



Recommendations for MyCare Vermont

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in collaboration with the Community Advisory Committee
and the Core Planning Team**

November 16, 2007

**Vermont Health and Long-Term Care Integration Project
Vermont Department of Disabilities, Aging, and Independent Living**

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TABLE OF CONTENTS

Introduction.....	1
Background.....	3
Summary of Grant from Centers for Medicaid and Medicare Services	13
Mission Statement and Guiding Principles.....	15
Overview.....	17
Proposed Program Requirements.....	25
Centralized Comprehensive Participant Record	25
Community-Based Physicians	27
Consumer/Surrogate Directed Care	31
Decision Method.....	35
Extra Services	37
Flexible Services.....	39
Interdisciplinary Care Team	41
Person-Centered Care	45
Quality Management.....	51
Workforce Initiative to Promote Staff Retention and High Quality Performance.....	59
A Consumer’s Perspective on Patient-Centered Planning and Care	61
Data Analysis: Review of Medicaid Data.....	69

INTRODUCTION

In October 2004, Vermont was awarded three-year Real Choice Systems Change Grant from the Centers for Medicaid and Medicare Services (CMS). This document represents the culmination of planning work under this grant. The goal of this systems reform effort is to plan, design and implement systems that integrate funding streams, and integrate acute/primary and long-term care service delivery as a choice for frail, vulnerable, and chronically ill elderly and physically disabled adults. The purpose for creating these systems includes the following:

- Enhance consumer quality of life and autonomy
- Enable, promote, and support consumer's ability to live at home and in the community as long as medically and socially feasible
- Preserve and support consumer's family units
- Provide person-centered planning, thus putting consumers in the middle of their own planning.

To accomplish this reform a Core Planning Team and a Community Advisory Committee were developed. This document includes the recommendations developed by the Core Planning Team with the guidance and approval of the Community Advisory Committee.

The primary goals of the Core Planning Team include overseeing the development of the system reform. The key activities include: development of care delivery and administration policies and procedures; defining target populations; defining how the reform will add to rather than detract from what is currently available; development of data and reporting requirements; defining information systems; establishing reimbursement rates; building protocols for care management teams; identifying provider networks; and assisting in securing contracts with service providers. To accomplish these activities the Team met twice a month from January 2006 to June of 2007.

The Community Advisory Committee provided guidance to the Core Planning Team. This included advising the Core Planning Team in the development of the system reform to ensure that the reform meets the unique needs of the community and consumers, and creating community allies. Members included consumers, consumer advocates, health care providers, long-term care providers, other not-for-profit service providers, governmental agencies, and local and state officials.

It is important that all stakeholders have a chance to express their concerns and make suggestions, have their voices heard, and see how their input may be reflected in the end result of this reform. For this reason, the Core Planning Team members worked interactively with the Community Advisory Committee on program planning and implementation. Joint meetings were held periodically to facilitate communication.

At the conclusion of this planning phase the project has moved into a second phase. This phase includes working with interested organizations to conduct feasibility studies which will include writing business plans and developing financial proformas. The Community Advisory Committee will continue to provide guidance as the State works with potential organizations in developing the systems necessary to accomplish this reform.

BACKGROUND

This system reform builds on what has been learned from the development of the PACE (Program of All-inclusive Care for the Elderly) model, the VIP Care Partner Program and the waiver programs in Vermont. Integrated care is the next step in reforming Vermont's delivery of long-term care services. Separation between health and long-term support systems and the discontinuity across service delivery settings and providers are addressed by this systems change. The target population includes adults with complex medical needs; this consists mainly of adults who use multiple providers in both health and long-term support systems. Integrating care across systems would be done through the use of integrated funding and the interdisciplinary care management teams in alternative settings.

The business case for integrating health and long-term care

Low-income older Vermonters who are frail and chronically ill and adults with physical disabilities are among the most vulnerable citizens in our state. They often have multiple complex health and long-term care needs, struggle to access necessary services, and find that their health and long-term care needs are poorly coordinated. These shortcomings in the system can compromise health, safety and wellbeing, and make it more difficult for these vulnerable Vermonters to continue to live in their own homes or in other community settings.

There is also a compelling business case to be made for focusing on the needs of these Vermonters:

- Annual Medicaid expenditures currently approach \$40,000 per individual.
- Demographic projections indicate that between 2003 and 2013, Vermont's population of elders living in the community and persons with physical disabilities will grow by 42 percent.
- Documented examples of integrated care strategies from other states have demonstrated a positive return on investment in terms of State expenditures, improved quality of care, and increased Participant satisfaction.

Doesn't the State already have programs for this group of Vermonters?

Vermont currently has several progressive long-term care programs. Some of these include:

- Choices for Care, a federal long-term care waiver demonstration program that aims to equalize access to home and community-based services and nursing home services, by eliminating the traditional Medicaid coverage bias for nursing home services;
- Consumer- and surrogate-directed options and Flexible Choices (Cash and Counseling) which are part of the Choices for Care demonstration program;
- Attendant Services Program, an attendant care program that includes self direction of personal care services; and

- PACE, a site-based, integrated health and long-term care program for individuals who are at least 55 and are frail, which will start in Burlington and then in Rutland.

