Integrated Health Systems: Model of Care

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Discussion Topics & Goals

Reminder of Goals & Principles

Benefits of Integrated Health Care Delivery System

Model of Care

- Vermont Model of Care (VHCIP)
- Comparison to National Efforts

Design Elements

- Identify approaches and considerations for further development

Reform Goals & Principles*

- **Ensure Access to Care for Consumers with Special Health Needs**
  - Access to Care includes availability of high quality services as well as the sustainability of specialized providers
  - Ensure the State's most vulnerable populations have access to comprehensive care
- **Promote Person and/or Family Centered Care**
  - Person and/or Family Centered includes supporting a full continuum of traditional and non-traditional Medicaid services based on individual and/or family treatment needs and choices
  - Service delivery should be coordinated across all systems of care (physical, behavioral and mental health and long term services and supports)
- **Ensure Quality and Promote Positive Health Outcomes**
  - Quality Indicators should utilize a broad measures that include structure, process and experience of care measures
  - Positive Health Outcomes include measures of independence (e.g., employment and living situation) as well as traditional health scores (e.g., assessment of functioning and condition specific indicators)
- **Ensure the Appropriate Allocation of Resources and Manage Costs**
  - Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences of decisions in one area made in isolation of other factors
- **Create a Structural Framework to Support the Integration of Mental and Physical Health Services**
  - Any proposed change should be goal directed and promote meaningful improvement
  - Departmental structures must support accountability and efficiency of operations at both the State and provider level
  - Short and long term goals aligned with current Health Care Reform efforts

As presented to the VT General Assembly in 2016 Act 58 DMH/DVHA Unified Implementation Planning Budget Report

Benefits of Integration

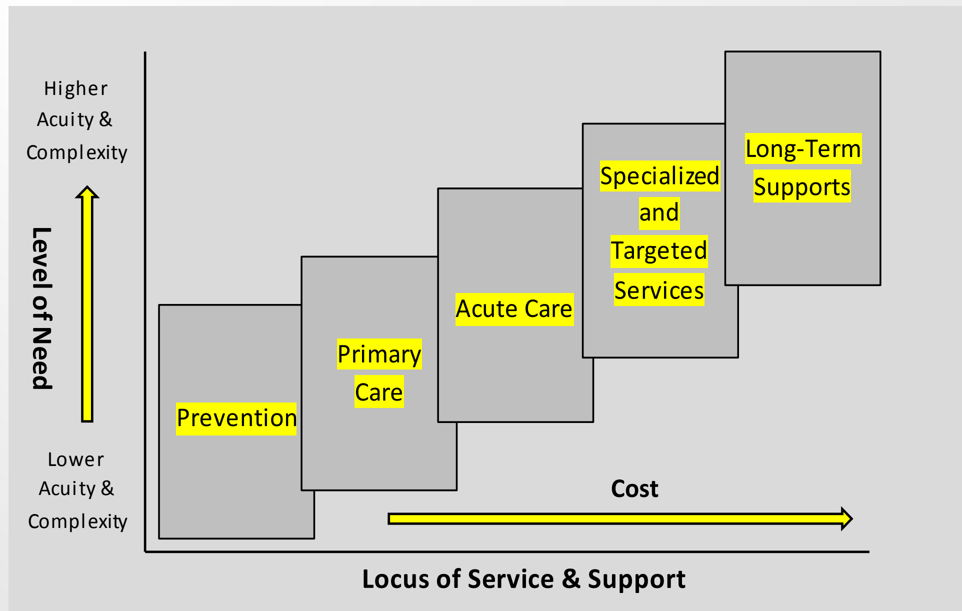
- Older people, and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports.
  - In VT approx. 25% of Medicaid beneficiaries are enrolled in Specialized Programs, however the account for 72% of Medicaid Expenditures (55% in specialized programs, 17% in physical health care)
- Evidence suggests that the integrationof care (primary care, acute care, chronic care, mental health, substance abuse services and disability and long term services and supports) is an effective approach to pursing the triple aim: improved health quality, better experience of care and lower costs.
- Community based supports help prevent the need for care in more expensive, acute care settings, thus improving well-being, quality and controlling costs
- Research has shown that environmental and socio-economic factors are crucial to overall health
- Integration is a fundamental component of comprehensive, person-centered care

VHCIP DLTSS WORKGROUP EFFORTS

VERMONT'S MODEL OF CARE

Vermont's System of Care

- Specialized support needs vary by individual and situation and may require short-term, intermittent and/or long term supports
- The full continuum of care must be available for people with mental health, substance abuse, disability and long term service and support needs:
  - From prevention through long term supports
  - Including a diverse range of medical, mental health, substance abuse, developmental disability, personal care, employment, housing and social services and supports



Vermont's Model of Care

1. **Person /Family Centered and/or Directed Services and Supports**

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

   "One size does not fit all" organizational/systemic capacity is needed to effectively respond to a range of preferences regarding services and coordination.

