

# Care Models and Care Management Work Group Meeting Agenda 2-10-15

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

February 10, 2015; 10:30 AM to 12:30 PM

ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

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

| Item # | Time Frame     | Topic  | Relevant Attachments   | Vote To Be Taken                  |
|--------|----------------|--|--|-----------------------------------|
| 1      | 10:30 to 10:40 | Welcome; Introductions; Approval of Minutes  | <b><u>Attachment 1a:</u></b> October meeting minutes<br><b><u>Attachment 1b:</u></b> November meeting minutes              | Yes (approval of minutes)         |
| 2      | 10:40 to 11:00 | Update on Integrated Communities Care Management Learning Collaborative:<br><ul style="list-style-type: none"> <li>-Status of Quality Improvement Facilitator procurement</li> <li>-January 13<sup>th</sup> Learning Session</li> <li>-Next Steps: February Webinar and March 10 Learning Session</li> </ul> <b>Public Comment</b> | <b><u>Attachment 2:</u></b> Summary of Learning Session Evaluation Results   |                                   |
| 3      | 11:00 to 11:20 | ACO Care Management Standards<br><b>Public Comment</b>   | <b><u>Attachment 3:</u></b> Draft Care Management Standards  | Yes (vote to recommend standards) |
| 4      | 11:20 to 11:50 | Care Management Inventory Report<br>(Marge Houy and Christine Hughes, Bailit Health Purchasing)<br><b>Public Comment</b>   | <b><u>Attachment 4a:</u></b> Care Management Inventory Report<br><b><u>Attachment 4b:</u></b> Inventory Report Power Point |                                   |
| 5      | 11:50 to 12:15 | Update on Regional Blueprint and ACO Committees  |  |                                   |
| 6      | 12:25 to 12:30 | Wrap-Up and Next Steps<br><b>Next Meeting:</b> Monday, March 23, 10 AM - 12 PM (note date change)  |  |                                   |

Attachment 1a - CMCM  
Work Group  
Meeting  
Minutes 10-31-14



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

*Date of meeting: Friday, October 31<sup>st</sup>, 2014: 9:00 AM to 11:00 AM, 4<sup>th</sup> Floor Conference Room, Pavilion Building, Montpelier, VT*

| Agenda Item   | Discussion  | Next Steps |
|---|---|------------|
| <b>1. Welcome and Introductions, Approval of meeting minutes</b>  | Due to delays caused by building security, Co-Chair Nancy Eldridge called the meeting to order at 9:30 and asked for a motion to approve the August and September meeting minutes. Dale Hackett moved approval of the August and September meeting minutes as is, and Laural Ruggles seconded the motion. There was no discussion, and Georgia Maheras took a roll call vote. The motion to approve August and September meeting minutes passed.  |            |
| <b>2. Co-Chairs Update</b>  | In light of the delayed start, Co-Chairs Bea Grause and Nancy Eldridge elected to skip updates this month to allow sufficient time for the presentation from the Blueprint for Health and One Care Vermont.   |            |
| <b>3. Presentation on Blueprint-OneCare Vermont Collaboration</b> | <p>Co-Chair Nancy Eldridge introduced Craig Jones, MD, Executive Director of the Blueprint for Health, and Todd Moore, CEO of OneCare Vermont to present <b>Attachment 3a</b> regarding OneCare Vermont and the Blueprint for Health collaboration. Additionally, a report submitted to the Vermont Legislature titled “Blueprint for Health Report: Medical Homes, Teams and Community Health Systems” was provided as attachment 3b to the meeting materials. Craig and Todd reviewed the presentation in detail and covered an agenda including: background and context, unified community health systems, payment modifications, and solicitation of input for strategies and implementation from the work group. Discussion of the presentation ensued, and the following comments/questions were raised:</p> <ul style="list-style-type: none"> <li>• Co-Chair Bea Grause commented that the actual conversation is very granular and comes down the process surrounding each individual. How does this fit into the high level picture? Craig Jones responded that at a high level we have an opportunity to better understand the population, and the people who are doing the work can execute these recommendations. This is one example of how ACOs can add value in a collaborative way by enforcing common principles. Pat Jones noted that the integrated communities learning collaborative is seeking to better understand and support people at the community level.</li> <li>• Lily Sojourner asked for clarification about the differences amongst communities. What is the plan to make sure that each HSA is developing to meet its community’s specific needs? The ACOs have</li> </ul> |            |

| Agenda Item | Discussion  | Next Steps |
|-------------|---|------------|
|             | <p>started to collaborate on this, but what about non-medical providers? Do they know that these meetings are occurring? Craig Jones responded that the Blueprint teams will utilize their resources to do just that. For example, most Blueprint staff already organize meetings with medical and non-medical providers, and will utilize these relationships to pull together those larger groups. Right now, discussions amongst leadership are being utilized as a forum to figure this out and to better understand who needs to be there, who isn't there already, and what is the framework to formalize this process.</p> <ul style="list-style-type: none"> <li>• Dale Hackett asked how to address people who get their care out of state, or organizations that provide services and don't realize that they are impacting health outcomes. Co-Chair Bea Grause responded that there isn't necessarily one answer, and it happens in many ways. The conversation needs to happen in the community, at a local level you can try to figure it out. It is a very iterative process. Craig Jones noted that Medicaid on average spends more on social services than other payers in its efforts to link beneficiaries with social support systems. He offered three ways that we can do a better job at this: measure effectively to better understand the need, use the results to do better planning, and finally where there are fundamental gaps in support, raise the issue up the ranks to get the problem fixed.</li> <li>• In response to Dale's question, Laural Ruggles noted that at the local level communities work hard to meet their population's needs every day. She suggested that it would be helpful if decision/policy makers from several departments across the state (transportation, housing, education, etc.) came to these meetings to engage in more integrated discussion of how to best serve all needs of Vermonters in an integrated way. Co-Chair Bea Grause noted that the Department of Health is initiating a Health in All program to better understand how all state policies can impact health.</li> <li>• Trinka Kerr noted that clearer consumer involvement is important. We are addressing issues that are important to consumers, and they need to be engaged. Todd Moore responded that consumers are generally being engaged through the consumer advisory boards as well as the unified community health system collaboratives, and the hope is that this will continue in a more formalized way as the process is further refined. Trinka noted that especially at the local community level, consumer involvement will be important.</li> <li>• Julie Wasserman asked why there are more people attributed to Blueprint than ACOs? Craig Jones indicated that the programs follow different attribution methodologies, and Pat Jones indicated that another reason is that the commercial shared savings program is based off of the state's health insurance exchange population, not the full commercial population served by the Blueprint. Craig added that eventually the goal is that attribution will align and that everyone in Vermont will have a meaningful relationship with a medical home.</li> <li>• Joyce Gallimore added that the learning collaborative is another way we are collaborating, and that there is a lot of work going on around consumer engagement.</li> </ul> |            |

| Agenda Item   | Discussion  | Next Steps |
|---|---|------------|
|   | <ul style="list-style-type: none"> <li>• Susan Besio suggested that it may be more effective to insist that all organizations become involved in these collaborations. Craig responded that collaboration is happening, and that there are already meetings being convened with representatives from the full continuum of care. There is a lot more work to be done, but we are making progress.</li> <li>• Beverly Boget noted that it is one thing to get people at a meeting, and another to change the funding model so that they are part of the fundamental change. Increasing team capacity in each community is a core part of this.</li> <li>• Co-Chair Bea Grause added that it is one thing to get people to come to the table, another to stay at the table, and another to do something meaningful when they are at the table. There needs to be clarity around this work, for example, charters, leadership and clear objectives. Todd Moore responded that he agrees that priorities will have to be set, and that you can't solve every issue in the first week. He also noted that the unified community health system collaboratives need to be representative of the community so that people buy in and really take ownership.</li> <li>• Craig Jones noted that another key activity is focusing on the capability to produce shared core measures of effective care. The Blueprint has been putting out practice profiles for a couple years that have been helpful to practices, as well as at an HSA level. Right now work is underway to try to include ACO performance measures in these practice profiles. He also noted that it is important that all participants contribute to the collection of data as part of a fundamental new way of contributing and working together in a collaborative system.</li> <li>• Dale Hackett asked if these programs are just looking at data, or if you really look at the person as a whole? Craig Jones responded that while it is important to utilize data in making decisions, data is never going to fully explain a person or their needs. Therefore, we need to keep working together across all organizations and departments to get the most complete picture that we can.</li> </ul> |            |
| <b>4. Draft Care Management Standards</b>                 | <p>Time did not allow for a discussion of the draft care management standards for ACOs and comments received to date. Pat Jones and Erin Flynn reminded work group members that they need to submit their comments by Tuesday November 11<sup>th</sup> at 5:00pm, and that the work group will further discuss these comments and vote on the care management standards for ACOs at its November work group meeting.</p>  |            |
| <b>5. Next Steps, Wrap-Up and Future Meeting Schedule</b> | <p><b>Next Meeting:</b> <i>Tuesday, November 18, 2014 10:00 AM – 12:00 PM, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</i></p>   |            |

# VHCIP CMCM Work Group 10-31-14 Member Roll Call

1<sup>o</sup> Dale  
2<sup>o</sup> Laural  
Avg. minutes  
Sept. minutes

Motion carries

| Member     |                 | Member Alternate |           |          |   |  |  |
|------------|-----------------|------------------|-----------|----------|---|--|--|
| First Name | Last Name       | First Name       | Last Name |          |   |  | Organization                                       |
| Nancy      | Breiden         | Rachel           | Seelig    |          |   |  | VLA/Disability Law Project                         |
| Dr. Dee    | Burroughs-Biron | Trudee           | Ettlinger |          |   |  | Vermont Department of Corrections                  |
| Barbara    | Cimaglio        | X                |           |          |   |  | AHS - VDH  |
| Peter      | Cobb            | X                |           |          |   |  | VNAs of Vermont                                    |
| Dana       | Demartino       | X                |           |          |   |  | Central Vermont Medical Center                     |
| Nancy      | Eldridge        | ✓                |           |          | ✓ |  | Cathedral Square and SASH Program                  |
| Joyce      | Gallimore       | ✓                |           |          |   |  | Bi-State Primary Care/CHAC                         |
| Eileen     | Girling         | ✓                | Dawn      | Weening  | ✓ |  | AHS - DVHA   |
| Bea        | Grause          | ✓                |           |          | ✓ |  | Vermont Association of Hospital and Health Systems |
| Dale       | Hackett         | ✓                |           |          | A |  | None   |
| Linda      | Johnson         | X                | Cameron   | Erickson |   |  | MVP Health Care                                    |
| Pat        | Jones           | ✓                | Richard   | Slusky   | ✓ |  | GMCB   |
| Trinka     | Kerr            | ✓                | Julia     | Shaw     | A |  | VLA/Health Care Advocate Project                   |
| Patricia   | Launer          | ✓                |           |          | ✓ |  | Bi-State Primary Care                              |
| Vicki      | Loner           | ✓                | Maura     | Crandall | ✓ |  | OneCare Vermont                                    |
| Clare      | McFadden        | ✓                |           |          | A |  | AHS - DAIL   |
| Jeanne     | McLaughlin      | X                |           |          |   |  | Visiting Nurse Association & Hospice of VT & NH    |
| Madeleine  | Mongan          | ✓                |           |          | ✓ |  | Vermont Medical Society                            |
| Judy       | Morton          | ✓                |           |          | ✓ |  | Mountain View Center                               |
| Mary       | Moulton         | X                |           |          |   |  | Washington County Mental Health Services Inc.      |
| Paul       | Reiss           | X                | Amy       | Cooper   |   |  | Accountable Care Coalition of the Green Mountains  |
| Laural     | Ruggles         | ✓                |           |          | ✓ |  | Northeastern Vermont Regional Hospital             |
| Ken        | Schatz          | X                | April     | Allen    |   |  | AHS - DCF  |
| Catherine  | Simonson        | X                |           |          |   |  | HowardCenter for Mental Health                     |
| Patricia   | Singer          | X                |           |          |   |  | AHS - DMH  |
| Lily       | Sojourner       | ✓                |           |          | A |  | AHS - Central Office                               |
| Audrey-Ann | Spence          | ✓                | Robert    | Wheeler  | ✓ |  | Blue Cross Blue Shield of Vermont                  |
| Jason      | Wolstenholme    | X                | Jessica   | Oski     |   |  | Vermont Chiropractic Association                   |

## VHCIP CMCM Work Group 10-31-14 Attendance List

|           |                         |
|-----------|-------------------------|
| <b>C</b>  | <b>Chair</b>            |
| <b>IC</b> | <b>Interim Chair</b>    |
| <b>M</b>  | <b>Member</b>           |
| <b>MA</b> | <b>Member Alternate</b> |
| <b>A</b>  | <b>Assistant</b>        |
| <b>S</b>  | <b>Staff/Consultant</b> |
| <b>X</b>  | <b>Interested Party</b> |

| First Name | Last Name       |              | Organization                               | Care Models |
|------------|-----------------|--------------|--|-------------|
| Peter      | Albert          |              | Blue Cross Blue Shield of Vermont          | X           |
| April      | Allen           |              | AHS - DCF                                  | MA          |
| Ena        | Backus          |              | GMCB                                       | X           |
| Melissa    | Bailey          |              | Otter Creek Associates and Matrix Health   | X           |
| Michael    | Bailit          | <i>phone</i> | SOV Consultant - Bailit-Health Purchasing  | X           |
| Susan      | Barrett         |              | GMCB                                       | X           |
| Susan      | Besio           | <i>here</i>  | SOV Consultant - Pacific Health Policy Gro | X           |
| Charlie    | Biss            |              | AHS - Central Office - IFS                 | X           |
| Beverly    | Boget           | <i>here</i>  |  | X           |
| Heather    | Bollman         |              | AHS - DVHA                                 | X           |
| Mary Lou   | Bolt            |              | Rutland Regional Medical Center            | X           |
| Nancy      | Breiden         |              | VLA/Disability Law Project                 | M           |
| Stephen    | Broer           |              | Northwest Counseling and Support Servic    | X           |
| Martha     | Buck            |              | Vermont Association of Hospital and Heal   | A           |
| Dr. Dee    | Burroughs-Biron |              | Vermont Department of Corrections          | M           |
| Nick       | Carter          |              | Planned Parenthood of Northern New Eng     | X           |
| Jane       | Catton          |              | Northwestern Medical Center                | X           |
| Amanda     | Ciecior         | <i>phone</i> | AHS - DVHA                                 | S           |
| Barbara    | Cimaglio        |              | AHS - VDH                                  | M           |
| Peter      | Cobb            |              | VNAs of Vermont                            | M           |

|           |           |              |   |      |
|-----------|-----------|--------------|---|------|
| Amy       | Coonradt  |              | AHS - DVHA                                | X    |
| Amy       | Cooper    |              | Accountable Care Coalition of the Green M | M    |
| Maura     | Crandall  |              | OneCare Vermont                           | MA   |
| Claire    | Crisman   |              | Planned Parenthood of Northern New Eng    | A    |
| Dana      | Demartino |              | Central Vermont Medical Center            | M    |
| Steve     | Dickens   | <i>here</i>  | AHS - DAIL                                | X    |
| Nancy     | Eldridge  | <i>here</i>  | Cathedral Square and SASH Program         | C/M  |
| Cameron   | Erickson  |              | MVP Health Care                           | MA   |
| Trudee    | Ettlinger |              | Vermont Department of Corrections         | MA   |
| Erin      | Flynn     | <i>here</i>  | AHS - DVHA                                | S    |
| Aaron     | French    |              | AHS - DVHA                                | X    |
| Meagan    | Gallagher |              | Planned Parenthood of Northern New Eng    | X    |
| Joyce     | Gallimore | <i>phone</i> | Bi-State Primary Care/CHAC                | MA/M |
| Lucie     | Garand    |              | Downs Rachlin Martin PLLC                 | X    |
| Christine | Geiler    | <i>here</i>  | GMCB                                      | S    |
| Eileen    | Girling   | <i>phone</i> | AHS - DVHA                                | M    |
| Kelly     | Gordon    |              | AHS - DVHA                                | X    |
| Bea       | Grause    | <i>here</i>  | Vermont Association of Hospital and Heal  | C/M  |
| Dale      | Hackett   | <i>here</i>  | None                                      | M    |
| Bryan     | Hallett   |              | GMCB                                      | X    |
| Selina    | Hickman   |              | AHS - DVHA                                | X    |
| Bard      | Hill      |              | AHS - DAIL                                | X    |
| Breena    | Holmes    |              | AHS - Central Office - IFS                | X    |
| Marge     | Houy      | <i>phone</i> | SOV Consultant - Bailit-Health Purchasing | X    |
| Christine | Hughes    |              | SOV Consultant - Bailit-Health Purchasing | X    |
| Jay       | Hughes    |              | Medicity                                  | X    |
| Linda     | Johnson   |              | MVP Health Care                           | M    |
| Pat       | Jones     | <i>here</i>  | GMCB                                      | S/M  |

|           |            |              |   |    |
|-----------|------------|--------------|---|----|
| Joelle    | Judge      | <i>here</i>  | UMASS                                     | S  |
| Trinka    | Kerr       | <i>here</i>  | VLA/Health Care Advocate Project          | M  |
| Kelly     | Lange      |              | Blue Cross Blue Shield of Vermont         | X  |
| Patricia  | Launer     | <i>phone</i> | Bi-State Primary Care                     | M  |
| Diane     | Leach      |              | Northwestern Medical Center               | X  |
| Deborah   | Lisi-Baker |              | Unknown                                   | X  |
| Vicki     | Loner      | <i>phone</i> | OneCare Vermont                           | M  |
| Georgia   | Maheras    | <i>here</i>  | AOA                                       | S  |
| Mike      | Maslack    |              |   | X  |
| John      | Matulis    |              |   | X  |
| James     | Mauro      |              | Blue Cross Blue Shield of Vermont         | X  |
| Clare     | McFadden   | <i>here</i>  | AHS - DAIL                                | M  |
| Elise     | McKenna    |              | AHS - DVHA - Blueprint                    | X  |
| Jill      | McKenzie   |              |   | X  |
| Jeanne    | McLaughlin |              | Visiting Nurse Association & Hospice of V | M  |
| Darcy     | McPherson  |              | AHS - DVHA                                | A  |
| Madeleine | Mongan     | <i>here</i>  | Vermont Medical Society                   | M  |
| Monika    | Morse      | <i>here</i>  |   | X  |
| Judy      | Morton     | <i>here</i>  | Mountain View Center                      | M  |
| Mary      | Moulton    |              | Washington County Mental Health Service   | M  |
| Kirsten   | Murphy     | <i>here</i>  | AHS - Central Office - DDC                | X  |
| Reeva     | Murphy     |              | AHS - Central Office - IFS                | X  |
| Sarah     | Narkewicz  | <i>phone</i> | Rutland Regional Medical Center           | X  |
| Jessica   | Oski       |              | Vermont Chiropractic Association          | MA |
| Annie     | Paumgarten | <i>here</i>  | GMCB                                      | X  |
| Luann     | Poirer     |              | AHS - DVHA                                | X  |
| Betty     | Rambur     |              | GMCB                                      | X  |
| Allan     | Ramsay     |              | GMCB                                      | X  |

|            |            |             |   |    |
|------------|------------|-------------|---|----|
| Helen      | Reid       |             | Planned Parenthood of Northern New Eng    | X  |
| Paul       | Reiss      |             | Accountable Care Coalition of the Green M | M  |
| Debra      | Repice     |             | MVP Health Care                           | X  |
| Julie      | Riffon     |             | North Country Hospital                    | X  |
| Laural     | Ruggles    | <i>here</i> | Northeastern Vermont Regional Hospital    | M  |
| Jenney     | Samuelson  | <i>here</i> | AHS - DVHA - Blueprint                    | X  |
| Jessica    | Sattler    |             | Accountable Care Transitions, Inc.        | X  |
| Ken        | Schatz     |             | AHS - DCF                                 | M  |
| Rachel     | Seelig     |             | VLA/Senior Citizens Law Project           | MA |
| Maureen    | Shattuck   |             | Springfield Medical Care Systems          | X  |
| Julia      | Shaw       |             | VLA/Health Care Advocate Project          | MA |
| Catherine  | Simonson   |             | HowardCenter for Mental Health            | M  |
| Tom        | Simpatico  |             | AHS - DVHA                                | X  |
| Patricia   | Singer     |             | AHS - DMH                                 | M  |
| Shawn      | Skaflestad | <i>here</i> | AHS - Central Office                      | X  |
| Richard    | Slusky     |             | GMCB                                      | MA |
| Pam        | Smart      |             | Northern Vermont Regional Hospital        | X  |
| Lily       | Sojourner  |             | AHS - Central Office                      | M  |
| Audrey-Ann | Spence     | <i>here</i> | Blue Cross Blue Shield of Vermont         | M  |
| Kara       | Suter      |             | AHS - DVHA                                | X  |
| Beth       | Tanzman    |             | AHS - DVHA - Blueprint                    | X  |
| Win        | Turner     |             |   | X  |
| Anya       | Wallack    |             | SIM Core Team Chair                       | X  |
| Marlys     | Waller     |             | Vermont Council of Developmental and M    | X  |
| Julie      | Wasserman  | <i>here</i> | AHS - Central Office                      | X  |
| Dawn       | Weening    |             | AHS - DVHA                                | MA |
| Kendall    | West       | <i>here</i> |   | X  |
| Robert     | Wheeler    |             | Blue Cross Blue Shield of Vermont         | MA |

|              |                |              |                                  |   |
|--------------|----------------|--------------|----------------------------------|---|
| Bradley      | Wilhelm        |              | AHS - DVHA                       | X |
| Jason        | Wolstenholme   |              | Vermont Chiropractic Association | M |
| Cecelia      | Wu             | <i>phone</i> | AHS - DVHA                       | X |
| Mark         | Young          |              |                                  | X |
| <i>Susan</i> | <i>Aranoff</i> |              |                                  |   |
| <i>Liba</i>  | <i>Viles</i>   |              |                                  |   |
|              |                |              |                                  |   |
|              |                |              |                                  |   |

