Vermont Model of Care "Core Elements" Comparison with DAIL Programs *DRAFT 8.18.2016*				
Core Elements Vermont Model of Care*	**Choices for Care**	**Developmental Disabilities**	**Traumatic Brain Injury**	**Notes**
1. Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	**CFC:** Nursing facilities and residential care/assisted living per licensing rules **CFC/DS/TBI**: Home care programs are required under VT law and federal HCBS rules.
2. Access to Independent Options Counseling & Peer Support	✓	✓	✓	**CFC/DS:** Options Counseling as part of ADRC programs for all persons and independent support organizations for persons who are interested in self/surrogate managed services; Peer Support offered through AAA for CFC and GMSA for DDS. **TBI**: Reviewed as part of application, process and options discussed with consumer by State staff; TBI offers statewide peer support group meetings most facilitated by the Brain Injury Association.
3. Actively Involved Primary Care Physician	Partial	Partial		**CFC:** Nursing facilities and residential care/assisted living: licensing rules require physician orders prn; Informally there is some connection with MD and medical services, but integration is not included or required in current HCBS structure or process. **DS:** Health and wellness guidelines require various annual screenings, PCP visits and provide guidelines for certain common conditions. **TBI:** Working on Health & Wellness guidelines, while involvement occurs as best practice, it is not currently a documented standard.
4. Provider Network with Specialized Program Expertise	✓	✓	✓	**CFC/DS/TBI:** All programs have specialized provider networks, quality standards and conditions for provider participation in the program
5. Integration between Medical & Specialized Program Care	Partial	Partial	✓	**CFC:** Nursing facilities and residential care/assisted living: integrate care provided under license; Informally there is some connection with MD and medical services, but integration is not included or required in current HCBS structure or process **DS:** Health and wellness guidelines require various annual screenings, PCP visits and provide guidelines for certain common conditions. **TBI:** Integration is part of care coordination many people have multiple complex medical needs, therapies and procedures.
6. Single Point of Contact for person with Specialized Needs across All Services	✓	✓	✓	**CFC:** Nursing facilities and residential care/assisted living are lead for all care provided under license, including coordination with physician; Home based Case Management standards require single point **DS:** Persons involved in DS have single point, family directed or public guardian services **TBI:** Plans of Care are expected to address all necessary domains with single

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				case manager
7. Standardized Assessment Tool	✓	✓	✓	**CFC:** Nursing Facilities: Minimum Data Set (MDS) Residential care/assisted living: Resident Assessment (RA) HCBS Independent Living Assessment, app 20 years old; revisions related to CMS HCBS rules TBD
8. Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services	Partial	✓	✓	**CFC:** Nursing facilities and residential care/assisted living: care plans address range of needs and services provided under license; includes coordination with physician and physician orders; Home based service plans are specific to type/volume/cost of CFC services, but not all Medicaid services **DS:** DS plans are meant to be all-inclusive of consumer's needs **TBI:** TBI plans are meant to be all-inclusive
9. Care Coordination and Care Management	✓	✓	✓	**CFC:** Nursing facilities and residential care/assisted living: staff coordinate range of needs and services provided under license; includes coordination with physician and physician orders; Home based care offers choice of case management agency (Area Agency on Aging or Home Health Agency); revisions related to CMS HCBS rules TBD **DS:** State designates one provider per geographic area or specialized population/services **TBI**: State designated specialized providers statewide
10. Interdisciplinary Care Team	No	✓	✓	**CFC:** Nursing facilities and residential care/assisted living: internal care teams including physician orders; Home based case management standards encourage collaboration among providers but current structure/process does not include interdisciplinary care teams **DS/TBI:** Care teams are identified by consumer and based on needs and preferences
11. Coordinated Support during Care Transitions	✓	✓	✓	**CFC**: Nursing facilities and residential care/assisted living: staff support care transitions under licensing rules **DS/TBI:** Case managers support during care transitions is required
12. Use of Technology for Sharing Information	Partial	No	Partial	**CFC:** Nursing facilities or residential care/assisted living: MDS is shared with CMS via technology; no sharing across providers or with DAIL; **CFC/TBI**: Case managers and DAIL staff share access to information including assessments and service plans via Mediware SAMS platform; Providers do not universally have licenses or access **DS:** Currently no shared IT services or data

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Other relevant elements	**CFC:** LTC Ombudsman services: independent consumer advocate to address complaints including nursing facilities, residential care/assisted living, and home based services **CFC/DS/TBI**: Grievances/appeals via DAIL and Human Services Board regarding eligibility and service authorization **CFC/DS/TBI:** Provider quality and certification audits for adherence to standards			
*VT Model of Care aligns with CMS and NCQA standards for Long Term Services and Supports for persons who are dually eligible for Medicare and Medicaid services				