None of these programs, however, comprehensively addresses the range of problems faced by the statewide population of older Vermonters who are low-income, frail and chronically ill and adults with physical disabilities. Specifically, the existing programs do not integrate and coordinate acute, primary and long-term care services funded by Medicare and Medicaid, with the exception of PACE, which covers limited geographic areas and a limited age group (55+). The chart on page 7 depicts the relationship between MyCare Vermont and other State programs.

Five key concepts

The Department's vision reflects five key concepts:

1. Coordinating all care planning through a **Person-Centered Interdisciplinary Care Team**, comprised of the Participant, the Participant's primary care provider, a non-medical service coordinator, and a registered nurse;
2. Facilitating communication and coordination through the use of a common **Centralized Comprehensive Record**
3. Providing far greater **flexibility of covered services** than is allowed under traditional Medicare or Medicaid through a capitated payment (a per person rate) to the entity operating the program;
4. **Integrating Medicare and Medicaid funding** to eliminate existing perverse incentives and complexities for those who are eligible for both programs; and
5. Producing **program savings** to reinvest in services for participating Vermonters.

By pursuing these five concepts, Vermont can deliver necessary services and supports to vulnerable Vermonters in a way that better meets their needs, improves quality of life and health status, and uses State resources more efficiently.

Broad community involvement to design the program

Since starting work on this planning grant, the Department has employed three processes to ensure that there is broad and informed community input into the program design.

Core Planning Team

The Department convened a Core Planning Team in January 2006. The team consists of health and long-term care professionals from the community including: a physician; a supervising nurse from a home health agency; an supervising case manager from an Area Agency on Aging; consumer; the executive director of the Vermont Center for Independent Living; a consultant from Pacific Health Policy Group. The Team was facilitated by staff from Bailit Health Purchasing.

The Core Planning Team met twice a month to develop the program design and make policy and program recommendations.

Community Advisory Committee

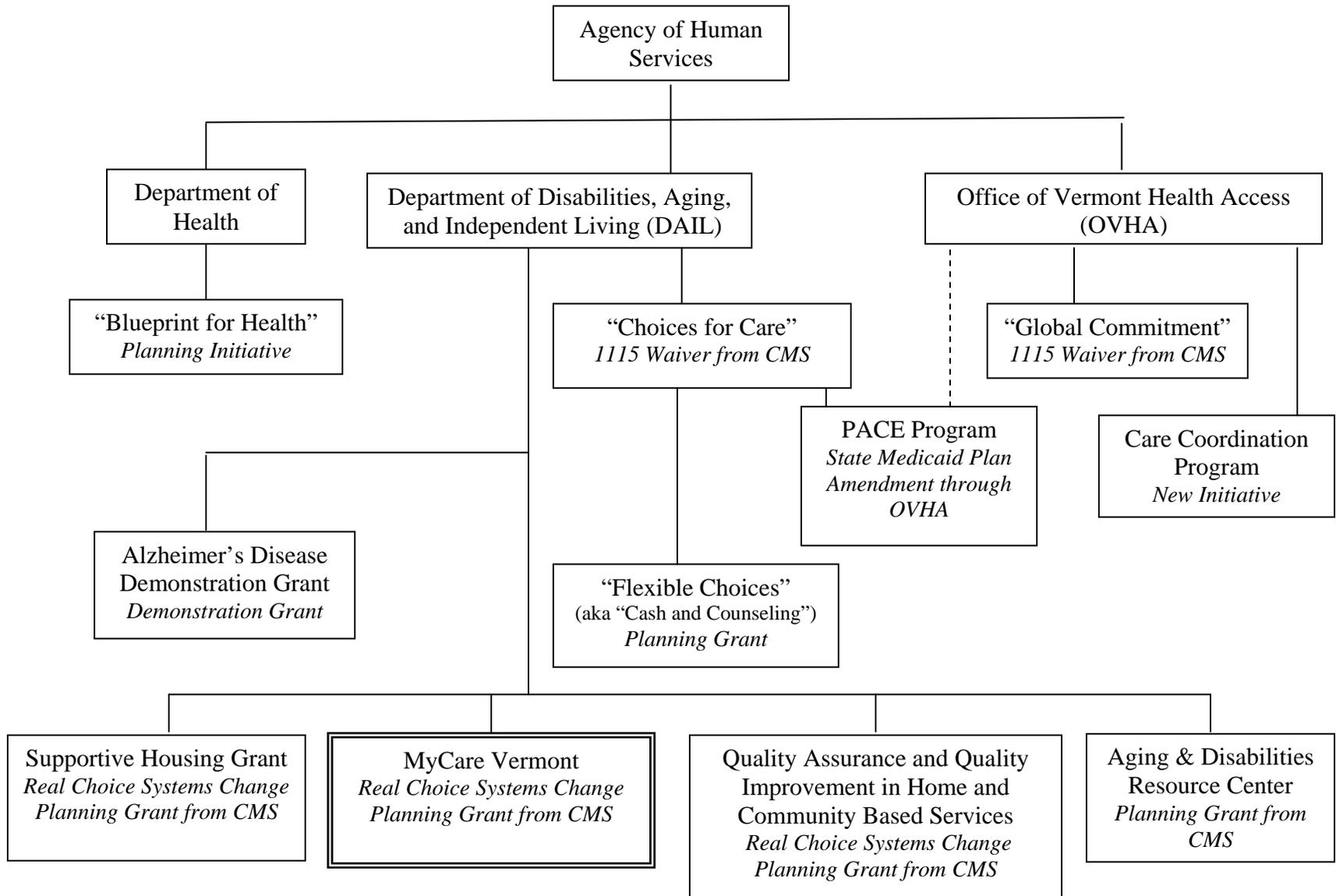
The Core Planning Team has been aided and advised in its work by a much larger body, the Community Advisory Committee, comprised of health, social service and long-term care providers, state agency representatives, advocates, and most importantly, consumers. Over 30 individuals participated in each of the five Community Advisory Committee meetings held during the first ten months of 2006. In this respect it serves as both a sounding board and a partner to the Core Planning Team in the design of the new integrated care model. The Community Advisory Committee to the grant has decided to name this new system of care “MyCare Vermont: Resources for Independence and Coordinated Health Care.” The Community Advisory Committee will continue to meet as the State works with potential organizations to develop a pilot project.