Attachment 1b - CMCM  
Work Group  
Meeting  
Minutes 11-18-14



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

*Date of meeting: Tuesday, November 18<sup>th</sup>, 2014: 10:00 AM to 11:00 AM, 4<sup>th</sup> Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier*

| Agenda Item  | Discussion  | Next Steps |
|--|---|------------|
| <b>1. Welcome and Introductions, Approval of meeting minutes</b>                   | <p>Erin Flynn called the meeting to order at 10:00AM and indicated that co-chairs Bea Grause and Nancy Eldridge would not be in attendance at this month’s work group meeting. Erin asked for a motion to approve the October meeting minutes. Beverly Boget moved approval of the October meeting minutes as is, and Vicki Loner seconded the motion. There was no discussion of the meeting minutes, and Georgia Maheras took a role call vote. The results of the vote indicated that a quorum was not present, and therefore the meeting minutes could not be approved.</p>   |            |
| <b>2. Update on Integrated Communities Care Management Learning Collaborative:</b> | <p>Erin Flynn provided an update on progress of the Integrated Communities Care Management Learning Collaborative, including:</p> <ul style="list-style-type: none"> <li>• <b>Status of quality improvement facilitator procurement:</b> Erin indicated that after conducting interviews of bidders to the quality improvement facilitator RFP, the bid review team has identified two apparently successful bidders. A contract is currently routing through state approvals for one of the two approved bidders to begin work in December. The second bidder is an organization that put forth a proposal consisting of staff to be hired (with input from the bid review team), with support from organization-wide resources. The planning group will continue to update the full work group of the status of this procurement in future meetings.</li> <li>• <b>November kickoff webinars:</b> The Learning Collaborative planning group conducted two kickoff webinars on November 12<sup>th</sup> and November 21<sup>st</sup>. Nearly 100 participants signed up for the kickoff webinars from across the three communities: Burlington, Rutland and St. Johnsbury. The power point presentation from those webinars is included as attachment 2 to the meeting materials. The goal of these webinars was to introduce participants to the background, goals, expectations, timeline, and processes for participation in the integrated communities learning collaborative</li> </ul> |            |

| Agenda Item  | Discussion  | Next Steps |
|--|---|------------|
|  | <p>throughout the year to come.</p> <ul style="list-style-type: none"> <li> <b>Potential Learning Session Topics:</b> the dates and location for the first three in-person learning sessions of 2015 have been confirmed; January 13<sup>th</sup>, March 10<sup>th</sup> and May 19<sup>th</sup> at the Three Stallion Inn in Randolph. The planning group continues work to solidify logistics and materials for the first learning session, which will focus on an overview of the Plan-Do-Study-Act (PDSA) model for quality improvement, as well as using data effectively to identify at risk individuals. </li> </ul>   |            |
| <b>3. Support and Services at Home (SASH) Evaluation Results</b> | <p>Molly Dugan from Support and Services at Home (SASH) presented results from a recent evaluation of the SASH program conducted by RTI International under contract to the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. The goal of this evaluation was to better understand the impacts of affordable congregate housing models that provide long-term services and supports to low income seniors who wish to age in an independent setting. The evaluation sought to assess whether the SASH model of coordinated health and supportive services in affordable housing properties improved the health and functional status of participants, and lowered medical expenditures and acute care utilization for seniors. The findings of this evaluation showed that the SASH program reduced the rate of growth in total Medicare expenditures and expenditures for post-acute care among SASH participants residing in SASH properties that implemented their program before April 2012 and relative to both comparison groups. Furthermore, the authors observed the rate of growth among the SASH program participants' Medicare expenditures trending lower in seven of the ten payment categories analyzed, and described very positive findings with respect to reduced rates of growth in Medicare expenditures. More specifically, the evaluation found that savings began to appear in the second year of operation of a SASH panel, reflecting the time-intensive intake and assessment process that occurred in year one. The savings SASH produced were relative to two control groups: a demographically similar group of rural, upstate New York Medicare beneficiaries living in HUD-funded properties who were not SASH participants and who were not part of an MAPCP innovation program, and Vermont Medicare beneficiaries who lived in HUD-funded properties and were included in a Blueprint medical home but were not SASH participants. For Vermonters receiving care from a medical home, supplemented by SASH services provided by experienced, well-established panels, the growth in annual total Medicare expenditures was \$1,756 - \$2,197 lower than the growth in expenditures among Medicare fee-for-service beneficiaries in the two comparison groups.</p> |            |
| <b>4. ACO Care Management Standards</b>                          | <p>Pat Jones provided a summary of the work group's process to date for developing Care Management Standards for ACO Shared Savings Programs, and reviewed the current draft standards provided as attachment 3a. Pat reviewed a summary of comments on draft standards included as attachment 3b, and indicated that since meeting materials were distributed, additional comments and suggested edits were received from a combination of DAIL and DLTSS work group co-chairs and staff. Since distributing those last minute edits and suggestions, further comment was received from the ACOs and the Vermont Medical</p>   |            |

| Agenda Item | Discussion  | Next Steps |
|-------------|---|------------|
|             | <p>Society. The consensus was that more time is needed to discuss these suggested edits before a vote can take place.</p> <p>Marybeth McCaffrey reviewed the suggested edits from DAIL/DTSS work group leadership, and the following comments were made:</p> <p>Regarding a suggested edit to include language about culturally competent, accessible, and universal design:</p> <ul style="list-style-type: none"> <li>• Vicki Loner requested clarification of the definition of Universal Design.</li> <li>• Susan Aranoff offered NIH definitions of cultural competency and universal design.</li> <li>• Madeleine Mongan questioned if these standards have been presented to the HIE work group, and Georgia indicated that they have not. Madeleine suggested that as there are federal requirements regarding these concepts, that work group is likely aware of it. Madeleine also indicated that she would be interested in seeing the NIH paper referenced by Susan Aranoff. Finally, she suggested that there may be opportunity to add language about complying with state and federal law.</li> <li>• Nancy Breiden noted that she supports the idea of being compliant with federal law, as well as addressing the disparate needs of different populations.</li> <li>• Vicki Loner indicated that the Medicaid contracts contain language about complying with existing federal and state law, and that we should be careful to keep the language relevant to care management more so than HIE.</li> </ul> <p>Regarding the suggested language for standard #4:</p> <ul style="list-style-type: none"> <li>• Madeleine indicated that she would like some examples of what a DTSS service guideline is.</li> <li>• Trish Singer from DMH indicated that she thinks that this is implied in the word clinical (i.e. - something that is given by a clinician, a service and an intervention). It is a slippery slope to start listing out every single population.</li> <li>• Beverly Boget indicated that a lot of supports are not necessarily clinical.</li> <li>• Vicki Loner noted that OCVT has been cautious about calling out specific populations as they have been trying to take a population health approach. If you start calling out sub-populations, there is great potential to forget to include every population.</li> <li>• Dale Hackett indicated that he agrees that the term clinical doesn't cover it all. That said, he agrees that we should include broader language rather than more specific so as not to exclude anyone.</li> <li>• Beverly Boget suggested adding the language "evidence based clinical and support services."</li> <li>• Mary Moulton noted that in many communities, this communication and collaboration is really starting to happen. We may not need this language a year from now, but we need it now. She also thinks that DTSS includes a very broad range of people, and is ok with the suggested language. Finally, she recognizes the balance between calling out specific sub-populations and taking a</li> </ul> |            |

| Agenda Item | Discussion  | Next Steps |
|-------------|---|------------|
|             | <p>population wide approach.</p> <ul style="list-style-type: none"> <li>• Trish Singer noted that if we list out specific sub-populations, we have to make sure we don't forget anyone (i.e. – peer supports).</li> <li>• Marlys Waller indicated that she supports the addition of DLTSS, and suggested removing the last instance of the word clinical.</li> <li>• Dale Hackett posed a question: are social determinants of health included? Yes, there is language about considering social determinants of health in the new standard #7.</li> <li>• Clare McFadden indicated that she supports adopting guidelines where they exist, but for a lot of the populations there are not existing guidelines. There needs to be flexibility to innovate in places where these practices don't currently exist.</li> </ul> <p>Regarding the suggested language for standard #5:</p> <ul style="list-style-type: none"> <li>• Kristin Murphy indicated that people don't view themselves as managing a disability, and it would be hard for the self-advocacy community to support this language.</li> <li>• Trish Singer noted that she also has trouble with the word "needed" or "required." Who determines the need? Who determines the requirement?</li> <li>• Dale Hackett indicated that he prefers the word challenges. He would like to see the word that is most commonly used so that there is a common understanding.</li> </ul> <p>Regarding the suggested language for standard #6, no comments were offered.</p> <p>Regarding the suggested language for standard #8:</p> <ul style="list-style-type: none"> <li>• Nancy Breiden noted that this is good broadening language. Mary Moulton agrees that it is more integrative.</li> </ul> <p>Regarding the suggested language for standard #9, no comments were made.</p> <p>Regarding the suggested language for standard #10:</p> <ul style="list-style-type: none"> <li>• Beverly Boget suggested changing adult day care to adult day services.</li> <li>• Vicki Loner commented that she does not think the HIE will achieve this aspirational goal in 2015; we need to be aware of what is possible and what we can do.</li> <li>• Georgia Maheras indicated that the federal barrier on part 2 data is one of the biggest challenges.</li> <li>• Marybeth McCaffrey noted that the intro clause indicates that there are challenges and that there are many things that aren't currently possible, but there are many that are.</li> <li>• Vicki Loner responded indicating that she is hesitant to put binding language into a contract that is dependent on an outside organization, such as VITL. It could result in people looking to the ACOs to</li> </ul> |            |

| Agenda Item  | Discussion  | Next Steps |
|--|---|------------|
|  | <p>do this work when much of it is being led by VITL.</p> <ul style="list-style-type: none"> <li>• Madeleine noted that right now we are at the pilot level. It is hard to make a standard that all the ACOs have to follow. This can have unintended consequences, we don't want people to avoid trying something because they could be held to a standard.</li> </ul> <p>Next steps were discussed, including convening another meeting of the subgroup with representation from the DAIL/DLTSS leadership group that proposed edited language, and potentially pulling together the full work group for a vote by phone in December.</p> |            |
| <p><b>5. Care Models and Care Management Work Plan Review and Revision</b></p> | <p>Time did not allow for discussion of this agenda item.</p>   |            |
| <p><b>6. Next Steps, Wrap-Up and Future Meeting Schedule</b></p>               | <p><i>Please note that the work group will not meet in December 2014. Work group meeting times and locations for 2015 will be distributed shortly.</i></p>  |            |

# VHCIP CMCM Work Group Member List

Roll Call: **11/18/2014**

*no quorum  
10 Beverly Boget  
20 Vicki  
minutes*

| Member     |                   | Member Alternate          |           |   |  |  |
|------------|-------------------|---------------------------|-----------|---|--|--|
| First Name | Last Name         | First Name                | Last Name |   |  | Organization                                       |
| Beverly    | Boget ✓           |                           |           | ✓ |  | VNAs of Vermont                                    |
| Nancy      | Breiden ✓         | Rachel                    | Seelig    | A |  | VLA/Disability Law Project                         |
| Dr. Dee    | Burroughs-Biron X | Trudee                    | Ettlinger |   |  | Vermont Department of Corrections                  |
| Barbara    | Cimaglio X        |                           |           |   |  | AHS - VDH  |
| Peter      | Cobb X            | <i>Robert Lee Fogelin</i> |           |   |  | VNAs of Vermont                                    |
| Dana       | Demartino X       |                           |           |   |  | Central Vermont Medical Center                     |
| Nancy      | Eldridge X        |                           |           |   |  | Cathedral Square and SASH Program                  |
| Joyce      | Gallimore X       |                           |           |   |  | CHAC   |
| Eileen     | Girling X         | Heather                   | Bollman   |   |  | AHS - DVHA   |
| Bea        | Grause X          |                           |           |   |  | Vermont Association of Hospital and Health Systems |
| Dale       | Hackett ✓         |                           |           | ✓ |  | None   |
| Linda      | Johnson X         | Cameron                   | Erickson  |   |  | MVP Health Care                                    |
| Pat        | Jones ✓           | Richard                   | Slusky    |   |  | GMCB   |
| Trinka     | Kerr X            | Julia                     | Shaw      |   |  | VLA/Health Care Advocate Project                   |
| Patricia   | Launer X          | Joyce                     | Gallimore |   |  | Bi-State Primary Care                              |
| Vicki      | Loner ✓           | Maura                     | Crandall  | ✓ |  | OneCare Vermont                                    |
| Clare      | McFadden ✓        |                           |           | A |  | AHS - DAIL   |
| Madeleine  | Mongan ✓          |                           |           | ✓ |  | Vermont Medical Society                            |
| Judy       | Morton ✓          |                           |           | ✓ |  | Mountain View Center                               |
| Mary       | Moulton ✓         |                           |           | A |  | Washington County Mental Health Services Inc.      |
| Paul       | Reiss X           | Amy                       | Cooper    |   |  | Accountable Care Coalition of the Green Mountains  |
| Laural     | Ruggles X         |                           |           |   |  | Northeastern Vermont Regional Hospital             |
| Ken        | Schatz X          | April                     | Allen     |   |  | AHS - DCF  |
| Catherine  | Simonson X        |                           |           |   |  | HowardCenter for Mental Health                     |
| Patricia   | Singer ✓          |                           |           |   |  | AHS - DMH  |
| Lily       | Sojourner         |                           |           |   |  | AHS - Central Office                               |
| Audrey-Ann | Spence ✓          | Robert                    | Wheeler   | ✓ |  | Blue Cross Blue Shield of Vermont                  |
| Jason      | Wolstenholme      | Jessica                   | Oski      |   |  | Vermont Chiropractic Association                   |

# VHCIP CMCM Work Group Participant List

Attendance:

**11/18/2014**

|           |                         |
|-----------|-------------------------|
| <b>C</b>  | <b>Chair</b>            |
| <b>IC</b> | <b>Interim Chair</b>    |
| <b>M</b>  | <b>Member</b>           |
| <b>MA</b> | <b>Member Alternate</b> |
| <b>A</b>  | <b>Assistant</b>        |
| <b>S</b>  | <b>Staff/Consultant</b> |
| <b>X</b>  | <b>Interested Party</b> |

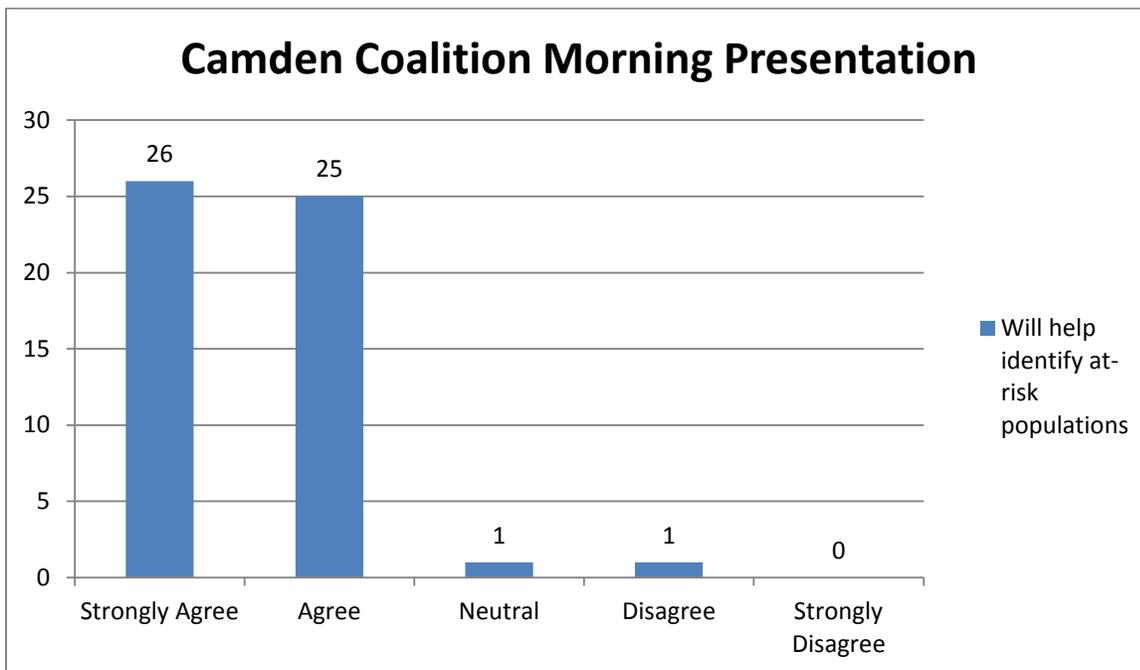
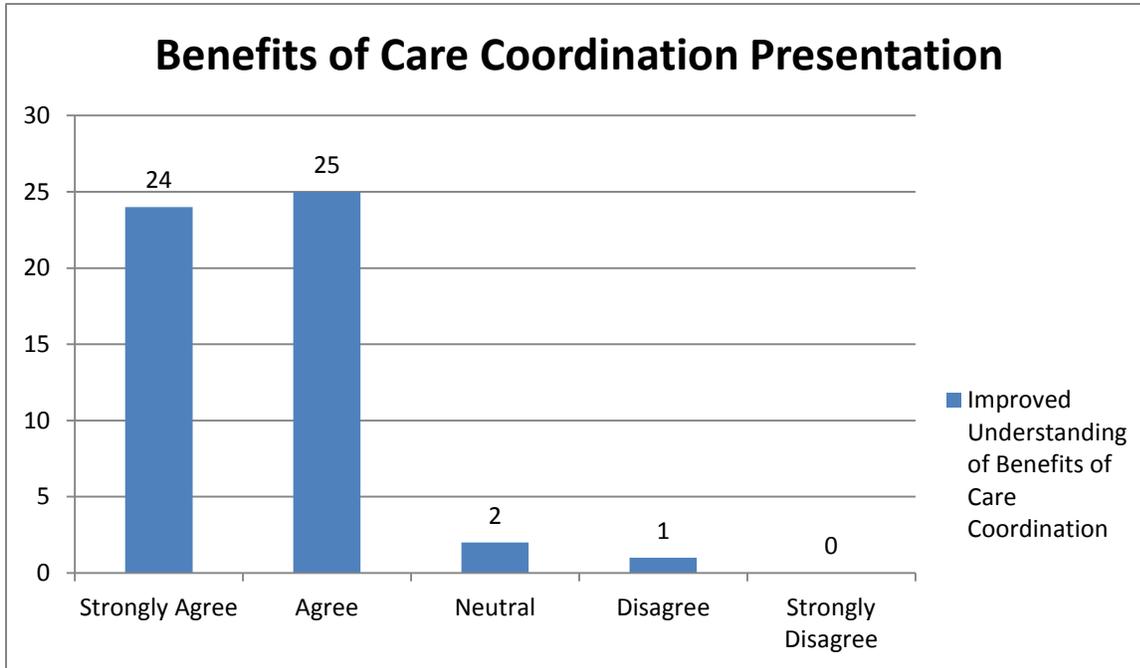
| First Name | Last Name       |             | Organization                               | Care Models |
|------------|-----------------|-------------|--|-------------|
| Peter      | Albert          |             | Blue Cross Blue Shield of Vermont          | X           |
| April      | Allen           |             | AHS - DCF                                  | MA          |
| Susan      | Aranoff         | <i>here</i> | AHS-DAIL                                   | X           |
| Ena        | Backus          |             | GMCB                                       | X           |
| Melissa    | Bailey          |             |  | X           |
| Michael    | Bailit          |             | SOV Consultant - Bailit-Health Purchasing  | X           |
| Susan      | Barrett         |             | GMCB                                       | X           |
| Susan      | Besio           | <i>here</i> | SOV Consultant - Pacific Health Policy Gro | X           |
| Charlie    | Biss            |             | AHS - Central Office - IFS                 | X           |
| Beverly    | Boget           | <i>here</i> | VNAs of Vermont                            | M           |
| Heather    | Bollman         |             | AHS - DVHA                                 | MA          |
| Mary Lou   | Bolt            |             | Rutland Regional Medical Center            | X           |
| Nancy      | Breiden         | <i>here</i> | VLA/Disability Law Project                 | M           |
| Stephen    | Broer           |             | Northwest Counseling and Support Servic    | X           |
| Martha     | Buck            |             | Vermont Association of Hospital and Hea    | A           |
| Dr. Dee    | Burroughs-Biron |             | Vermont Department of Corrections          | M           |
| Nick       | Carter          |             | Planned Parenthood of Northern New En      | X           |
| Jane       | Catton          |             | Northwestern Medical Center                | X           |

|           |           |      |   |      |
|-----------|-----------|------|---|------|
| Amanda    | Ciecior   |      | AHS - DVHA                                      | S    |
| Barbara   | Cimaglio  |      | AHS - VDH                                       | M    |
| Peter     | Cobb      |      | VNAs of Vermont                                 | M    |
| Amy       | Coonradt  | here | AHS - DVHA                                      | X    |
| Amy       | Cooper    |      | Accountable Care Coalition of the Green Mts     | MA   |
| Maura     | Crandall  |      | OneCare Vermont                                 | MA   |
| Claire    | Crisman   |      | Planned Parenthood of Northern New England      | A    |
| Dana      | Demartino |      | Central Vermont Medical Center                  | M    |
| Steve     | Dickens   |      | AHS - DAIL                                      | X    |
| Nancy     | Eldridge  |      | Cathedral Square and SASH Program               | C/M  |
| Cameron   | Erickson  |      | MVP Health Care                                 | MA   |
| Trudee    | Ettlinger |      | Vermont Department of Corrections               | MA   |
| Erin      | Flynn     | here | AHS - DVHA                                      | S    |
| Aaron     | French    |      | AHS - DVHA                                      | X    |
| Meagan    | Gallagher |      | Planned Parenthood of Northern New England      | X    |
| Joyce     | Gallimore |      | Bi-State Primary Care/CHAC                      | MA/M |
| Lucie     | Garand    |      | Downs Rachlin Martin PLLC                       | X    |
| Christine | Geiler    |      | GMCB  | S    |
| Eileen    | Girling   |      | AHS - DVHA                                      | M    |
| Kelly     | Gordon    |      | AHS - DVHA                                      | X    |
| Bea       | Grause    |      | Vermont Association of Hospital and Health Care | C/M  |
| Dale      | Hackett   | here | None  | M    |
| Bryan     | Hallett   |      | GMCB  | X    |
| Selina    | Hickman   |      | AHS - DVHA                                      | X    |
| Bard      | Hill      |      | AHS - DAIL                                      | X    |
| Breena    | Holmes    |      | AHS - Central Office - IFS                      | X    |
| Marge     | Houy      |      | SOV Consultant - Bailit-Health Purchasing       | X    |
| Christine | Hughes    |      | SOV Consultant - Bailit-Health Purchasing       | X    |
| Jay       | Hughes    |      | Medicity  | X    |

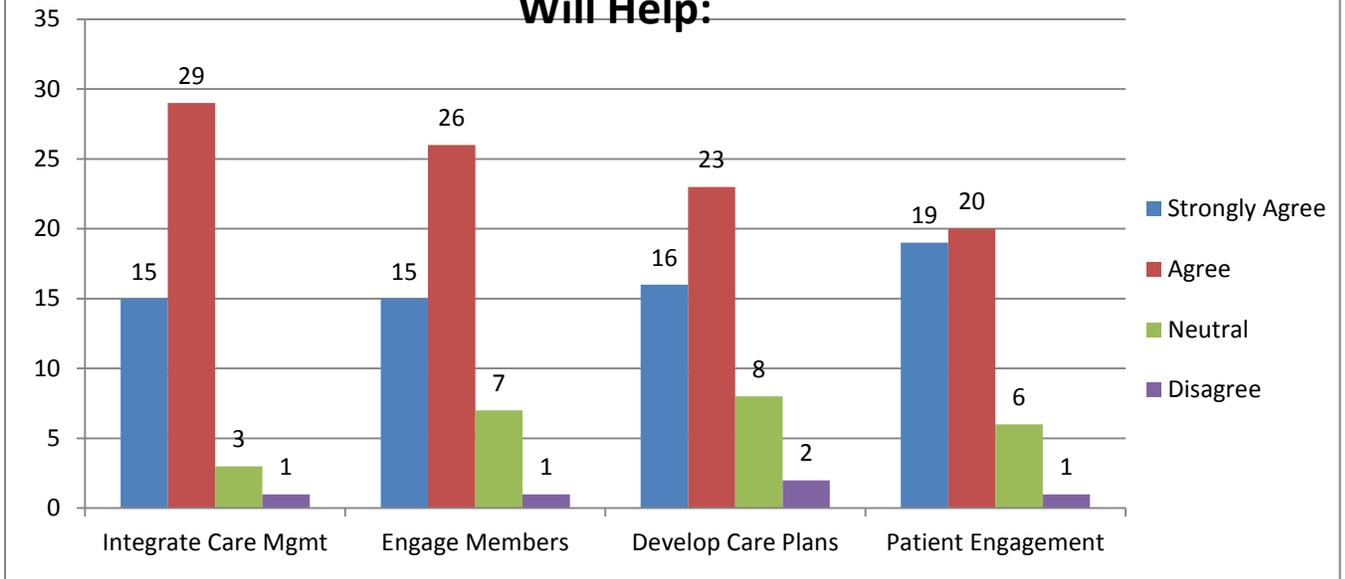
|           |            |      |   |     |
|-----------|------------|------|---|-----|
| Linda     | Johnson    |      | MVP Health Care                         | M   |
| Pat       | Jones      | here | GMCB                                    | S/M |
| Joelle    | Judge      |      | UMASS                                   | S   |
| Trinka    | Kerr       |      | VLA/Health Care Advocate Project        | M   |
| Kelly     | Lange      |      | Blue Cross Blue Shield of Vermont       | X   |
| Patricia  | Launer     |      | Bi-State Primary Care                   | M   |
| Diane     | Leach      |      | Northwestern Medical Center             | X   |
| Deborah   | Lisi-Baker | here | Unknown                                 | X   |
| Vicki     | Loner      | here | OneCare Vermont                         | M   |
| Georgia   | Maheras    | here | AOA                                     | S   |
| Mike      | Maslack    |      |   | X   |
| John      | Matulis    |      |   | X   |
| James     | Mauro      |      | Blue Cross Blue Shield of Vermont       | X   |
| Clare     | McFadden   | ✓    | AHS - DAIL                              | M   |
| Elise     | McKenna    |      | AHS - DVHA - Blueprint                  | X   |
| Jill      | McKenzie   |      |   | X   |
| Jeanne    | McLaughlin |      | VNAs of Vermont                         | X   |
| Darcy     | McPherson  |      | AHS - DVHA                              | A   |
| Madeleine | Mongan     | here | Vermont Medical Society                 | M   |
| Monika    | Morse      | here |   | X   |
| Judy      | Morton     | here | Mountain View Center                    | M   |
| Mary      | Moulton    | here | Washington County Mental Health Service | M   |
| Kirsten   | Murphy     | here | AHS - Central Office - DDC              | X   |
| Reeva     | Murphy     |      | AHS - Central Office - IFS              | X   |
| Sarah     | Narkewicz  |      | Rutland Regional Medical Center         | X   |
| Jessica   | Oski       |      | Vermont Chiropractic Association        | MA  |
| Annie     | Paumgarten |      | GMCB                                    | X   |
| Luann     | Poirer     |      | AHS - DVHA                              | X   |
| Betty     | Rambur     |      | GMCB                                    | X   |

