

Integrated Model of Care for
People with Disabilities and Long-term Services and
Supports Needs

Slide Deck Outline
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VHCIP DLTSS Work Group
PowerPoint Presentation

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I. Introduction

A. Description of Population

People with disability and long-term services and supports (DLTSS) needs are individuals of all ages who have a physical, cognitive or mental condition who need services and supports to assist with the limitations related to their condition:

- An individual's DLTSS support needs may be simple or complex;
- Effective services and supports must be provided within the context of self-determination, self-direction and understanding of the individual's unique needs.

B. Vermont DLTSS Providers

Specialized mental health, developmental disability, and substance abuse treatment services and supports are provided by 11 Designated Agencies and 7 Specialized Service Agencies. Other long term services and supports are provided by diverse groups:

- 112 Residential Care Homes;
- 36 Therapeutic Community Residences;
- 40 Nursing Homes;
- 12 Home Health Agencies;
- 5 Area Agencies on Aging;
- 14 Adult Day Providers;
- Substance Abuse Providers;
- Traumatic Brain Injury Providers;
- Durable Medical Equipment Providers;
- Vocational Rehabilitation;
- 6 Designated Regional Housing Organizations and 16 Housing Authorities and Land Trusts;
- Vermont Center for Independent Living and other peer support and advocacy providers and organizations;
- Guardians;
- Thousands of direct care/personal care workers who work directly for elderly and disabled individuals or their family; and
- Other independent practitioners and providers (e.g., mental health, rehabilitation, physical and occupation therapy).

C. What is Working Well for People with DLTSS Needs

Those enrolled in Medicaid Specialized Programs (i.e., Choices for Care , CRT, DS, TBI, SED) receive services and supports based in the values of self-determination and community integration with each program specializes in unique needs:

- Service and supports are provided by staff who understand the complexities and subtleties of the individual's issues and needs, such as:
 - Communication barriers,
 - Intellectual / cognitive barriers,
 - Physical barriers,
 - Symptoms and coping mechanisms related to severe mental illness,
 - Medical needs related to their disability or functional limitations, and

- Isolation due to the individual's functional limitations.

D. Gaps, Barriers and Disincentives in Receiving Services

The traditional medical system has not been designed to meet the diverse needs of people with DLTSS needs. The more predominant challenges in overcoming barriers include:

- Lack of understanding regarding how to address disability or functional issues;
- Lack of understanding about availability and effectiveness of specialized services and supports;
- Private health insurance typically does not cover some DLTSS-related services or non-medical expenses beyond short-term, rehabilitation-oriented care (e.g., PT/OT, DME, assistive technology, hearing aids, supplies, personal care);
- Medicare which covers people over 65 and those with a disability under 65, does not cover long-term services and supports;
- When the need for LTSS arises in the wake of a medical event – a hospitalization for an accident or illness, or a transition from a post-acute stay to long-term care – the planning and organization of LTSS for an individual is often handled separately from the health care planning, and there are few incentives for health care providers to integrate LTSS with medical care planning or service delivery. (*Excerpted from Commission on Long-Term Care, September 2013 Report to Congress*);
- For most people, DLTSS for individuals with more than one condition are managed by different state agencies and community providers;
- Many individuals (and their families) must navigate through different provider systems (e.g., Medical, Mental Health, Developmental Disability, Home Health, DME, Area Agencies on Aging, Centers for Independent Living, Vocational Rehabilitation, Housing Providers) to try to get all their needs met;
- The network of DLTSS providers is complex, multifaceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in the DLTSS network evaluate a person's overall situation in order to arrange for the right combination of services based on one's actual needs. Instead, access to services is often organized in relationship to their funding streams. (*Commission on Long-Term Care, September 2013 Report to Congress*);
- Many people with DLTSS needs do not have case management or other DLTSS:
 - *They do not meet clinical and/or financial criteria for Medicaid Specialized Program eligibility (i.e., people who are not able to get developmental services due to the increasing restrictions on Funding Priorities in the State System of Care Plan, or are not eligible for CfC, CRT, TBI or SED services due to strict clinical criteria),*
 - There may be limitations on the availability of Medicaid resources for case management or other services related to health and well-being (e.g., employment supports, adult dental care),
 - Medicare and Commercial insurance do not typically cover case management or DLTSS,
 - Those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED) may have multiple case managers and treatment plans that do not inform each other (e.g., medical care vs DLTSS needs).

