CARE MANAGEMENT IN VERMONT: GAPS AND DUPLICATION

Prepared for the Vermont Care Models and Care Management Work Group

By

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Executive Summary

Drawing on information collected from surveys completed by Vermont organizations providing care management and from presentations made by care management organizations to the Care Models and Care Management (CMCM) Work Group, Bailit Health has summarized gaps and duplication in care management services. Bailit Health has also summarized recommendations from presenters on how to address gaps and duplication.

In assessing the recommendations, we organized the responses into the following categories:
- Vision for Coordinated Delivery System
- Targeted Areas Needing Coordination
- Recommendations Regarding New Models of Care
- Recommendations Regarding Creating New Organizational Structures to Standardize and Coordinate Care
- Recommendations Regarding Standardized Tools and Practices
- Recommendations Regarding Data and Evaluation Infrastructure
- Recommendations Regarding Technical Support

While some of the recommendations may be inconsistent, it seems clear that Work Group members believe that there needs to be:
- Increased process standardization, including increased use of common care management tools;
- Creation of an organizational mechanism to coordinate the "family of care coordinators;"
- Increased development and use of IT resources to coordinate care management activities;
- Increased use of a shared data set to coordinate care and measure effectiveness; and
- Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.

A. Summary of Responses

As part of its work, the Care Models and Care Management Work Group surveyed organizations providing care management services to collect information on existing activities, perceived barriers to doing their work, and recommendations on improving care management in Vermont. 42 organizations responded to the survey. In addition, 13 organizations volunteered to present more detail to the Work Group regarding their care management programs; when presenting they were asked to identify specific areas of gaps and overlaps. This report summarizes observations and recommendations for closing gaps and eliminating duplication that survey participants included in their response and presenters identified in their presentations. To understand this qualitative information, we have organized the material into several categories, which we discuss in detail below.

Table II provides a summary of identified areas of duplication, gaps and barriers in care management that were included in the presentations made to the Work Group.

Vision for Coordinated Delivery System

Several respondents included vision statements regarding how the ideal system would be structured. We include these statements because they serve as a "North Star" for the CMCM Committee. One respondent described a system of easy access and highly coordinated care:

> "Develop a system that provides 'no wrong door' for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the Area Agency on Aging, the home care staff must have the knowledge and ability to arrange for the services needed."

A few respondents identified specific services for which improved access should be achieved. Those services included:
- prevention, wellness, risk mitigation and stabilizing people in the community;
- mental health services, affordable housing, food and fuel assistance;
- Early Intervention and Essential Early Education services for children ages 3 to 4;
- adult dental care;
- transportation;
- affordable behavioral health services, especially for seniors on fixed incomes and who are homebound; and
- accessible Gerontology services.

Targeted Areas Needing Coordination

Several respondents identified specific areas of inter-agency activities that needed to be better coordinated. They included:
- Improve inter-agency coordination with integration of social services and the criminal justice system.
- Optimize interactions between Visiting Nurse Associations, Designated Mental Health Agencies, Federally Qualified Health Centers, and SASH (Support and Services at Home) partners.

Recommendations Regarding New Models of Care

Two of the respondents proposed implementing new models of care as solutions to eliminate duplication and fill in gaps in care. One recommended designing and testing peer support/family engagement models, but provided no more details. The other suggested developing an integrated care model for seriously ill people that includes: team-based care, communication across disciplines, and process and outcome measures. This model would be supported by a new payment strategy, such as episodes of care/bundled payments, or enhanced per member per month (PMPM) payments. The respondent suggested testing the model in a pilot setting.

Recommendations Regarding Creating New Organizational Structures to Standardize and Coordinate Care

Most of the recommendations from the participants centered on creating more infrastructure to improve coordination. One recommendation was to create or identify organizations to drive coordination across

multiple entities. Some suggestions focused on creating totally new organizational structures other focused on using existing organizations in new ways. Specific recommendations for new or repurposed organizations include:

- Develop "Care Resource Teams" which would include representatives from a variety of providers;
- Use Area Agency on Aging (AAA) services to complement services and scope of other community-based providers.
- Use AAA wraparound services (case management/care coordination, nutrition services, transportation, falls prevention, etc.) to improve success of care transitions and avoid hospitalizations, institutionalization and readmissions.
- Use the Unified Community Collaborative (UCC) in each Health Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks (i.e., the Accountable Care Organizations) meet their organization goals.
    - The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers work together to achieve the stated goals.
    - The UCCs would develop and adopt plans for improving:
        - quality of health services,
        - coordination across service sectors, and
        - access to health services.