Molly Dugan  
Marybeth McCaffrey

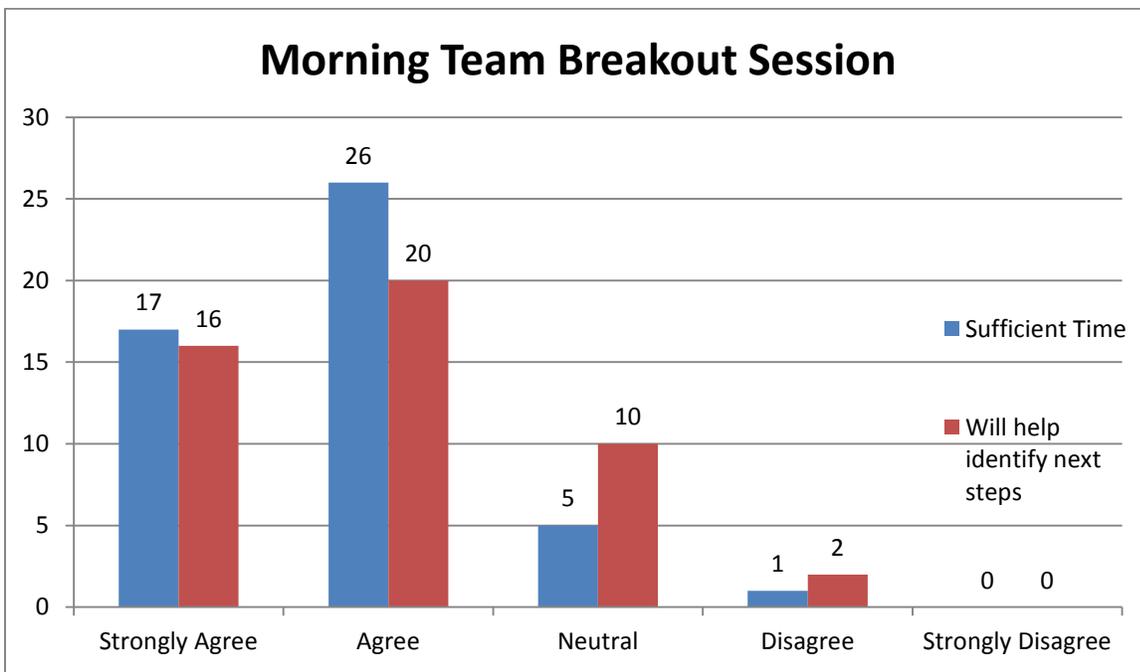
# Attachment 2 - Summary of Learning Session Evaluation Results



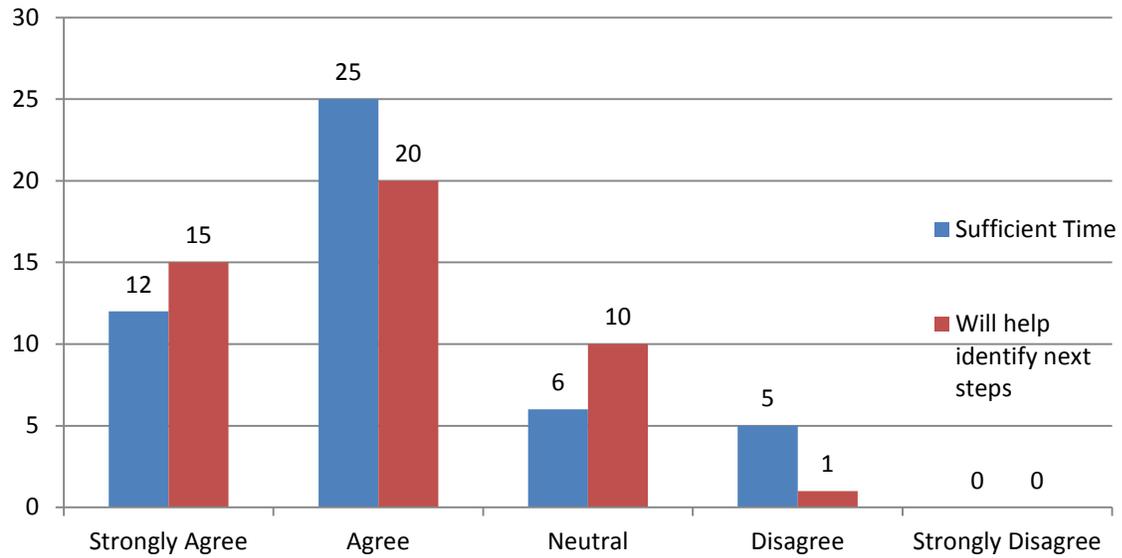
## Camden Coalition Afternoon Presentation Will Help:



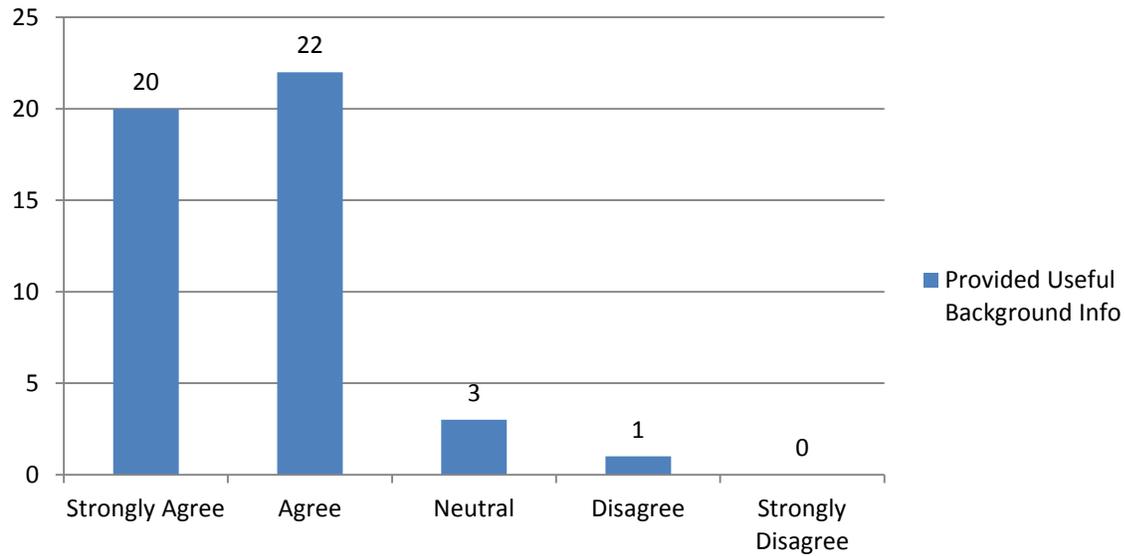
## Morning Team Breakout Session

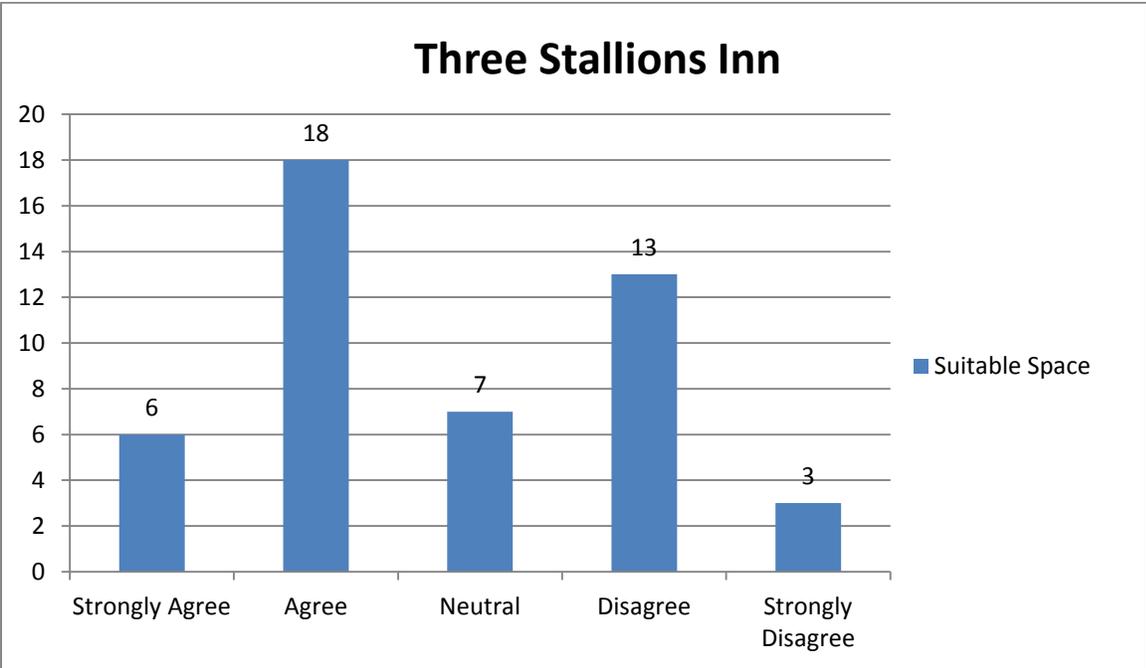
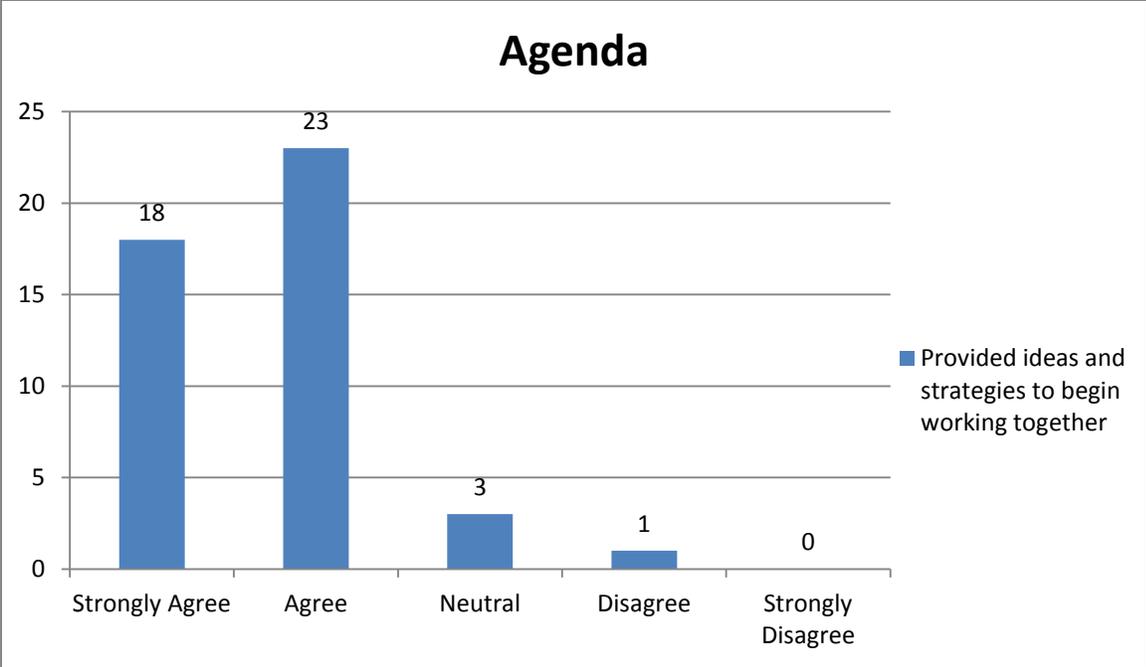


## Afternoon Team Breakout Session



## Pre-Reading Material







# Attachment 3 - Draft Care Management Standards

**DRAFT**  
**Care Models and Care Management Work Group**  
**Proposed ACO Care Management Standards**  
**December 30 ~~November 14~~, 2014**

**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. It is understood that in order to support individuals and to strengthen community support systems,<sup>7</sup> care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

In order for care management programs to be effective, we recommend that ACOs ~~agree to~~ be guided by the following standards:

**A. Care Management Oversight** (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

**B. Guidelines, Decision Aids, and Self-Management** (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports its participating providers in -the consistent adoption of evidence-based clinical guidelines, and supports the exploration of emerging best practices. ~~s and/or supports its participating providers in the consistent adoption of evidence based clinical guidelines.~~

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, ~~and self-advocacy, and self-management of health and disability conditions that is inclusive of the needs of people with disabilities.-~~

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

**C. Population Health Management** (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#76: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#87: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
- Recognizing DLTSS disability and long term services and supports providers as partners in serving people with high or complex needs.

#98: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs.

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

#109: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: is accessible to people and a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, and b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) provides people access to their own health care information as required by law.

#110: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.



# Attachment 4a - Care Management Inventory Report

# **Care Management Inventory Survey Results**

## **Report to CMCM Work Group**

### **February 3, 2014**

The following report presents data from the care management survey, the highlights of which were presented to the Vermont Health Care Innovation Project (VHCIP) Care Models and Care Management (CMCM) Work Group on September 11, 2014. In developing this report, Bailit Health focused on detailing the data that were included in the CMCM Work Group presentation. The data are grouped into topic categories for easier understanding.

#### **I. Description of Responding Organizations**

Tables 1 through 5 provide descriptive information about the responding organizations. Key highlights include:

- 42 organizations responded; reported results reflect the responses from those organizations.
- The predominant respondents were Community Service Providers (33%), Blueprint Community Health Teams (26%), and Health Care Providers (21%).
- Of the nine respondents reallocated from “Others” to specific respondent categories, four were moved into the Community Service Provider category. Two each were moved to the Health Plan category and the State Agency category. One was moved into the Health Plan category.
- 31% of the respondents reported having a statewide service area.
- All responding ACOs, State Agencies and Health Plans reported providing services in all counties (organizations were instructed that if they selected “Statewide,” there was no need to check individual counties).
- Caledonia (5%), Essex (5%), Grand Isle (5%), Lamoille (5%) and Orleans (25%) Counties had the fewest respondents.

Table 1 below summarizes the number and type of responding organizations. All who responded “Other” were re-categorized as described above and as shown in Table 2.

**Table 1: Number and Type of Responding Organizations**

| Type of Organization            | Number of Respondents | Percent of Total Respondents |
|---------------------------------|-----------------------|------------------------------|
| ACO                             | 2                     | 5%                           |
| Blueprint Community Health Team | 11                    | 26%                          |
| Health Plan                     | 3                     | 7%                           |
| State Agency                    | 3                     | 7%                           |
| Community Service Provider      | 14                    | 33%                          |
| Health Care Provider            | 9                     | 21%                          |
| Other                           | 0                     | 0%                           |
| <b>Total</b>                    | <b>42</b>             | <b>100%</b>                  |

**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 as participants in CHAC were categorized as Health Care Providers.

The following table summarizes the responding organizations by organizational type.

| Table 2: List of Responding Organizations by Type of Organization |   |                           |
|---|---|---------------------------|
| Responding Organizations  | Organization Name   | Contact Person Name       |
| ACOs  | Accountable Care Coalition of the Green Mountains (ACCGM)             | Jill McKenzie             |
|   | OneCare Vermont   | Vicki Loner               |
| Blueprint Community Health Teams                                  | 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               |
| Community Service Providers                                       | 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             |
|   | Howard Center   | Catherine Simonson        |
|   | Lamoille County Mental Health Services                                | Jennifer Stratton         |
|   | Lincoln Street Inc.   | Cheryl Thrall, Exec. Dir. |
|   | Northwestern Counseling & Support Services                            | Amy Putnam                |
| United Counseling Service   | Ralph Provenza  |                           |

**Table 2: List of Responding Organizations by Type of Organization**

| <b>Responding Organizations</b> | <b>Organization Name</b>  | <b>Contact Person Name</b>                 |
|---------------------------------|---|--|
|                                 | 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                               |
| <b>Health Care Providers</b>    | 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 & Matrix Health Systems                              | Melissa Bailey                             |
| <b>Health Plans</b>             | BCBSVT  | Audrey Spence                              |
|                                 | DVHA/VCCI   | Eileen Girling                             |
|                                 | MVP Health Care   | Linda Johnson, Dir. Population Health Mgmt |
| <b>State Agencies</b>           | 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                                |

The following table represents changes that were made, in consultation with DVHA and GMCB staff, to the categorization of 'Organization Type'.

**Table 3: List of Re-categorized Agencies by New Category Designation**

| 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                         |
| Howard Center   | 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                               |
| 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                                       |

Tables 4 and 5 present the responding organizations' data on service areas.

**Table 4: Respondent Organization's Service Areas by Type of Organization**

| County                                  | Type of Organization |             |              |                                 |                            |                      |                        |
|---|----------------------|-------------|--------------|---------------------------------|----------------------------|----------------------|------------------------|
|   | ACO                  | Health Plan | State Agency | Blueprint Community Health Team | Community Service Provider | Health Care Provider | All Organization Types |
| <b>Statewide</b>                        | 100%                 | 100%        | 100%         | 9%                              | 7%                         | 33%                  | 31%                    |
| Addison County                          |                      |             |              | 18%                             | 21%                        | 11%                  | 14%                    |
| Bennington County                       |                      |             |              | 18%                             | 14%                        | 0%                   | 10%                    |
| Caledonia County                        |                      |             |              | 0%                              | 0%                         | 22%                  | 5%                     |
| Chittenden County                       |                      |             |              | 9%                              | 14%                        | 11%                  | 10%                    |
| Essex County                            |                      |             |              | 9%                              | 0%                         | 11%                  | 5%                     |
| Franklin County                         |                      |             |              | 9%                              | 14%                        | 11%                  | 10%                    |
| Grand Isle County                       |                      |             |              | 0%                              | 14%                        | 0%                   | 5%                     |
| Lamoille County                         |                      |             |              | 0%                              | 7%                         | 11%                  | 5%                     |
| Orange County                           |                      |             |              | 9%                              | 36%                        | 11%                  | 17%                    |
| Orleans County                          |                      |             |              | 9%                              | 0%                         | 0%                   | 2%                     |
| Rutland County                          |                      |             |              | 9%                              | 14%                        | 11%                  | 10%                    |
| Washington County                       |                      |             |              | 9%                              | 36%                        | 0%                   | 14%                    |
| Windham County                          |                      |             |              | 18%                             | 21%                        | 0%                   | 12%                    |
| Windsor County                          |                      |             |              | 27%                             | 21%                        | 0%                   | 14%                    |
| <b>Count of Organizations Reporting</b> | <b>2</b>             | <b>3</b>    | <b>3</b>     | <b>11</b>                       | <b>14</b>                  | <b>9</b>             | <b>42</b>              |

**Table 5: Responding Organizations by Geographic Area**

| County            | # of Organizations | % of Responses |
|-------------------|--------------------|----------------|
| <b>Statewide</b>  | <b>13</b>          | <b>31%</b>     |
| 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%            |

## II. Care Management Services Provided by Responding Organizations

The following are the definitions of care management services that the responding organizations were asked to use to categorize the type of services they provided. The tables and bar charts within this section of the report categorize responses using these care management definitions.

- **High Risk Management** is the deliberate organization of care activities for high risk individuals, designed to improve their health status and reduce the need for expensive services. High risk people may include individuals experiencing serious illness, high utilization of health care services and/or transitions in care (e.g., changes in setting, service, practitioner, or level of care).
- **Special Services Management** is the deliberate organization of care activities for a specified population requiring ongoing management (other than high risk individuals and those receiving disease management services), for an undetermined time frame. Examples of specified populations include people with mental health or substance abuse needs, and children with special health needs.
- **Episodic Pathways** are standardized care processes used to promote organized and efficient care based on evidence-based practice for a specific group of individuals with a condition that is characterized by a predictable clinical course with a limited time frame (e.g. pregnancy, joint replacements). The interventions involved in the evidence-based practice are defined, optimized and sequenced; they are also known as clinical pathways, care pathways, critical pathways, integrated care pathways, or care maps.
- **Disease Management** is a system of coordinated interventions and communications for specific groups of people with chronic conditions for which self-care efforts can have significant impact. Disease management supports the practitioner/person relationship, development of a plan of care, and prevention of exacerbations and complications. It is characterized by evidence-based practice guidelines and strategies that empower people.
- **Post-Discharge Follow-Up** consists of a phone call or visit to discharged individuals within 48 to 72 hours of their departure from a care facility. The purpose is to ask about the individual's condition, adherence to and understanding of medication orders and other treatment orders, general understanding of his or her condition, and intent to attend follow-up appointments. Post-discharge follow-up is for individuals other than those served by High Risk Care Coordination, Special Services Care Coordination, Episodic Pathways, or Disease Management.
- **Short-Term Case Management Programs** are targeted and short term (30-60 days maximum) interventions with the goals of empowering individuals to better understand their illnesses and manage their own conditions, and coordinating care between individuals, providers and the community.
- **Utilization Management** is the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures to ensure appropriate access to and management of the quality and cost of health care services provided to health plan members or other populations.

- **Prevention/Wellness Engagement** activities are interventions designed to increase engagement and activation and promote positive behavior across populations, such as obtaining preventive care, exercising regularly, and modifying dietary habits. These activities may draw on the principles of positive psychology and the practices of motivational interviewing and goal setting (e.g., health coaching).
- **Life Resource Management** involves providing resources and counseling to help mitigate acute and chronic life stressors; and may include health care as well as social and/or community services.