II. PROPOSED MODEL OF CARE and CASE MANAGEMENT for VERMONTERS with DLTSS NEEDS

A. Basis for Design of Proposed DLTSS Model of Care

Person-Centeredness and Person-Direction are material to the foundation for the design of the proposed DLTSS Model of Care which:

- Builds on Vermont’s DLTSS current emphasis on self-determination and that people have a right to live meaningful lives in their communities;
- Builds on Strengths of Existing Vermont System of Care and Health Care Reform Elements (e.g., Blueprint, Community Health Teams, SASH, Medicaid Health Home “Hub and Spoke” model; DLTSS system of care) that:
 - Utilizes existing Vermont Waiver population care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations (i.e., CFC, DS, TBI, CRT and Substance Abuse),
 - Augments and develops additional mechanisms to address identified barriers, using national evidence-based strategies;
- Leverages Vermont Dual Eligible Demonstration Work Group Discussions and Products:
 - Person-Centered Care Work Group, Person-Directed Work Group and Essential Components of Person-Directed Approach Report,
 - Service Delivery Model Workgroup,
 - Individual Assessment & Comprehensive Care Plan Workgroup;
- Benefits from the DVHA Medicare-Medicaid Plan Model of Care Submission to CMS (as part of DE Demonstration):
 - DVHA Model of Care approved by CMS and NCQA (March, 2013) for three years (highest approval range) with a score of 96%.

B. Description of Core Elements in Proposed Model of Care

1. Person-Centered and Person-Directed Services and Supports

(Primary Source: Dual Eligible Demonstration Person-Directed Work Group)

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.

- Key Principles of Delivering DLTSS Person-Centered and Person-Directed Services and Supports:
 - Individuals feel welcome and heard and their choices are supported;
 - Individuals have access to independent supports for Informed decision-making and rights protection;
 - Availability of stable well-trained workforce and contractor network, including access to alternative providers and peer run services;
 - Commitment & capacity to promote self- help and person-directed services for individuals with diverse and multiple disabilities, over time, and across service settings;
 - “One size does not fit all”: organizational/systemic capacity to effectively respond to a range of preferences regarding service information & assistance and service coordination:
 - ◇ Individuals have access to services and supports when needed,

- ◇ Assessment, planning, coordination and service delivery practices are shaped by the interests, needs and preferences of individuals rather than agencies,
- ◇ Written, verbal and/or other forms of communication about treatment and services is provided in a manner that is accessible and understandable for the individual,
- ◇ Services are coordinated across all the individual's needs, and
- ◇ Supports are provided, as needed, to assist individuals with DLTSS to participate in all aspects of society and have a high quality of life.

(a) Person-Centered and Person-Directed Services and Supports – Care Management Roles:

- Ensure that the individual is at the center of all planning and decision-making regarding their services and supports;
- Educate, empower and facilitate the individual to exercise his or her rights and responsibilities on an ongoing basis;
- Provide information and support to the individual in making choices, including connections with options counseling and peer-support;
- Involve the individual as an active team member and stress person-centered collaborative goal setting;
- Ensure that all needed accommodations for planning participation and access to services are identified and provided when needed;
- As appropriate, represent the individual's point of view when the individual is unable to participate in discussions;
- Adhere to and respect all policies regarding individual rights, anonymity, and confidentiality.

2. Access to Independent Options Counseling & Peer Support

- Provide independent, easy-to-access information and assistance to assist individuals and families/caregivers to:
 - Understand insurance options, eligibility rules and benefits;
 - Understand specialized program eligibility rules;
 - Choose services;
 - Choose providers;
 - Navigate the delivery system;
 - Obtain information and on-going peer support regarding self-management of services and supports;
 - Make decisions about appropriate long-term care choices.
- Access to Independent Options Counseling & Peer Support examples include:
 - Aging and Disability Resource Connections (ADRCs) Member Organizations, such as:
 - ◇ Area Agencies on Aging,
 - ◇ Vermont Center for Independent Living,
 - ◇ Green Mountain Self Advocacy,
 - ◇ Vermont Family Network, and
 - ◇ Brain Injury Association of Vermont;
 - Peer-run Mental Health Programs; and
 - Health Care Advocate Office, Long-term Care and Mental Health Ombudsmen.

3. Involved Primary Care Physician (PCP)

- Ensures that all people with DLTSS needs have an identified PCP that is actively involved in their care:
 - Provides routine medical care,
 - Adjusts care as medical needs change,
 - Who has knowledge about DLTSS service options (via training, resource materials, etc.) and helps make connections (but does not function as a gatekeeper) to these options;
- Encourage individuals to choose Blueprint practices via Health Plan enrollment process and web-site information which provides access to:
 - Blueprint Community Health Teams for short-term interventions and support regarding medical needs;
 - PCP practices that utilize technology (e.g., EHRs, care management tools, information exchange) to support patients and improve care; and
 - Blueprint Leadership and Community Service Networks (which enhances PCP knowledge and networking to support patient care).

