
# Shared Care Plans & Universal Transfer Protocol

# Final Report

**May 2016**

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# 1. Introduction

## *Purpose of This Document*

As the final deliverable for Phase I of the Shared Care Plans (SCP) and Universal Transfer Protocol (UTP) projects, this document provides recommendations to support Vermont's providers and caregivers in implementing the principles of integrated care management with a particular focus on successfully navigating transitions and facilitating relationships between various care settings. Through partnerships and interviews, the SCP and UTP project team has gathered requirements for the Shared Care Plan and Universal Transfer Protocol tools, discussed in more detail in later sections of this document. Additionally, the project team has participated in a review of six technical solutions that are either proposed or in use in provider offices around the state. Each solution is detailed and evaluated for its alignment with the overall goals of the project.

**What is a Shared Care Plan?**

A Shared Care Plan, as defined by the Integrated Communities Care Management Learning Collaborative of the Vermont Health Care Innovation Project[1] (ICCMLC), is a care coordination document created by a person receiving services and/or his/her family and care team with the primary goal of facilitating communication between all parties involved in an individual's care. It "tells the person's story," by describing strengths and interests, short and long-term needs, and personal and clinical goals and priorities. The Shared Care Plan identifies strategies and a timeline for achieving goals, and specifies who on the care team is responsible for each part of the plan. Finally, the Shared Care Plan incorporates a basic level of key demographic and clinical data elements.

Most notably, a Shared Care Plan:

- Is able to organize information about a person receiving care or services from multiple organizations;
- Is focused on person-centered care and a person's identified priorities;
- Is updated as needed by only the Lead Care Coordinator or designee;
- Uses a format with which all members of the care team are familiar;
- Contains only information needed to coordinate care, and is not a treatment record or clinical record;
- Identifies high-level patient and medical goals and lists strategies and care team members responsible for achieving goals within a specific time frame;
- Allows individuals to direct and participate in their own care, and is designed to be written and shared with the person receiving services; and
- Offers easy access to critical information about complex people receiving services from multiple organizations.

Shared Care Plans are not meant to replace any organization's clinical record, but rather are meant to serve as a tool of integrated care management across organizations. Shared Care Plans should condense information needed for care coordination in order to better facilitate communication between

[1] More information can be found on the VHCIP website: healthcareinnovation.vermont.gov.

organizations, ultimately resulting in improved outcomes for individuals, and avoid including so much information that it becomes confusing or overwhelming to providers.

**What is a Universal Transfer Protocol?**

> *"Universal Transfer Protocol (UTP) is a process across the entire system that gives all partners who have a role in the patient's care access to the same standardized information and the responsibility to ensure that the information is accurate, current, and supports the patient's goals and quality of life."*
>
> Heather Johnson, ADRC (Aging and Disabilities Resource Centers) Project Manager

The recommendations in this proposal for establishing a UTP will support workflow changes to improve communication to support people with complex, chronic, or long-term needs for services and supports across the health continuum. UTP is not a form; it is a process for developing shared information.

## 2. Project Findings – Requirements Gathering

As communities across Vermont continue to shift the focus of care delivery to a person-directed, team-based, cross-organizational, and community-wide approach to care coordination, various work flows and communication tools have emerged in support of these models of care. Shared Care Plans (SCP) and a Universal Transfer Protocol (UTP) have been identified as key tools in facilitating integrated care management across a community. In support of this concept, the SCP and UTP project team partnered with three communities – Rutland, St. Johnsbury, and Bennington – to gather information and business and technical requirements. Working with these communities, multi-organizational teams of providers were interviewed to help the SCP and UTP project team gain a better understanding of communities' current implementation of the Shared Care Plan and Universal Transfer Protocol use cases. The project team then worked with the communities to identify their future goals and unmet needs to systematically embed these tools within their care delivery workflows.

Two of the three partner communities (Rutland and St. Johnsbury) are also participants in the Integrated Communities Care Management Learning Collaborative (ICCMLC) of the Vermont Health Care Innovation Project. Therefore, the Shared Care Plan templates, as well as processes and workflows for implementing Shared Care Plans, reflect the model supported by the ICCMLC.

### *2.1 Summary of Community Findings: Shared Care Plans*

Through their participation in the ICCMLC, the Rutland and St. Johnsbury communities were among the first in the state to pilot a paper version of the SCP with a population of high needs individuals receiving services from multiple organizations within their communities. At the time of the business requirements gathering sessions with Rutland and St. Johnsbury, both communities had implemented a similar workflow (as referenced in Appendix A) and process behind populating and distributing the SCP across the integrated care team. Given the exploratory nature of the ICCMLC pilot program and the novelty of embedding this tool in existing care delivery processes, the Rutland and St. Johnsbury teams are just beginning to clarify a process for updating and refining the information contained within the SCP over time. A key feature of this process includes the identification of a lead care coordinator, who is generally responsible for monitoring, revisiting and updating the Shared Care Plan over time. Neither team has yet identified a mechanism to share the SCP electronically, and is largely relying on secure email, fax, or hard copy to share the SCP amongst care team members. The ability to support this work with an electronic solution that is accessible to all members of the care team was identified by interviewees as a tool that could greatly improve the workflows and processes on the ground in both Rutland and St. Johnsbury, leading to more efficient delivery of care and improved outcomes for individuals.

Primarily through the work of the Vermont Aging and Disabilities Resource Connection (ADRC), the Bennington community has been working to improve the ability of community members, particularly those with Long-Term Services and Supports needs, to access services from a wide range of medical and social services organizations and to improve transitions of care. Vermont's Person-Centered Options Counseling (PCOC) Program's "My Options Plan" is one tool to support communication across an integrated care team of providers working with an individual. It incorporates elements of the project's Universal Transfer Protocol, along with the requirements for the PCOC program and consumer-directed care planning. Much like the SCP, the My Options Plan identifies members of an individual's care team,

lists clinical and non-clinical goals that are important to an individual and their care team, and names the responsible party as well as a due date for action against these goals.

The Bennington community's workflow supporting the My Options Plan begins when the Southwestern Vermont Medical Center identifies patients who would benefit from the services of one of the ADRC partner agencies: the Council on Aging, Brain Injury Association, or Vermont Center for Independent Living. A referral is then made to the Options Counselor best equipped to support the patient, and the Counselor schedules a visit. The Options Counselor conducts PCOC and completes the My Options Plan in collaboration with the consumer. Finally, the My Options Plan (as a PDF document) is emailed to the hospital case managers and social workers as well as the medical home, if appropriate, using the hospital's secure email system. The ability to support this work with an electronic solution that is accessible to all members of the care team would greatly improve the workflows and processes on the ground in Bennington, thus leading to more efficient delivery of care and improved outcomes for individuals.

While working with the three identified communities, the SCP and UTP project team has found that the need to share information about individuals across a multi-organizational team of providers in a community through a Shared Care Plan tool is critical to the success of integrated care management, and ultimately to addressing the needs of the individual across all aspects of their physical and mental health including the impact of social determinants of health on an individual's overall well-being. The ability of this tool to be accessible to all members of the care team regardless of type, setting, or payer relationship is key to meeting these goals.

