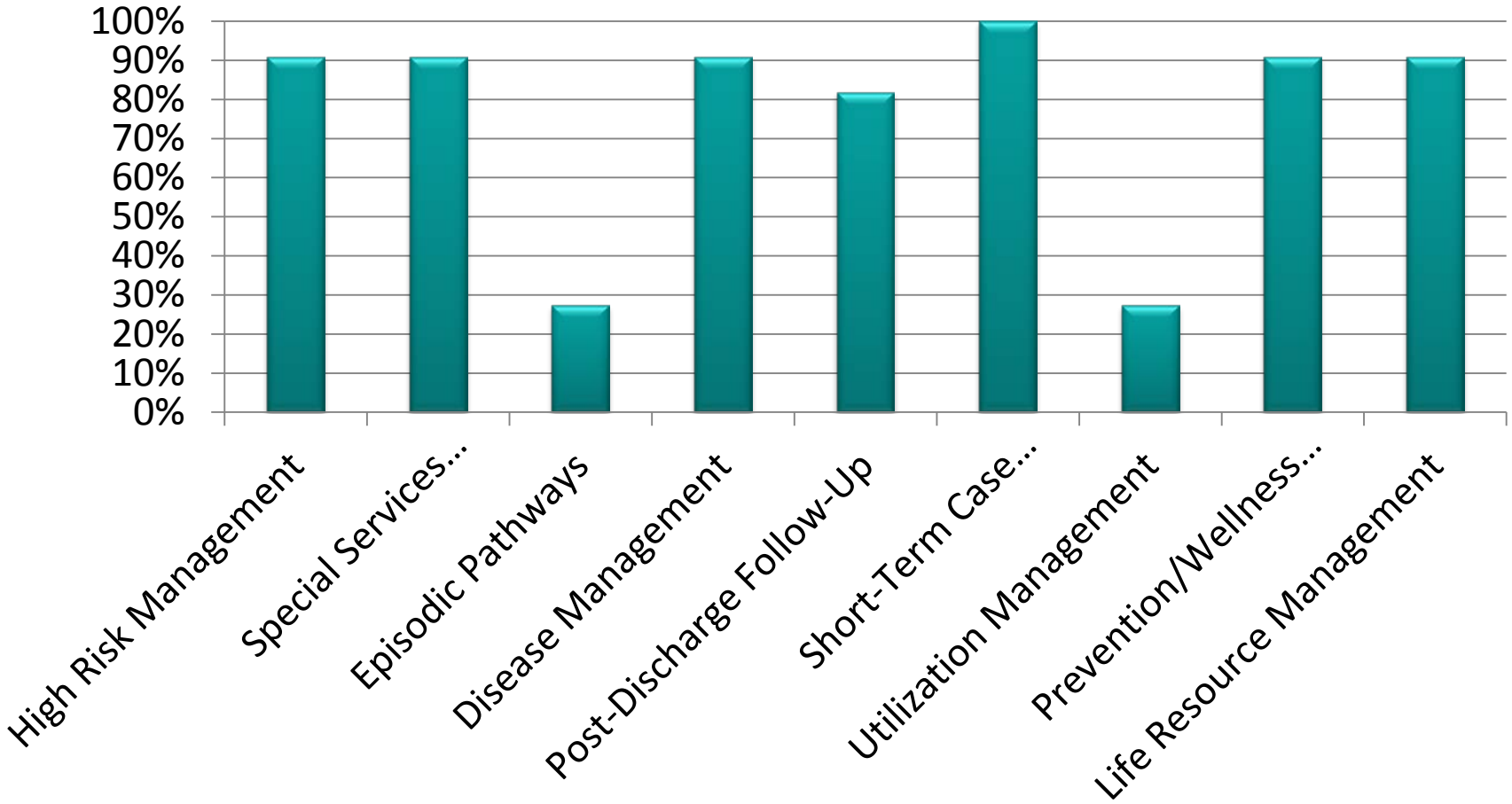
Number of Respondents: 42

Percent of ACOs Providing Care Management Services By Type of Service



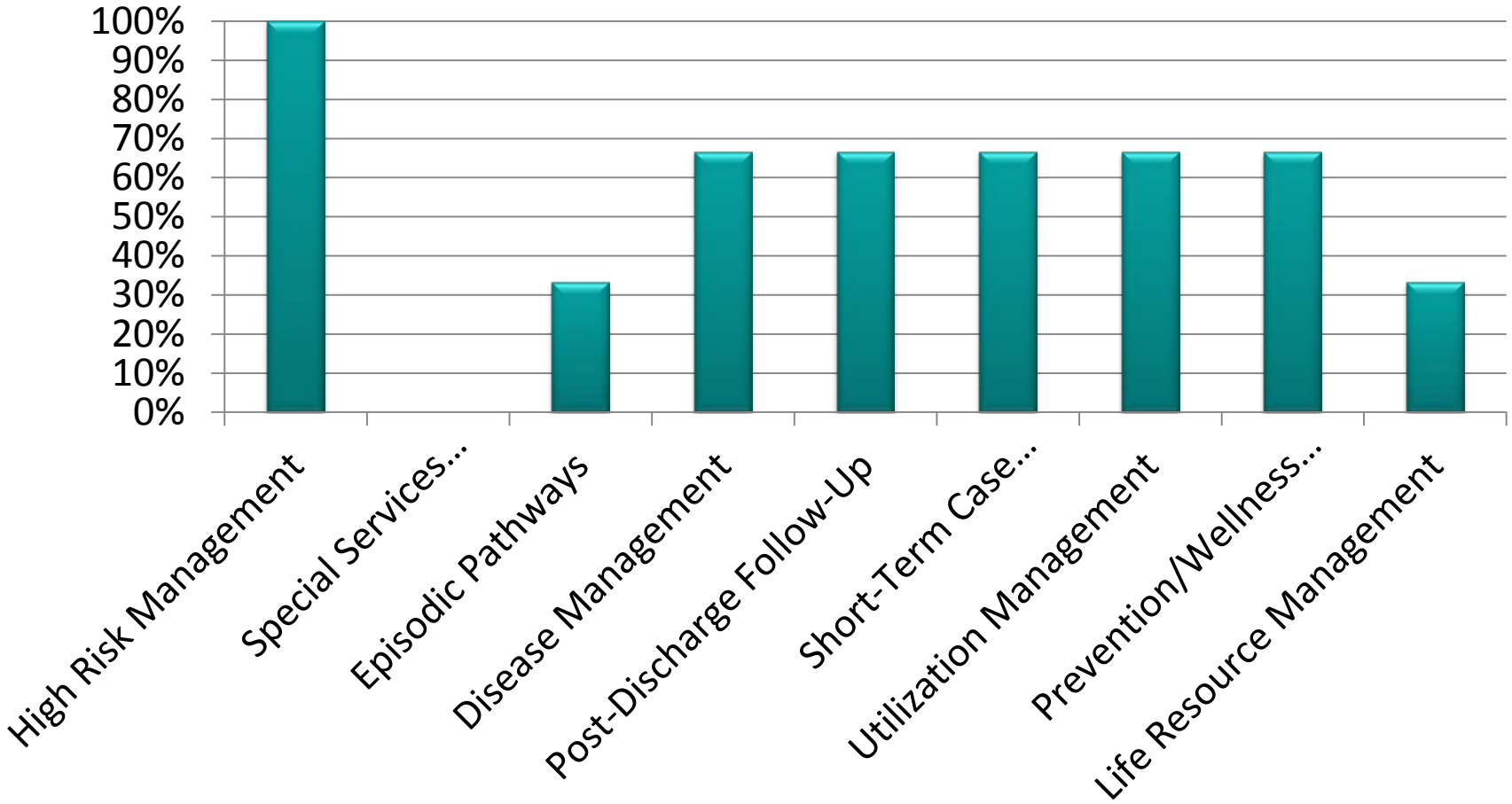
Number of Respondents: 2

Percent of Blueprint Community Health Teams Providing Care Management Services By Type of Service