Table 6 and Bar Charts 1 through 6 summarize the types of care management services provided by the responding organizations. Key highlights include:

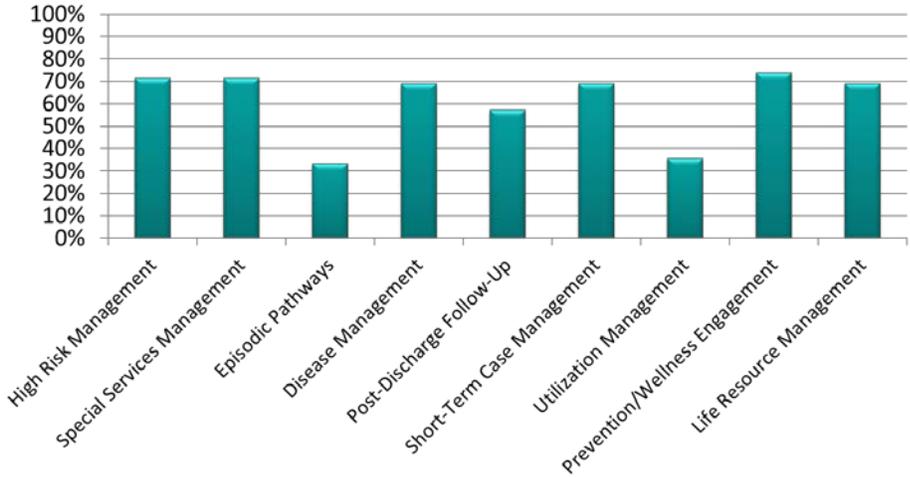
- The services most often provided by responding organizations were Prevention/Wellness Engagement (74%), High Risk Management (71%) and Special Services Management (71%).
- The services least often provided by the responding organizations were Episodic Pathways (33%), and Utilization Management (36%).
- While the other categories of responding organizations often provided the full range of care management services, ACOs focused their care management services on High Risk Management, Post-Discharge Follow-up and Prevention/Wellness Engagement, with 100% of responding ACOs providing those services.
- Special Services Management was predominantly provided by Blueprint Community Health teams (91%), State Agencies (100%) and Community Service Providers (93%)

**Table 6: Percent of Responding Organizations Providing Care Management Services by Type of Organization and Type of Service**

| Percentage of each Category of Organization Providing Each Service | ACO      | Blueprint Community Health Team | Health Plan | State Agency | Community Service Provider | Health Care Provider | All Organization Types |
|--|----------|---------------------------------|-------------|--------------|----------------------------|----------------------|------------------------|
| High Risk Management   | 100%     | 91%                             | 100%        | 67%          | 71%                        | 33%                  | 71%                    |
| Special Services Management  | 0%       | 91%                             | 0%          | 100%         | 93%                        | 44%                  | 71%                    |
| Episodic Pathways  | 0%       | 27%                             | 33%         | 33%          | 57%                        | 11%                  | 33%                    |
| Disease Management   | 50%      | 91%                             | 67%         | 67%          | 50%                        | 78%                  | 69%                    |
| Post-Discharge Follow-Up   | 100%     | 82%                             | 67%         | 0%           | 43%                        | 56%                  | 57%                    |
| Short-Term Case Management   | 50%      | 100%                            | 67%         | 33%          | 64%                        | 56%                  | 69%                    |
| Utilization Management   | 0%       | 27%                             | 67%         | 33%          | 43%                        | 33%                  | 36%                    |
| Prevention/Wellness Engagement                                     | 100%     | 91%                             | 67%         | 67%          | 71%                        | 56%                  | 74%                    |
| Life Resource Management   | 50%      | 91%                             | 33%         | 67%          | 71%                        | 56%                  | 69%                    |
| <b>Count of Organizations Reporting</b>                            | <b>2</b> | <b>11</b>                       | <b>3</b>    | <b>3</b>     | <b>14</b>                  | <b>9</b>             | <b>42</b>              |

**Bar Chart 1: Percent of All Responding Organizations Providing Care Management Services by Type of Service**

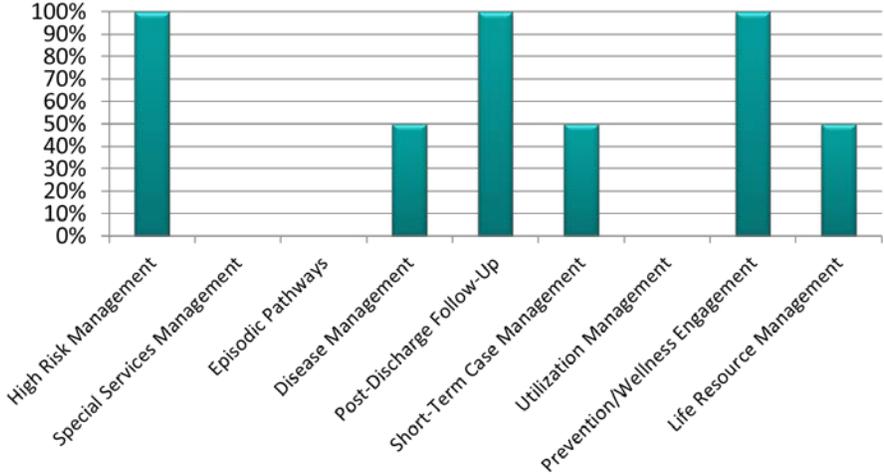
Number of Respondents: 42



Both responding ACOs indicated that they provided High Risk Management, Post Discharge Follow-up and Prevention/Wellness Engagement services. Half also provided Disease Management, Short-Term Case Management and Life Resource Management services.

**Bar Chart 2: Percent of ACOs Providing CM Services By Type of Service**

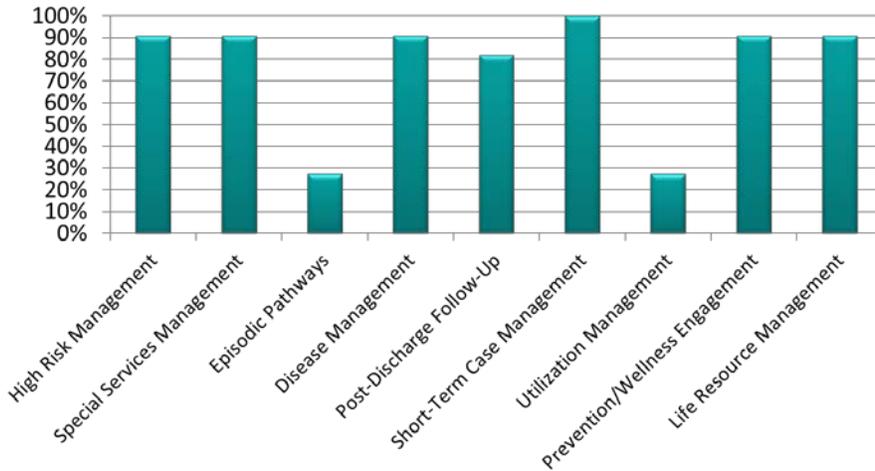
Number of Respondents: 2



Over 80% of Blueprint Community Health Teams provided all care management services except for Episodic Pathways and Utilization Management services, with less than 30% of responding Community Health Teams providing those two services.

**Bar Chart 3: Percent of Blueprint Community Health Teams Providing CM Services by Type of Service**

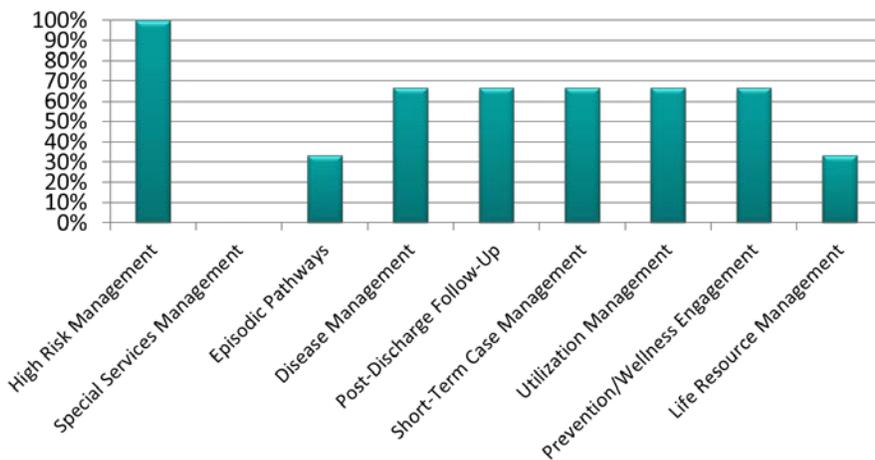
Number of Respondents: 11



As shown in Bar Chart 4, all Health Plans provided High Risk Management, approximately 30% provided Episodic Pathways and Life Resource Management services, and none provided Special Services Management services. Almost 70% of Health Plans reported providing the remaining categories of care management services.

**Bar Chart 4: Percent of Health Plans Providing CM Services by Type of Service**

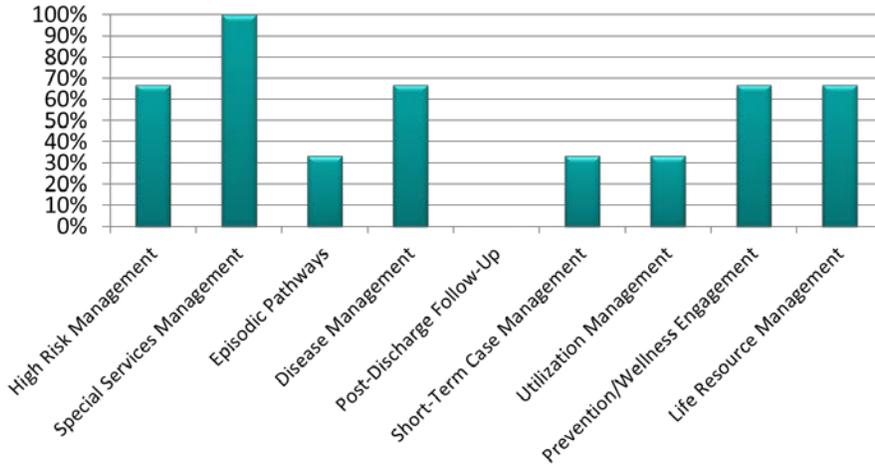
Number of Respondents: 3



As shown in Bar Chart 5, all State Agency respondents indicated that they provided Special Services Management and over half provided High Risk Management, Disease Management, Prevention/Wellness Engagement and Life Resource Management. Approximately 30% provided Episodic Pathways, Short-Term Case Management and Utilization Management, and none provided Post-Discharge Follow-up.

**Bar Chart 5: Percent of State Agencies Providing CM Services by Type of Service**

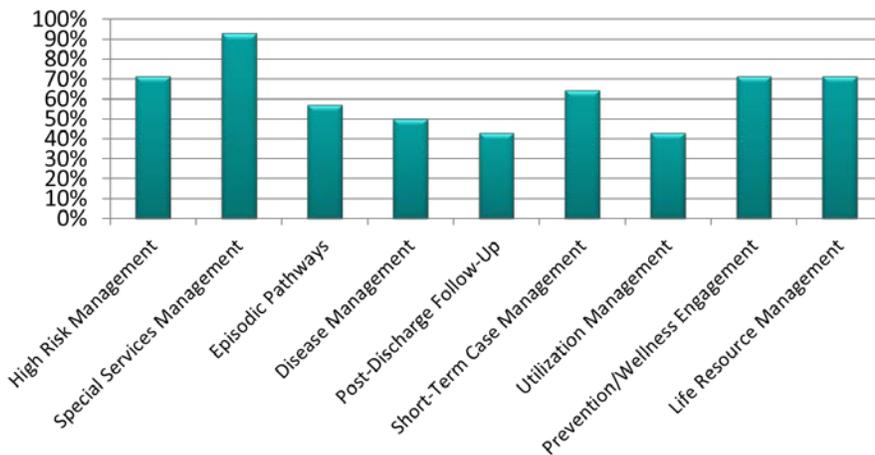
Number of Respondents: 3



As shown in Bar Chart 6, the predominant service provided by Community Service Providers was Special Services Management. Over 50% provided all other care management services, except approximately 40% provided Post-Discharge Follow-up and Utilization Management services.

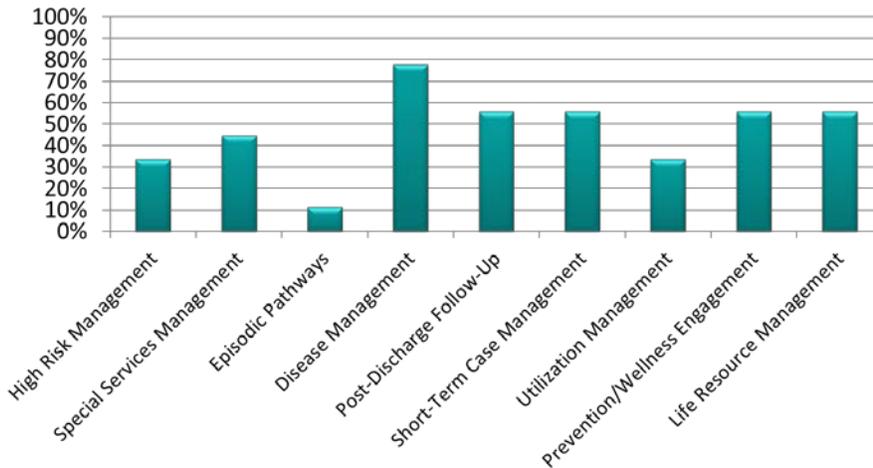
**Bar Chart 6: Percent of Community Service Providers Providing CM Services by Type of Service**

Number of Respondents: 14



Health Care Providers most often provided Disease Management services and least often provided Episodic Pathways services. Over half also provided Post-Discharge Follow-up, Short-Term Case Management, Prevention/Wellness Engagement and Life Resource Management.

**Bar Chart 7: Percent of Health Care Providers Providing CM Services by Type of Service**  
 Number of Respondents: 9



Tables 7 and 8 below summarize the responses when the organizations were asked to “indicate population(s) served by each Type of Care Management Service that they provide.” Table 7 indicates which service for which population was provided at rates significantly higher (H) or lower (L) than the average. If the percentage of responding organizations providing a particular service to a particular population was above the standard deviation, it was noted by the use of “H” in the cell. Alternatively, if the percentage of responding organizations providing the specific service to a specific population was below the standard deviation, it was noted by the use of “L” in the cell. Table 8 includes the percentages and standard deviations used to determine if the rates were higher (H) or lower (L).

Key highlights included:

People with multiple co-morbidities received the following services at rates significantly above the average:

- High Risk Management
- Special Services Management
- Disease Management
- Short-term Case Management
- Prevention/Wellness Engagement
- Life Resource Management

People with mental health and substance abuse needs received the following services at rates significantly above the average:

- High Risk Management
- Special Services Management
- Episodic Pathways
- Disease Management
- Prevention/Wellness Engagement
- Life Resource Management

People at risk regarding social determinants of health received the following services at rates significantly above the average:

- Episodic Pathways
- Short-term Case Management
- Prevention/Wellness Engagement
- Life Resource Management

Other key highlights included:

People needing pre-natal care received the following services at rates significantly below the average:

- High Risk Management
- Special Services Management
- Disease Management
- Post-discharge follow-up
- Short-term Case Management
- Utilization Management
- Prevention/Wellness Engagement
- Life Resource Management

People discharged from skilled nursing facilities received the following services at rates significantly below the average:

- Special Services Management
- Episodic Pathways
- Short-term Case Management Programs
- Utilization Management
- Prevention/Wellness Engagement

When considering the populations being served, these patterns of services are not surprising.

**Table 7: Populations Receiving Services at Rates Higher (H) or Lower (L) Than the Average**

For each service, rates that were significantly (at least one standard deviation) higher or lower than the average are indicated by an (H) and an (L)

| Total for All Types of Organizations (percentage)                 | High Risk Mgmt | Special Services Mgmt | Episodic Pathways | Disease Mgmt | Post-Discharge Follow-Up | Short-Term Case Mgmt Programs | Utilization Mgmt | Prevention / Wellness Engagement | Life Resource Mgmt |
|---|----------------|-----------------------|-------------------|--------------|--------------------------|-------------------------------|------------------|----------------------------------|--------------------|
| People with multiple comorbidities                                | H              | H                     |                   | H            |                          | H                             |                  | H                                | H                  |
| People with rare complex and high cost conditions (e.g. lupus)    | L              |                       | L                 |              |                          |                               |                  |                                  |                    |
| People with cancer  |                | L                     | L                 |              | L                        |                               |                  |                                  |                    |
| People with chronic conditions (e.g. diabetes, asthma, CHF, COPD) |                |                       |                   | H            |                          |                               |                  |                                  |                    |
| People with developmental disabilities                            |                | H                     |                   |              |                          |                               |                  |                                  |                    |
| People with MH and SA needs                                       | H              | H                     | H                 | H            |                          |                               |                  | H                                | H                  |
| People needing prenatal care                                      | L              | L                     |                   | L            | L                        | L                             | L                | L                                | L                  |
| People with multiple admissions to facilities                     | H              |                       |                   |              |                          |                               |                  |                                  |                    |
| People with multiple ED visits                                    |                |                       |                   |              |                          |                               | H                |                                  |                    |
| People at risk re: social determinants of health                  |                |                       | H                 |              |                          | H                             |                  | H                                | H                  |
| People discharged from acute inpatient                            |                |                       |                   |              | H                        |                               |                  |                                  |                    |
| People discharged from SNF  |                | L                     | L                 |              |                          | L                             | L                | L                                |                    |
| People discharged from inpatient rehab                            |                |                       | L                 |              |                          |                               |                  |                                  |                    |
| People discharged from mental health/substance abuse facility     |                | H                     | H                 |              |                          |                               |                  |                                  |                    |
| People discharged from home health agencies                       |                | L                     |                   |              |                          |                               |                  |                                  |                    |
| <b>Average</b>  | 51%            | 44%                   | 17%               | 43%          | 39%                      | 46%                           | 26%              | 41%                              | 51%                |
| <b>Standard Deviation</b>   | 12%            | 10%                   | 6%                | 11%          | 9%                       | 9%                            | 7%               | 12%                              | 11%                |

**Table 8: Percent of Responding Organizations Providing Specific Services to Specific Populations**

For each service, rates that were significantly (one standard deviation or more) above the average are in bold font, and below the average are in blue font.

| Total for All Types of Organizations (percentage)                 | High Risk Mgmt | Special Services Mgmt | Episodic Pathways | Disease Mgmt | Post-Discharge Follow-Up | Short-Term Case Mgmt Programs | Utilization Mgmt | Prevention/Wellness Engagement | Life Resource Mgmt |
|---|----------------|-----------------------|-------------------|--------------|--------------------------|-------------------------------|------------------|--------------------------------|--------------------|
| People with multiple comorbidities                                | <b>67%</b>     | <b>55%</b>            | 19%               | <b>64%</b>   | 45%                      | <b>60%</b>                    | 33%              | <b>67%</b>                     | <b>67%</b>         |
| People with rare complex and high cost conditions (e.g. lupus)    | <b>38%</b>     | 36%                   | <b>10%</b>        | 38%          | 33%                      | 40%                           | 24%              | 33%                            | 45%                |
| People with cancer  | 40%            | <b>33%</b>            | <b>10%</b>        | 33%          | <b>29%</b>               | 40%                           | 19%              | 29%                            | 43%                |
| People with chronic conditions (e.g. diabetes, asthma, CHF, COPD) | 52%            | 36%                   | 14%               | <b>57%</b>   | 38%                      | 48%                           | 31%              | 52%                            | 48%                |
| People with developmental disabilities                            | 40%            | <b>55%</b>            | 19%               | 36%          | 31%                      | 43%                           | 24%              | 45%                            | 60%                |
| People with MH and SA needs                                       | <b>67%</b>     | <b>67%</b>            | <b>29%</b>        | <b>55%</b>   | 45%                      | <b>55%</b>                    | 31%              | <b>60%</b>                     | <b>69%</b>         |
| People with physical disabilities                                 | 40%            | 43%                   | 14%               | 33%          | 31%                      | 45%                           | 19%              | 43%                            | 50%                |
| Elders needing support with ADL and/or other functional status    | 50%            | 45%                   | 19%               | 38%          | 40%                      | 50%                           | 26%              | 43%                            | 57%                |
| People needing prenatal care                                      | <b>26%</b>     | <b>31%</b>            | 14%               | <b>19%</b>   | <b>19%</b>               | <b>26%</b>                    | <b>12%</b>       | <b>26%</b>                     | <b>24%</b>         |
| People with multiple admissions to facilities                     | <b>64%</b>     | 48%                   | 19%               | 50%          | 48%                      | 52%                           | 33%              | 40%                            | 52%                |
| People with multiple admissions to outpatient programs            | 48%            | 43%                   | 19%               | 38%          | 36%                      | 48%                           | 29%              | 43%                            | 45%                |
| People with multiple ED visits                                    | 62%            | 45%                   | 21%               | 45%          | 48%                      | 50%                           | <b>36%</b>       | 38%                            | 52%                |
| People at risk re: social determinants of health                  | 62%            | 52%                   | <b>24%</b>        | 48%          | 40%                      | <b>60%</b>                    | 33%              | <b>57%</b>                     | <b>67%</b>         |
| People discharged from acute inpatient                            | 62%            | 48%                   | 19%               | 50%          | <b>55%</b>               | 52%                           | 31%              | 38%                            | 57%                |
| People discharged from SNF  | 40%            | <b>33%</b>            | <b>10%</b>        | 38%          | 40%                      | <b>33%</b>                    | <b>17%</b>       | <b>26%</b>                     | 43%                |
| People discharged from inpatient rehab                            | 45%            | 40%                   | <b>10%</b>        | 45%          | 38%                      | 40%                           | 24%              | 33%                            | 45%                |
| People discharged from mental health/substance abuse facility     | 62%            | <b>57%</b>            | <b>24%</b>        | 45%          | 48%                      | 48%                           | 26%              | 38%                            | 55%                |
| People discharged from home health agencies                       | 48%            | <b>33%</b>            | 14%               | 36%          | 31%                      | 38%                           | 19%              | 24%                            | 43%                |
| <b>Average</b>  | 51%            | 44%                   | 17%               | 43%          | 39%                      | 46%                           | 26%              | 41%                            | 51%                |
| <b>Standard Deviation</b>   | 12%            | 10%                   | 6%                | 11%          | 9%                       | 9%                            | 7%               | 12%                            | 11%                |

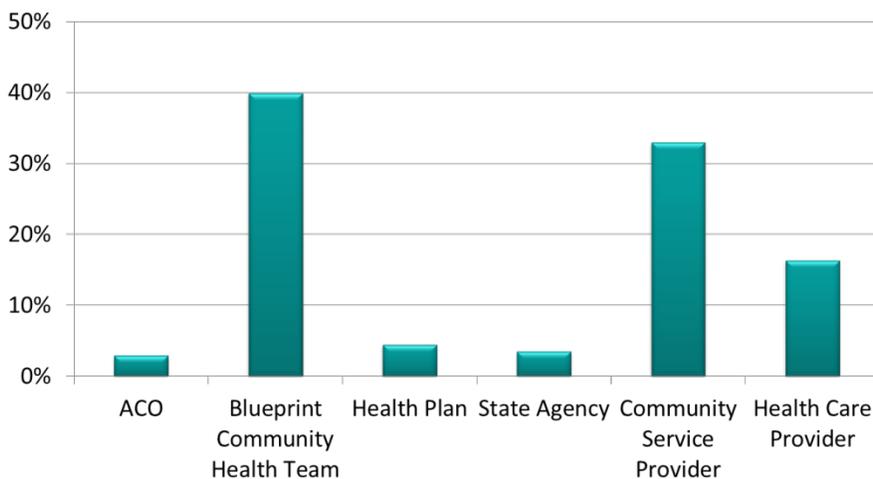
### III. Estimated Number of People Receiving Care Management Services

Organizations were asked to estimate the number of people receiving each type of service annually by selecting from a drop-down box with ranges of number of people served. To create estimates, we took the mid-value of each range to calculate the number of people served. Table 9 and Bar Charts 8 and 9 present the responses as percentages in order to demonstrate the relative values. Key findings include:

- Blueprint Community Health Teams, Community Service Providers and Health Care Providers were serving more people than ACOs, Health Plans and State Agencies, which suggests that most care management services in Vermont are being provided locally and in a de-centralized manner.
- High Risk Management, Life Resource Management and Short-Term Case Management were the three top services provided.
- Fewer people were receiving Episodic Pathways and Utilization Management services.