### *2.2 Summary of Community Findings: Universal Transfer Protocol*

In addition to exploring the use of a Shared Care Plan as a tool to facilitate communication and coordination across multiple providers within an individual's integrated care team; the SCP and UTP project team partnered with the same three communities – Rutland, St. Johnsbury and Bennington – to explore the use of a UTP as an important care coordination tool and process, particularly when an individual is transitioning from one care setting to another.

Through a series of interviews and conversations with multi-organizational community teams, it became clear that the Bennington community, through the support of the ADRC, is currently furthest along the path of implementing and embedding a UTP into their community-based care delivery system. While the tool and process are currently in the exploratory phase in both the Rutland and St. Johnsbury communities, all three communities reinforced the value of UTP as a tool to support integrated care management across provider settings.

Overarching findings indicate the need to further develop the workflows and processes that support the use of a universal set of information shared across various acute and long-term care settings in order to improve communication and coordination amongst providers when facilitating an individual's transition from one setting to another. A clearer process and workflow would lead to improved outcomes around provider satisfaction; clarity of information regarding the individual's hospital stay; and post-discharge service planning that includes non-medical and social service needs that often don't get shared back to primary care physicians, medical homes, and hospitals. Feedback from both the hospitals and medical homes has been very positive regarding the additional information that is being shared. The ability to

support this work with an electronic solution that is accessible to all members of the care team could greatly improve the workflows and processes in participating communities, as well as provide a timelier and less onerous process than is currently in place, leading to more efficient delivery of care and improved outcomes for individuals.

Through conversations with multi-organizational teams in the Rutland, St. Johnsbury, and Bennington communities, the SCP and UTP project team has identified that the need to implement a UTP process and workflow supporting the transfer of a standardized set of information about an individual as they transition from various care settings in a community is critical to the success of integrated care management, and ultimately to addressing the needs of the individual across all aspects of their health and well-being.

### *2.3 Summary of Community Findings: Obtaining and Communicating Consent to Release Confidential Client Information[2]*

The SCP and UTP project team quickly identified the receipt of consent to share confidential client information across a multi-organizational team as a key challenge. The receipt and documentation of informed consent from individuals receiving care, and the documentation and management of consent within existing systems and any new technical solutions, are critical steps in shared care planning and UTP. Development of policies and technical architecture to support both of these processes must be a precursor to implementation of a technical solution for SCP or UTP.

Both SCP and UTP rely on the transfer of confidential client information between providers. Tools to support both SCP and UTP are currently in use to some extent in the communities interviewed without the aid of computer technology. The team sought to determine whether either of these processes raised any barriers or concerns surrounding consent to release confidential client information. The team also considered whether a technical solution would introduce new confidentiality issues, and developed recommendations for addressing these issues.

In the context of the Shared Care Plan, the project found that some providers were hesitant or unwilling to share information across the care team due to uncertainties regarding the applicability of releases and confidentiality laws to the SCP process. Through conversations with multi-organizational teams, the SCP and UTP project team determined that a technical solution, alongside a standardized consent form, could alleviate these concerns either as part of a standalone solution or in concert with updates to the Vermont Health Information Exchange (VHIE) consent architecture.

There were no concerns among providers in the communities interviewed over the paper-based UTP process. The requirements for obtaining consent to release information during transitions of care remains the same whether or not providers are using the UTP. To accommodate broader sharing of UTP information, the workflow described below incorporates a process for obtaining consent to share UTP elements with all participating providers, and updating consents as new providers join the system.

[2] Please note that this report does not attempt to provide a legal opinion as to whether any solution discussed herein will satisfy all consent-related regulatory requirements when put into practice.

**Obtaining Informed Consent and Standardized Consent Forms**

Use of a standardized consent form – similar in composition to those employed by many provider organizations to authorize the release of information protected both by HIPAA and under 42 C.F.R. Part 2 – could further support the SCP and UTP processes by facilitating the informed consent process. A standardized consent form could be developed with consumer/client comprehension as a key feature (i.e., with plain language, at an appropriate reading level, including examples), and would contain the elements required under State and federal laws for documentation of consent. Sufficient granularity at the form-level would allow patients to tailor consent to specify what kinds of health information they agree to share, and with whom.

The SCP and UTP project team developed a list of release elements required by HIPAA (45 C.F.R. Parts 160-164) and 42 C.F.R. Part 2; these elements are compiled in Appendix E. The project team also surveyed other applicable confidentiality laws (see Appendix D) and found that such a form could contain adequate information to document compliance with other applicable laws as well[3]. A technical SCP solution could assist in disseminating documentation of consent by allowing users to access a scanned copy of the consent form to incorporate into their records.

**System Functions and Consent Architecture**

While much work has been done through the SCP and UTP project to support development of a standardized consent form and best practices for its use, aligning this process with consent management at the technology and system levels is more challenging.

A revised consent architecture should be able to interpret consent forms, manage consent information to allow authorized users access to client information, warn users when a consent has expired or been revoked, and inform users who are accessing information that is subject to restrictions on re-disclosure carrying possible criminal or administrative penalties. These requirements are also described in the high-level system features below.

[3] Additional State and federal laws may apply, resulting in additional data elements being identified.

## 3. High-Level System Features

This list describes the ideal features and behaviors of a system that would address the needs of both a Shared Care Plan and a Universal Transfer Protocol.

- Any Shared Care Plan template will incorporate the key features of a Shared Care Plan as outlined in Section 1 of this document, and will support the existing workflows in place in communities as outlined in Appendix A of this document.
- The system will appropriately handle consent throughout the care continuum, including compliance with HIPAA, FERPA, and 42 CFR Part II requirements.
    - The system will protect the confidentiality of client information and prevent the unlawful disclosure of protected data.
    - The system will record consent information specifying:
        - The types information to be shared;
        - The users authorized to upload and access each type of information;
        - The expiration date or event of the consent; and
        - The purpose of the consent (UTP elements, Shared Care Plan, or both).
    - The system will ensure user's authorization has been documented and has not been revoked before allowing a user to look up a client or access the client's information.
    - The system will provide a user only with the types of information specified on a release and only for the purpose specified; for example, there will be no access to Shared Care Plans if a user is only authorized to receive UTP elements.
    - The system will alert users of special restrictions on the use of information imposed by law or by request of the client.
    - The system will prompt users to obtain up-to-date consent documents from clients when new providers are added to the system.
- The system will display the client's care team, and will be accessible to all members of the care team regardless of provider type of setting, as appropriate based on the security of roles defined within the system.
- The system will allow users with appropriate access levels to create/modify/delete/update the SCP/UTP using referral forms, letter templates, and other appropriate documentation, including summary level information and complete data sets, as defined by the user.
- The system will have the ability to populate the appropriate data elements when supplied from another approved electronically formatted interfaced system.
- The system will create and send notifications to users (both releasing and receiving) if:
    - Consent has been revoked by the patient;
    - Consent expiration event has occurred;
    - Consent expiration date is approaching;
    - Client has died;
    - Client has moved outside of the State temporarily or permanently;
    - Medication will be expiring soon; and/or
    - Recommended action (e.g. follow-up appointment) has not been documented.
- The system will be capable of exporting information that can be saved in different file formats (e.g., .pdf, .xls, .csv).