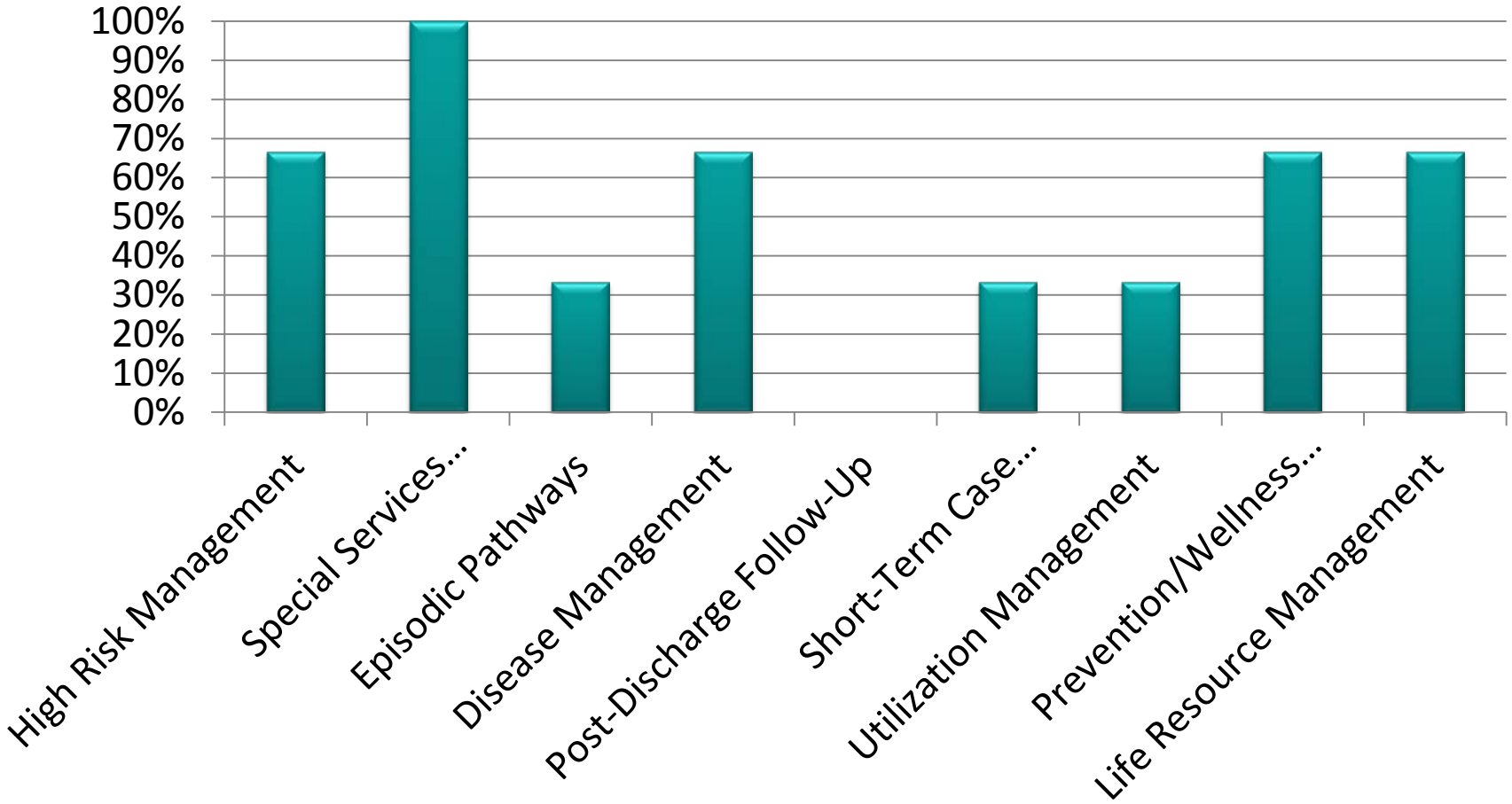
Number of Respondents: 11

Percent of Health Plans Providing Care Management Services By Type of Service



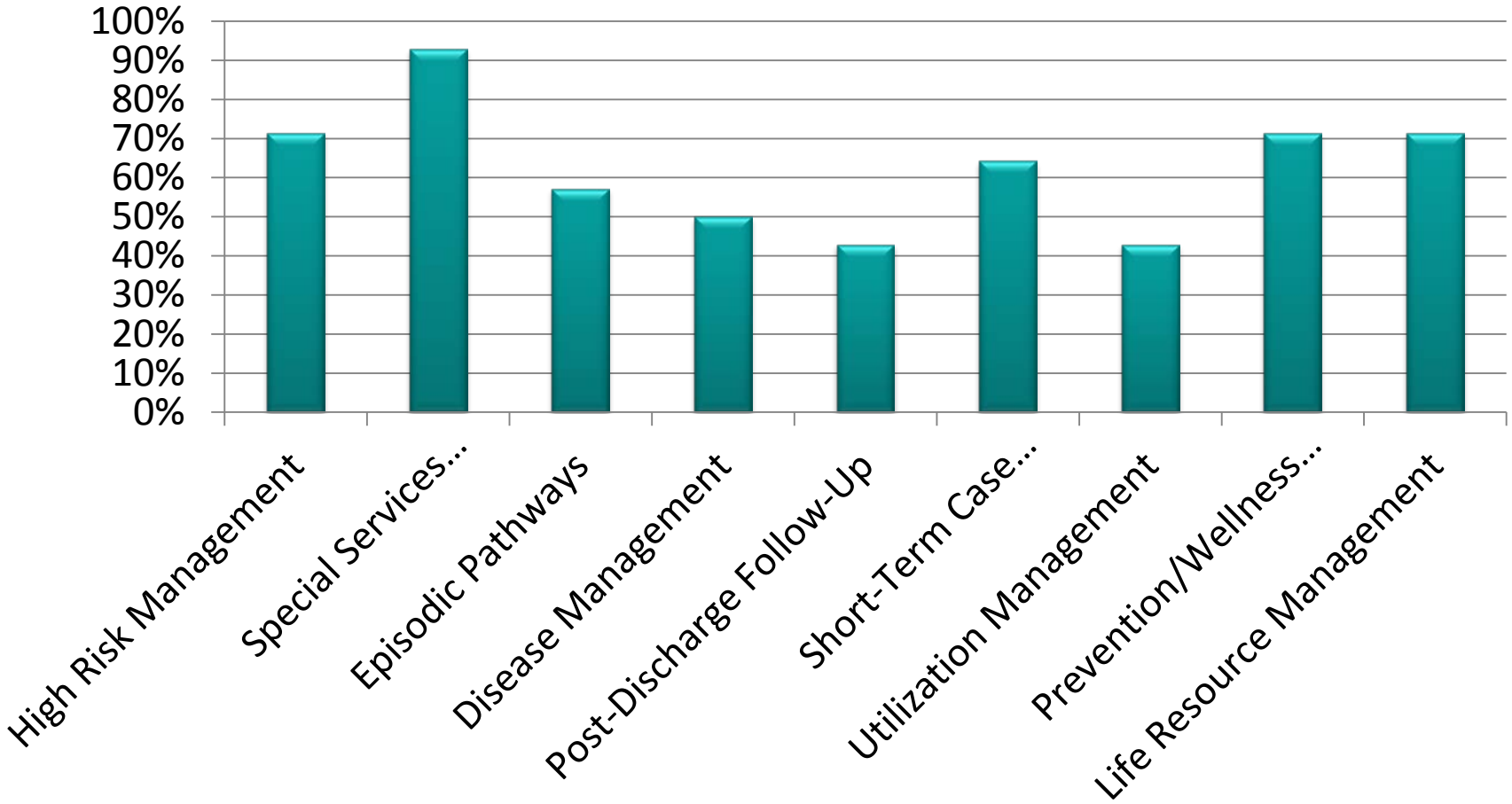
Number of Respondents: 11

Percent of State Agencies Providing Care Management Services By Type of Service



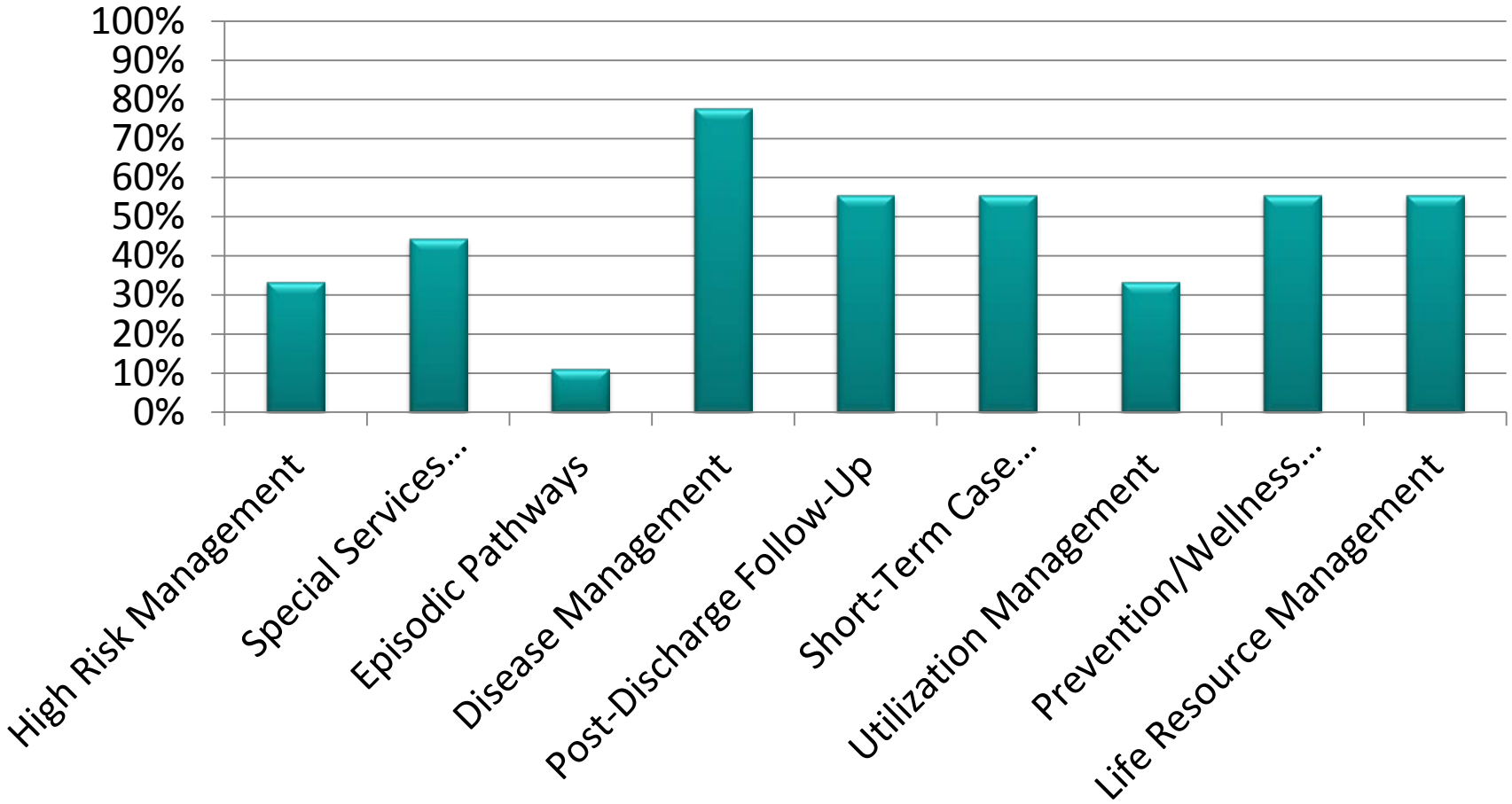
Number of Respondents: 3

Percent of Community Service Providers Providing Care Management Services By Type of Service



Number of Respondents: 14

Percent of Health Care Providers Providing Care Management Services By Type of Service



Number of Respondents: 9

Attachment 5 - DLTSS Model of Care Presentation

MODEL OF CARE FOR PEOPLE WITH DISABILITIES AND LONG-TERM SERVICES AND SUPPORTS (DLTSS) NEEDS

June 16, 2014

Description of DLTSS Population

- People with disability and long-term services and supports (DLTSS) needs are..
  - Individuals of all ages who have a physical, cognitive or mental condition who need services and supports to assist with the limitations related to their condition