Bar Chart 8 depicts the percentages of people served by type of organization. The major providers of care management services among the responding organizations were Blueprint Community Health Teams and Community Service Providers. More detailed results are presented in Table 9, below.

**Bar Chart 8: Estimated Percentage of All People Receiving CM Services by Type of Responding Organization**

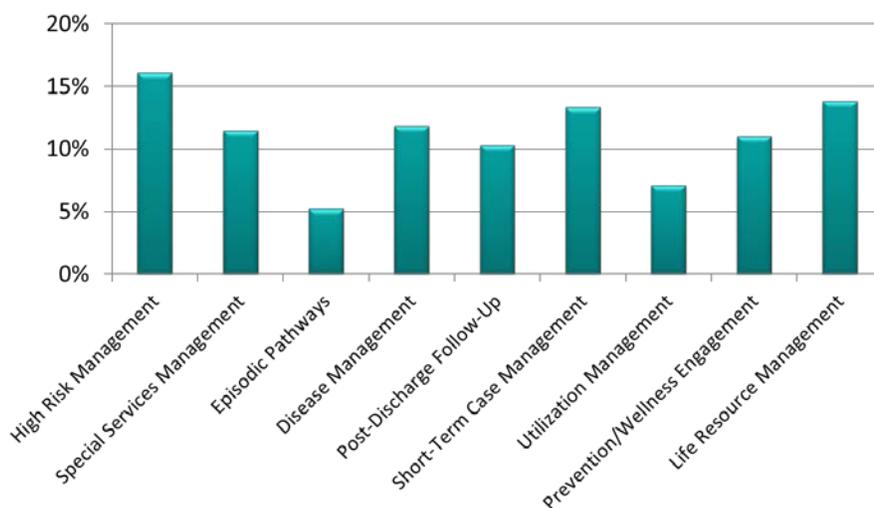


**Table 9: Estimated Percentage of People being Served by Type of Organization, by Specific Services**

| Care Management Category       | ACO       | Blueprint Community Health Team | Health Plan | State Agency | Community Service Provider | Health Care Provider | All Org. Types |
|--------------------------------|-----------|---------------------------------|-------------|--------------|----------------------------|----------------------|----------------|
| High Risk Mgmt                 | 5%        | 14%                             | 41%         | 45%          | 18%                        | 5%                   | 16%            |
| Special Services Mgmt          | 0%        | 12%                             | 8%          | 0%           | 13%                        | 11%                  | 11%            |
| Episodic Pathways              | 0%        | 4%                              | 3%          | 0%           | 9%                         | 3%                   | 5%             |
| Disease Management             | 21%       | 19%                             | 3%          | 10%          | 4%                         | 11%                  | 12%            |
| Post-Discharge Follow-Up       | 21%       | 12%                             | 11%         | 0%           | 8%                         | 9%                   | 10%            |
| Short-Term Case Mgmt           | 21%       | 13%                             | 17%         | 10%          | 14%                        | 10%                  | 13%            |
| Utilization Mgmt               | 0%        | 5%                              | 0%          | 0%           | 9%                         | 14%                  | 7%             |
| Prevention/Wellness Engagement | 21%       | 8%                              | 13%         | 17%          | 11%                        | 15%                  | 11%            |
| Life Resource Mgmt             | 12%       | 13%                             | 3%          | 17%          | 13%                        | 21%                  | 14%            |
| <b>Total</b>                   | <b>3%</b> | <b>40%</b>                      | <b>4%</b>   | <b>3%</b>    | <b>33%</b>                 | <b>16%</b>           | <b>--</b>      |

Bar Chart 9 presents the estimated percentage of people receiving care management services by type of care management service. More people were receiving High Risk Management, Short-Term Case Management and Life Resource Management. Fewer people were receiving Episodic Pathways and Utilization Management services. These estimates are generally consistent with Bar Chart 1, which summarizes the most frequently provided services, as reported by responding organizations.

**Bar Chart 9: All Organization Types: Estimated Percentage of People Receiving CM Services**



#### IV. Staffing of Care Management Services

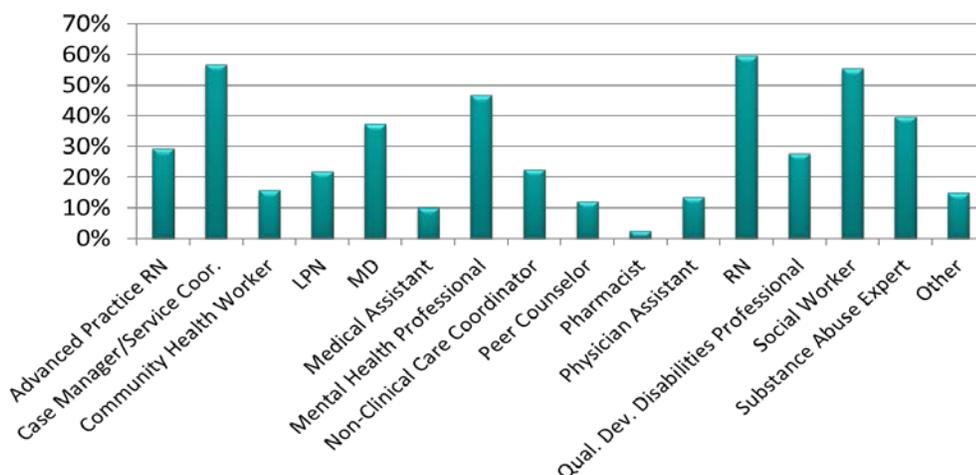
Organizations were asked to indicate the type and number (in FTEs) of staff they employ. As depicted in Table 10 and Bar Chart 10, the four staffing types with the greatest number of FTEs across all organizations responding to this question were RNs, Social Workers, LPNs and Substance Abuse Experts. Community Health Worker, Pharmacist and Physician Assistant had the smallest number of FTEs.

**Table 10: Number of FTEs by Staffing and Organization Type**

|   | ACO | Blueprint<br>Community<br>Health<br>Team | Community<br>Service<br>Provider | Health<br>Care<br>Provider | Health<br>Plan | State<br>Agency | Total FTEs<br>across all<br>orgs. |
|---|-----|--|----------------------------------|----------------------------|----------------|-----------------|-----------------------------------|
| Advanced Practice Registered Nurse                | 0   | 3  | 8                                | 12.5                       | 0              | 5               | 28.5                              |
| Case Manager/Service Coordinator                  | 0   | 15                                       | 12                               | 5                          | 2              | 5               | 39                                |
| Community Health Worker                           | 0   | 2.5                                      | 0                                | 5                          | 0              | 0               | 7.5                               |
| LPN   | 0   | 8.5                                      | 25                               | 18                         | 1              | 0               | 52.5                              |
| MD  | 0   | 0  | 21.5                             | 13                         | 3              | 5               | 42.5                              |
| Medical Assistant                                 | 0   | 7  | 5                                | 6                          | 0              | 0               | 18                                |
| Mental Health Professional                        | 0   | 9  | 1                                | 4                          | 2              | 0               | 16                                |
| Non-Clinical Care Coordinator                     | 0   | 12                                       | 10                               | 4.5                        | 0              | 12              | 38.5                              |
| Peer Counselor                                    | 0   | 0  | 16                               | 0                          | 0              | 5               | 21                                |
| Pharmacist  | 0   | 0  | 0                                | 4.5                        | 1.5            | 0               | 6                                 |
| Physician Assistant                               | 0   | 2  | 0                                | 6                          | 0              | 0               | 8                                 |
| Qualified Developmental Disabilities Professional | 0   | 0  | 24                               | 0                          | 0              | 0               | 24                                |
| RN  | 3   | 19.5                                     | 17                               | 12.5                       | 1              | 11              | 64                                |
| Social Worker                                     | 0   | 15                                       | 13                               | 12                         | 2.5            | 10              | 52.5                              |
| Substance Abuse Expert                            | 0   | 14                                       | 27                               | 1                          | 4              | 0               | 46                                |
| Other   | 0   | 10.5                                     | 6                                | 0                          | 0              | 0               | 16.5                              |

Responding organizations reported approximately 481 FTEs.

**Bar Chart 10: Total Percentage of FTEs by Staffing Type Across All Responding Organizations**



To develop information on how these personnel are used in providing care management services, we asked the responding organizations to indicate which type of staff performed nine key care management functions that have been identified by the Center for Medicare and Medicaid Innovation (CMMI). The key care management functions as identified by CMMI are as follows:

- Individual Identification and Outreach
- Needs Assessment
- Develops, Modifies, Monitors Care/Support Plan
- Referrals to Specialty Care
- Planning and Managing Transitions of Care
- Medication Management
- Individual Education
- Connections to Community/Social Service Organizations
- Team-based Care

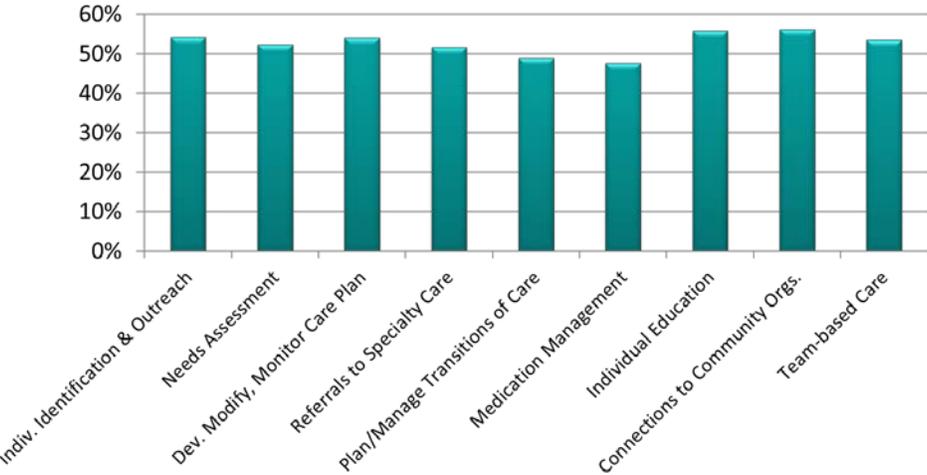
We first analyzed the data to assess what percentage of the responding organizations actually performed the CMMI-identified key care management functions and within which service. As Bar Chart 11 and Table 11 show, respondents incorporated the key care management functions least frequently within Episodic Pathways (28%) and Utilization Management (32%), which is not surprising in light of the structure of those functions. However, it is worth noting that Post-discharge Follow-up was provided by only 51% of the respondents and was most frequently provided within the context of Planning and Managing Transitions of Care (57%) and Medication Management (57%).

The data also show that the responding organizations indicated that, on average, approximately 50% were performing each of the nine key care management functions. The only two functions that were

below 50% were Medication Management, at 48% on average, and Planning and Managing Transitions of Care at 49%. These nine key functions were most frequently incorporated into High Risk Management (67%) and Disease Management (66%), and least frequently incorporated into Episodic Pathways (28%) and Utilization Management (32%).

These data suggest that there is significant opportunity to provide additional training around key care management functions as a way to improve effectiveness of services provided, particularly Medication Management and Managing Transitions of Care. Successful implementation of these two functions may help to reduce unnecessary readmissions. Benefits are also likely to occur from focused training on effective Post-discharge Follow-up to assure that all key case management functions are incorporated.

**Bar Chart 11: Percent of Responding Organizations Performing Key Care Management Functions**



**Table 11: Percent of Responding Organizations Performing CMMI Key Care Management Functions, by Type of Service**

| Answer Options  | High Risk Mgmt | Special Services Mgmt | Episodic Pathways | Disease Mgmt | Post-Discharge Follow-Up | Short-Term Case Mgmt Programs | Utilization Mgmt | Prevention / Wellness Engagement | Life Resource Mgmt | All CM Services |
|---|----------------|-----------------------|-------------------|--------------|--------------------------|-------------------------------|------------------|----------------------------------|--------------------|-----------------|
| <b>Average Percent using CMMI Best Practices</b>      | 67%            | 61%                   | 28%               | 66%          | 51%                      | 63%                           | 32%              | 54%                              | 51%                | <b>51%</b>      |
| Individual Identification and Outreach                | 69%            | 57%                   | 29%               | 71%          | 52%                      | 60%                           | 31%              | 62%                              | 57%                | <b>54%</b>      |
| Needs Assessment                                      | 67%            | 62%                   | 29%               | 64%          | 48%                      | 64%                           | 31%              | 55%                              | 52%                | <b>52%</b>      |
| Develops, Modifies, Monitors Care/Support Plan        | 67%            | 62%                   | 26%               | 69%          | 52%                      | 67%                           | 33%              | 55%                              | 55%                | <b>54%</b>      |
| Referrals to Specialty Care                           | 67%            | 62%                   | 31%               | 67%          | 48%                      | 64%                           | 31%              | 45%                              | 50%                | <b>52%</b>      |
| Planning and Managing Transitions of Care             | 64%            | 60%                   | 29%               | 60%          | 57%                      | 60%                           | 31%              | 40%                              | 40%                | <b>49%</b>      |
| Medication Management                                 | 69%            | 57%                   | 26%               | 64%          | 57%                      | 55%                           | 31%              | 38%                              | 31%                | <b>48%</b>      |
| Individual Education                                  | 62%            | 64%                   | 21%               | 69%          | 48%                      | 74%                           | 33%              | 74%                              | 57%                | <b>56%</b>      |
| Connections to Community/Social Service Organizations | 67%            | 62%                   | 29%               | 67%          | 50%                      | 67%                           | 31%              | 64%                              | 69%                | <b>56%</b>      |
| Team-based Care                                       | 71%            | 67%                   | 29%               | 67%          | 45%                      | 62%                           | 33%              | 57%                              | 50%                | <b>53%</b>      |
| <b>Count of Organizations Reporting</b>               | <b>42</b>      |                       |                   |              |                          |                               |                  |                                  |                    |                 |

We next analyzed the data to assess the types and numbers of staff used for specific care management activities defined by CMMI as best practices. RNs (62%), Case Managers/Service Coordinators (62%) and Social Workers (60%) most frequently performed the functions entitled “Develop/Modify/Monitor Care or Support Plans”. Case Managers/Service Coordinators performed the function entitled “Plan and Manage Transitions of Care” slightly more frequently (60%) than RNs (57%) and Social Workers (55%). Social Workers (69%) most frequently performed “Connections to Community and Social Service Organizations,” followed by Case Managers/Service Coordinators (67%) and Social Workers (55%). Table 12 presents the responding organizations’ results.

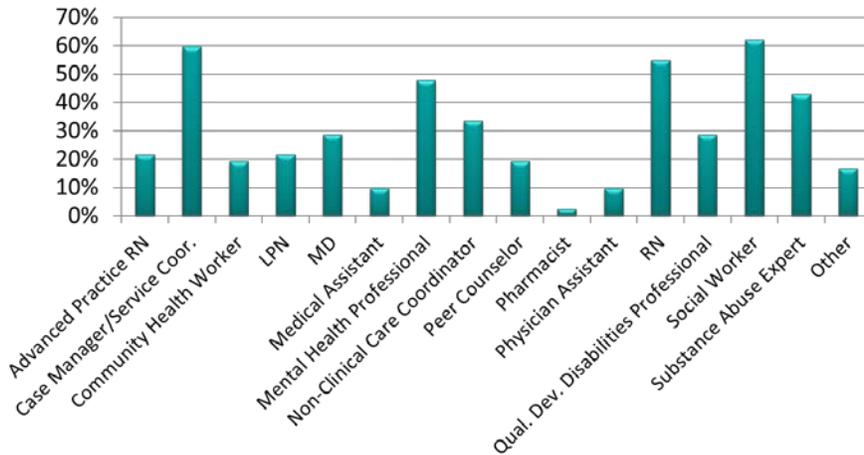
**Table 12: Percentage of Responding Organizations' Use of Staff Types to Perform CMMI Key Care Management Functions**

| Type of Staff Used, by CMMI Key Care Management Function | Individual Identification and Outreach | Needs Assessment | Develops, Modifies, Monitors Care / Support Plan | Referrals to Specialty Care | Planning & Managing Transitions of Care | Medication Management | Individual Education | Connections to Community / Social Service Organizations | Team-Based Care | Average |
|--|--|------------------|--|-----------------------------|---|-----------------------|----------------------|---|-----------------|---------|
| Advanced Practice RN                                     | 21%                                    | 31%              | 31%  | 33%                         | 26%                                     | 33%                   | 31%                  | 21%   | 33%             | 29%     |
| Case Manager/Service Coordinator                         | 60%                                    | 60%              | 62%  | 55%                         | 60%                                     | 33%                   | 62%                  | 67%   | 52%             | 57%     |
| Community Health Worker                                  | 19%                                    | 17%              | 14%  | 7%                          | 12%                                     | 7%                    | 24%                  | 21%   | 19%             | 16%     |
| LPN  | 21%                                    | 12%              | 21%  | 14%                         | 7%                                      | 29%                   | 31%                  | 26%   | 33%             | 22%     |
| MD   | 29%                                    | 33%              | 36%  | 40%                         | 40%                                     | 48%                   | 40%                  | 29%   | 40%             | 37%     |
| Medical Assistant  | 10%                                    | 5%               | 7%   | 7%                          | 5%                                      | 7%                    | 19%                  | 14%   | 17%             | 10%     |
| Mental Health Professional                               | 48%                                    | 57%              | 50%  | 50%                         | 40%                                     | 24%                   | 48%                  | 55%   | 48%             | 47%     |
| Non-Clinical Care Coordinator                            | 33%                                    | 26%              | 24%  | 14%                         | 14%                                     | 5%                    | 19%                  | 33%   | 33%             | 22%     |
| Peer Counselor   | 19%                                    | 7%               | 10%  | 5%                          | 10%                                     | 2%                    | 19%                  | 19%   | 17%             | 12%     |
| Pharmacist   | 2%                                     | 0%               | 0%   | 0%                          | 0%                                      | 10%                   | 5%                   | 0%  | 5%              | 2%      |
| Physician Assistant                                      | 10%                                    | 14%              | 12%  | 17%                         | 17%                                     | 14%                   | 12%                  | 12%   | 14%             | 13%     |
| RN   | 55%                                    | 64%              | 62%  | 55%                         | 57%                                     | 57%                   | 69%                  | 60%   | 57%             | 60%     |
| Qualified Dev. Disabilities Prof.                        | 29%                                    | 31%              | 31%  | 26%                         | 26%                                     | 17%                   | 29%                  | 31%   | 31%             | 28%     |
| Social Worker  | 62%                                    | 67%              | 60%  | 55%                         | 55%                                     | 19%                   | 57%                  | 69%   | 55%             | 55%     |
| Substance Abuse Expert                                   | 43%                                    | 45%              | 40%  | 38%                         | 43%                                     | 19%                   | 43%                  | 48%   | 38%             | 40%     |
| Other  | 17%                                    | 14%              | 17%  | 12%                         | 5%                                      | 7%                    | 21%                  | 19%   | 21%             | 15%     |
| <b>Count of Organizations Reporting</b>                  |  | <b>42</b>        |  |                             |   |                       |                      |   |                 |         |

Bar Charts 12 through 19 present the staffing patterns reported for each of the CMMI Key Care Management Functions.

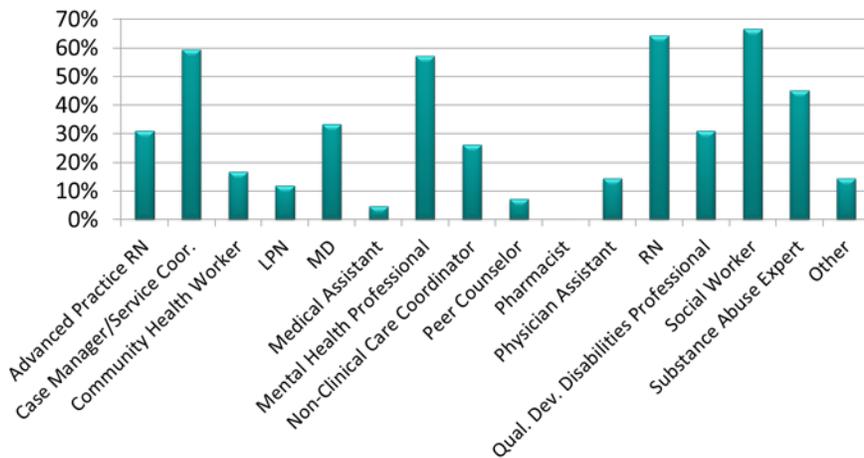
The four top staffing types most frequently doing Individual Identification and Outreach were the Case Manager/Service Coordinator, Social Worker, RN and Mental Health Professional. Least likely to provide this function was the Pharmacist.

**Bar Chart 12: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Individual Identification and Outreach**



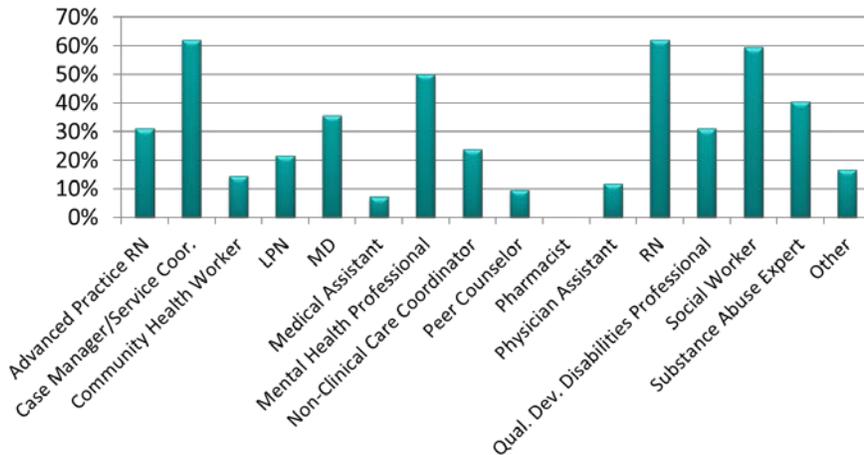
The top four staffing types providing Needs Assessments were the Social Worker, RN, Case Manager/Service Coordinator and Mental Health Professional. Least likely to provide this function was the Medical Assistant. Pharmacists did not perform this service at all.

**Bar Chart 13: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Needs Assessment**



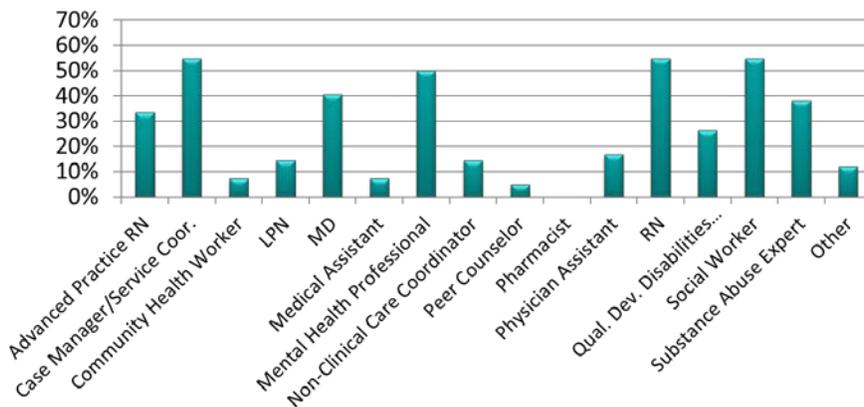
The four top staffing types most likely to Develop, Modify, Monitor Care/Support Plans were the RN, Case Manager/Service Coordinator, Social Worker and Mental Health Professional. Least likely to provide this function was the Medical Assistant. Pharmacists did not perform this service at all.

