Vermont's Integrated Model of Care Summary Overview

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Adapted from:
The VHCIP Disability and Long Term Services & Supports Model of Care

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 approximately 25% of Medicaid beneficiaries are enrolled in Specialized Programs, however they account for 72% of Medicaid Expenditures (55% in specialized programs, 17% in physical health care).
- Evidence suggests that the integration of care (primary care, acute care, chronic care, mental health, substance abuse services and disability and long term services and supports) is an effective approach to 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.

Vermont's Integrated Model of Care

1. **Person/Family Centered and Person/Family 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.

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.

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 functional, cognitive, mental health, or substance abuse 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).

8. **Individual Care Team and Integration Between Medical and Specialized Care**

For individuals with specialized needs that go beyond PCP care, the case manager is responsible for ensuring that the Individual Care Team 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)

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 Care Team 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, privacy and confidentiality rules and standards, HIPAA compliant “releases”, and 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 of Care

- 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, adults 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, youth and adults
- 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 the State's Health Care Reform efforts preserve and enhance our ability to incorporate all elements across the health care delivery system?