Recommendations Regarding Standardized Tools and Practices

Others recommended establishing processes among existing organizations that would result in better coordination among different agencies. These recommendations include:

- When coordinating services across multiple organizations with their own care managers, identify a central case manager (or team leader) to address coordinating the "family of case managers."
- Develop formalized collaborative relationships, including joint case management and care coordination.

Improved, standardized processes were recommended as a way to reduce duplication and gaps in care. Suggestions included:

- Develop a site visit tool for state staff;
- Create Utilization Management tools for state and provider staff;
- Create standards for uniform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) developmental screening, assessment and treatment planning across physical and mental health, early childhood, and school-based Medicaid and (Children's Health Insurance (CHIP) programs;
- Design and test population-based developmental and mental health promotion and prevention practices for statewide implementation; and
- Design a treatment plan across domains of a person's life.

Recommendation Regarding Data and Evaluation Infrastructure

Many of the respondents made recommendations regarding better use of data to reduce duplication and gaps in care. Their data-oriented recommendations included:

- Develop standard processes for evaluation and continuous quality improvement for collaborative projects.
- Integrate and analyze as a system rather than just by provider (e.g., analyze home care data with data from other settings).
- Coordinate common measures across programs providing like services, including standardized and streamlined provider reporting requirements.
- Manage "gaps in care" data from payers.

The participants also made recommendations regarding data infrastructure improvements to reduce gaps and duplications in care management services, which included:
- Design and implement health information exchange (HIE) interfaces, communication and integrated clinical information sharing and information technology (IT) structures (state and local).
- Create new business processes and state IT tools for standard decision support and outcome tracking.
- Address internal service integration between AAA programs by continuing to consolidate to a single software platform.
- Decrease resource burden of Transitional Care Management for CMS billing by using a platform called ACT.md.

Recommendations Regarding Technical Support

To enhance care manager skills to reduce gaps in care and duplication of services, the respondents made recommendations with regard to both mentoring and skill development. Their recommendations included:

- Create regional Technical Assistance Staff/System of Care Facilitators.
- Develop public best-practice forums (e.g., for top-scoring HSAs in each component).
- Develop workforce training and provider development to support:
  - early intervention;
  - family centered clinical models;
  - family wellness;
  - local governance and affiliation agreements;
  - mitigation of social determinants of health, etc.

B. Conclusion

In order to harmonize and coordinate all the different care management programs, the CMCM Work Group members appear to believe that changes need to be made in multiple areas and that there is no simple solution. While some of the recommendations may be inconsistent, it seems clear that Work Group members believe that there needs to be:
  - Increased process standardization, including increased use of common care management tools;
  - Creation of an organizational mechanism to coordinate the "family of care coordinators;"
  - Increased development and use of IT resources to coordinate care management activities;
  - Increased use of a shared data set to coordinate care and measure effectiveness; and
  - Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.

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C. Tables

Table I summarizes the information identified in presentations made to CMCM Work Group members regarding specific areas of duplication in care management services. Many of the presentations did not identify specific organizational duplication; therefore, only those that did are included in this analysis. Table II summarizes needs, gaps, barriers and areas of duplication regarding care management services that were identified in each presentation made to the CMCM Work Group. The presenting organization is also included in the table.

Table I: Summary of Duplication of Services Identified by Presenters

Potential Overlapping Programs	Programs Reporting Duplication				
	Community Rehabilitative Services – Designated Mental Health Agencies	Care Alliance for Opioid Addiction: "Hub and Spoke"	VCCI High Risk Pregnancy Program	Area Agencies on Aging + Care Partners Network + VNAs of Vermont	VNAs of Vermont Care Management
VNAs, Home Health and Hospice Agencies	X				
Support And Services at Home (SASH)	X				X
Area Agencies on Aging	X				
Hospital Social Workers/Discharge Planners	X				X
Blueprint Community Health Teams	X		X		X
"Hub and Spoke" Medication Assisted Therapy Teams			X		
Designated Mental Health Agencies		X			X
Vermont Chronic Care Initiative (Medicaid)		X			
Agency of Human Services (AHS) Case Management		X			
Criminal Justice Case Management		X			
Maternal Child Health			X		
Reach-up Case Management			X		
FQHCs				X	