Community Feedback Partners

The Department has taken an additional step to ensure that community perspectives are incorporated into the creation of the integrated program. Each of the draft Core Planning Team program requirements is distributed to the Long-Term Care Coalitions across the state, as well as to any other statewide organizations expressing interest in participating in the feedback process. The Coalitions and other organizations review the draft policies and then utilize a structured questionnaire to provide their feedback. The responses are analyzed by the Department’s consultant and are then presented to the Community Advisory Committee, which in turn communicates with the Core Planning Team. Eight of the State’s eleven Long-Term Care Coalitions are participating in the process. In addition, the Community Geriatric Group of the Department of Community and Family Medicine at Dartmouth Medical School, the Vermont Association of Adult Day Services, the Vermont Association of Professional Care Providers, and the Area Agencies on Aging are participating as Community Feedback Partners. A separate report is available documenting this work.

The flow chart on page 11 depicts the relationship between these three groups, the State and the Centers for Medicare/Medicaid Services (CMS).

New Planning Grants and Initiatives Related to the Health and Long Term Care Integration Project



Descriptions of New Planning Grants and Initiatives Related to the Health and Long Term Care Integration Project

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING (DAIL):

Choices for Care – 1115 Waiver from the federal Center for Medicare and Medicaid Services

- Individuals can receive long term care services only.
- Medicaid Individuals eligible for Long-Term Care Medicaid (elderly and younger physically disabled)
- Provides long-term care services (Personal Care Attendant [PCA], adult day, case management, emergency response, home modifications), Nursing Home, ERC.
- Responsible for managing budget neutrality for all acute and primary care for this population
- Fee-for-service

PACE Program (Program for All-inclusive Care for the Elderly):

- Individuals can receive acute, primary and long term care services in one package
- Must be 55 years or older
- Must be eligible for Long Term Care Medicaid
- Is a State Medicaid Plan Amendment through OVHA, administered through DAIL
- Capitated payment Medicaid and Medicare

Flexible Choices (formerly “Cash and Counseling”)

- Individuals receive a “cash” benefit (through vouchers) to purchase and manage their long term care services only
- Self-directed care that provides flexibility for individuals to purchase non-traditional long-term care services
- Capitated payment determined individually–Cash value of PCA services

Alzheimer’s Disease Demonstration Grant to States (Demonstration Grant)

- Grant has four parts: two programs and two training components
- Dementia Respite Program: to prevent caregiver burnout and prevent or delay nursing home placements by providing respite care to family caregivers so they may remain in their roles.
- Caregiver Bridges: to establish links between primary care practices and other community providers, in order to improve and expand services for people with dementia and their family caregivers.
- Two training components: 1) Increase capacity of case managers, eldercare clinicians and other community providers to address the physiological and psychological needs of family caregivers; 2) Training for support teams of individuals with developmental disabilities and dementia.
- Funding is a mix of state general funds and federal grant funds.

MyCare Vermont (Health & Long Term Care Integration Project) (CMS Real Choice Systems Change Planning Grant)

- Develop a model that integrates funding streams and integrates acute/primary and long-term care service delivery as a choice for elderly who are frail, at-risk or chronically ill and adults with physical disabilities for individuals who are Medicaid eligible.
- Once operational, new provider entity will receive a capitated payment.

Supportive Housing Grant (CMS Real Choice Systems Change Planning Grant)

- A planning grant to figure out how individuals can receive supportive services in congregate housing settings so they can “age in place.”
- Funding is from a federal Real Choice Systems Change grant.

Quality Assurance and Quality Improvement in Home and Community Based Services (CMS Real Choice Systems Change Planning Grant)

- A grant to develop quality assurance (QA) and quality improvement (QI) systems for programs for individuals receiving waiver services from the department, to ensure waiver services are adequate, appropriate and of high quality.
- The goal is to have a consistent system of QA and QI across waiver services and supports.
- Funded through a grant from CMS.