    - An individual's DLTSS support needs may be simple or complex
    - Effective services and supports must be provided within the context of self-determination, self-direction and understanding of the individual's unique needs
- Total number of all Vermonters with DLTSS needs is undetermined
  - Approximately 40,000 are **Medicaid** enrollees (some of whom also are enrolled in Medicare):
    - Defined as Medicaid enrollees who receive DLTSS-related specialized services and programs [i.e., Choices for Care (CfC); Personal Care; Traumatic Brain Injury (TBI) Program; Developmental Services (DS); Community Rehabilitation Treatment (CRT), Children and Adolescents with Serious Emotional Disturbances (SED), and other Mental Health Treatment; Substance Abuse Treatment; Department for Children and Families (DCF) Case Management; School-Based Health Services; and Success Beyond Six]
    - These individuals represent approximately **25% of total Medicaid enrollees**, but coverage of services to meet their **DLTSS needs represents 55% of the Medicaid budget** and **more than 70% of the Medicaid budget when traditional medical services are included** *(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to DLTSS Work Group, April 24, 2014)*
  - Others are enrolled in **Medicare only** (people over 65 who have DLTSS needs but do not qualify for Medicaid)
  - Others have **private / commercial insurance**

Why are DLTSS Fundamental to Health Care Reform?

- For at least a decade, there has been consensus that older people and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports. *(Sources: Kaiser, Robert Wood Johnson, Center for Health Care Strategies, CMS)*

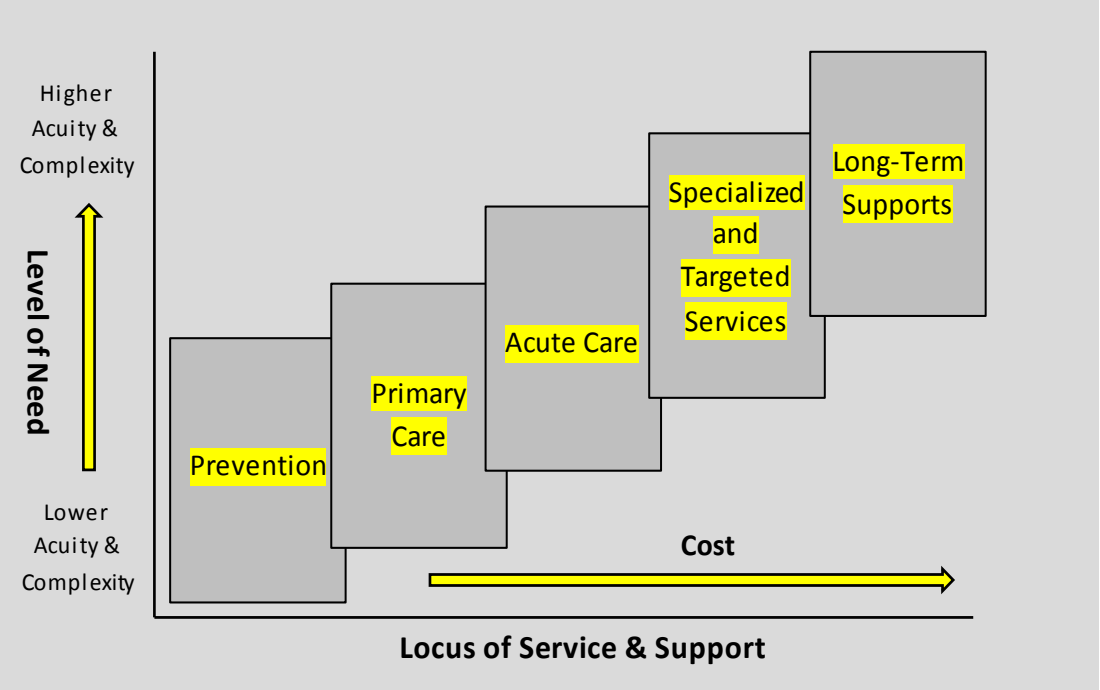
- Evidence suggests that integration of care (primary care, acute care, chronic care, mental health, substance abuse services, and disability and long-term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care, and lower costs. (*Sources: Commonwealth Care Alliance, SNPs)*

- DLTSS helps prevent the need for care in more expensive, acute care settings - thus improving a person's well-being, improving quality of care, and controlling health care costs.