- The system will have security parameters that restrict exporting/saving files to only users/providers with appropriate level of access.
- The system will allow a web-based workflow application to integrate patient data.
- The system will allow real time surveillance of acute events using admission, discharge and transfer (ADT) data to prompt care manager interventions via an event notification mechanism.
- The system will be configurable and dynamic so that data elements can be displayed or hidden, as defined by the individual communities.
- The system will utilize roles-based security, including the ability to adjust roles such as Lead Care Coordinator to ensure the appropriate people are documented within the system.
- The system will utilize common field validation techniques, including saving data after each entry is made.
- The system will electronically track the history of each data record, creating an easily accessible audit trail, including reporting ability.
- The system will allow users to attach documents of various formats (e.g., .doc, .pdf) to the client record, and tag the document with appropriate keys for easy retrieval.
- The system will allow workflows to be configured and defined by each user community, and will be flexible enough to maintain multiple workflows.

## 4. Recommendations

As of Fall 2015, at least six possible SCP solutions were simultaneously in-flight, and there are additional projects that have been implemented or are in process of being implemented that meet UTP business requirements or provide event notifications.

Below are the six solution providers evaluated as part of the SCP and UTP project:

1. PatientPing
2. VITLDirect and VITLAccess (Vermont Information Technology Leaders)
3. MMIS Care Management Solution (EQHealth Solutions, with Cognizant)
4. Allscripts dbMotion (North Country Hospital)
5. Healarium
6. OneCare Vermont Care Management Solution (BluePrint Care Navigator)

Since the completion of key informant interviews, the State has continued to identify solutions that are implemented or soon-to-be implemented in Vermont, including an SCP solution developed by the Windsor Health Service Area, currently in use, and an SCP solution currently being piloted in select pediatrics practices supported by the Vermont Child Health Improvement Program at the University of Vermont.

From the outset, this project sought to understand the business requirements of the three participating communities, process those requirements into technical requirements, and compare technical requirements to known solutions in production, development, or planned development within Vermont.

In development of these recommendations, the SCP and UTP project team was required to work through careful considerations of the technical capabilities, deployment schedules, and funding mechanisms of the identified solution providers. As the review of the technical solutions proceeded, it rapidly became apparent that the technical requirements of a Shared Care Plan solution are achievable, and that many communities around the state are already pursuing this capability through a variety of solutions; the field of potential SCP solutions in Vermont is crowded, and it is quickly expanding. Additionally, a significant barrier was identified in the ability to manage an individual's consent to share information within a potential technical solution.

The SCP and UTP project team also determined that the process of a UTP would best fit within the existing Learning Collaborative structure as a work flow improvement.

### *Shared Care Plan*

The SCP component of the project, as previously described, involves a complex use case and customized work flows such as those currently in place in different communities. The key SCP functional requirements can be met in varying degrees by a variety of technical solutions and, in fact, communities around the state are already developing and implementing solutions to meet these requirements.

In Fall 2015, the project team chose to focus their research on three of the most promising potential solutions: one policy solution (revision of VHIE consent policy and architecture) and two technical solutions (MMIS Care Management solution; OneCare Vermont's BluePrint Care Navigator).

The team also identified three critical challenges: consent, timing, and funding (short- and long-term). Consent management is a significant complicating factor which, if unaddressed, will be a continued barrier. Timing and funding are somewhat limited by the end of Vermont's State Innovation Model Testing Grant and the VHCIP project, scheduled for June 2017. Any VHCIP-funded solution would need to fit within the project's overall budget; long-term funding sustainability is also an ongoing concern for the State and participating providers.

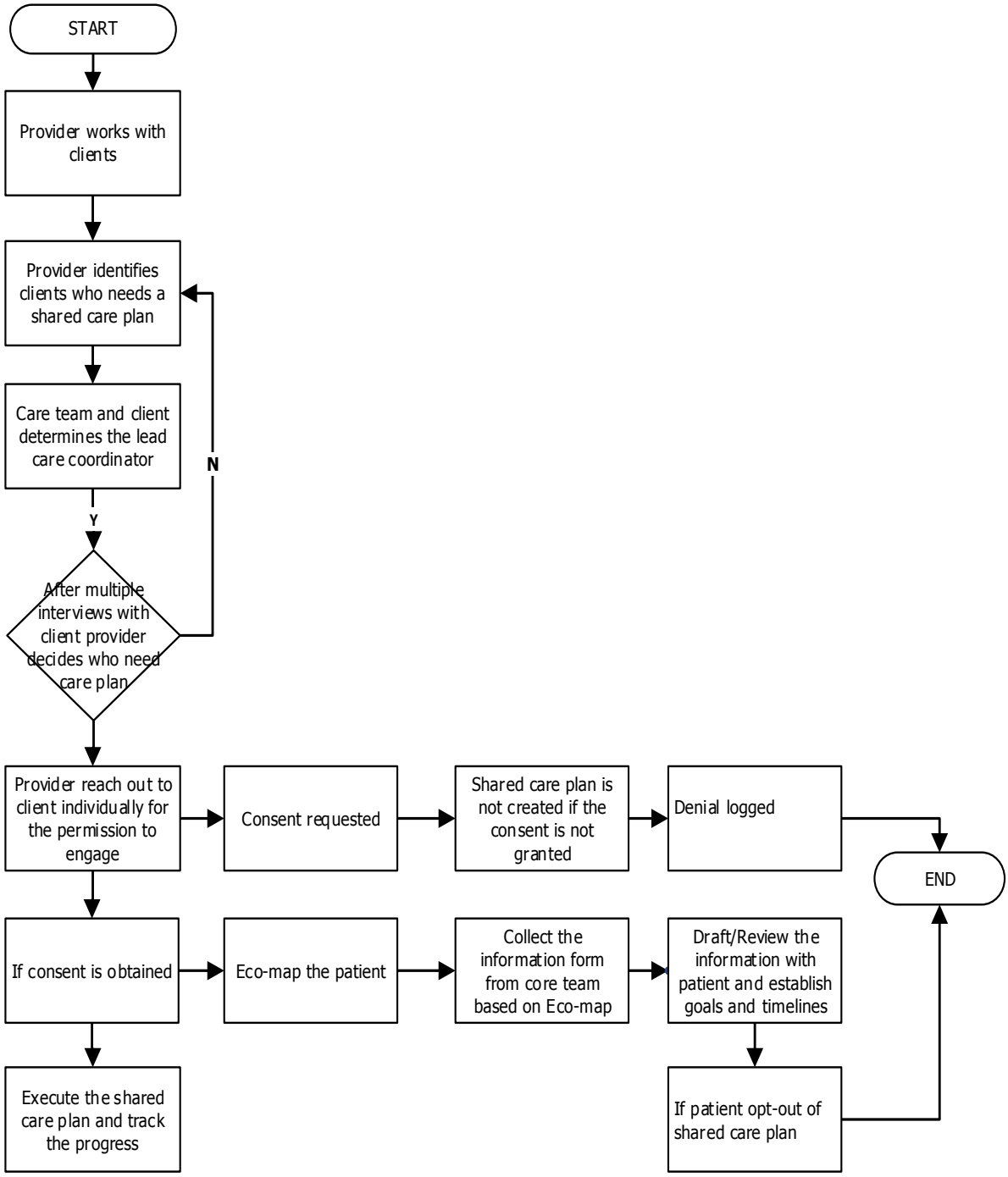
Given these three major challenges, as well as the large and growing body of solutions already implemented or in process in this field, the project team recommends that the State not pursue a technical solution at this time, and instead focus efforts on revising the VHIE consent policy and architecture to support future work in this area. This is an area of ongoing work, building on previous work funded through the State's HIE Implementation Advanced Planning Document (IAPD), which drew on HITECH funds, as well as State discussions about the proposed rule changes to 42 C.F.R. Part 2, released recently by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) (see Appendix D for additional information). The State and VITL will continue to collaborate in this area through the end of the SIM grant and beyond, leveraging available federal funds.