**Bar Chart 14: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Develops, Modifies, Monitors Care / Support Plan**



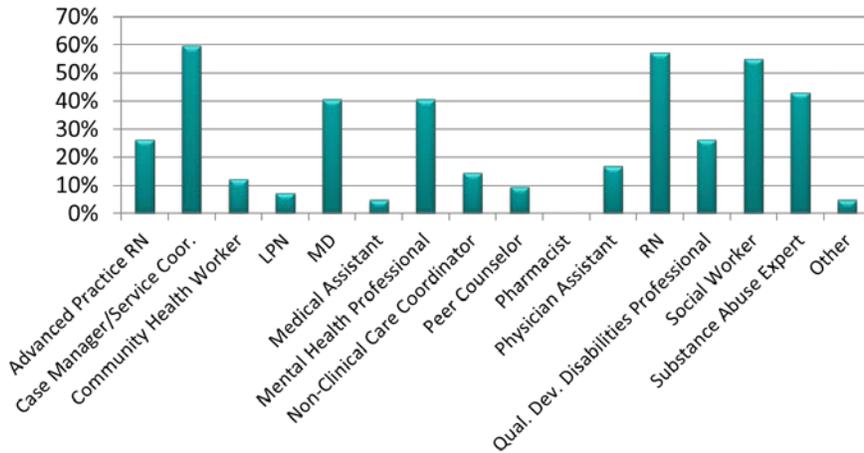
The four top staffing types most frequently making Referrals to Specialty Care were the RN, Social Worker, Case Manager/Service Coordinator and Mental Health Professional. Peer Counselors were least likely to make these referrals. Pharmacists did not perform this function at all.

**Bar Chart 15: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Referrals to Specialty Care**



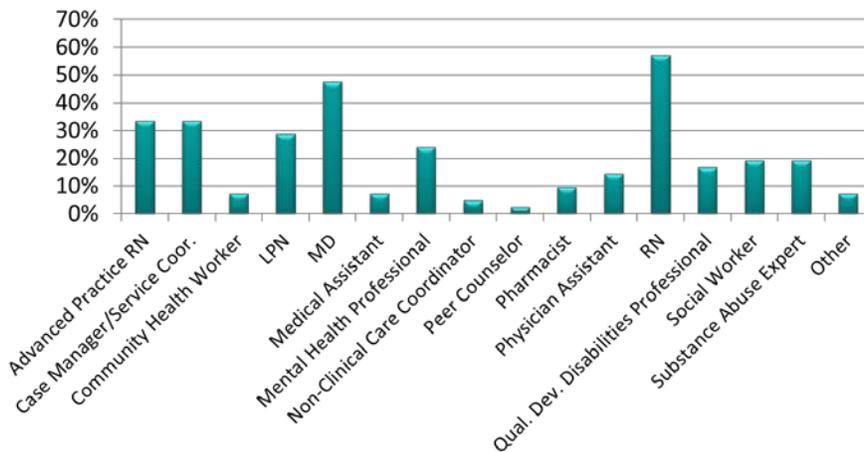
The four staffing types most frequently Planning and Managing Transitions of Care were the Case Manager/Service Coordinator, RN, Social Worker and Substance Abuse Expert. Least likely to provide this function was the Medical Assistant. Pharmacists did not perform this function at all.

**Bar Chart 16: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Planning and Managing Transitions of Care**



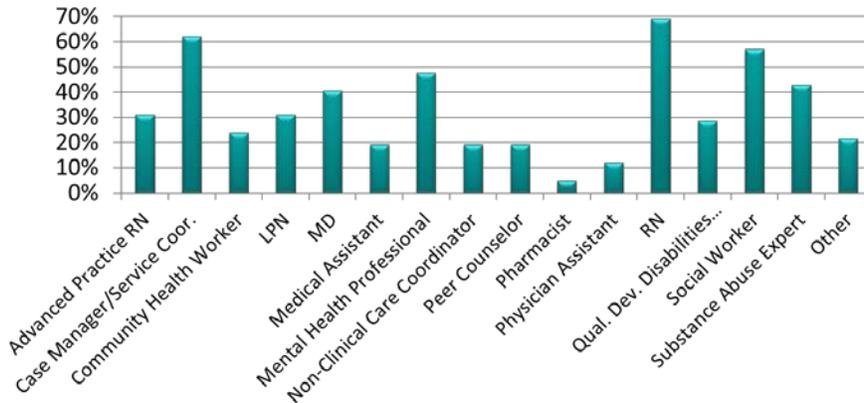
The top two staffing types performing Medication Management were the RN and MD. Pharmacists performed this function about 10% of the time. Peer Counselors were least likely to perform this function.

**Bar Chart 17: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Medication Management**



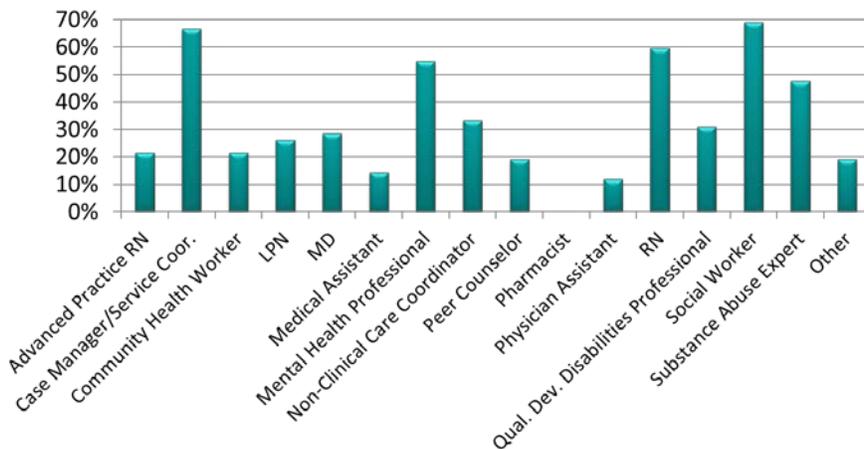
The top four staffing types providing Individual Education were the RN, Case Manager/Service Coordinator, Social Worker and Mental Health Professional. Least likely to provide this service was the Pharmacist.

**Bar Chart 18: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Individual Education**



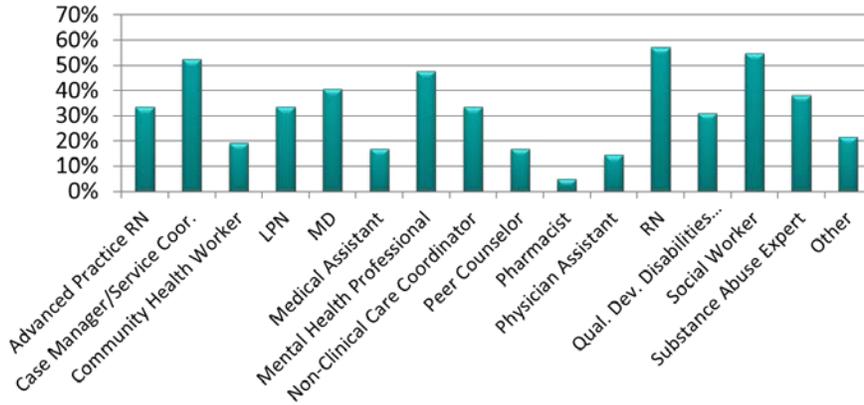
The top four staffing types performing Connections to Community/Social Service Organizations were Social Workers, Case Managers/Service Coordinators, RNs, and Mental Health Professionals. Least likely to provide this service was the Physician Assistant. Pharmacists did not provide this service at all.

**Bar Chart 19: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Connections to Community/Social Service Organizations**



The top four staffing types providing Team-Based Care were RNs, Social Workers, Case Managers/Service Coordinators and Mental Health Professionals. Pharmacists were least likely to provide Team-Based Care.

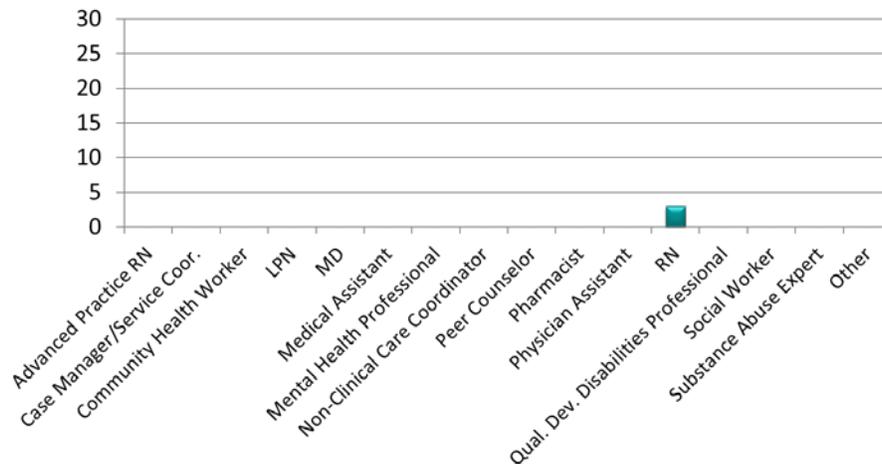
**Bar Chart 20: Responding Organizations' Staffing to Perform CMMI Key CM Functions: Team-Based Care**



The next several charts show staffing distributions, in number of FTEs, by type of responding organization.

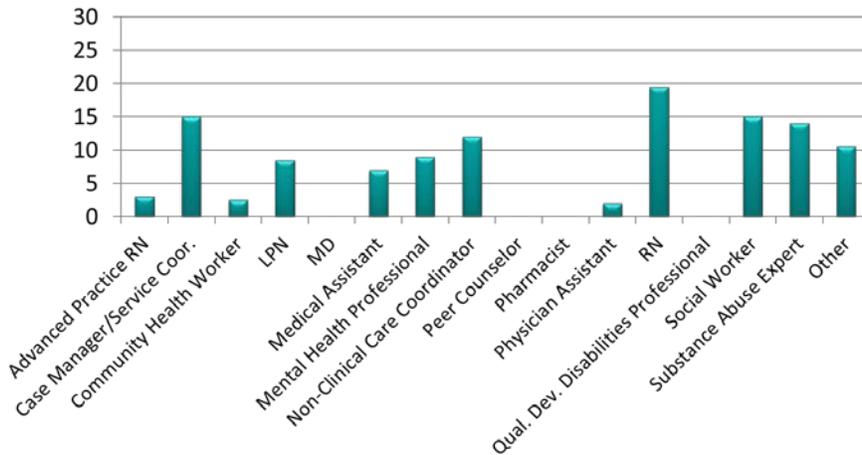
Bar Chart 21 indicates that ACOs used RNs for all care management functions.

**Bar Chart 21: ACOs: Total Number of FTEs Providing CM Services, by Staffing Type**



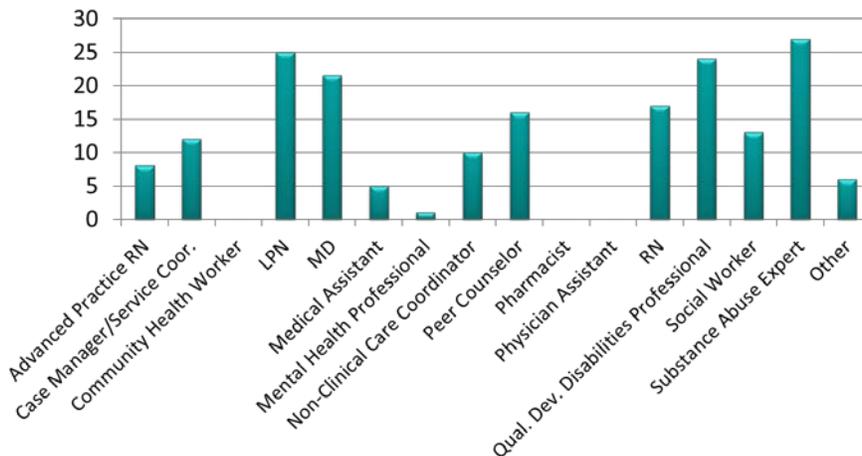
As presented in Bar Chart 22, Blueprint Community Health Teams used a range of staffing types to provide care management services, with the greatest number of FTEs being RNs, Case Managers, Social Workers and Substance Abuse Experts.

**Bar Chart 22: Blueprint Community Health Teams: Total Number of FTEs Providing CM Services, by Staffing Type**



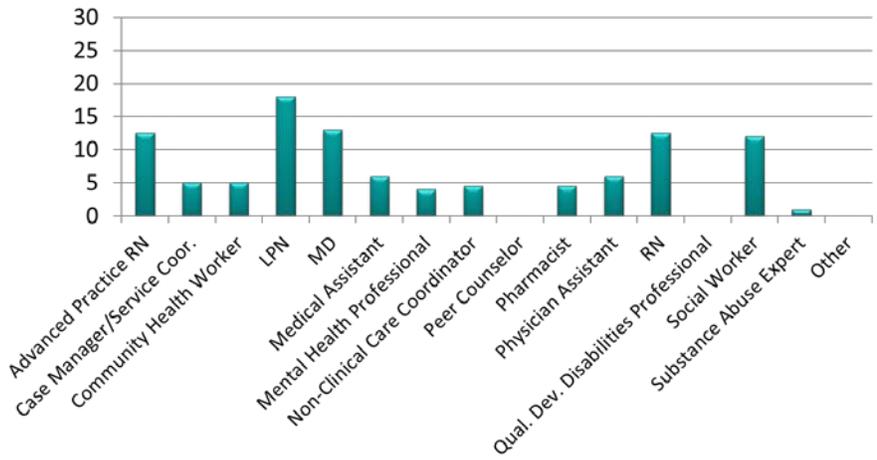
As indicated in Bar Chart 23, the staffing distribution for Community Service Providers is different from other respondents, with the greatest number of FTEs being substance abuse experts, LPNs, qualified developmental disabilities professionals, MDs and peer counselors. It is also worth noting that this organizational type was the only one that reported using qualified developmental disabilities professionals and is one of two organization types that reported using peer counselors. State Agencies also reported using peer counselors.

**Bar Chart 23: Community Service Providers: Total Number of FTEs Providing CM Services, by Staffing Type**



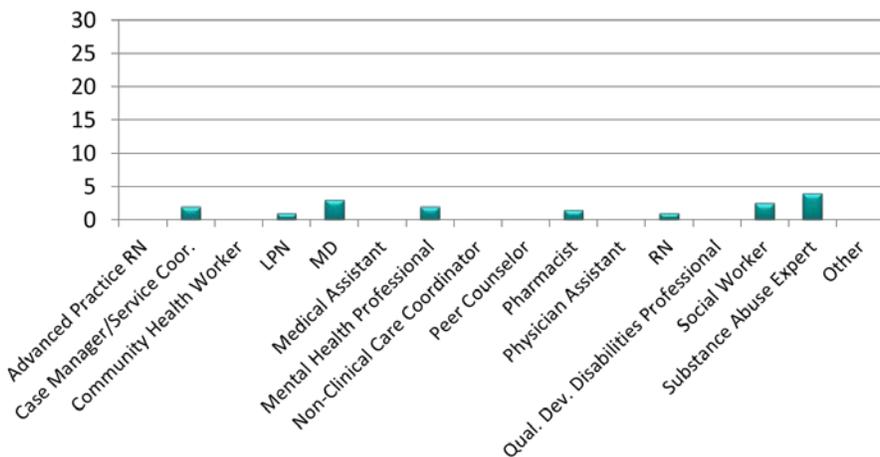
As indicated in Bar Chart 24, Health Care Providers also reported primarily using traditional health care staff to provide care management services (LPNs, MDs, Advanced Practice RNs, RNs and Social Workers).

**Bar Chart 24: Health Care Providers: Total Number of FTEs Providing CM Services, by Staffing Type**



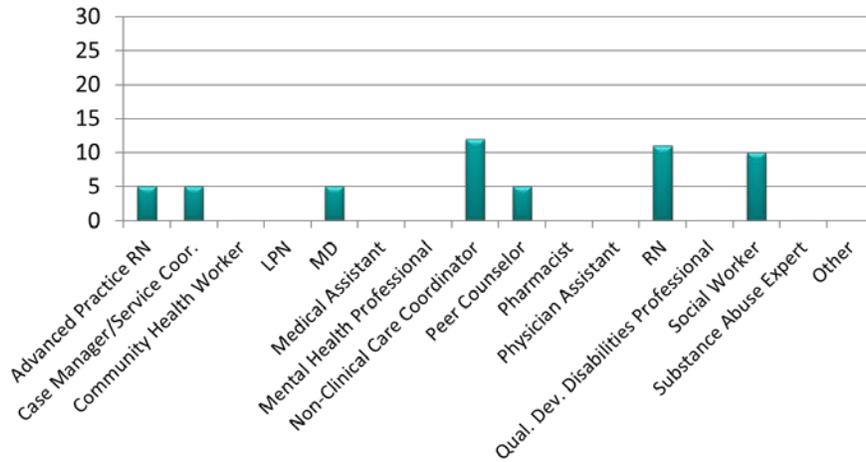
When reviewing the data reported by Health Plans, we see in Bar Chart 25 that fewer numbers of FTEs were providing care management services than in other organizations. Health Plans reported more MDs and Substance Abuse Experts than other types of care management employees. Health Plans were also one of two organizational types using Pharmacists (Health Care Providers were the other).

**Bar Chart 25: Health Plans: Total Number of FTEs Providing Care Management Services, by Staffing Type**



As indicated in Bar Chart 26, State Agencies generally hired Non-Clinical Care Coordinators, RNs and Social Workers to provide care management services. It is also notable that State Agencies were the second type of organization to use Peer Counselors (Community Service Providers were the other).

**Bar Chart 26: State Agencies: Total Number of FTEs Providing CM Services, by Staffing Type**



## V. Types of Relationships Among Care Management Organizations

This section reviews the types of relationships care management organizations reported having with other organizations. Respondents were asked to indicate which of the following four types of interactions they had with other care management organizations: 1) sharing information; 2) sharing resources; 3) making referrals, and 4) receiving referrals.

Table 13 shows the frequency of interaction by type of interaction for all respondents. The key finding is that respondents indicated that Sharing Information and Receiving Referrals were the two most frequent types of interactions. Information was shared most frequently with Blueprint Community Health Teams, Community Service Providers, Health Care Providers and State Agencies. Referrals were received most frequently from Blueprint Community Health Teams, Community Service Providers and Health Care Providers.

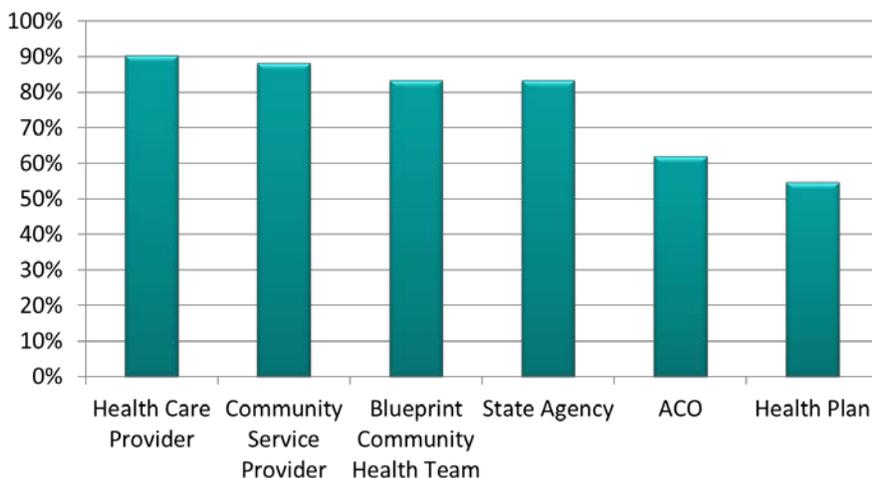
**Table 13: Percent of all responding organizations indicating that they:**

| Organization Type                       | share information with this organization | share resources with this organization | make referrals to this organization | receive referrals from this organization |
|---|--|--|-------------------------------------|--|
| ACO                                     | 62%                                      | 19%                                    | 17%                                 | 29%                                      |
| Blueprint Community Health Team         | 83%                                      | 64%                                    | 74%                                 | 71%                                      |
| Community Service Provider              | 88%                                      | 62%                                    | 81%                                 | 88%                                      |
| Health Care Provider                    | 90%                                      | 60%                                    | 86%                                 | 88%                                      |
| Health Plan                             | 55%                                      | 21%                                    | 24%                                 | 36%                                      |
| State Agency                            | 83%                                      | 40%                                    | 62%                                 | 67%                                      |
| <b>Count of Organizations Reporting</b> | <b>42</b>                                |  |                                     |  |

The next four Bar Charts (27-30) further illustrate the information in Table 13.

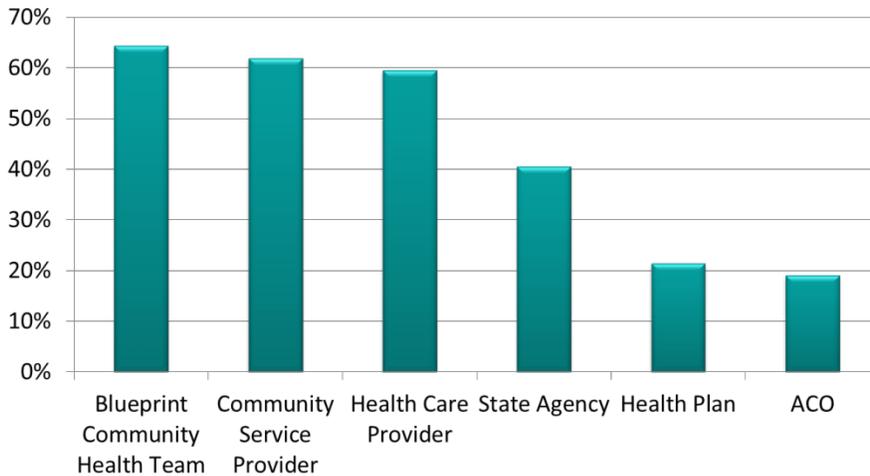
Bar Chart 27 indicates that 55% to 62% of organizations reported sharing information with ACOs and Health Plans, which was noticeably lower than the percentages of responding organizations that reported sharing information with the four other types of organizations, which are at 80% or above.

**Bar Chart 27: Percentage at which responding organizations answered, “We share information with this organization,” by Organization Type**



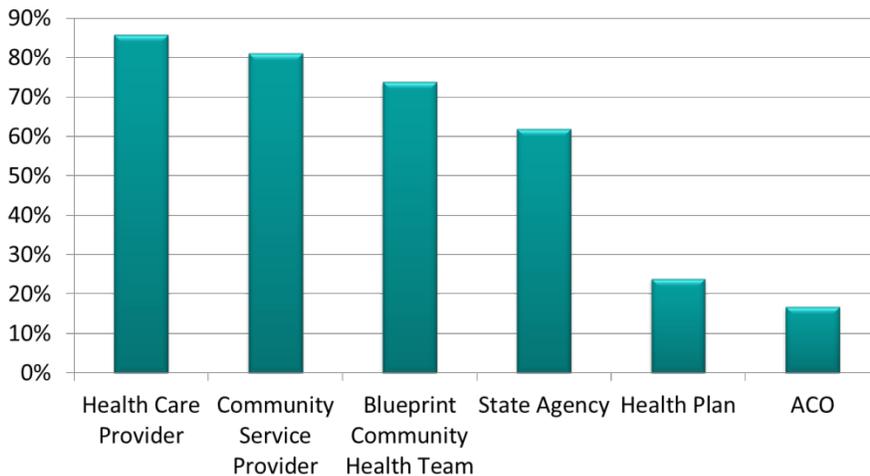
Bar Chart 28 indicates that 60% or more of responding organizations reported sharing resources with Blueprint Community Health Teams, Community Service Providers and Health Care Providers. Less than 20% of responding organizations reported sharing resources with Health Plans and ACOs.