- Research has shown that environmental and socio-economic factors are crucial to people's overall health. DLTSS provide assistance related to these factors on an individualized basis.
  - For example, people that are employed tend to be healthier and therefore have lower utilization of health care services. Other social determinants of health include financial resources, housing, education, safety, nutrition, and access to transportation. *(Source: IBM Cúram Research Institute, 2013)*

DLTSS Needs Vary by Individual and Situation

- The full continuum of care must be available for people with DLTSS needs:
  - From prevention through lifelong supports
  - Including a diverse range of medical, mental health, substance abuse, developmental disability, personal care, employment, housing and social services and supports
  - Specific needs can vary at any given time



DLTSS-Related Services Covered by Medicaid

- DLTSS-related specialized services funded by Medicaid include, but are not limited to:
  - Assistance with activities of daily living (e.g. personal care, eating, grocery shopping, food preparation, money management)
  - Mental health counseling
  - Crisis services
  - Medication management
  - Substance abuse treatment
  - Assistive Technologies
  - Employment and Housing Supports
  - Residential Services
  - Nursing Home Care
  - Support during medical services (primarily DS)
  - Assistance to make connections in the community
  - Case Management & Coordination
- Some individuals who meet stringent clinical/level of care and/or funding priority criteria receive DLTSS through Medicaid-funded specialized programs (CfC, DS, CRT, TBI, and SED)
- Any Medicaid enrollee can receive some of these DLTSS on an as-needed basis through Medicaid fee-for-service benefits

DLTSS Providers

- Specialized mental health, developmental disability, and substance abuse treatment services and supports are provided by:
  - 11 Designated Agencies and 6 Specialized Service Agencies
- Other long term services and supports are provided by diverse groups:
  - 112 Residential Care Homes
  - 36 Therapeutic Community Residences
  - 40 Nursing Homes
  - 12 Home Health Agencies
  - 5 Area Agencies on Aging
  - 14 Adult Day Providers
  - Substance Abuse Providers
  - Traumatic Brain Injury Providers
  - Durable Medical Equipment Providers
  - Vocational Rehabilitation
  - 6 Designated Regional Housing Organizations and 16 Housing Authorities and Land Trusts
  - Vermont Center for Independent Living and other peer support and advocacy providers and organizations
  - Guardians
  - Thousands of direct care/personal care workers who work directly for elderly and disabled individuals or their family
  - Other independent practitioners and providers (e.g., mental health, rehabilitation, physical and occupation therapy)

Traditional Medical Services Covered by Medicaid

- Individuals who receive DLTSS-related Medicaid specialized services and programs (see definition on Slide 2) *also* utilize approximately $180 million annually in traditional medical services funded by Medicaid
  - This $180 million represents 37% of the total $488 million in Medicaid expenditures for traditional medical services across all Medicaid enrollees
  - Traditional Medical Services include but are not limited to):
    - Inpatient and Outpatient Hospital
    - Primary Care Physicians
    - Specialists
    - Federally Qualified Health Centers (FQHCs)
    - Pharmacy
    - Dental
    - Laboratory Tests
    - Medical supplies
    - Occupational, Physical, Speech Therapy
    - Home Care
    - Hospice
    - Ambulance

(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to DLTSS Work Group, April 24, 2014)

Interactions with Other Programs and Providers

- People with DLTSS needs also may receive other support and case management services from:
  - **Blueprint Community Health Teams (CHTs)**
    - Provide care coordination, education and support as needed to patients of Hospital Owned Primary Care Practices, Independent Single Site Primary Care Practices, Independent Multi-Site Primary Care Practices and Federally Qualified Health Centers (FQHCs)
      - These practices served 514,385 Vermonters (82%) as of December, 2014 *(Blueprint 2013 Annual report)*
    - Focused on medical issues / needs for people with chronic conditions
    - Time limited (due to focus and staffing)
  - **Hub and Spoke Health Home for Opioid Addiction**
    - Provides targeted services for people with Opioid addictions
    - Services include:
      - An established medical home, including comprehensive care management/care coordination
      - A single medication-assisted treatment prescriber and pharmacy home
      - Access to CHT resources
      - Access to Hub and Spoke nurses and clinicians
  - **Federally Qualified Health Centers (FQHCs)**
    - Provide comprehensive services for underserved areas or populations
      - Must provide primary care services and the following services on site or by arrangement with another provider: preventive care, dental, mental health and substance abuse, transportation necessary for adequate patient care, hospital and specialty care
    - Not time limited (intensity of services adapted as needed)

Interactions with Other Programs and Providers, cont.

- People with DLTSS needs also may receive other support and case management services from:
  - **Support and Services at Home (SASH)**
    - Focused on Medicare beneficiaries of all ages and low income residents of affordable housing regardless of payer
    - Provides a care coordinator and wellness nurse who work in partnership with a team of community providers to assist SASH participants to access the care and support they need to stay healthy while living comfortably and safely at home.
    - Not time limited (intensity of services adapted as needed)
  - **Vermont Chronic Care Initiative (VCCI)**
    - Provides care coordination for Medicaid beneficiaries who have chronic health conditions and/or high utilization of medical services to access clinically appropriate health care information and services and educates and empowers them to eventually self-manage their conditions.
    - Time limited (3 months)
    - Excludes:
      - Children
      - Individuals who are dually eligible for Medicare and Medicaid
      - People enrolled in Medicaid-funded specialized programs (CfC, DS, CRT, TBI)
  - **Commercial Insurance case management for special cases**
  - **Commercial Long Term Care Insurance programs**
  - **Veterans Administration and other Military benefit programs**

What is Working Well for People with DLTSS Needs

- For those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - Receive services and supports based in the values of self-determination and community integration
  - Each program specializes in unique needs
    - Service and supports are provided by staff who understand the complexities and subtleties of the individual's issues and needs, such as:
      - Communication barriers
      - Intellectual / cognitive barriers
      - Physical barriers
      - Symptoms and coping mechanisms related to severe mental illness
      - Medical needs related to their disability or functional limitations
      - Isolation due to the individual's functional limitations

Gaps, Barriers and Disincentives in Receiving Services

- The traditional medical system has not been designed to meet the diverse needs of people with DLTSS needs
  - Lack of understanding regarding how to address disability or functional issues
  - Lack of understanding about availability and effectiveness of specialized services and supports
  - Private health insurance typically does not cover some DLTSS-related services or non-medical expenses beyond short-term, rehabilitation-oriented care (e.g., PT/OT, DME, assistive technology, hearing aids, supplies, personal care)
  - Medicare which covers people over 65 and those with a disability under 65, does not cover long-term services and supports
  - When the need for LTSS arises in the wake of a medical event – a hospitalization for an accident or illness, or a transition from a post-acute stay to long-term care – the planning and organization of LTSS for an individual is often handled separately from the health care planning, and there are few incentives for health care providers to integrate LTSS with medical care planning or service delivery.
    (*Excerpted from Commission on Long-Term Care, September 2013 Report to Congress*)