Aging and Disability Resource Center (ADRC) Grant (CMS Planning Grant)

- Establishes highly-visible and trusted places in the community where people can go for comprehensive information, referral and assistance, short-term case management, and eligibility screening and determination.
- Designs a streamlined eligibility process for Medicaid and Medicaid LTC for one-stop shopping.
- Serves older adults, people with physical or developmental disabilities, and/or traumatic brain injury.
- Funded through grants from CMS and the Administration on Aging

DEPARTMENT OF HEALTH:

Blueprint for Health

- A project targeted at all Vermonters to enhance cooperation between providers, patients, the community, and insurers
- Supports health care providers to deliver world class care through the provision of improved information technologies and training in chronic care issues
- Optimizes treatment options for people with chronic disease by creating information networks that allow them to tap into community resources, classes, and activities to improve quality of life
- Funding from legislative appropriation

OFFICE OF VERMONT HEALTH ACCESS (OVHA):

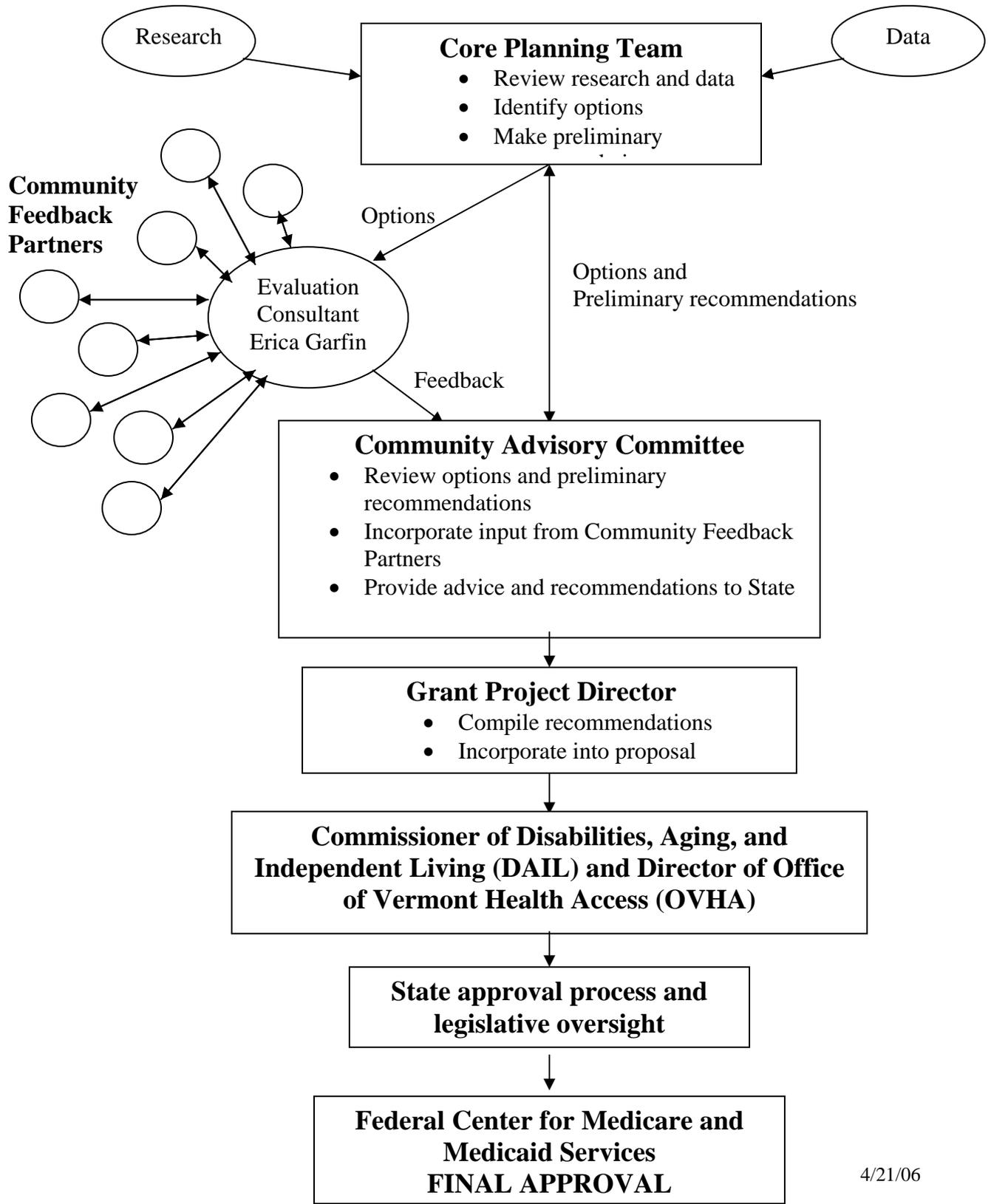
Global Commitment - 1115 Waiver from CMS

- Serves Medicaid population with the exception of Individuals eligible for Choices for Care Medicaid Waiver (Elderly and younger physically disabled)
- Provides program flexibility
- Responsible for budget neutrality for populations served
- Currently fee-for-service

Care Coordination Program

- Regionally-based RN/Medical Social Worker Teams will work in collaboration with PCP.
- Targets most expensive cases, no clinical eligibility
- Fee-for Service: reimbursement is enhanced bill for care plans and time spent in monthly care conferences

Health and Long Term Care Integration Project Flow Chart



4/21/06

SUMMARY OF GRANT

FROM CENTERS FOR MEDICAID AND MEDICARE SERVICES

VERMONT

Grant Information

Name of Grantee	State of Vermont		
Title of Grant	Vermont Real Choice Systems Change Comprehensive Systems Reform		
Type of Grant	Comprehensive Systems Reform		
Amount of Grant	\$2,089,863	Year Original Funding Received	2004

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Subcontractor(s)

To be determined.