4. Single Point of Contact (Case Manager)

- Role of Single Point of Contact (Case Manager within Health Home):
 - Ensures Individual Self-Direction and Self-Management, as desired,
 - Coordination across *all* of the individual's medical, mental health, substance abuse, developmental, and long-term care service needs,
 - Assures that all relevant assessments are completed,
 - Develops and maintain the Individual Comprehensive Care Plan,
 - Communicates with and convene the Individual's Care Team as needed,
 - Provides Routine Individual Support, as requested, and
 - Ensures Support during Transitions in Care and Settings;
- Identification of Single Point of Contact:
 - If individual mainly has primary or acute health care needs, their single point of contact (and health home) would be their PCP and CHT (if involved);
 - For individuals with more complex DLTSS needs, their single point of contact (and health home) should have knowledge about the individual's DLTSS needs, such as:
 - ◇ Designated Agencies for Mental Health,
 - ◇ Designated Agencies for Developmental Services,
 - ◇ Home Health Agencies,
 - ◇ Area Agencies on Aging,
 - ◇ Traumatic Brain Injury providers,
 - ◇ Preferred Providers for Substance Abuse Treatment,
 - ◇ SASH, and
 - ◇ Others with specialized DLTSS expertise;
 - For individuals enrolled in Vermont state specialized programs (i.e., CFC, CRT, DS, and TBI), their single point of contact should be someone who has experience with the care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations;

- For individuals without an existing case manager, the individual's PCP should be responsible for identifying the need for a DLTSS case manager (via a brief DLTSS screening tool) and work with the individual to identify and refer to an appropriate health home organization:
 - ◇ May need payers to include this as PCP requirement,
 - ◇ Will require ACO / PCP education regarding DLTSS Provider network and triage protocols, and
 - ◇ Referrals could also occur via other sources, such as VCCI.

5. Medical Assessments and DLTSS Screening by PCPs, Medical Specialists

- PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits:
 - CHTs may conduct additional assessments regarding medical needs, if warranted;
- If a person has functional or cognitive impairments, PCP should be informed about DLTSS services, use a brief DLTSS screening tool (if necessary) and refer to DLTSS providers for more in-depth assessments as necessary to determine if there are unmet DLTSS needs:
 - VHCIP DLTSS Work Group should review the existing inventory of screening tools that could help inform the VHCIP Care Models & Care Management Work Group,
 - If screening indicates need, PCP works with the individual to identify and then make referral to appropriate provider in DLTSS network.

6. DLTSS-specific Assessments

- DLTSS needs-specific assessments already exist:
 - DAIL Independent Living Assessment (used for CfC),
 - Developmental Services Assessment,
 - Community Rehabilitation and Treatment Assessment,
 - SASH Assessment;
- Consistent elements should be assessed for all individuals with DLTSS needs:
 - An analysis and listing of questions that would need to be added to these assessments has been developed via planning for the Dual Eligible Demonstration Project,
 - Some initial DLTSS intake screening will lead to the above comprehensive assessments, as needed;
- The Individual's Single Point of Contact (Case manager) is responsible for assuring that:
 - All screening and assessment results (medical and DLTSS-related) should be included in and inform the individual's Comprehensive Care Plan and be shared with the Individual's Care Team members,
 - Necessary assessments are updated when a significant change occurs in the beneficiary's medical, DLTSS, or life situation.

7. Comprehensive Care Plan

- Current Situation:
 - PCPs currently develop and maintain an individual's Care Plan related to their medical needs:
 - ◇ The CHT may re-evaluate the patient Care Plan and initiate appropriate modifications in collaboration with the individual and members of the healthcare team;
 - DLTSS providers develop and maintain an individual's Care Plan related to their DLTSS needs;
 - An individual may have multiple Care Plans:
 - ◇ For medical and for DLTSS services and supports,
 - ◇ If individual receives multiple DLTSS services, and
 - ◇ If individual is transitioning across care settings;
- Proposed Model:
 - PCPs and CHTS continue to develop and maintain an individual's Care Plan related to their medical needs,
 - DLTSS providers develop and maintain an individual's Care Plan related to their DLTSS needs,
 - For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
 - ◇ Developing and maintaining a single Comprehensive Care Plan that includes all identified needs, goals, preferences, services and supports (which requires communication and coordination with the Individual's PCP),
 - ◇ Identifying the individual's informal support systems/networks in relationship to his or her functional and safety needs, and including this information in the Comprehensive Care Plan as appropriate,
 - ◇ Reviewing the effectiveness of the care plan with the individual and implementing modifications as needed in collaboration with other providers as appropriate,
 - ◇ Revising the Care Plan during and after Care Transitions, and
 - ◇ Ensuring that all key members of the Individual's Care Team have the most current Comprehensive Care Plan.