### *Universal Transfer Protocol*

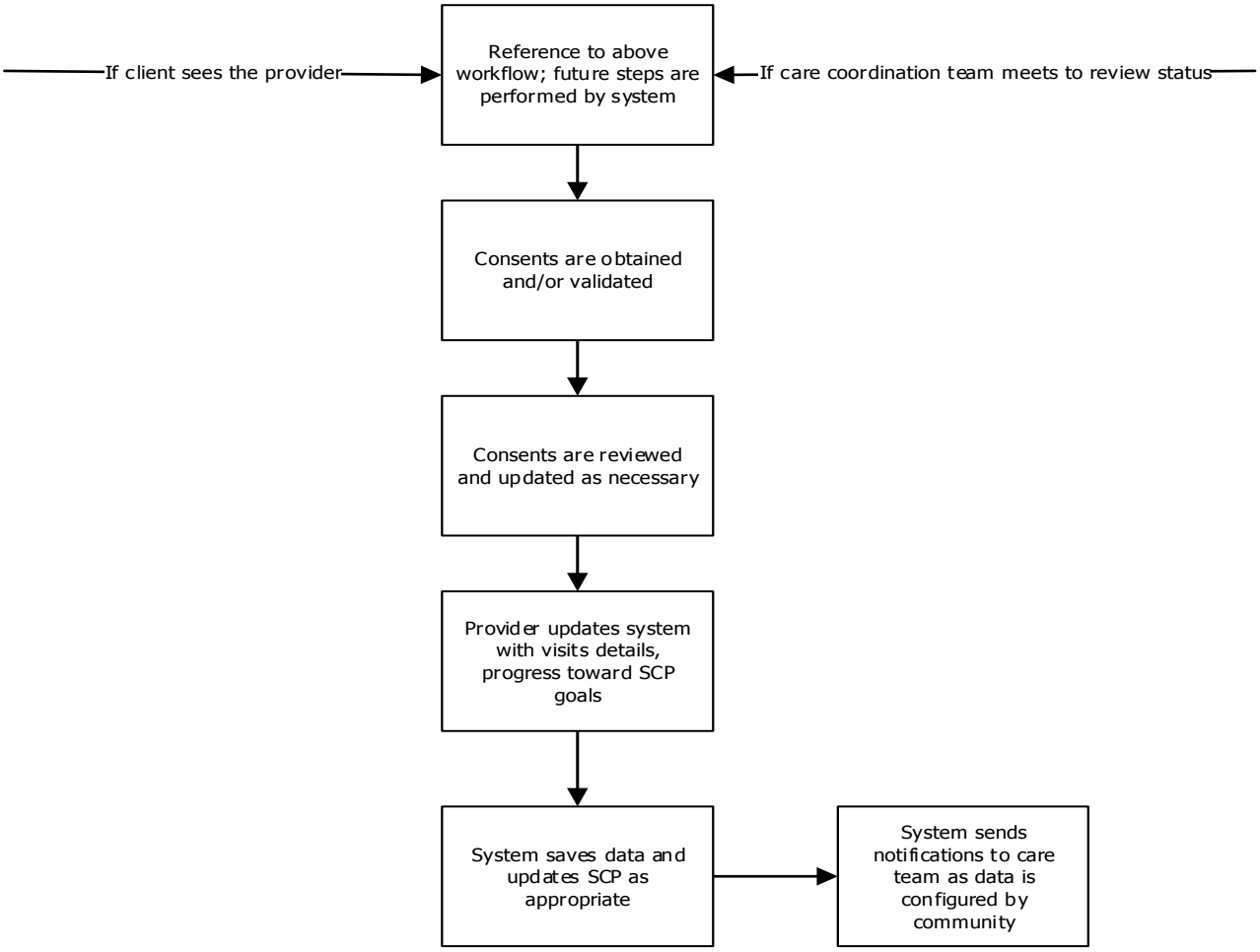
The project team recommends that the Universal Transfer Protocol, which is a process, be deployed through the Integrated Communities Care Management Learning Collaborative. This will leverage existing infrastructure and participants, and enable rapid-cycle workflow improvements.

# Appendix A: Workflow Diagrams

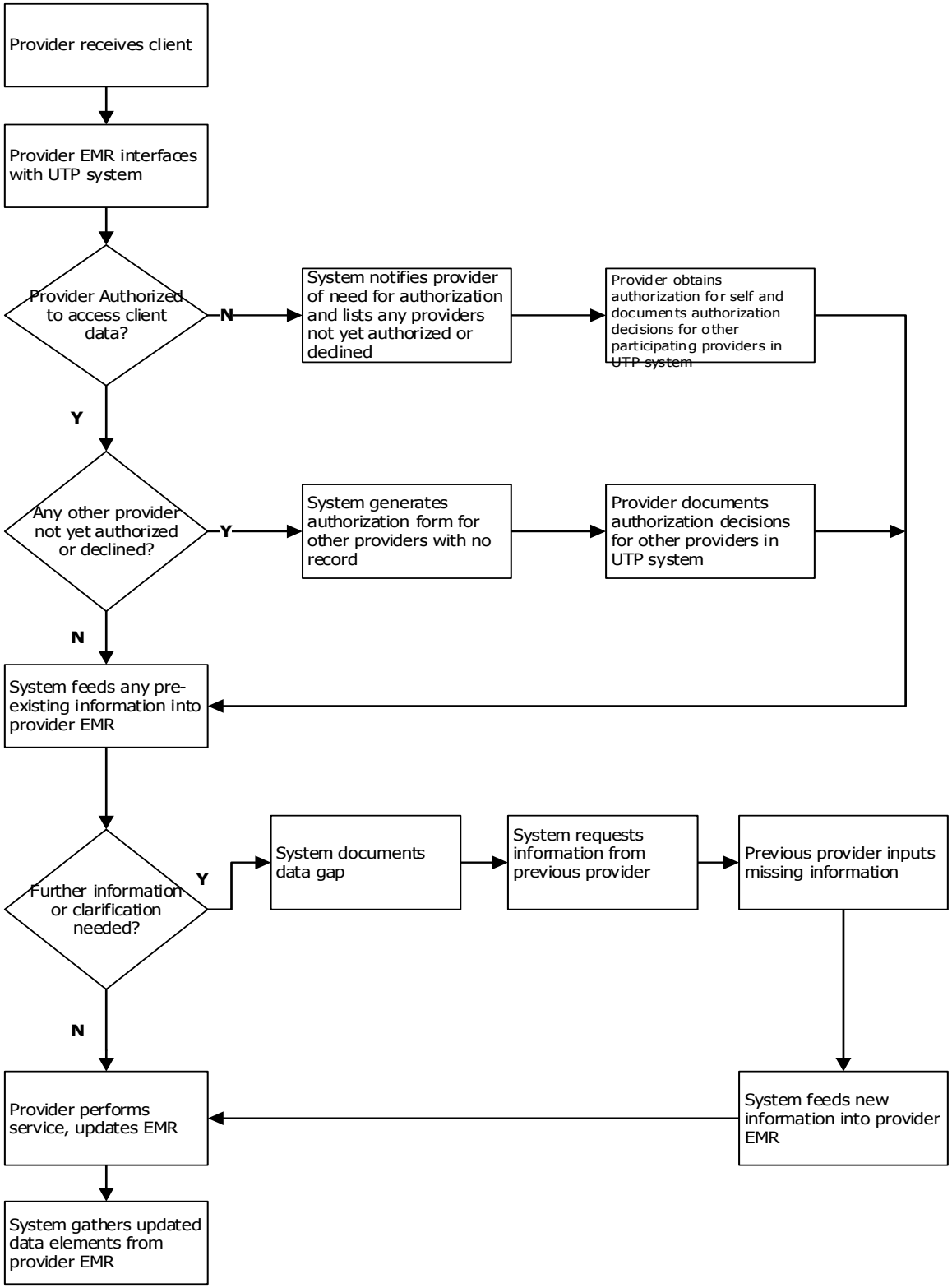
## *A.1 Shared Care Plan Workflow Diagram*