Gaps, Barriers and Disincentives in Receiving Services

- For most people, DLTSS for individuals with more than one condition are managed by different state agencies and community providers
- Many individuals (and their families) must navigate through different provider systems (e.g., Medical, Mental Health, Developmental Disability, Home Health, DME, Area Agencies on Aging, Centers for Independent Living, Vocational Rehabilitation, Housing Providers) to try to get all their needs met
- The network of DLTSS providers is complex, multifaceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in the DLTSS network evaluate a person's overall situation in order to arrange for the right combination of services based on one's actual needs. Instead, access to services is often organized in relationship to their funding streams. (*Commission on Long-Term Care, September 2013 Report to Congress*)
- Many people with DLTSS needs do not have case management or other DLTSS:
  - *They do not meet clinical and/or financial criteria for Medicaid Specialized Program eligibility (i.e., people who are not able to get developmental services due to the increasing restrictions on Funding Priorities in the State System of Care Plan, or are not eligible for CfC, CRT, TBI or SED services due to strict clinical criteria)*
  - There may be limitations on the availability of Medicaid resources for case management or other services related to health and well-being (e.g., employment supports, adult dental care)
  - Medicare and Commercial insurance do not typically cover case management or DLTSS
- Those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - May have multiple case managers and treatment plans that do not inform each other (e.g., medical care vs DLTSS needs)

PROPOSED MODEL OF CARE and CASE MANAGEMENT for VERMONTERS with DLTSS NEEDS

Basis for Design of Proposed DLTSS Model of Care

- Person-Centeredness and Person-Direction as the Foundation
  - Builds on Vermont's DLTSS current emphasis on self-determination and that people have a right to live meaningful lives in their communities
- Builds on Strengths of Existing Vermont System of Care and Health Care Reform Elements (e.g., Blueprint, Community Health Teams, SASH, Medicaid Health Home "Hub and Spoke" model; DLTSS system of care)
  - Utilizes existing Vermont Waiver population care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations (i.e., CFC, DS, TBI, CRT and Substance Abuse)
  - Augments and develops additional mechanisms to address identified barriers, using national evidence-based strategies
- Vermont Dual Eligible Demonstration Work Group Discussions and Products:
  - Person-Centered Care Work Group, Person-Directed Work Group and Essential Components of Person-Directed Approach Report
  - Service Delivery Model Workgroup
  - Individual Assessment & Comprehensive Care Plan Workgroup
- DVHA Medicare-Medicaid Plan Model of Care Submission to CMS (as part of DE Demonstration)
  - DVHA Model of Care approved by CMS and NCQA (March, 2013) for three years (highest approval range) with a score of 96%

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓

Possible Over-arching Framework: Integrated Health Home

- Medicaid Health Home as possible model
  - Purpose of Medicaid health homes: To provide whole-person care coordination and facilitate access to, and collaboration with, primary care and long-term services and supports
    - Health Homes complement but do not supplant traditional healthcare treatment services
    - Health Homes are not the same as “medical homes” that focus on PCP practices as the locus of care
    - Health homes are responsible for all of the person’s care management and care coordination
      - Presents an opportunity to rationally organize and integrate multiple parallel case/care management programs for special needs populations
      - Supports community providers to provide services in an integrated manner, across special needs and primary care
      - Must include six core services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Support Services
  - States have flexibility to designate health home providers
    - May include community mental health organizations, addiction treatment providers, home health agencies, and other provider groups
  - In the Medicaid health home program, states can draw down enhanced (90%) federal match for these services for two years – this might provide a mechanism to fund the more enhanced single point of contact/care coordination role that is being proposed, and to gain support from other payers where applicable
  - Caution: Health homes must be designed to provide better care for all individuals with diverse DLTSS needs, not just special populations

Description of Core Elements in Proposed DLTSS Model of Care

Person-Centered and Person-Directed Services and Supports

- Definition: Care that is life-affirming, comprehensive, continuous and respectful in its focus on health needs (medical, behavioral, long term care) as well as social needs (housing, employment), while promoting empowerment and shared decision-making through enduring relationships.

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

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

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

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

Access to Independent Options Counseling & Peer Support

- Provide independent, easy-to-access information and assistance to assist individuals and families/caregivers to:
  - Understand insurance options, eligibility rules and benefits
  - Understand specialized program eligibility rules
  - Choose services
  - Choose providers
  - Navigate the delivery system
  - Obtain information and on-going peer support regarding self-management of services and supports
  - Make decisions about appropriate long-term care choices
- Examples:
  - Aging and Disability Resource Connections (ADRCs) Member Organizations, such as:
    - Area Agencies on Aging
    - Vermont Center for Independent Living
    - Green Mountain Self Advocacy
    - Vermont Family Network
    - Brain Injury Association of Vermont
  - Peer-run Mental Health Programs
  - Health Care Advocate Office, Long-term Care and Mental Health Ombudsmen

Involved Primary Care Physician (PCP)

- Ensure that all people with DLTSS needs have an identified PCP that is actively involved in their care
  - Provide routine medical care
  - As medical needs change
  - Who has knowledge about DLTSS service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options
- Encourage individuals to choose Blueprint practices via Health Plan enrollment process and web-site information
  - Provides access to:
    - Blueprint Community Health Teams for short-term interventions and support regarding medical needs
    - PCP practices that utilize technology (e.g., EHRs, care management tools, information exchange) to support patients and improve care
    - Blueprint Leadership and Community Service Networks (which enhances PCP knowledge and networking to support patient care)

Single Point of Contact (Case Manager)

- Role of Single Point of Contact (Case Manager within Health Home):
  - Ensures Individual Self-Direction and Self-Management, as desired
  - Coordination across *all* of the individual's medical, mental health, substance abuse, developmental, and long-term care service needs
  - Assure that all relevant assessments are completed
  - Develop and maintain the Individual Comprehensive Care Plan
  - Communicate with and convene the Individual's Care Team as needed
  - Provide Routine Individual Support, as requested
  - Ensure Support during Transitions in Care and Settings