Table II: Summary of VT CMCM Presentations

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
Washington County Mental Health	Designated Agency Case Management for Community Rehabilitative Treatment (CRT) Services (Community Support Program)	Process for assignment of a care coordinator/team leader: • Develop qualification for coordinator • Develop process for coordination • Address "family of case managers" ▸ Mental Health ▸ Home Health ▸ SASH ▸ AAA ▸ Hospital Social Worker ▸ Blueprint • Develop treatment plan across domains of a person's life • Establish electronic interface with other components of the health care system • Coordinate common measures across programs providing like services	None indicated
Peter Cobb, VNAs of Vermont Director	VNAs of Vermont: Home Health Care Management	• Improved system of interagency communication and information sharing to assure appropriate coordination among the various providers serving a client or patient. • Ability to integrate and analyze home care data with data from other settings. Ability to share data across settings. Member agencies currently are working with VITL to create a two-way system of IT information exchange.	• Several organizations provide care management including home health, SASH, hospitals, nursing homes, Blueprint, and mental health agencies. • Mostly, the care management provided is not duplicative as each agency provides a valuable service to its patients.
Agency of Human Services Melissa Bailey, MA, LCMHC	Integrated Family Services (IFS)	• Design and test peer support/family engagement models. • Create Regional Technical Assistance Staff/System of Care Facilitators. • Improve coordination and create standards for	None Indicated

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		uniform EPSDT developmental screening, assessment and treatment planning across physical and mental health, early childhood, and school based Medicaid and CHIP programs. • Design and test population-based developmental and behavioral health promotion and prevention practices for statewide implementation. • Workforce training and provider development to support: early intervention; family centered clinical models; family wellness; local governance and affiliation agreements; mitigation of social determinants of health, etc. • Create new utilization management tools for state and provider staff. • Design and implement HIE interfaces, communication and integrated clinical information sharing and IT structures (state and local). • Analyze and align data dictionaries and create core data reporting requirements across programs, including standardization and streamlined provider reporting requirements. • Create new business processes and state IT tools for standard decision support and outcome tracking. • Create new quality oversight standards and site visit tools for state staff.	
	Care Alliance for Opioid Addiction: "Hub and Spoke"	• New approach – start-up issues • Lack of private insurance coverage • Lack of physicians willing to treat population • Challenge with integration of social services • Link with criminal justice system poses unique challenges	• Co-Occurring Mental Health Services/Models – D.A.s • Other Chronic Care Initiatives: VCCI, Community Health Teams • Other AHS Case Management • Criminal Justice Case Management
	Vermont Chronic Care Initiative High Risk Pregnancy Program	• Difficulty in obtaining early referrals, and finding women early in pregnancy in order to make an impact. • There is no incentive for member or provider to	None indicated

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		participate in program • Potential Duplication: External and internal partners – CHT, Maternal Child Health, Reach-up, MAT (Hub and Spoke) teams, etc.	

Allan Ramsay, M.D.	Green Mountain Care Board (including palliative care for the seriously ill in a care management system)	• Convene the stakeholders
		   ▸ PCMH, DA, LTSS, VAHHS, ACO, others?
		• Develop an integrated care model for the seriously ill
		   ▸ Team-based care
		   ▸ Communication across disciplines
		   ▸ Process and outcome measures
		• Identify a new payment strategy
		   ▸ Episode of care/Bundle
		   ▸ Enhanced payment
		   ▸ PMPM
		• Test the model in a pilot setting
			None indicated

Area Agencies on Aging + Care Partners Network + VNAs of Vermont	Coordinated Care Management	• Increasing focus on prevention, wellness, risk mitigation -- stabilizing people in the community • Difficult/impossible to age-in-place if you're not healthy • Recognition that AAA wraparound services (case management/care coordination, nutrition services, transportation, falls prevention, etc.) essential to success of care transitions; avoiding hospitalization/ institutionalization / readmits • Collaboration / service integration will be critical • AAAs are addressing internal service integration between AAA programs (consolidating single software platform) • While acknowledging existing collaboration / interactions with VNAs, DAs & FQHCs, SASH partner, it is clear that these relationships need to be optimized. Actively exploring closer / formalized collaborative relationships – joint case management / care coordination	• Increasingly apparent that AAAs, VNAs, DAs & FQHCs have high degree of client overlap