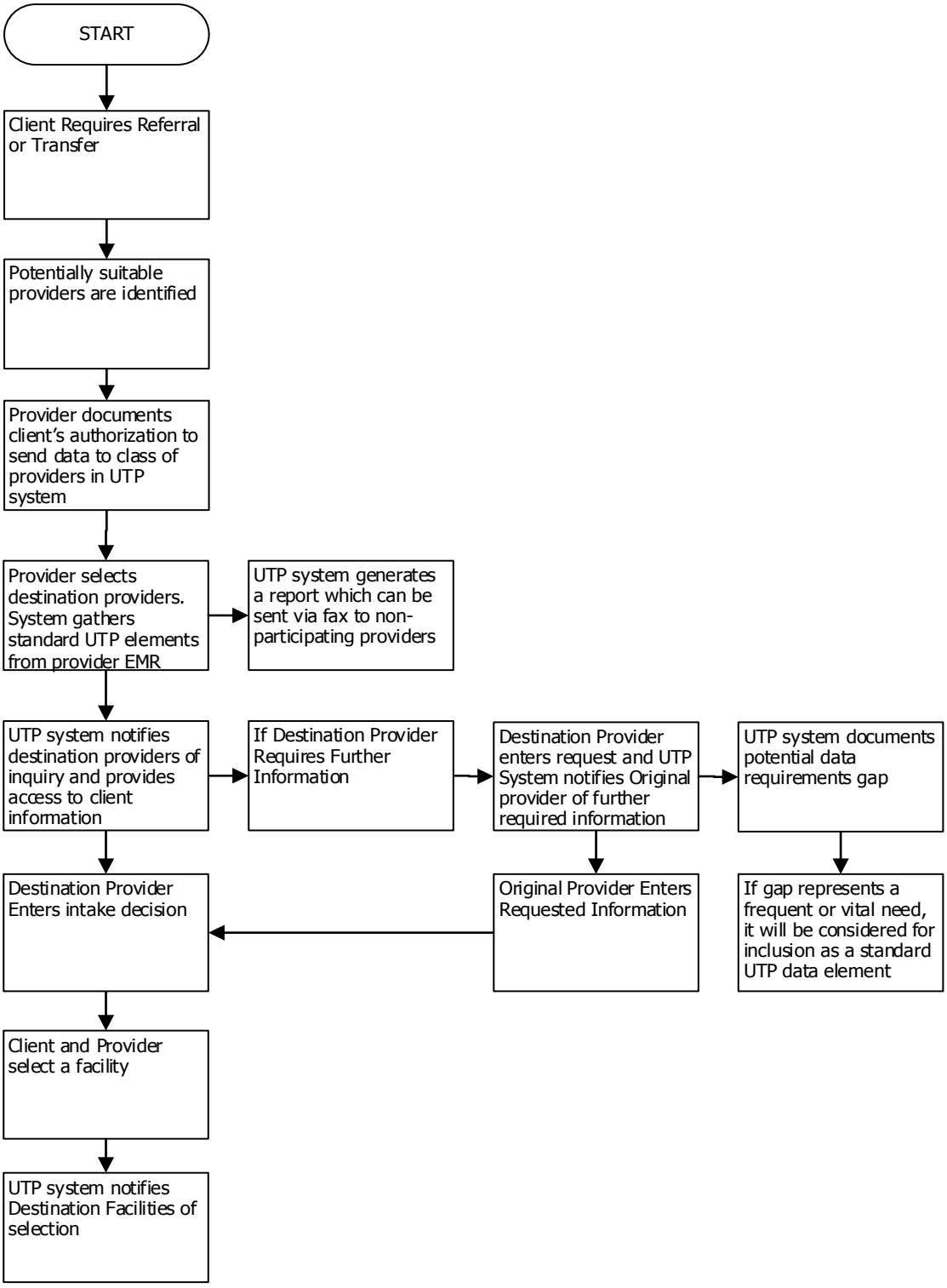
*After execution of Shared Care Plan below steps are performed by the system:*