2. **Access to Independent Options Counseling & Peer Support**

   Independent, easy-to-access information and assistance to assist individuals and families/caregivers to: understand insurance options, eligibility rules and benefits; choose services and providers; obtain information and make informed decisions about services, including Peer and Recovery Support.

Vermont's Model of Care

3. **Involved Primary Care Physician (PCP)**

   All people with specialized needs will have an identified PCP that is actively involved in their care and who has knowledge about specialized service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options.

4. **Single Point of Contact (Case Manager)**

   To ensure person centered care; coordination across *all* of the individual's physical , mental health, substance abuse, developmental, and long-term care service needs; relevant assessments are completed; develop and maintain comprehensive care plan; ensure support during transitions in care and settings.

Vermont's Model of Care

5. **Medical Assessments and Disability and Long Term Services and Support Screening by PCPs, Medical Specialists**

   PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits. If person has mental health, substance abuse, functional or cognitive impairment, PCP should be informed about specialized services, use a brief screening tool (if necessary) and refer to specialized providers for more in depth assessments as necessary.

6. **Disability and Long Term Services and Support Specific Assessments**

   The Individual's Case manager is responsible for assuring that *all* screening and assessment results (medical and specialized program related) are included in, and inform, the individual's Comprehensive Care Plan and are shared with the Individual's Care Team members.

7. **Comprehensive Care Plan**

   For individuals with specialized service needs that go beyond PCP care, the case manager is responsible for developing and maintaining a single Comprehensive Care Plan that includes *all* identified needs, goals, preferences, services and supports (paid and unpaid).

Vermont’s Model of Care

8. **Individual Care Team (ICT)**

   For individuals with specialized needs that go beyond PCP care, the case manager is responsible for ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP.

9. **Support During Care Transitions**

   For individuals with specialized needs that go beyond PCP care, the case manager is responsible for: initiating and maintaining contact at the beginning, during, and at the end of the care transition (including such things as identifying barriers to care and working with the individual, family and providers to overcome barriers)

Vermont’s Model of Care

10. **Use of Technology for Information-Sharing**

Ultimate goal: A technological infrastructure that would:

- House a common case management database/system.
- Enable integration between the case management database and electronic medical records and between all providers of an Individual's ICT to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information.
- Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options.
- Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent.

Vermont and National Models of Care

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

*** Elements Fully Align with CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care**

Expected Impact of Vermont's Model

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

Model of Care Implementation

- Created by SIM DLTSS work group and agreed upon by stakeholders as foundational to reform efforts
- Adopted by SIM Practice Transformation Work Group and utilized to inform transformation activities
- Foundational to ACO discussions
- Vermont Specialized Programs support many of the model of care elements.
  - How can this reform effort preserve and enhance our ability to incorporate <u>all</u> elements across the health care delivery system?

Getting from Concept to Implementation

DESIGN ELEMENTS

Elements to Support Model of Care

1. Local System of Care (core set of services in every region)
   - Can it be phased? If so, what is the priority order?
2. Organization and Governance
   - Does the model of care require local affiliation agreements?
   - Does the model of care require one administrative entity or fiscal agent?
3. Reimbursement Methodologies
   - Does the reimbursement model create incentives to promote integration?
   - How can value based purchasing support the goals of the model of care ?
   - How will the money flow to the provider system?
4. Quality Monitoring and Oversight
   - What are the performance measures? What encounter data is needed?
   - What outcomes will be tracked?
5. Funding
   - Is additional funding needed to support transformation and infrastructure ?
   - Is there an opportunity for other payers to participate in funding the model?
6. Other Elements?

Design Considerations

Design Considerations to Support Vermont Model of Care		
Element	Options/Approach	How does the approach support integration, including coordination with the APM/ACO?
Local System of Care (core set of services in every region)		
Organization and Governance		
Reimbursement Methodologies		
Quality Monitoring and Oversight		
Funding		

Next Steps

- Review and evaluate approaches
  - Potential sub-groups
- Discuss criteria to evaluate approaches (provider readiness, funding, infrastructure needs, etc.)
- Identify preferred approach and develop model design and implementation plan