Single Point of Contact (Case Manager)

- Identification of Single Point of Contact
  - If individual mainly has primary or acute health care needs, their single point of contact (and health home) would be their PCP and CHT (if involved)
  - For individuals with more complex DLTSS needs, their single point of contact (and health home) should have knowledge about the individual's DLTSS needs, such as:
    - Designated Agencies for Mental Health
    - Designated Agencies for Developmental Services
    - Home Health Agencies
    - Area Agencies on Aging
    - Traumatic Brain Injury providers
    - Preferred Providers for Substance Abuse Treatment
    - SASH
    - Others with specialized DLTSS expertise
  - For individuals enrolled in Vermont state specialized programs(i.e., CFC, CRT, DS, and TBI), their single point of contact should be someone who has experience with the care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations
  - For individuals without an existing case manager, the individual's PCP should be responsible for identifying the need for a DLTSS case manager (via a brief DLTSS screening tool) and work with the individual to identify and refer to an appropriate health home organization
    - May need payers to include this as PCP requirement
    - Will require ACO / PCP education regarding DLTSS Provider network and triage protocols
    - Referrals could also occur via other sources, such as VCCI

Medical Assessments and DLTSS Screening by PCPs, Medical Specialists

- PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits
  - CHTs may conduct additional assessments regarding medical needs, if warranted
- If person has functional or cognitive impairments, PCP should be informed about DLTSS services, use a brief DLTSS screening tool (if necessary) and refer to DLTSS providers for more in depth assessments as necessary to determine if there are unmet DLTSS needs
  - VHCIP DLTSS Work Group should review the existing inventory of screening tools that could help inform the VHCIP Care Models & Care Management Work Group
  - If screening indicates need, PCP works with the individual to identify and then make referral to appropriate provider in DLTSS network

DLTSS-specific Assessments

- DLTSS needs-specific assessments already exist:
  - DAIL Independent Living Assessment (used for CfC)
  - Developmental Services Assessment
  - Community Rehabilitation and Treatment Assessment
  - SASH Assessment
- Consistent elements should be assessed for all individuals with DLTSS needs
  - An analysis and listing of questions that would need to be added to these assessments has been developed via planning for the Dual Eligible Demonstration Project.
  - Some initial DLTSS intake screening will lead to the above comprehensive assessments, as needed
- The Individual's Single Point of Contact (Case manager) is responsible for assuring that:
  - All screening and assessment results (medical and DLTSS-related) should be included in and inform the individual's Comprehensive Care Plan and be shared with the Individual's Care Team members
  - Necessary assessments are updated when a significant change occurs in the beneficiary's medical, DLTSS, or life situation

Comprehensive Care Plan

- Current Situation
  - PCPs currently develop and maintain an individual's Care Plan related to their medical needs
    - The CHT may re-evaluate the patient Care Plan and initiate appropriate modifications in collaboration with the individual and members of the healthcare team
  - DLTSS providers develop and maintain an individual's Care Plan related to their DLTSS needs
  - An individual may have multiple Care Plans:
    - For medical and for DLTSS services and supports
    - If individual receives multiple DLTSS services
    - If individual is transitioning across care settings

Comprehensive Care Plan

- Proposed Model
  - PCPs and CHTS continue to develop and maintain an individual's Care Plan related to their *medical* needs
  - DLTSS providers develop and maintain an individual's Care Plan related to their *DLTSS* needs
  - For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
    - Developing and maintaining a single Comprehensive Care Plan that includes *all* identified needs, goals, preferences, services and supports
      - Requires communication and coordination with the Individual's PCP
    - Identifying the individual's informal support systems/networks in relationship to his or her functional and safety needs, and including this information in the Comprehensive Care Plan as appropriate
    - Reviewing the effectiveness of the care plan with the individual, and implementing modifications as needed in collaboration with other providers as appropriate
    - Revising the Care Plan during and after Care Transitions
    - Ensuring that all key members of the Individual's Care Team have the most current Comprehensive Care Plan

Individual Care Team (ICT)

- For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
  - Ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP.
  - Establishing a routine working relationship with the individual's PCP / CHT member(s), and with other ICT providers as appropriate
  - Convening the ICT (in person or by phone) when needed to integrate and coordinate care, especially during care transitions
  - Provide links/coordination/integration with care providers across settings
  - Reporting new information to ICT members and other appropriate providers as needed

Interdisciplinary Care Team- Working Principles

- Mutual respect for the expertise of all members of the team, including the individual with DLTSS needs
- Knowledge and trust among all parties establishes quality working relationships
- Shared responsibility which leads to joint decision-making
- Equal participation and responsibility on the part of team members to ensure the beneficiary's needs and goals are met, with "shifting" responsibility determined by the nature of the problem to be solved.
- Communication that is not hierarchical, but rather multi-directional - facilitating sharing of information and knowledge
- Cooperation and coordination which promote the use of the skills of all team members, prevent duplication, and enhance productivity
- Emphasis by the team on "health care, environmental determinants of health and public health" rather than the more narrow focus of "medical care"
- Optimism that the ICT process is the most effective method to achieve quality care and improved outcomes

Support During Care Transitions

- For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
  - Initiating and maintaining contact at the care transition point of service
    - At the beginning, during, and at the end of the care transition
  - Identifying barriers to follow-up treatment, services, supports, and medication adherence and working with the individual, family and providers to overcome barriers
  - Ensuring the individual has the relevant information specific to their new condition
  - Coordinating linkages and follow-up with targeted services
    - Assuring that PCP, specialty care, home health, community mental health center, or other appointments are scheduled within 7 days of discharge, or more quickly if clinically indicated
  - Changing the Individual Care Plan to reflect any new needs
  - Communicating changes in Individual Care Plan with the individual’s care team

Use of Technology for Information-Sharing

- Ultimate goal: A technological infrastructure that would:
  - House a common case management database/system
  - Enable integration between the case management database and electronic medical records and between all providers of an Individual's ICT
  - Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options
  - Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent

- The Population-Based Collaborative (ACO) Proposal is designed to “effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients.”