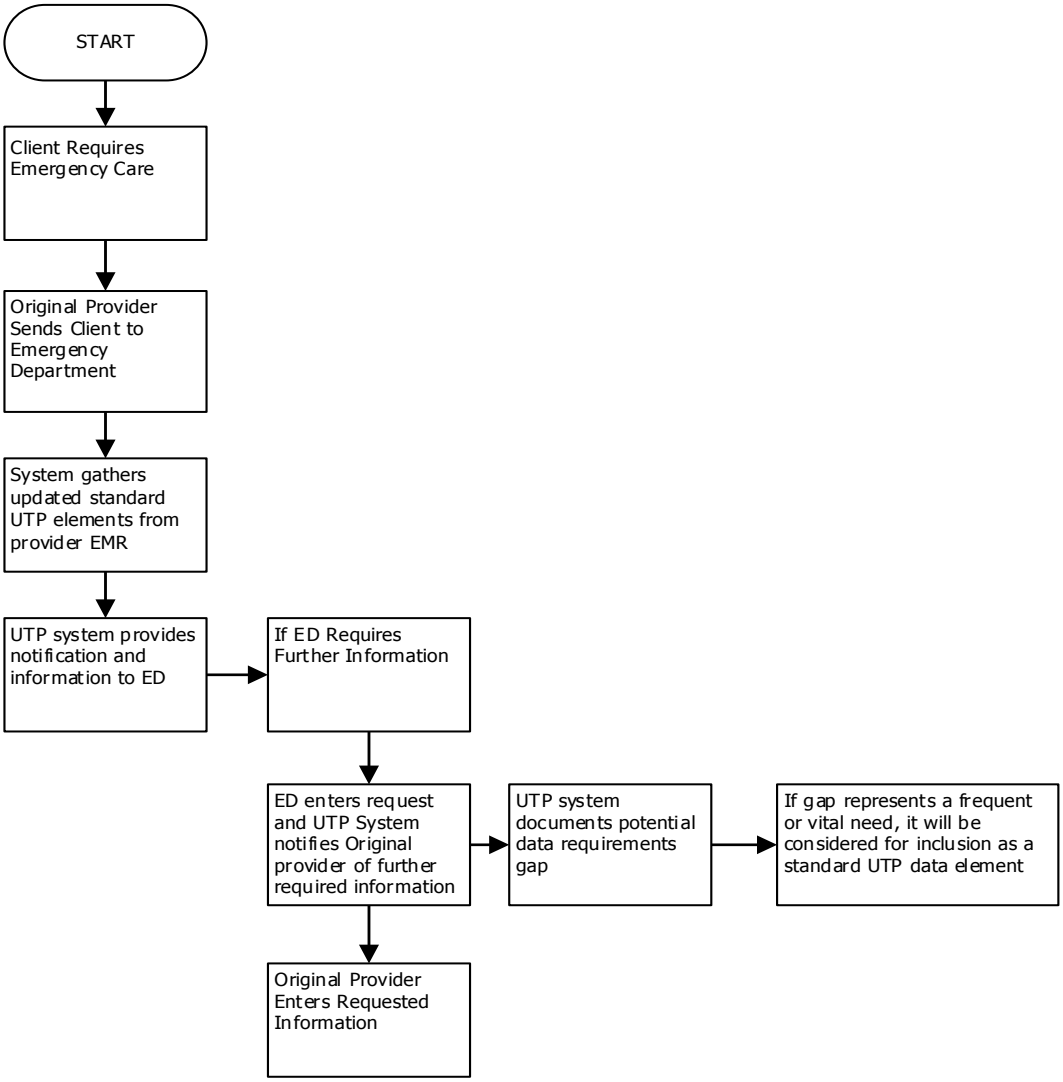
### *A.2 UTP Intake Workflow Diagram*



### *A.3 UTP Planned Transfer Workflow Diagram*



### *A.4 UTP Emergency Transfer Workflow Diagram*



## Appendix B: Data Elements

### *B.1 Bennington Shared Care Plan*

*Note: The Bennington work flow and data elements contain elements unique to the My Options Plan

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| Consumer First Name | | |
| Consumer Last Name | | |
| Date of Birth | | |
| Gender | • Male<br>• Female<br>• Other | Only one can be selected |
| Street Address/PO Box | | |
| Town | | |
| State | | |
| Phone Number | | |
| Zip Code | | |
| Email address | | |
| Referred by | • Self<br>• Family/friends<br>• Hospital<br>▪ Primary care doctor<br>▪ Medical home<br>▪ Nursing facility<br>▪ Other | Only one can be selected |
| Referral made by | • Primary care doctor<br>• Medical home<br>• Nursing facility<br>• Other | Can be multi-select |
| Individual refused/declined Options Counseling | • Yes | |
| Special accommodations required (check all that apply) | • Large print/Braille<br>• Language interpreter<br>• Support person (for learning/prompts/cues)<br>• Computer Assisted Real Time Translation (CART) services<br>• American Sign Language interpreter<br>• Other | Can be multi-select |
| Primary Disabilities of consumer (check all that apply) | • Brain injury<br>• Psychiatric disability<br>• Alzheimer's/Dementia | Can be multi-select |

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| | • Physical disability<br>• Cognitive disability<br>• Severe health issue(s)<br>• Hearing<br>• Substance abuse<br>• Intellectual/developmental disability<br>• Vision<br>• Learning disability<br>• N/A<br>• Other | |
| Primary Disabilities of the caregiver/family member | • Brain injury<br>• Psychiatric disability<br>• Alzheimer's/Dementia<br>• Physical disability<br>• Cognitive disability<br>• Severe health issue(s)<br>• Hearing<br>• Substance abuse<br>• Intellectual/developmental disability<br>• Vision<br>• Learning disability<br>• N/A<br>• Other | |
| Current diagnoses of consume | | Can be multiple |
| Power of Attorney Flag | • Yes<br>• No | |
| Name | | Name of person having power of attorney |
| Phone | | Phone number of the person having power of attorney |
| Guardian Flag | • Yes<br>• No | |
| Name | | Name of guardian |
| Phone | | Phone number of guardian |
| Representative Payee Flag | • Yes<br>• No | |
| Name | | Name of Representative Payee |
| Number | | Number of Representative Payee |
| Advanced Directives Flag | • Yes<br>• No | |
| Name of the healthcare agent | | |

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| Phone | | Phone number of healthcare agent |
| DNR/COLST | • Yes<br>• No | (Do Not Resuscitate/Clinical Order for Life Sustaining Treatment) |
| Current living situation | • Independent<br>• Nursing home<br>• Residential care/enhanced residential care/assisted living<br>• Supportive living<br>• Adult family care<br>• Shared living<br>• Couch surfing<br>• Family/friends<br>• Minor child with parent(s)/relative(s)<br>• Foster home<br>• Homeless<br>• Institutionalized<br>• Other | Only one can be selected |
| Social Supports | • Family<br>• Spouse/partner<br>• Military network<br>• Friends<br>• Coworker<br>• Church/Spiritual Network<br>• Teacher(s)<br>• Neighbor<br>• Other | Can be multi-select |
| Current Community Support Services | • Area Agency on Aging (AAA)<br>• Brain Injury Association of Vermont (BIAVT)<br>• Green Mountain-Self Advocates (GMSA)<br>• VT Center for Independent Living (VCIL)<br>• VT Family Network (VFN)<br>• Family Caregiver Support Program/Respite<br>• Home Health/VNA<br>• Supports and Services at Home (SASH)<br>• Meals on Wheels<br>• Lifeline<br>• Choices for Care<br>• Adult Day Care<br>• Supported Employment<br>• Vocational Rehabilitation<br>• Developmental Disability Services<br>• Children's Personal Care Services<br>• Reach Up | Can be multi-select |

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| | • Community Rehabilitation and Treatment (CRT)<br>• Community Mental Health<br>• Substance Abuse Supports<br>• Individualized Education Program (IEP)<br>• Veterans Independence Program (VIP)<br>• Deployed Military Families<br>• Other | |
| My Functional Wellness | • Bathing<br>• Dressing<br>• Eating<br>• Toileting<br>• Transferring<br>• Mobility<br>• Using the bathroom/Continence<br>• Using the telephone<br>• Preparing meals<br>• Shopping<br>• Housekeeping<br>• Laundry<br>• Managing money/finances<br>• Medication management<br>• Transportation<br>• Health practices/managing health<br>• Housing stability/maintenance<br>• Communication<br>• Safety<br>• Managing time<br>• Cognition/Memory<br>• Other | Can be multi-select (Please check if you, or the person for whom you are seeking Options Counseling, are experiencing challenges with any of the following. Check all that apply.): |
| Income Source | • SSI<br>• SSDI<br>• Social Security<br>• Community Medicaid<br>• Employment<br>• Other Retirement/Investments<br>• Family/Friends<br>• Other | Can be multi-select |
| Annual Income | • $0 - $1,999<br>• $2,000 - $4,999<br>• $5,000 -$9,999<br>• $10,000 - $14,999<br>• $15,000 - $29,999<br>• $30,000 - $49,999 | |