**Bar Chart 28: Percentage at which responding organizations answered, “We share resources with this organization,” by Organization Type**



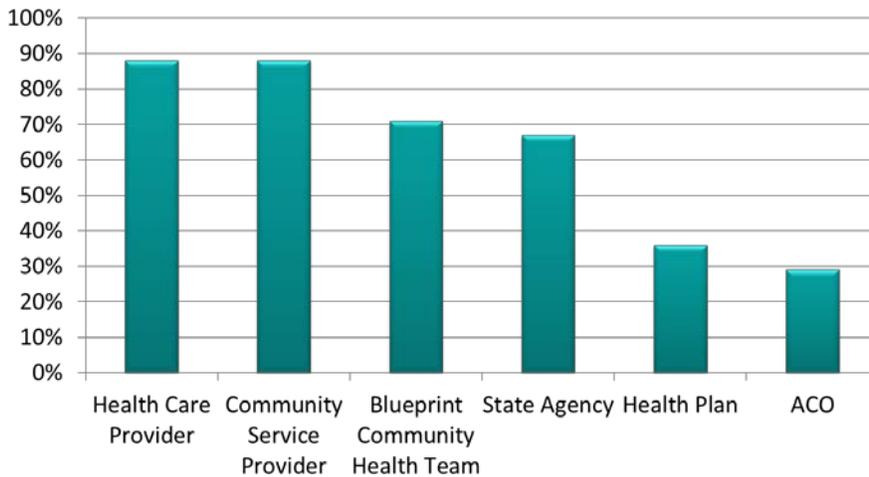
Bar Chart 29 indicates that there was a high rate of making referrals to three types of organizations, with 74% to 86% referring to Health Care Providers, Community Service Providers and Blueprint Community Health Teams. Fewer than 20% of responding organizations reported making referrals to Health Plans and ACOs.

**Bar Chart 29: Percentage at which responding organizations answered, “We make referrals to this organization,” by Organization Type**



Bar Chart 30 indicates that there was the same distribution for receiving referrals as for making referrals.

**Bar Chart 30: Percentage at which responding organizations answered, “We receive referrals from this organization,” by Organization Type**



In an effort to describe the extent of functional care management team activity between non-integrated organizations, respondents were asked to describe the nature of their relationships with other organizations. To identify the nature of relationships, responding organizations were asked about four types of relationships: Legal, Financial, Regular, Structured, and Ad Hoc.

Table 14 indicates which type of relationship for which organizational type was established at a rate significantly higher (H) or lower (L) than the average. If the percentage of responding organization types established a particular type of relationship at a rate that was above the standard deviation, it was noted by the use of “H” in the cell. Alternatively, if the percentage of responding organization types’ rate was below the standard deviation, it was noted by the use of “L” in the cell. Table 15 includes the percentages and standard deviations used to assign the Hs and Ls.

Key findings are that the following organization types had more types of relationships at higher rates than the average:

**Blueprint Community Health Teams**

- Legal Relationships
- Financial Relationships
- Regular, Structured Interactions

**Health Care Provider Offices**

- Legal Relationships
- Regular, Structured Interactions
- Ad Hoc Interactions Using Established Communication Mechanisms

## Hospitals

- Legal Relationships
- Financial Relationships
- Regular, Structured Interactions
- Ad Hoc Interactions Using Established Communication Mechanisms

It is also notable that the following two organizations had certain types of relationships at lower rates than the average:

## Adult Day Providers and Faith Based Organizations

- Legal Relationships
- Financial Relationships
- Regular, Structured Interactions

Transportation, Schools, and Housing Organizations had predominately Ad Hoc Interactions with the responding organizations.

ACOs had primarily Legal Relationships and Health Insurers had primarily Financial Relationships with the responding organizations.

## Relatively High (H) and Low (L) Percentages of Relationships by Type of Relationship, as Indicated by Responding Organizations

| Table 14: Nature of Relationships with Specific Organizations, as Reported by Responding Organizations | Legal Relationship (e.g., contract, MOU) | Financial Relationship (funding supports team interaction) | Regular, Structured Interaction (e.g., scheduled meetings) | Ad Hoc Interaction Using Established Communication Mechanisms |
|--|--|--|--|---|
| <b>Average Rate for All Respondents</b>  | <b>24%</b>                               | <b>19%</b>   | <b>43%</b>   | <b>54%</b>  |
| ACOs   | H  |  |  | L   |
| Adult Day Providers  | L  | L  | L  |   |
| Blueprint Community Health Teams   | H  | H  | H  |   |
| Children with Special Health Needs Providers   | L  |  |  |   |
| Community Action Agencies  | L  | L  |  |   |
| EPSDT Providers  |  |  | L  | L   |
| Faith-Based Organizations  | L  | L  | L  |   |
| Fitness Providers  |  |  | L  | L   |
| Health Care Provider Offices   | H  |  | H  | H   |
| Health Insurers  |  | H  |  |   |
| Home Health Agencies/VNAs  |  |  | H  | H   |
| Hospitals  | H  | H  | H  | H   |
| Housing Organizations  |  |  |  | H   |
| Medicaid VCCI  |  | L  |  |   |
| Mental Health Providers (Designated Agencies)  | H  | H  | H  |   |
| Public Health District Offices   | L  |  |  |   |
| Schools  |  |  |  | H   |
| Transportation Providers   |  |  |  | H   |

Table 15 includes the actual percentages reported by all responding organizations. The rates that are significantly below the average are in blue font and those significantly above the average appear in bold font.

| Table 15: Nature of Interactions Between Organizations (Functional Care Mgmt Teams) | Legal Relationship (e.g., contract, MOU) | Financial Relationship (funding supports team interaction) | Regular, Structured Interaction (e.g., scheduled meetings) | Ad Hoc Interaction Using Established Communication Mechanisms | Average |
|---|--|--|--|---|---------|
| <b>Average</b>  | <b>24%</b>                               | <b>19%</b>   | <b>43%</b>   | <b>54%</b>  | --      |
| <b>Standard Deviation</b>   | <b>15%</b>                               | <b>10%</b>   | <b>15%</b>   | <b>7%</b>   | --      |
| ACOs  | <b>52%</b>                               | 26%  | 45%  | <b>33%</b>  | 39%     |
| Adult Day Providers   | <b>7%</b>                                | <b>7%</b>  | <b>21%</b>   | 55%   | 23%     |
| Area Agencies on Aging  | 21%                                      | 14%  | 50%  | 52%   | 35%     |
| Blueprint Community Health Teams  | <b>40%</b>                               | <b>38%</b>   | <b>62%</b>   | 50%   | 48%     |
| Children with Special Health Needs Providers  | <b>7%</b>                                | 10%  | 36%  | 52%   | 26%     |
| Community Action Agencies   | <b>2%</b>                                | <b>5%</b>  | 43%  | 55%   | 26%     |
| Department of Corrections   | 12%                                      | 12%  | 29%  | 52%   | 26%     |
| Developmental Service Providers (Designated Agencies)                               | 29%                                      | 19%  | 50%  | 52%   | 38%     |
| Developmental Service Providers (Other)   | 24%                                      | 21%  | 38%  | 50%   | 33%     |
| EPSDT Providers   | 17%                                      | 17%  | <b>21%</b>   | <b>43%</b>  | 24%     |
| Faith-Based Organizations   | <b>0%</b>                                | <b>0%</b>  | <b>10%</b>   | 48%   | 14%     |
| Fitness Providers   | 10%                                      | 17%  | <b>24%</b>   | <b>45%</b>  | 24%     |
| Health Care Provider Offices  | <b>50%</b>                               | 29%  | <b>67%</b>   | <b>64%</b>  | 52%     |
| Health Insurers   | 36%                                      | <b>38%</b>   | 29%  | 50%   | 38%     |
| Home Health Agencies/VNAs   | 21%                                      | 17%  | <b>60%</b>   | <b>67%</b>  | 41%     |
| Hospitals   | <b>52%</b>                               | <b>31%</b>   | <b>62%</b>   | <b>64%</b>  | 52%     |
| Housing Organizations   | 21%                                      | 14%  | 55%  | <b>62%</b>  | 38%     |
| Integrated Family Services  | 17%                                      | 17%  | 48%  | 57%   | 35%     |
| Medicaid VCCI   | 10%                                      | <b>5%</b>  | 48%  | 50%   | 28%     |
| Mental Health Providers (Designated Agencies)                                       | <b>45%</b>                               | <b>40%</b>   | <b>62%</b>   | 57%   | 51%     |
| Mental Health Providers (Other)   | 26%                                      | 24%  | 43%  | 57%   | 38%     |
| Public Health District Offices  | <b>7%</b>                                | 10%  | 36%  | 55%   | 27%     |
| SASH  | 38%                                      | 24%  | 57%  | 50%   | 42%     |
| Schools   | 21%                                      | 24%  | 43%  | <b>62%</b>  | 38%     |
| Substance Abuse Providers   | 26%                                      | 17%  | 48%  | 57%   | 37%     |
| Transportation Providers  | 21%                                      | 19%  | 33%  | <b>64%</b>  | 35%     |
| Vocational Rehabilitation Providers   | 24%                                      | 24%  | 36%  | 52%   | 34%     |
| <b>Count of Organizations Reporting</b>   | <b>42</b>                                |  |  |   |         |

## VI. Program Accreditation

Responding organizations were asked to indicate if their care management program was accredited by an external organization; 55% reported being accredited. Of those reporting having accredited programs, half indicated their program was accredited by NCQA.

**Pie Graph 1: Percent of Accredited CM Programs by Accrediting Organization**

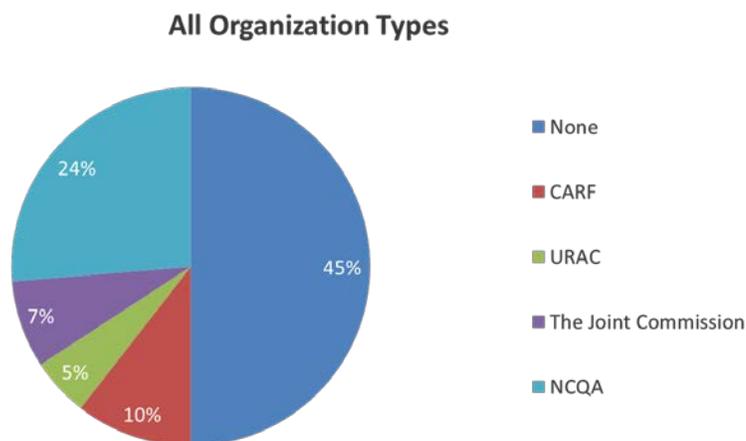


Table 16 indicates the percentage of accredited care management program by accreditation organization by type of organization. No responding ACO had an accredited care management program and less than half of the Community Service Providers had accredited programs. All Health Plans had accredited care management programs. The percentage total exceeds 100% because several Health Plans reported that their care management programs were accredited by more than one organization.

| Table 16: Percent of Accredited Care Management Programs by Accreditation Organization |      |                                 |             |              |                            |                      |                |
|--|------|---------------------------------|-------------|--------------|----------------------------|----------------------|----------------|
| Type of Organization   |      |                                 |             |              |                            |                      |                |
| Accreditation Organization   | ACO  | Blueprint Community Health Team | Health Plan | State Agency | Community Service Provider | Health Care Provider | All Org. Types |
| None   | 100% | 45%                             |             | 33%          | 57%                        | 33%                  | 45%            |
| CARF   |      |                                 |             | 33%          | 21%                        |                      | 10%            |
| URAC   |      |                                 | 67%         |              |                            |                      | 5%             |
| The Joint Commission   |      | 18%                             |             |              | 7%                         |                      | 7%             |
| NCQA   |      | 45%                             | 67%         |              |                            | 33%                  | 24%            |
| <b>Count of Organizations Reporting</b>  | 2    | 11                              | 3           | 3            | 14                         | 9                    | 42             |

## VII. Challenges Facing Care Management Programs

Responding organizations were asked to indicate the challenges they experienced when providing care management services. The respondents were asked to identify challenges from the list below. The top four challenges faced by all respondents across all types of services are highlighted in **bold**.

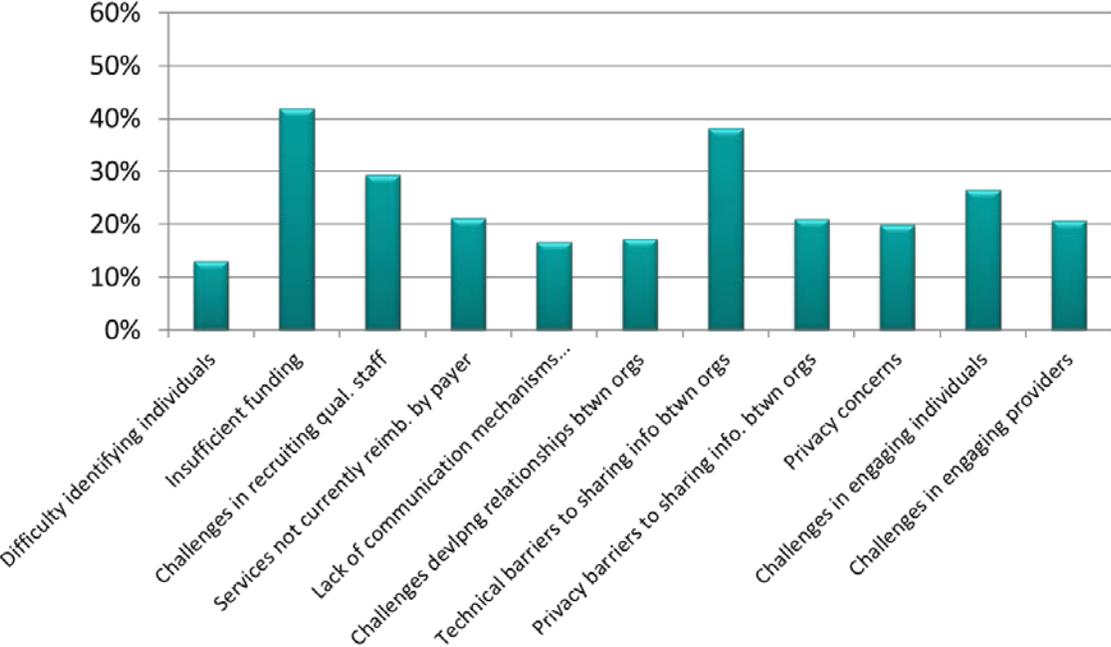
- Difficulty identifying individuals
- **Insufficient funding**
- **Challenges in recruiting qualified staff**
- Services not currently reimbursed by payers
- Lack of communication mechanisms with other organizations
- Challenges to developing relationships between organizations
- **Technical barriers to sharing information between organizations**
- Privacy barriers to sharing information between organizations
- Privacy concerns
- **Challenges in engaging individuals**
- Challenges in engaging providers

When reviewing Table 17 and Bar Chart 30 below for the top challenges, it is notable that 42% of respondents listed Insufficient Funding and 38% listed Technical Barriers to Sharing Information between Organizations as challenges. The next two top challenges, Challenges in Recruiting Qualified Staff (29%) and Challenges in Engaging Individuals (26%) came in a distant third and fourth. The least frequently identified challenge is Difficulty in Identifying Individuals (13%).

Table 17: Percentage of Responding Organizations Reporting Challenges, by Type of Challenge and Type of Care Management Service

| Challenges   | High Risk Mgmt | Special Services Mgmt | Episodic Pathways | Disease Mgmt | Post-Discharge Follow-Up | Short-Term Case Mgmt Programs | Util. Mgmt | Prevention / Wellness Engagement | Life Resource Mgmt | Average for all Categories of Care Mgmt |
|--|----------------|-----------------------|-------------------|--------------|--------------------------|-------------------------------|------------|----------------------------------|--------------------|---|
| Difficulty identifying individuals                                     | 14%            | 14%                   | 7%                | 12%          | 7%                       | 17%                           | 12%        | 14%                              | 19%                | 13%                                     |
| <b>Insufficient funding</b>  | <b>45%</b>     | <b>55%</b>            | <b>29%</b>        | <b>45%</b>   | <b>26%</b>               | <b>45%</b>                    | <b>33%</b> | <b>48%</b>                       | <b>50%</b>         | <b>42%</b>                              |
| <b>Challenges in recruiting qualified staff</b>                        | <b>43%</b>     | <b>48%</b>            | <b>19%</b>        | <b>24%</b>   | <b>17%</b>               | <b>31%</b>                    | <b>24%</b> | <b>29%</b>                       | <b>31%</b>         | <b>29%</b>                              |
| Services not currently reimbursed by payer                             | 21%            | 31%                   | 5%                | 21%          | 12%                      | 26%                           | 17%        | 29%                              | 29%                | 21%                                     |
| Lack of communication mechanisms with other organizations              | 21%            | 19%                   | 10%               | 19%          | 17%                      | 17%                           | 10%        | 19%                              | 19%                | 17%                                     |
| Challenges to developing relationships between organizations           | 26%            | 21%                   | 10%               | 17%          | 14%                      | 21%                           | 14%        | 14%                              | 17%                | 17%                                     |
| <b>Technical barriers to sharing information between organizations</b> | <b>50%</b>     | <b>45%</b>            | <b>24%</b>        | <b>48%</b>   | <b>33%</b>               | <b>40%</b>                    | <b>29%</b> | <b>38%</b>                       | <b>36%</b>         | <b>38%</b>                              |
| Privacy barriers to sharing information between organizations          | 26%            | 33%                   | 10%               | 24%          | 17%                      | 21%                           | 12%        | 17%                              | 29%                | 21%                                     |
| Privacy concerns   | 24%            | 26%                   | 10%               | 21%          | 19%                      | 21%                           | 17%        | 19%                              | 21%                | 20%                                     |
| <b>Challenges in engaging individuals</b>                              | <b>40%</b>     | <b>31%</b>            | <b>10%</b>        | <b>31%</b>   | <b>17%</b>               | <b>33%</b>                    | <b>12%</b> | <b>31%</b>                       | <b>33%</b>         | <b>26%</b>                              |
| Challenges in engaging providers                                       | 33%            | 31%                   | 12%               | 21%          | 14%                      | 26%                           | 12%        | 17%                              | 19%                | 21%                                     |

**Bar Chart 30: Frequency of Challenges Experienced by Responding Organizations, by Type of Challenge**



The data presented in Table 18 show the challenges reported by responding organizations with respect to type of care management service. Insufficient Funding and Technical Barriers to Sharing Information between Organizations were identified as challenges across all types of care management services. Challenges in Recruiting Qualified Staff was reported as a challenge for all types of care management services except for Post-Discharge Follow-up.

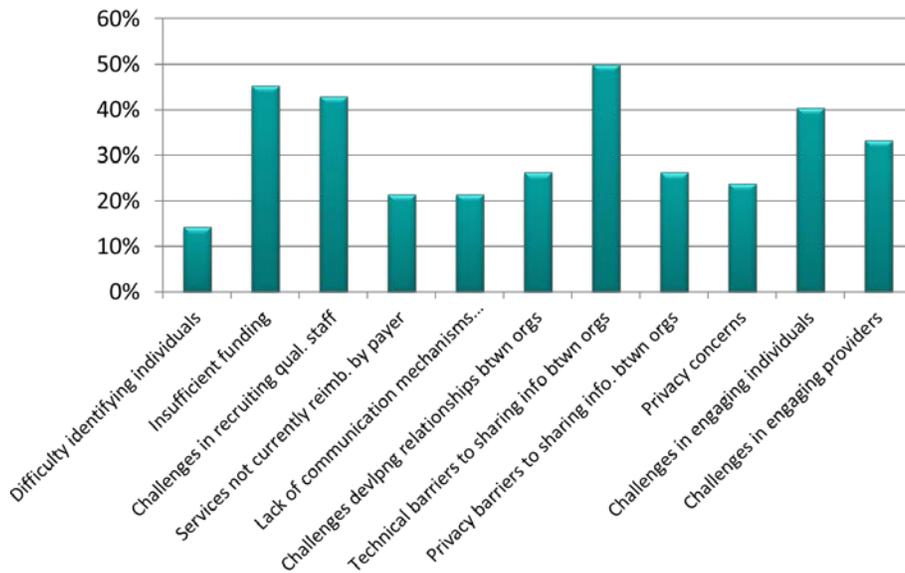
**Table 18: Responding Organizations' Challenges by Type of Care Management Service**

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

The remaining Bar Charts (31-39) illustrate, for each type of care management service, the distribution of challenges that were reported.

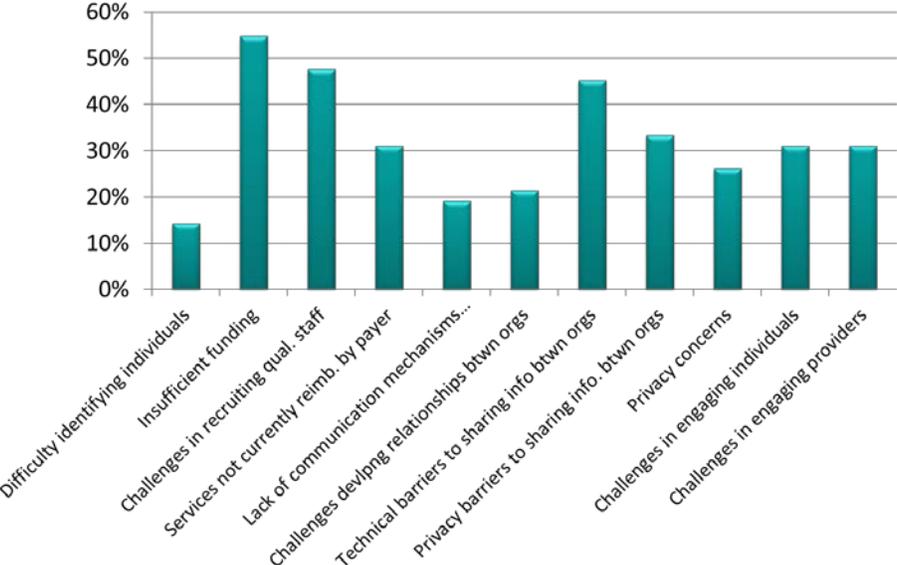
For High Risk Management, the top four challenges were the same as shown in aggregate for all organizations in Bar Chart 30; however, the frequencies of Challenges Recruiting Qualified Staff and Challenges Developing Relationships Between Organizations were approximately 10 percentage points higher than the average.

**Bar Chart 31: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: High Risk Management**



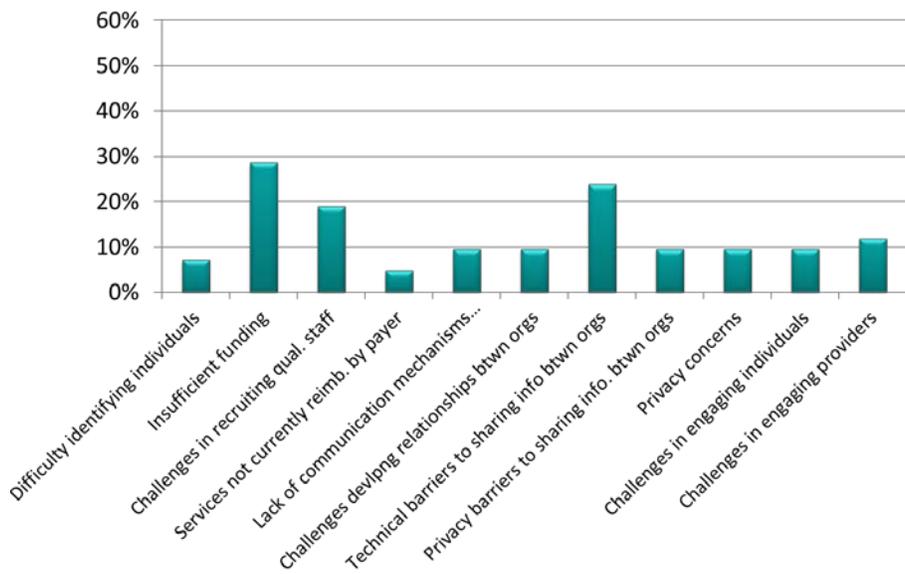
For Special Services Management, Insufficient Funding was the most frequent challenge and was 10 percentage points higher than the average. Challenges Recruiting Qualified Staff was also a frequent challenge and was 10 percentage points higher than the average across all service types. Privacy Barriers to Sharing Information was one of the top four challenges (this is the only care management service type for which this was the case).