8. Individual Care Team (ICT)

For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (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;
- Establishing a routine working relationship with the individual's PCP / CHT member(s), and with other ICT providers as appropriate;
- Convening the ICT (in person or by phone) when needed to integrate and coordinate care, especially during care transitions;
- Provide links/coordination/integration with care providers across settings;
- Reporting new information to ICT members and other appropriate providers as needed;
- Interdisciplinary Care Team- Working Principles:
 - Mutual respect for the expertise of all members of the team, including the individual with DLTSS needs,

- Knowledge and trust among all parties establishes quality working relationships
- Shared responsibility which leads to joint decision-making,
- Equal participation and responsibility on the part of team members to ensure the beneficiary's needs and goals are met, with "shifting" responsibility determined by the nature of the problem to be solved,
- Communication that is not hierarchical, but rather multi-directional - facilitating sharing of information and knowledge,
- Cooperation and coordination which promote the use of the skills of all team members, prevent duplication, and enhance productivity,
- Emphasis by the team on "health care, environmental determinants of health and public health" rather than the more narrow focus of "medical care", and
- Optimism that the ICT process is the most effective method to achieve quality care and improved outcomes.

9. Support During Care Transitions

- For individuals with DLSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
 - Initiating and maintaining contact at the care transition point of service –
 - ◇ At the beginning, during, and at the end of the care transition;
 - Identifying barriers to follow-up treatment, services, supports, and medication adherence and working with the individual, family and providers to overcome barriers;
 - Ensuring the individual has the relevant information specific to their new condition
 - Coordinating linkages and follow-up with targeted services –
 - ◇ Assuring that PCP, specialty care, home health, community mental health center, or other appointments are scheduled within 7 days of discharge, or more quickly if clinically indicated;
 - Changing the Individual Care Plan to reflect any new needs; and
 - Communicating changes in Individual Care Plan with the individual's care team.

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,
 - 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,
 - The Population-Based Collaborative (ACO) Proposal is designed to “effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients”;
- The ACTT Proposal for the DLSS Network “builds on the ACO work to broaden responsive, integrated, person-centered services across additional parts of the full continuum of care” to:
 - Ensure high quality clinical data for population health and quality/outcome improvement and reporting from ACTT providers,

- Enable ACTT to securely transmit, exchange and store health information,
- Enable a 42 CFR Part 2 compliant database system/repository for designated and specialized service agencies,
- Develop a uniform and efficient EHR infrastructure for 4 Developmental Disability Specialized Service Agencies (SSAs) and 1 Designated Agency, and
- Develop and implement an ACTT transitions of care/uniform care transfer protocol.

III. What should improve under this MOC?

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

IV. Sample Case Study

Peter is 50. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He sees a mental health counselor and receives medication management by a psychiatrist at his local designated mental health agency. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy.

Under the proposed DLTSS MOC, Peter's designated mental health agency case manager is Peter's single point of contact for coordinating his care and ensuring that all his care and treatment planning is integrated.

Peter's Case Manager finds a PCP that is taking new patients and assists him to get to the appointment. The PCP, who is part of a Blueprint Advanced Primary Care Practice, conducts a thorough physical and discovers Peter has diabetes, which has compromised his immune system and is causing the repeated pneumonia. The PCP prescribes an antibiotic for the pneumonia, and schedules routine visits for evidenced-based diabetes care, including blood work and foot exams. The PCP gives Peter some information about diabetes and how to control it, but also suggests that Peter could access the practice-affiliated Blueprint Community Health Team (CHT) if he would like additional information and support in managing his diabetes. Peter agrees, and the PCP office sets up appointments for that afternoon. Peter meets with the CHT Nurse who further explains diabetes symptoms and management, and with the CHT Nutritionist who provides information about nutrition related to diabetes.

In the meantime, Peter's Case Manager has notified the PCP office of her role (providing a signed agreement from Peter to release information to her on his behalf). As such, Peter's diagnosis of diabetes and other CHT action steps are entered into his Individual Care Plan.

With Peter's permission, Peter's Case Manager arranges for Peter and his mental health counselor to talk with the CHT staff regarding how to integrate diabetes management with the management of his depression. In addition, Peter's Case Manager ensures that Peter's PCP and DA psychiatrist are both aware of all of Peter's medications and that Peter understands the side effects and potential interactions for all of them. Peter and his Case manager then meet to update his Individual Care Plan to reflect the new goals and action steps related to his diabetes, and the revised Plan is shared with all the members of his care team.