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| | • 50,000 - $99,999<br>• 100,000 and above | |
| Served in military flag | • Yes<br>• No | |
| **MY OPTIONS PLAN** | | |
| My Options Counselor's First Name | | |
| My Options Counselor's Last Name | | |
| My Options Counselor's Phone Number | | |
| My Options Counselor's Email Address | • Remaining at home (e.g. services to help remain at home)<br>• Returning home from the hospital, short term rehabilitation, incarceration/institutionalization, or long term nursing home stay (e.g. services needed to transition home)<br>• Alternative housing arrangement (e.g. accessible/affordable/subsidized housing, foster care, home share, assisted living/residential care, adult family care, or other housing options)<br>• Home modifications/accessibility for my home/place of residence (e.g. ramps, bathroom renovation/adaptive equipment, assistive technology, financing for)<br>• Self-directed services (e.g. consumer-directed programs, Veterans Independence Program, Flexible Choices, Attendant Services Program)<br>• Employment (e.g. obtaining, training, accommodations for, legal concerns)<br>• Education (e.g. school-based options, IEPs, youth in transition)<br>• Special health care needs (e.g. specialized programs/services, preventative and chronic disease management programs, financial support for, support groups)<br>• Insurance (e.g. finding, problems with, private, Medicare, Medicaid, other)<br>• Behavioral health concerns (e.g. recent diagnosis, available services, support groups)<br>• Substance use (e.g. treatment for, support | |

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| | groups)<br>• Planning for the future (e.g. retirement, financial planning, education, future needs/goals)<br>• Caregiving/support as a caregiver/guardian/parent (e.g. caregiver burnout, respite, support groups)<br>• Legal issues and concerns (living will, advance directives, representative payee, guardian, trusts, etc.)<br>• Other | |
| Most Important Things To Me | | Most Important Things TO Me (Things that make me happy, content, feeling fulfilled such as people in my life, pets, daily rituals and routines, things I own/products I like, interests and hobbies, places I like to go and things I like to do): |
| Most Important Things For Me | | Most Important Things FOR Me (Things that usually help me stay healthy, safe, well, and productive/meaningful in my surroundings): |
| Most Important Relationships and Supports | | Most Important Relationships and Supports (list or describe the people in your life that support or help you the most, and who you'd like to be sure are there to help you reach your goal(s). Please be sure to list any important healthcare or formal service providers who you would like to include in your plan, or made aware of your plan.): |
| **GOALS** | | |
| Next Steps Responsible Parties and Due Dates for the Goals listed above. | | Please list below and include who might be able to help or support you in accomplishing these steps, and include specific due dates if desired. |
| Resources/Programs/ Services: (please list below) | | Use the section below to record those resources, programs or services you'd like to think about applying for or obtaining. These may |

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| | | be formal programs and services, or informal supports. |
| Important Contact Information for my follow up | | |
| Decline My Options Plan Flag | • Yes<br>• No | |
| Options Counselor to follow-up time frame | • In the next few days<br>• Next week<br>• In two weeks<br>• In a month<br>• In two months<br>• In three months | Only one can be selected |
| Your preferred method(s) for follow-up | • In-Person<br>• Phone<br>• Email<br>• I will contact my Options Counselor myself with a preferred date and time<br>• Please do not follow up with me<br>• Other | Can be multi-select |
| Other important notes | | |
| **RELEASE OF INFORMATION/CONSENT** | | |
| Disclose information provided | • Family/friend<br>• Hospital<br>• Physician<br>• Mental health agency<br>• Community health team<br>• Medical home<br>• Housing provider<br>• Area Agency on Aging<br>• Brain Injury Association<br>• Green Mountain Self-Advocates<br>• Developmental Disability Services<br>• VT Center for Independent Living<br>• VT Family Network<br>• Other | Can be multi-select |
| Other - disclose information provided | | |
| Signature | | |
| Date | | |
| Designated Representative | | |
| Options Counselor | | |

### *B.2 Rutland Shared Care Plan*

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| **COMMUNITY CARE PLAN** | N/A | N/A |
| Date | | |
| Primary Coordinator/Lead Care Coordinator | | |
| **PATIENT INFORMATION** | N/A | N/A |
| Patient last name | | |
| Patient first name | | |
| Patient middle name | | |
| Patient honorific | • Mr.<br>• Miss<br>• Mrs.<br>• Ms. | |
| Marital Status | • Single<br>• Married<br>• Divorced<br>• Separated<br>• Widowed | |
| Legal Name Flag | • Yes<br>• No | |
| Legal/Former Name | | |
| Birth date | | |
| Age | | |
| Sex | • Male<br>• Female | |
| Street Address | | |
| Cell Phone Number | | |
| Phone number | | |
| PO Box | | |
| City | | |
| State | | |
| Zip code | | |
| PCP | | |
| Care Coordinator | | |
| Diagnosis | | Can be multiple |
| Care Team | | Names of Individual Members of Patient's Care Team |
| Care Team Contact Info. | | Contact Info. for each member of patient's care team |

| **CARE PLAN** | N/A | **Data Field-Description** |
|---|---|---|
| Treatment Goals | | A field for each individual treatment goal. Treatment goals reflect the steps the care team will take to improve the patient's care/outcomes. |
| Person responsible for treatment goals | | Each individual treatment goal will have a responsible person assigned to it. |
| Due date for treatment goals | | Each individual treatment goal will have a due date assigned to it. |
| Patient goals | | A field for each individual patient goal. Patient goals reflect what is important to the individual, and may not reflect the treatment goal. |
| Person responsible for Patient goals | | Each individual patient goal will have a responsible person assigned to it. |
| Due date for Patient goals | | Each individual patient goal with have a due date assigned to it. |
| Shared strengths | | One field to reflect all shared strengths (no person responsible or due date needed) |
| Potential barriers | | One field to reflect all potential barriers (no person responsible or due date needed) |
| Action/Self-Management Plan | | One field to reflect all action/self-management plans (no person responsible or due date needed) |
| Name of local friend or relative | | |
| Relationship to patient | | |
| Home phone number | | |
| Work phone number | | |

### *B.3 St. Johnsbury Shared Care Plan*

| DB Fields | List of Values (if applicable) | Rules (if any) |
|---|---|---|
| **COMMUNITY CARE PLAN** | | |
| Date | | |
| Lead Care Coordinator | | |
| **PATIENT INFORMATION** | | |
| Patient Last Name | | |
| Patient First Name | | |
| Patient Middle Name | | |
| Patient honorific | • Mr.<br>• Miss<br>• Mrs.<br>• Ms. | |
| Phone number | | |
| Legal Name Flag | • Yes<br>• No | |
| Legal/Former Name | | |
| Birth date | | |
| Age | | |
| Sex | • Male<br>• Female | |
| Street Address | | |
| SSN | | |
| Marital Status | • Single<br>• Married<br>• Divorced<br>• Separated<br>• Widowed | |
| City | | |
| State | | |
| Zip code | | |
| Advanced Directive Flag | • Yes<br>• No | |
| Diagnosis | | |
| PCP Care Coordinator | | |
| 10 Year Medical Record review flag | • Yes<br>• No | |
| PCP | | |
| Names of Individual Members of Patient's Care Team | | |
| Contact Info. for each member of patient's care team | | |

| | | |
|---|---|---|
| **CARE PLAN** | | |
| Treatment Goals | | A field for each individual treatment goal. Treatment goals reflect the steps the care team will take to improve the patient's care/outcomes. |
| Person responsible for treatment goals | | Each individual treatment goal will have a responsible person assigned to it. |
| Due date for treatment goals | | Each individual treatment goal will have a due date assigned to it. |
| Patient goals | | A field for each individual patient goal. Patient goals reflect what is important to the individual, and may not reflect the treatment goal. |
| Person responsible for Patient goals | | Each individual patient goal will have a responsible person assigned to it. |
| Due date for Patient goals | | Each individual patient goal with have a due date assigned to it. |
| Shared strengths | | One field to reflect all shared strengths (no person responsible or due date needed) |
| Potential barriers | | One field to reflect all potential barriers (no person responsible or due date needed) |
| Action/Self-Management Plan | | One field to reflect all action/self-management plans (no person responsible or due date needed) |
| **IN CASE OF EMERGENCY** | | |
| Name of local friend or relative | | |
| Relationship to patient | | |
| Home phone number | | |
| Work phone number | | |