- The ACTT Proposal for the DLTSS Network “builds on the ACO work to broaden responsive, integrated, person-centered services across additional parts of the full continuum of care” to:
  - Ensure high quality clinical data for population health and quality/outcome improvement and reporting from ACTT providers
  - Enable ACTT to securely transmit, exchange and store health information
  - Enable a 42 CFR Part 2 compliant database system/repository for designated and specialized service agencies
  - Develop a uniform and efficient EHR infrastructure for 4 Developmental Disability Specialized Service Agencies (SSAs) and 1 Designated Agency
  - Develop and implement an ACTT transitions of care/uniform care transfer protocol

What should improve under this MOC?

- Beneficiary experience:
  - Increased involvement in decision-making
  - Decreased frustration regarding care coordination and access to services and supports due to integrated service delivery
  - Routine and timely primary care visits
  - Support during care transitions
  - Increased overall satisfaction with services and supports
  - Decreased out-of-pocket costs (e.g., fewer co-pays for ER, other services)
- Staff experience:
  - Increased efficiency regarding assisting consumers
  - Improved collaboration and communication between the medical and DLTSS systems of care
- Improved Consumer Outcomes:
  - Decreased emergency room utilization
  - Decreased avoidable hospital admissions / re-admissions
  - Decreased nursing home utilization
  - Increased appropriate use of medication
- Decreased Provider Cost-shifting across Payers
  - Due to more service oversight and coordination across all of the individual's medical and DLTSS needs via a single point of contact, comprehensive care plan, and integrated care team
- Decreased Overall Costs for Health Care System

Case Study

Peter is 50. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He sees a mental health counselor and receives medication management by a psychiatrist at his local designated mental health agency. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy.

Under the proposed DLTSS MOC, Peter's designated mental health agency case manager is Peter's single point of contact for coordinating his care and ensuring that all his care and treatment planning is integrated.

Peter's Case Manager finds a PCP that is taking new patients and assists him to get to the appointment. The PCP, who is part of a Blueprint Advanced Primary Care Practice, conducts a thorough physical and discovers Peter has diabetes, which has compromised his immune system and is causing the repeated pneumonia. The PCP prescribes an antibiotic for the pneumonia, and schedules routine visits for evidenced-based diabetes care, including blood work and foot exams. The PCP gives Peter some information about diabetes and how to control it, but also suggests that Peter could access the practice-affiliated Blueprint Community Health Team (CHT) if he would like additional information and support in managing his diabetes. Peter agrees, and the PCP office sets up appointments for that afternoon. Peter meets with the CHT Nurse who further explains diabetes symptoms and management, and with the CHT Nutritionist who provides information about nutrition related to diabetes.

In the meantime, Peter's Case Manager has notified the PCP office of her role (providing a signed agreement from Peter to release information to her on his behalf). As such, Peter's diagnosis of diabetes and other CHT action steps are entered into his Individual Care Plan.

With Peter's permission, Peter's Case Manager arranges for Peter and his mental health counselor to talk with the CHT staff regarding how to integrate diabetes management with the management of his depression. In addition, Peter' Case Manager ensures that Peter's PCP and DA psychiatrist are both aware of all of Peter's medications and that Peter understands the side effects and potential interactions for all of them. Peter and his Case manager then meet to update his Individual Care Plan to reflect the new goals and action steps related to his diabetes, and the revised Plan is shared with all the members of his care team.

Glossary of Acronyms

- ACCT: Advancing Care through Technology
- ACO: Accountable Care Organization
- ADRC: Aging and Disability Resource Connections
- BP: Blueprint for Health
- CfC: Choices for Care
- CHT: Community Health Teams
- CMS: Centers for Medicare and Medicaid Services
- CRT: Community Rehabilitation and Treatment Program
- DA: Designated Agency
- DAIL: Department of Disabilities, Aging and Independent Living
- DCF: Department for Children and Families
- DLTSS: Disability and Long-Term Services and Supports
- DOH: Department of Health
- DME: Durable Medical Equipment
- DMH: Department of Mental Health
- DS: Developmental Services
- DVHA: Department of Vermont Health Access
- EHR: Electronic Health Record
- ER: Emergency Room
- FQHC: Federally Qualified Health Center
- HHA: Home Health Agency
- ICT: Interdisciplinary Care Team
- IT: Information Technology
- MOC: Model of Care
- NCQA: National Committee for Quality Assurance
- OT: Occupational Therapy
- PCP: Primary Care Physician
- PT: Physical Therapy
- SASH: Support and Services at Home
- SSA: Specialized Services Agency
- SED: Serious Emotional Disturbance
- TBI: Traumatic Brain Injury
- VCCI: Vermont Chronic Care Initiative
- VHCIP: Vermont Health Care Innovation Project

Attachment 6 - Proposed Process for Developing Care Management Standards

Proposed Process for Developing Care Management Standards

August 5, 2014

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Develop recommendations for broad/aspirational ACO care management standards to support the achievement of a system of care management that: • utilizes advanced primary care infrastructure to the greatest extent possible, • fills gaps, • eliminates duplication of effort, • creates clear protocols for providers, • reduces confusion and improves the care experience for people needing care management services, and • follows best practice.	Development of draft broad/aspirational ACO care management standards	August 18, 2014	Co-chairs; Staff; Consultants	• NCQA standards and national model of care elements reviewed by work group • Work group input obtained, including ideas for additional standards • Co-chairs, staff and consultant have begun developing draft standards	Draft broad/aspirational ACO care management standards
	Obtain initial feedback from parties to contracts and agreements (ACOs and Payers)	September 1, , 2014	ACO and Payer Representatives		Feedback on whether draft standards are appropriate for contracts and agreements
	Obtain feedback from CMCM work group members	September 9, 2014	CMCM Work Group		Feedback on draft standards
	Redraft standards to reflect feedback received	September 22, 2014	Co-chairs; Staff; Consultants		Draft #2 of standards
	Vote on draft standards	October 14, 2014	CMCM Work Group		Recommended standards
	Present Recommendations to Steering Committee, Core Team and GMCB	November-December 2014	Co-chairs; Staff; Consultants		• Summary of and justification for recommended standards • Approved standards from Core Team and GMCB
	Identify additional implementation and compliance needs, including guidance for reporting on standards	TBD	Payers (including DVHA); ACOs; GMCB staff; Consultants		• Implementation tools for ACOs and other relevant organizations, if needed • Templates and other guidance for reporting on standards, if needed • Clarity for ACOs on how to operationalize the standards • No significant administrative burden in implementing and assessing compliance