Target Population(s)

Frail, vulnerable, and chronically ill elderly and physically disabled adults.

Goals

Form a core planning team to develop a model integrated care organization to serve frail, vulnerable and chronically ill elderly and physically disabled adults.

Improve access to services through integrated care organizations by using an interdisciplinary team and a single care plan.

Develop a reimbursement system for integrated care organizations.

Improve services and supports provided by integrated care organizations.

Ensure that services are available that match consumer's needs and preferences, and that sufficient workers are available to provide services.

Build quality management systems.

Activities

- Define target population and develop initial policies around legislative changes, service provider licensure, and risk-based entity licensure.
- Develop policy and procedures for administration, care delivery, and enrollment, and solicit and select provider organizations.
- Create a business plan that outlines the feasibility of creating integrated care organizations for the defined target population.
- Define core interdisciplinary team members, define relationship of primary care provider to the team, and define role of the consumer in planning and evaluating care.
- Define services to be provided and contracted by team members, develop an operational structure to promote collaboration and care integration, and develop a single care plan.
- Research spending by the target populations in various State Medicaid programs and identify services currently being reimbursed by Medicaid.
- Develop a Medicaid Capitation Rate; research current regulations from CMS for an 1115 Medicaid waiver, and Medicare Specialty Plans or Medicare 222 waivers; and develop a strategy for integration of funding, seeking CMS approval as appropriate.
- Develop guidelines for creative solutions for care, increased payment flexibility, and the involvement of consumers in identifying their treatment goals.
- Develop feedback loops and incentives to ensure best practices, develop support systems to increase retention and job satisfaction of the interdisciplinary team members, and develop funding integration to pay higher or different rates for needed services.
- Develop clear definition of consumer-centeredness that is incorporated into the program, conduct and review research on consumer preferences in Vermont, and research and develop a guide to be used for initial program development.
- Design systems to solicit ongoing participation from consumers in both planning and evaluation of care and quality service, and develop systems to ensure high technical standards of care.

Abstract

Under the umbrella of Vermont's Agency of Human Services, the Office of Vermont Health Access and the Department of Disabilities, Aging and Independent Living will collaborate to redesign a system in Vermont to coordinate both primary/acute and long-term care services for elderly and physically disabled adults. A commitment to integrated care is the starting place for the reform. Separation between health care and long-term support systems and the discontinuity across service delivery settings and providers will guide the development of the reform. The State will build upon the lessons learned from the Vermont Independence Project's Care Partners program (e.g., physical co-location of case management in a primary care setting) and the planning for the Program for All-Inclusive Care for Elderly (e.g., coordinated care delivery at an adult day/health care clinic by an interdisciplinary team).

To address identified problems, the project will undertake strategies to integrate funding streams for Medicaid, commercial health insurance, and Medicare; develop a community advisory committee, including consumers and other stakeholders, to develop policies and procedures; and use an interdisciplinary team to manage the long-term care and health care needs of adults with physical disabilities, chronic illnesses, and challenging life issues.

MISSION STATEMENT AND GUIDING PRINCIPLES

Health and Long Term Care Integration Project Core Planning Team Mission Statement and Guiding Principles

Mission Statement

Design a new integrated health care option that will offer Vermont consumers an alternative to the usual fragmented health care delivery system. This new option will use a person-centered interdisciplinary team approach and a flexible, single plan of care that preserves consumer choice and direction. Choosing this option will offer consumers improved access, service satisfaction, quality assurance and responsiveness. Projected costs for this new option will be budget neutral, predictable and controllable.

Definitions:

Integrated health care option:

This program will be a partnership between the consumer, the provider organization and State and Federal government and will integrate long-term care and acute care services. Payments from both Medicare and Medicaid are made to an organization (yet to be defined); the organization will be responsible for providing, at a minimum, all services covered by Medicare and Medicaid.

Consumers:

Adults with disabilities and elderly Vermonters who are eligible for both Medicare and Medicaid (“dual eligibles”), or are eligible for Medicaid only.

Health care:

Preventive, primary, acute and long term care services.

Person-centered:

Defining this term is a future task of the group. For the moment the best description identified by the group is the Wisconsin Partnership client's description that "I'm the boss!"

(Revised and Approved by Core Planning Team April 4, 2006)

Guiding Principles

Client-centered Care: Consumers will be treated with dignity and respect and be active partners in their care. Services should be timely and delivered where and when they are needed. The consumer (and family) will work with an interdisciplinary team to develop a mutually acceptable plan of care.

Coordinated Care: All the people involved with a consumer's care will communicate with each other, balancing the sharing of appropriate information with the consumer's right to privacy. As a result, transitions across care settings (for example from home health to hospital, or hospital to home) will be smooth and coordinated.

Quality of Care: The integrated health care option will ensure quality of care by utilizing best practice standards. Quality of services will be routinely monitored and assessed.