## Appendix C: Artifacts

| Document | Document Name | Document location |
|---|---|---|
| Draft_Requirement_to_Communities_8.14. | Approved Business Requirements | Embedded in this document |
| Functional and Non_Requirement_Fir | Detailed Functional and Non-Functional Requirements | Embedded in this document |

## Appendix D: Sample of Laws Protecting Confidential Information

*NOTE: For informational purposes only – this is not legal advice.

| Authority | Protected Information | Restrictions on Subsequent Re-Disclosure? | Penalties | Limitations on Protections |
|---|---|---|---|---|
| **HIPAA**<br><br>**45 C.F.R. parts 160-164** | Protected Health Information, excluding psychotherapy notes | Only for a covered entity | Covered entities are subject to disciplinary actions. | HIPAA does not protect information once it is disclosed to a non-covered entity. |
| **HIPAA** | Psychotherapy notes | For a covered entity, each subsequent disclosure must also be authorized | Covered entities are subject to disciplinary actions. | HIPAA does not protect information once it is disclosed to a non-covered entity |
| **42 C.F.R. Part 2** | Records of federally funded drug and alcohol treatment | Yes. Each disclosure must carry a warning on re-disclosure restrictions.<br><br>42 C.F.R. § 2.32 | Anyone who creates or receives this information is subject to fines of up to $5,000 for unauthorized disclosure or re-disclosure<br><br>42 C.F.R. § 2.4 | Does not protect drug and alcohol treatment information collected outside of Part 2 facilities |
| **Vermont Mental Health Statutes 18 V.S.A. Part 8 (§§ 7101-9335)** | Records created pursuant to State Mental Health statutes -<br><br>18 V.S.A. § 7103(a) | Yes. Records should be accompanied by re-disclosure warning similar to Part 2. | Any person who discloses records without authorization is subject to up to one year in prison and/or $2,000 in fines<br><br>18 V.S.A. § 7103(c) | Applies only to records of persons seeking or receiving hospitalization or care under state mental health system<br><br>18 V.S.A. § 7103 |

| Authority | Protected Information | Restrictions on Subsequent Re-Disclosure? | Penalties | Limitations on Protections |
|---|---|---|---|---|
| **The Family Educational Rights and Privacy Act (FERPA)**<br>**34 C.F.R. Part 99** | Information from educational records | Yes. Disclosure of records must be accompanied by re-disclosure restriction<br><br>34 C.F.R. § 99.33 | Educational institutions may lose funding; third parties may be restricted from doing business with educational institutions.<br><br>34 C.F.R. § 99.67 | Applies only to educational records.<br><br>34 C.F.R. § 99.30 |
| **Bill of Rights for Hospital Patients**<br><br>**18 V.S.A. § 1852** | Communications and records pertaining to care or treatment of those admitted to a hospital on an inpatient basis<br><br>18 V.S.A. § 1852(a)(7) | Each disclosure to non-medical personnel must be authorized | Failure to comply is basis for disciplinary action against a physician by the board of medical practice<br><br>18 V.S.A. § 1852(b) | Only protects records of those admitted to a hospital on an inpatient basis.<br><br>18 V.S.A. § 1851(2)<br><br>Only enforceable against those subject to the authority of the Board of Medical Practice |
| **Medicare and Medicaid Nursing Home Regulations**<br><br>**42 C.F.R. Part 483 Subpart B** | Personal and clinical records of an individual admitted to a nursing home<br><br>42 C.F.R. § 483.10(e) | No | Subject to disciplinary action by state survey organization | Applies to skilled nursing facilities participating in Medicare and Medicaid.<br><br>42 C.F.R. § 483.1<br>See 33 V.S.A. § 7301 for other nursing facilities. |

## Appendix E: Release elements of HIPAA (45 C.F.R. Parts 160-164) and 42 C.F.R. Part 2

*NOTE: For informational purposes only – this is not legal advice.

| Element | Description | Authority |
|---|---|---|
| The name of the client | | 42 C.F.R. § 2.31(a)(3) |
| Authorization for disclosure of information | The form must include the name or specific identification of each person or organization authorized to disclose protected information. | 42 C.F.R. § 2.31(a)(1); 45 C.F.R. § 164.508(c)(1)(ii) |
| Authorization for receipt of information | The form must include the name or specific identification of each person or organization authorized to receive the protected information. | 42 C.F.R. § 2.31(a)(2); 45 C.F.R. § 164.508(c)(1)(iii) |
| The purpose of the disclosure | Client selects the Shared Care Plan, the UTP, or both. | 42 C.F.R. § 2.31(a)(4); 45 C.F.R. § 164.508(c)(1)(iv) |
| Identification of the information to be disclosed | HIPAA requires a specific and meaningful description of the protected health information to be shared.<br><br>A release of Part 2 information must specify the kinds of substance abuse treatment information to be released as well as how information can be disclosed. | 45 C.F.R. § 164.508(c)(1)(i); 42 C.F.R. § 2.31(a)(5) |
| Signature and Date | If the authorization is signed by the client's personal representative, the authorization must also document a description of the representative's authority to act for the individual. | 42 C.F.R. § 2.31(a)(6)-(7); 45 C.F.R. § 164.508(c)(1)(vi) |
| Revocation statement | The revocation statement must explain that the client can revoke the authorization at any time, explain how the client can make a valid revocation, and a statement that revocation is not effective to the extent that the covered entity has released information in reliance on the authorization. | 42 C.F.R. § 2.31(a)(8); 45 C.F.R. § 164.508(c)(2)(i) |

| | | |
|---|---|---|
| Expiration | The expiration can be a date, an event, or both. The expiration should "relate to the individual or the purpose of the disclosure." | 42 C.F.R. § 2.31(a)(9); 45 C.F.R. § 164.508(c)(1)(v) |
| Conditioned treatment statement(s) | For most releases, including one for UTP, regulations require that providers notify client that treatment is not conditioned on the client's agreeing to release of confidential information.<br><br>Because the Shared Care Plan cannot be distributed without permission to share confidential information through, regulations require that the form to include a statement that treatment in the form of creating and sharing a plan of care is conditioned on obtaining a release and a statement informing the client of the consequences of refusing to agree to the release. | 45 C.F.R. § 164.508(c)(2)(ii)(A)-(B) |
| Re-disclosure statement | The release must notify the client of the potential that the information shared pursuant to the release will be subject to re-disclosure and no longer protected under HIPAA. | 45 C.F.R. § 164.508(c)(2)(iii) |
| Further requirements | Releases must be written in plain language. The client must receive a copy of the release. | 45 C.F.R. § 164.508(c)(3)-(4) |