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		• Reducing/preventing hospital/SNF readmits; reducing chronic disease admits depend on coordinated care / case management	
Designated and Specialized Service Agencies	Vermont Care Partners (VCP) is a collaboration between the Vermont Council for Developmental and Mental Health Services and the Vermont Care Network to support the sixteen Designated and Specialized Service Agencies.	**Challenges** • **Data Sharing -** Community-based providers need the ability to share and receive relevant patient-specific data electronically with physicians, hospital, nursing homes. This would increase efficiency and improve the quality of the care delivered. • **No Wrong Door vs. Single Point of Contact** - A single point of entry is not needed. What is needed is a system that provides "no wrong door" for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the Area Agency of Aging, the home care staff must have the knowledge and ability to arrange for the services needed. This can be achieved by Care Resource Teams which would include representatives from a variety of providers. **Opportunities** • Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks meet their organization goals. • The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers work together to achieve the stated goals. • The UCCs would develop and adopt plans for improving ▸ quality of health services	• A patient could receive care management services from a several providers.

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		▶ coordination across service sectors ▶ access to health services	
Howard Center	Service Coordination for Developmental Services Designated and Specialized Agency System	None indicated	None indicated
Blueprint Community Health Teams	Community Health Teams across Vermont	• Access to Mental Health Services, affordable housing, food and fuel assistance. • The size of Chittenden county and the large number of practices Biggest Gaps in Care - Services for ages three to four between Early Intervention and Essential Early Education services, adult dental care, transportation, affordable mental health services, especially for seniors on fixed incomes and who are homebound, accessible Gerontology services. • Transitional Care Management for CMS billing is time-consuming. • Managing "gaps in care" data from payers. • Prioritizing single-patient needs (tyranny of the urgent) vs. getting entire panels of patients to adopt healthier habits. • Juggling Transitional Care Management PLUS Care Coordination PLUS Panel management—self-management & education of smokers, diabetics, asthma patients PLUS Reduce ER visits and hospital admissions PLUS Work with multiple payers on reducing # of high-risk patients. • Communication, Releases, HIPAA Barriers • Motivating people who have been in "the system" for a few years to realize it is possible that they can gain control of their lives and future. • Identifying additional ways to quantify our team's efforts.	• Chittenden County is rich in services/resources, creating a challenge to really work on avoiding duplication. • Strong communication avoids many duplicated efforts, but it can sometimes be challenging to obtain certain information without proper releases in place.
Nancy Eldridge	Support & Services at Home (SASH)	• MAPCP demonstration capped at 5,400 participants • Need for more Wellness Nursing Hours	• Opportunity for more integration by SASH, VCCI and CHTs with shared participants

Presenter	Program Name	Needs/Gaps/Barriers	Duplication

		• Need for telemedicine capacity at home
		• Need for more root cause data
		• Move toward population management within which targeting can occur
		• Workforce gaps
		   ○ Need to push tasks down to paraprofessionals or community health workers
		Data Needs
		• DocSite capacity significant
		• Integrated Health Record barriers
		• VITL barriers:
		   ○ Who should have access?
		   ○ Risk when transforming systems
		• How can we build one data system
			○ Blending Episodic expertise with coaching and ongoing team support
			• Dual Eligible teams and SASH teams
			• Data collection
			• ACO performance measurement

VCCI and DAIL	Care Models and Case Management: a Long Term Services and Supports (LTSS) Perspective	None Indicated	None indicated
Vermont Blueprint for Health	Community Health Network Analysis of Blueprint HSAs	Organizations are less likely to measure the work they are doing together. Evaluation and continuous quality improvement should be encouraged. No one HSA always rated at the top or bottom of the score distribution. It may be beneficial for top-scoring HSAs to share their practices in a public forum, so that the other HSAs can learn from those best practices. Respondents experienced drawbacks far less frequently. Two worth watching are: • taking too much time and resources—reported by 60% • difficulty in dealing with partner organizations—reported by 46%	Key Player Analysis shows that these are fairly durable networks, as modelling removal of the 3 "key players" in each network causes fragmentation but not complete network breakdown Information about key players (not necessarily duplication): • Blueprint Community Health Teams are key players in the majority of HSAs—around 60%. • At least 1 State agency (e.g., Agency of Human Services, Vermont Department of Health) is a key player in about a third of HSAs. • Other key players include organizations that provide mental health and substance abuse services , services for the aging population and home-based care groups. • Each community network is substantially larger

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
			than its "core health team" and includes a range of public and private health and social service organizations that support a diverse swath of each community's population • It's common to see sub-networks that serve a specific population within the community, for instance area youth (see the St. Johnsbury HSA for an example) or area elders (see the Randolph HSA for an example).