Caregiver Support: The essential role of informal caregivers will be acknowledged and supported.

Integrated Funding: Funding streams for acute and long term care will be integrated to allow more flexibility to purchase services that will enable consumers to live in the least restrictive setting for as long as possible and desired.

(Revised 3/9/2006)

OVERVIEW

The state of Vermont anticipates contracting with an organization (Organization) to administer a new integrated health and long term care program.

This document describes the services the Organization will be required to provide as well as elements of the way in which the services will be provided.

The Organization shall provide services through a comprehensive interdisciplinary services delivery system that addresses both health and social needs. This new program will coordinate and integrate preventive, acute, post-acute, rehabilitation, primary, social and long-term care services to maximize the ability of Participants to live in the setting of their choice, participate in community life, and engage in the decision-making processes regarding their own care. The benefit package for all Participants would include all Vermont Medicaid State Plan Services, Choices for Care 1115 Demonstration Waiver services, and for all dually eligible individuals, Medicare services. Medicaid funds will be paid by the State on a capitated basis and the Organization will be required to provide services that are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished, and to ensure that members receive high quality health care, social services and other supports necessary to support them to be valued citizens living in and giving to the community. The Organization will be required to comply with all federal and state laws, regulations and policies concerning the protection of Participants' medical records and confidential information.

The cornerstone of this model is that services delivered are *person-centered*. A proposed definition of Person-Centered Care is: "Person-Centered Care is customized care that is respectful of and responsive to an individual's circumstances, preferences, needs and values. Key attributes of Person-Centered Care include:

1. Collaborative decision-making;
2. Support of an informed and educated care team;
3. Coordination and integration of care among providers and across all settings;
4. Promotion of well-being including physical comfort and emotional support; and
5. Involvement of the individual's self-identified support circle.

In addition to Medicaid State Plan services, Medicare services and Choices for Care 1115 Demonstration Waiver services, the Organization is expected to provide the following services defined below:

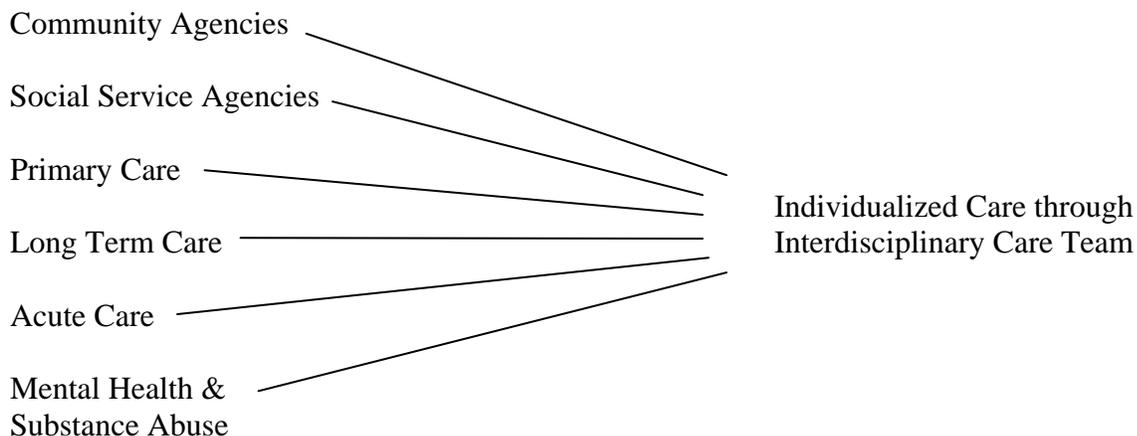
1. Integrated Services
2. Health Promotion and Risk Assessment/Reduction Services
3. Flexible Services

In addition, at its discretion, the Organization may provide Extra services.

Descriptions of these four new services follow below.

1. Integrated Services

The Organization is responsible for providing an integrated and coordinated delivery system for all health services needed by an individual. The Organization may provide the services directly or through contract arrangements. The system should be designed to ensure access to and integration of preventive, primary, acute, post acute, rehabilitation, social and long-term care services. The services must be designed to: 1) ensure communication among providers and ensure coordination of Participants' care across networks, provider types and settings; 2) ensure smooth transitions for Participants who move among various settings in which care may be provided over time; and 3) facilitate and maximize the level of Participants' self-determination and Participants' choice of services, providers and living arrangements. The model recognizes that Participants live with their illnesses and disabilities and can help themselves considerably by having a central role in the decision-making that affects their health and well-being. The system should provide each Participant with a primary contact person who will assist the Participants in simplifying access to services, information and decision-making. In addition, the system must be designed to promote and ensure service accessibility, attention to individual needs, continuity of care, comprehensive and integrated service delivery, culturally appropriate care, and fiscal and professional accountability.



To provide integrated services, the Organization will be required to use an Interdisciplinary Care Team and a Centralized Comprehensive Record as described below.

Interdisciplinary Care Team

The potential Organization will establish an Interdisciplinary Care Team (ICT) consisting of, at a minimum, the Participant (or representative selected by the Participant), a Primary Care Provider¹, Case Manager/Social Worker, and Registered Nurse. These team members will be employed by or operate under the direction of the Organization. It will be the responsibility of the Organization to ensure Participant and/or a designated representative involvement with the team to the extent needed or desired by the Participant. If appropriate, other members may be added to an individual Participant's team, based on the individual's condition and/or needs.