**Bar Chart 32: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Special Services Management.**



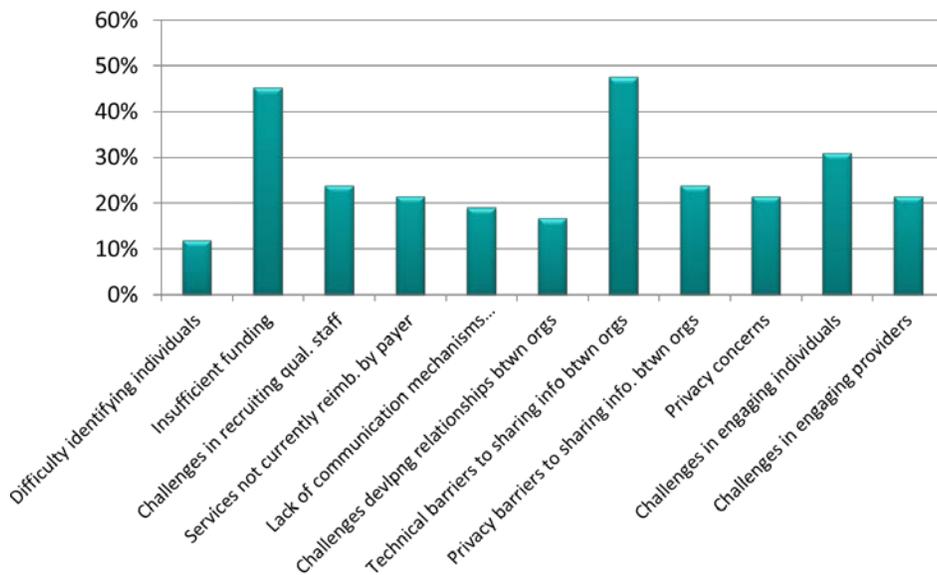
For Episodic Pathways there were lower percentages of challenges reported overall, but Insufficient Funding and Technical Barriers to Sharing Information between Organizations remained the most frequently-reported challenges. Challenges Engaging Providers was included within the top four challenges (this is the only care management service type for which this was the case).

**Bar Chart 33: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Episodic Pathways**



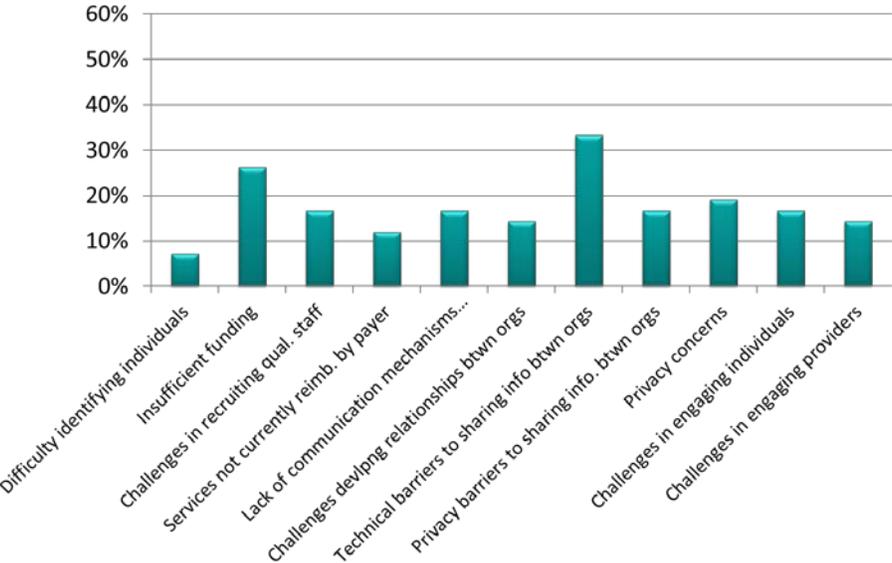
For Disease Management the overall frequency was very similar to the average, with Insufficient Funding and Technical Barriers to Sharing Information between Organizations being the most frequent challenges. Challenges in Recruiting Qualified Staff was five percentage points lower than the average across all service types.

**Bar Chart 34: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Disease Management**



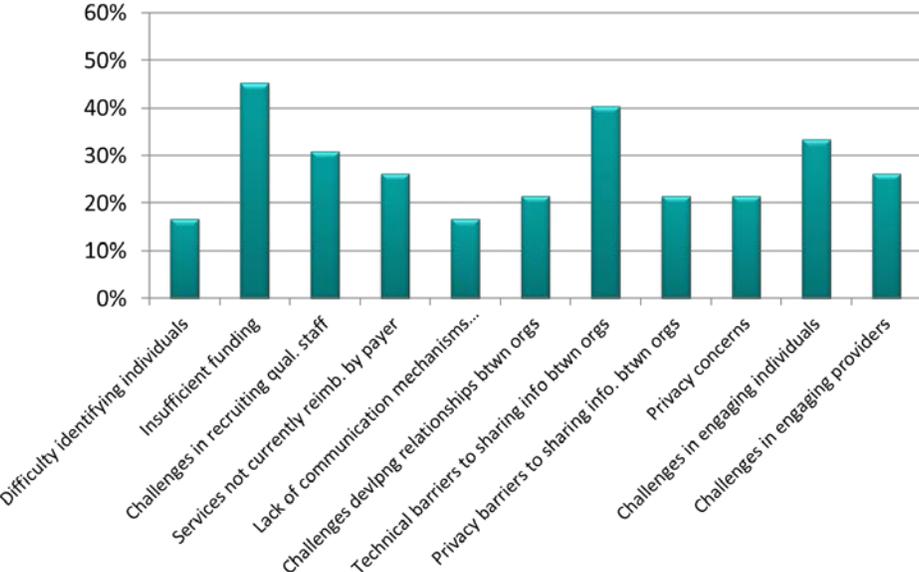
For Post-Discharge Follow-up, Privacy Concerns was among the top four challenges, along with Insufficient Funding and Technical Barriers to Sharing Information Between Organizations. There are four challenges that were tied for fourth place: Lack of Communication Mechanisms, Privacy Barriers to Sharing Information Between Organizations, Challenges in Recruiting Qualified Staff and Challenges in Engaging Individuals. Two challenges (Insufficient Funding and Challenges in Recruiting Qualified Staff) were among the top four challenges, but were 15 percentage points below the average across all service types.

**Bar Chart 35: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Post-Discharge Follow-Up**



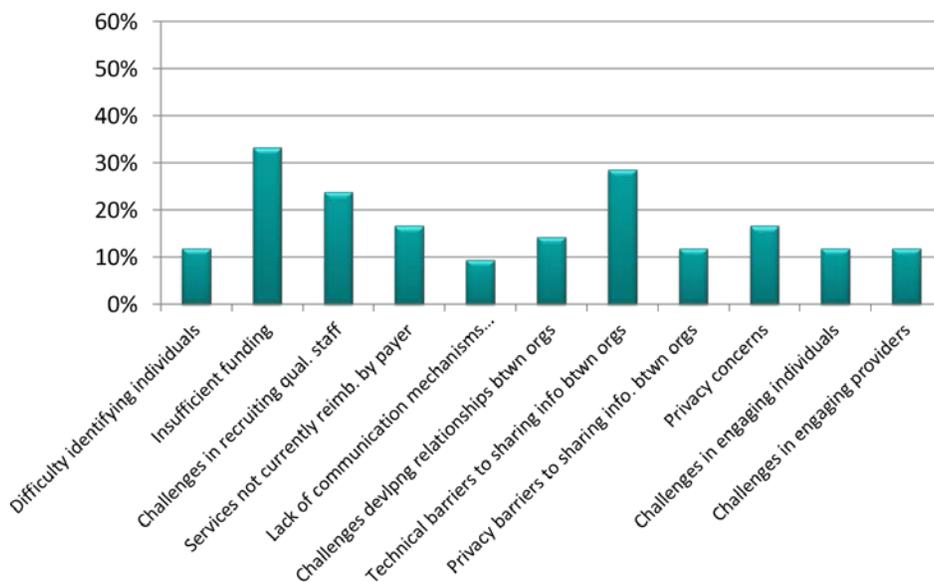
For Short-term Case Management the overall frequency was very similar to the average, including the same top four challenges.

**Bar Chart 36: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Short-Term Case Mgmt. Programs**



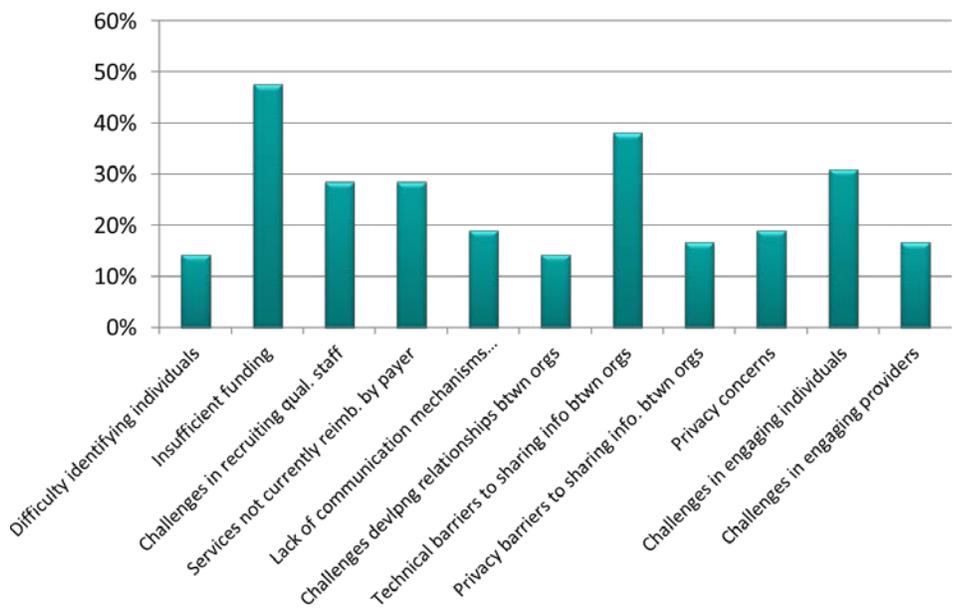
For Utilization Management, the most frequently-cited challenges were Insufficient Funding and Technical Barriers to Sharing Information Between Organizations. The third most frequent challenge was Challenges in Recruiting Qualified Staff. Services Not Currently Reimbursed and Privacy Concern were tied at 17% for fourth place in the list of most frequent challenges.

**Bar Chart 37: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Utilization Management**



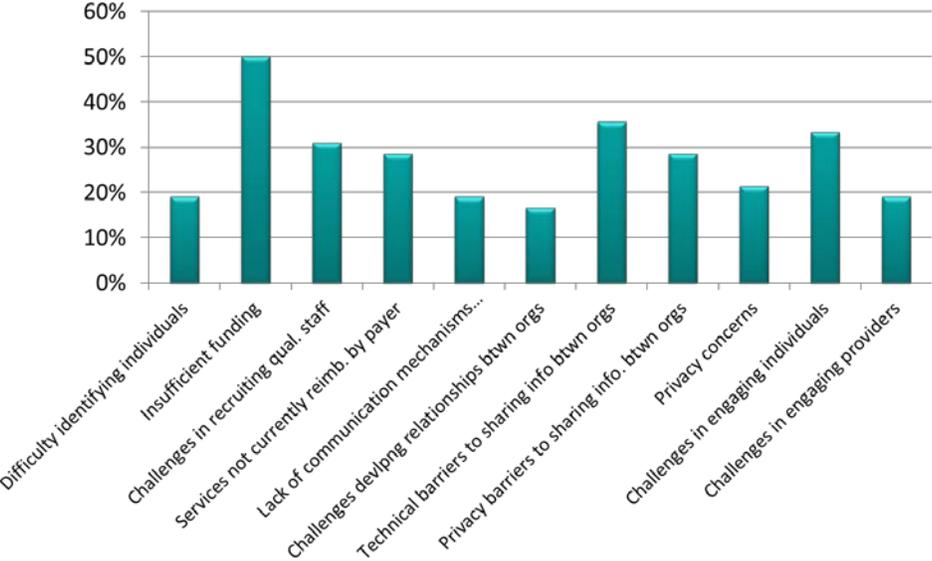
For Prevention/Wellness Engagement, the most frequently-cited challenges were Insufficient Funding and Technical Barriers to Sharing Information between Organizations. The third was Challenges in Engaging Individuals. Services Not Currently Reimbursed and Challenges Recruiting Qualified Staff were tied for fourth place at 29%.

**Bar Chart 38: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Prevention / Wellness Engagement**



Life Resource Management had the same distribution of challenges as the average, although Services Not Currently Reimbursed by Payer was ten percentage points higher than the average across all service types and was only a few percentage points from fourth place.

**Bar Chart 39: Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Life Resource Management**



## VIII. Conclusion

In reviewing the data presented in this report, there are key areas that the CMCM Work Group may be able to impact in a manner that could improve care management services in Vermont.

First, the data included in Table 11 indicated that for most types of care management services, the CMMI-identified key care management functions were being implemented less than 70% of the time. The highest implementation percentage was 67% for High Risk Management, and the lowest was 28% for Episodic Pathways. For Disease Management, which is a commonly provided service, key functions were reported as being followed among only 66% of the responding organizations. For Post-Discharge Follow-up, which is critical to reducing unnecessary readmissions, key functions were being implemented by only 51% of the responding organizations. There may be an educational opportunity to train care managers, wherever located, on these key care management functions.

Second, the information in Table 14 indicated the types of relationships responding organizations reported with other organizations. With the emergence of integrated delivery systems, such as ACOs, some of the organizations that have relied on ad hoc relationships have an opportunity to establish more formal and structured relationships that allow them to participate in delivery system transformation. Having such relationships will also create stronger ties for providing care management services across care settings and community service organizations, and provide opportunities to develop truly integrated delivery systems that include organizations traditionally on the periphery of traditional health care delivery.

Third, in examining the data in Bar Chart 20, which indicated the staffing types involved in Team-Based Care, it is notable that the highest rates of participation in Team Based Care were among RNs and Social Workers with rates of slightly less than 60%. MD participation was reported at 40% and Medical Assistant participation was below 20%. These data suggest that there may be an opportunity to provide additional training on implementing Team Based Care.

Fourth, the data included in Tables 7 and 8 indicate that people discharged from skilled nursing facilities received the following services at rates significantly below the average:

- Special Services Management
- Episodic Pathways
- Short-term Case Management Programs
- Utilization Management
- Prevention/Wellness Engagement

Ensuring the provision of some or all of these services, when appropriate, for people being discharged from skilled nursing facilities could result in fewer readmissions, which is a very important focus for cost containment.

Fifth, the staffing data in Table 10 indicate that the categories of Community Health Worker, Pharmacist and Physician Assistant had the smallest number of FTEs engaged in care management. Examining the roles that these disciplines could play in improving care management, and recruiting additional FTEs if warranted, could impact resource allocation.

Finally, the four key challenges faced by organizations providing managed care services -- Insufficient Funding, Challenges in Recruiting Qualified Staff, Technical Barriers to Sharing Information Between Organizations, and Challenges in Engaging Individuals - suggest opportunities for the CMM Work Group and the Vermont Health Care Innovation Project as a whole, to address these challenges as the project strives to create the type of care management system Vermont desires.

# Attachment 4b - Inventory Report Power Point

# Care Management Inventory Survey

Key Take-aways for Possible Action

# Context

- Third in a series of presentations on Care Management Inventory Survey results
- Focus today is on possible action steps suggested by data
- Would like to discuss six key take-aways
  - What the data suggests
  - Thoughts of Work Group members on possible responses



# #1: Increase Use of CMMI Best Practices

- We asked respondents to indicate which of the 9 CMMI best practices they followed when providing specific CM services
- Table 11 in Report shows percentages for each CMMI best practice, by type of service and in aggregate
- Best practices were used consistently by approximately half of the respondents
  - Planning and managing transitions of care and medication management were the practices with lowest percentages
- Organizations implementing post-discharge follow-up and high risk patient management – key CM functions -- reported lower rates of best practice adoption than optimal

# Average Percent of Organizations Using CMMI Best Practices, by Best Practice

| CMMI Best Practices                                   | Percentage Used |
|---|-----------------|
| Individual Identification and Outreach                | 54              |
| Needs Assessment                                      | 52              |
| Develop, Modify, Monitor Care/Support Plan            | 54              |
| Referrals to Specialty Care                           | 52              |
| Planning and Managing Transitions of Care             | 49              |
| Medication Management                                 | 48              |
| Individual Education                                  | 56              |
| Connections to Community/Social Service Organizations | 56              |
| Team-based Care                                       | 53              |

# Average Percent of Organizations Using CMMI Best Practices, by Type of Service

| Type of Service                | Average Percentage |
|--------------------------------|--------------------|
| High Risk Management           | 67                 |
| Special Services Management    | 61                 |
| Episodic Pathways              | 28                 |
| Disease Management             | 66                 |
| Post-Discharge Follow-up       | 51                 |
| Short-term CM Programs         | 63                 |
| Utilization Management         | 32                 |
| Prevention/Wellness Engagement | 54                 |
| Life Resource Management       | 51                 |
| All CM Services                | 51                 |



# Discussion

- Reaction to findings
- Ideas to increase adoption of best practices



## #2: Opportunity for More Formal, Structured Relationships

- We asked respondents to indicate the type of relationship (legal, financial, structured, ad hoc) they had with different types of organizations
- With growth of integrated delivery systems, it is likely that there will be increased emphasis on legal and formal, structured relationships with key partners, providing services along the continuum of care
- Survey suggests opportunities for community service providers to create more formal, structured relationships to solidify role in integrated delivery system



# Opportunities for Community Service Organizations

- Table 14 includes data that shows:
  - Transportation, School and Housing organizations were reported as having predominantly ad hoc interactions
  - Adult Day Providers and Faith-based Organizations were reported as having lower than average legal, financial and structured relationships
  - ACOs were reported as having primarily legal relationships



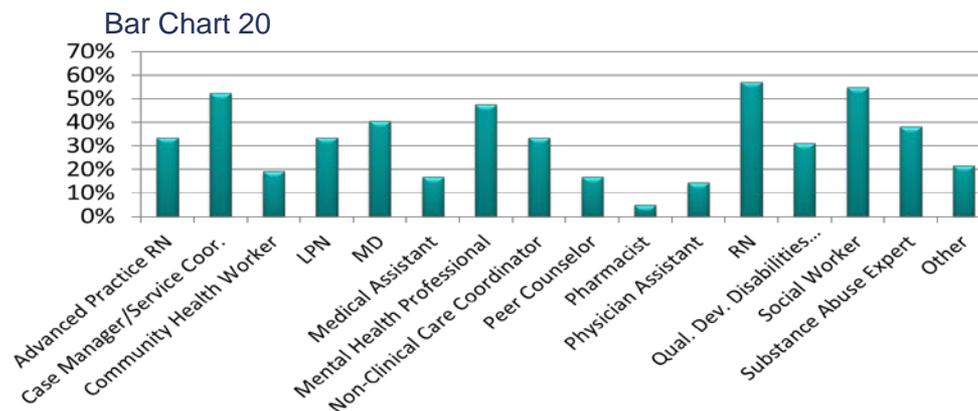
# Discussion

- Are there opportunities for community service providers?
- What action, if any, should the CMCM Work Group take?



# #3 More Robust Implementation of Team-based Care

- We asked respondents who was participating in team-based care, and received the following responses:
  - Top 4 staffing types to participate in team-based care were RNs, social workers, case managers, mental health professionals
  - 40% of the responding organizations reported that MDs participate on teams; substance abuse experts showed similar results
  - Pharmacists were least likely to participate



# Discussion

- Are there opportunities to improve implementation of team-based care?
- What steps could the CMCM Work Group take, if any?



# #4 Enhance Services to People Discharged from Skilled Nursing Facilities (SNFs)

- We asked respondents which populations were receiving care management service by type of service
- Tables 7 and 8 in the Report indicate that people discharged from SNFs received the following services at rates significantly below average:
  - Special Services Management
  - Episodic Pathways
  - Short-term Case Management Programs
  - Utilization Management
  - Prevention/Wellness Engagement
- Providing some of these services may reduce readmissions



# Discussion

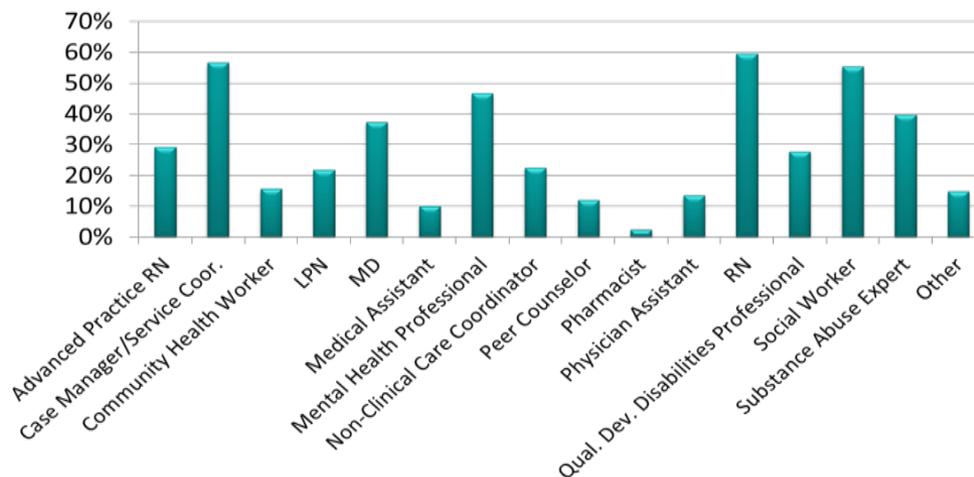
- Are there opportunities to increase coordination with SNFs?
- What can the CMCM Work Group do to support increased coordination?



# #5 Staffing Types and Resource Allocation

- We asked respondents about the number of FTEs providing CM services
- Pharmacists, Physician Assistants, Medical Assistants, Peer Counselors and Community Health Workers had the lowest FTE counts
- RNs, Social Workers and Case Managers had the highest FTE counts

Bar Chart 10



# #5 Resource Allocation (cont'd)

- There may be roles for less traditional staffing categories in providing care management services
- This could impact workforce planning and resource allocation



# Discussion

- Are there any workforce considerations that the CMCM Work Group should address?



# #6 Addressing Common Challenges

- We asked respondents to indicate the top challenges that they faced.
- The four most commonly cited challenges\* were:
  - Insufficient funding
  - Challenges in recruiting qualified staff
  - Technical barriers to sharing information between organizations
  - Challenges in engaging individuals

\*See Table 17 and Bar Chart 30 in Report



# Discussion

- How can the CMCM Work Group address the top four challenges?
- More generally, are any of the six take-aways of particular interest?
- If so, what can the CMCM Work Group do in response?
- What other Work Groups or entities should the CMCM Work Group partner with in developing a response?