¹ This could be either a primary care physician or a nurse practitioner.

Decisions will be made jointly by all team members including the Participant and/or a designated representative. Each will be responsible for clarifying his or her knowledge and preferences for the decision. In practice, Participant participation in decision-making is on a continuum, ranging from no participation to complete control of the decision, and, although joint decision making may be ideal, participation should be considered satisfactory when the individual has participated to the degree he or she desires and at which the individual feels comfortable.

Interdisciplinary Care Team Responsibilities:

A. Team:

- Educate, empower and facilitate the Participant to exercise his or her rights and responsibilities.
- Involve the Participant as an active team member and stress Participant-centered collaborative goal setting.
- Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active.
- Establish a set of guidelines or care responsibilities for the entire team and distribute these responsibilities to all team members.
- Provide information and support to the Participant in making choices within the parameters of the Organization.
- Develop, monitor and review the Participant's care plan with the Participant.
- Ensure Participant's goals and preferences are identified, documented in the care plan and addressed.
- Provide case management, including assessing needs, and authorizing and coordinating services.
- Evaluate the effectiveness of the current plan of care and implement modifications as needed in collaboration with the Participant and other providers as appropriate.
- Provide in-home assessment of safety issues, and work with the Participant to manage identified risks.
- Provide education to the Participants and families regarding health and social needs.
- Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs.
- Report information to team, Participant and other appropriate health care providers as needed.
- Assess and assist the Participant in identifying and addressing quality of life issues.
- Meet documentation and reporting requirements in a timely and accurate manner.
- Provide links/coordination/integration with care providers across settings.
- As appropriate, represent the Participant's point of view when the member is unable to participate in decisions.
- Provide Participant with necessary equipment and supplies.

B. Participant and/or designated representative:

- Understand the disease process, chronic illness, and/or disability.

- Realize his/her role as the daily self-manager.
- Engage family and caregivers in the Participant's self-management.

C. Primary Care Provider:

- Provide initial history and physical exam.
- Provide periodic re-evaluation of medical status.
- Provide, in the member's residence or in an office/clinic setting, evaluation of episodic acute illness.
- Provide prevention and health maintenance education to Participant.
- Assume leadership role in collaborating with appropriate providers prior to, during, and at discharge from hospital, rehabilitative and nursing facility settings.
- Order diagnostic or therapeutic interventions.

D. Registered Nurse:

- Assess physical health status and response to illness and/or disability.
- Assess effectiveness of medications including intended effect, side effects, and Participant knowledge and method of administration.
- Provide in-home assessment to identify functional limitations and adaptations to environment.
- Provide face-to-face skilled nursing services as required to manage care and maintain current knowledge of Participant needs.
- Delegate appropriate aspects of Participant care to supportive home care service providers including Personal Care Attendants (PCAs), Homemakers, or Licensed Nursing Assistants (LNAs); and supervise and evaluate the effectiveness of care given.
- Provide, in conjunction with the Primary Care Provider, prevention and health maintenance education to Participant.
- Assess the need for and coordinate supportive home care services provided to Participant.
- Ensure that the supportive home care provider's written plan is reflective of Participant needs, is current, and provides sufficient direction to the supportive home care provider.
- Communicate acute changes in health status to Participant in a timely manner and collaborate with Participant in implementing interventions.

E. Case Manager/Social Worker:

- Complete basic psychosocial, environmental and economic assessments.
- Provide on-going coordination of psychosocial services.
- Explore financial options and eligibility, including employment services.
- Provide information about and assist Participant in maintaining and establishing community links.

- Provide information about and assist Participant with housing and transportation issues.
- Assist in crisis intervention.
- Provide assessment and coordination of mental health, alcohol and/or drug abuse services.
- Coordinate supportive counseling as appropriate.

Centralized Comprehensive Record

The Organization must maintain a single, centralized, comprehensive record (CCR) that documents the Participant's medical, functional, and psychosocial status. The purpose of the record is to have information available so the Participant receives appropriate emergency and urgent care when needed. The information must also be available and accessible to specialty, long-term care, mental health and substance abuse providers so Participants do not have to repeat their story and so all providers have accurate information. This record must be available and accessible 24 hours per day, seven days per week, either in its entirety or in a current summary of key clinical information for triage. It is preferable to have an electronic record and the expectation is that the Organization will work toward that goal.

The Organization must ensure that the Primary Care Provider (PCP) and all members of the Interdisciplinary Care Team (ICT) as well as any other appropriate providers, including subcontracted providers, make appropriate and timely entries in the CCR describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed. The organization of and documentation included in the CCR must meet all applicable professional requirements. The record must be maintained in accordance with State and Federal law.

The Centralized Comprehensive Record must contain the following:

- a. Participant identifying information, including communication and service accommodations in response to the Participant's disability, and spiritual preference, if any;
- b. Documentation of contacts with Participant, family members and persons giving informal support, if any;
- c. Participant's goals;
- d. A list of Participant's strengths and problems;
- e. A summary of the Participant's medical and social history prior to joining MyCare Vermont;
- f. Prescribed medications, including dosages and any known drug contraindications that are Participant-specific, and any discontinued medications and the rationale for the discontinuation;
- g. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted;
- h. Multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate provider;
- i. Laboratory and radiology reports;
- j. Documentation about the services being received by the Participant from community agencies that are not part of the Provider Network;
- k. Physician orders;

- l. Disenrollment agreement, if applicable;
- m. Participant's individual advance directives and health care proxy, recorded and maintained in a prominent place;
- n. Plan for emergency conditions and Urgent Care, including identifying information about any emergency contact persons;
- o. Emergency code list;
- p. Allergies and special dietary needs;
- q. Activities of Daily Living (ADLs) deficits, if any; and
- r. HIPAA consent forms regarding who may access Participant's record.

2. Health Promotion and Risk Assessment/Reduction Services

Services will be designed by the Organization to help prevent, delay or minimize disease and disability progression. Two types of services will be made available to Participants:

- a. The potential Organization must inform Participants about the range of health promotional and wellness informational activities available in the community for Participants, family members and other significant informal caregivers. The focus and content of this information must be relevant to specific health-status and high risk behaviors for elderly who are frail, at-risk or chronically ill and adults with physical disabilities.
- b. In addition, for each Participant risk factors for chronic disease or increased disability will be identified. Condition-specific opportunities for self-management services will be made a part of the individual's care plan. These services will respond to Participants' personal and environmental circumstances. At a minimum, the following risk factors will be assessed: tobacco abuse, nutrition, lack of physical activity, excessive alcohol consumption, drug abuse and reduction in range of motion/fall risk.

3. Flexible Services

The Organization is expected to provide Flexible Services. Flexible Services are services that substitute for the traditional services covered by the Medicaid State Plan, 1115 Choices for Care Demonstration Waiver and Medicare, and that provide resourceful ways to meet the Participant's needs. The ICT is responsible for determining appropriate Flexible Services necessary to meet the Participant's needs. The Flexible Services will be Participant-specific, culturally appropriate care and supports provided in a way that is fiscally and professionally accountable.

Decision Method

The Organization will develop a decision methodology for use by the ICT for determining if Flexible Services are necessary or more appropriate to meet the Participant's needs than traditional Medicare or state plan Medicaid Services. At a minimum, the decision methodology should include consideration of the following questions:

- What is the need, goal, or problem for the Participant?
- Does it relate to the Participant's assessment, service plan or desired outcomes?
- How else could the need be met?
- Are there policy guidelines to guide the choice of option?
- Which option does the member (and/or their family) prefer?
- Which option(s) is/are the most effective and cost-effective in meeting the desired outcomes(s)?
- Have all the options been explained, discussed, and negotiated with the Participant?

Principles

The principles to be used by the Organization to deliver Flexible and other services will be:

1. Deliver and coordinate health and social services through an interdisciplinary care team.
2. Treat Participants as individuals who are accountable for decisions and responsibilities and entitled to their rights.
3. Allow Participants to manage their own services to the greatest extent possible or to the extent they desire.
4. Offer Participants the information necessary to make informed decisions.
5. Deliver quality services that are both Participant- and provider-friendly, on a timely basis.
6. Educate health care professionals regarding frail elders and people with disabilities.
7. Maintain physical and mental health standards to ensure optimal levels of health and functioning for each Participant.
8. Encourage Participants to develop and maintain friendships and to participate with their friends and families in their communities.
9. Consider the changing needs of Participants and flexibly adapt services as necessary.
10. Emphasize Participants' dignity, self-reliance and sense of self worth.
11. Carry out the Participant's care plan by effectively and equitably utilizing the available public and private resources.

4. Extra Services

The Organization may propose to offer additional services not already required by the State or Medicare. Unlike Flexible Services, which are identified and made available on an individual-

specific basis, Extra Services will be made available to all members with demonstrated need for the services. Extra Services must be actual health care or long-term care services rather than gifts, incentives, health assessments or educational classes that are provided at no additional cost to the State, Medicare, Participants or providers.

Additional Financial Considerations

1. If the Participant desires, he or she may elect to self-manage his or her personal care services, working with the team to determine a budget.
2. The Organization will not be required to provide items that Vermont Medicaid determines to be experimental in nature. This may include, but is not limited to, transplants of bone marrow, liver, heart, heart-lung, lung and pancreas. (Cornea and kidney transplants are not considered to be experimental in nature.)
3. The potential Organization will not be expected to fund the following covered services in the capitation rate:

- Ventilator Dependent Care
- Long-term Hemodialysis
- Kidney and Cornea Transplants

A separate capitation rate will be developed for Participants needing these types of care.

PROPOSED PROGRAM REQUIREMENTS

CENTRALIZED COMPREHENSIVE PARTICIPANT RECORD

A comprehensive Participant record was one the key concepts developed by the core planning Team. The Department of Disabilities, Aging and Independent Living (DAIL) already maintains a centralized Participant electronic database (“Social Assistance Management System” or “SAMS”) for the management and oversight of individuals enrolled in the Department’s Choices for Care 1115 waiver (CFC). Choices for Care is a Medicaid-funded, long-term care program to pay for care and support for older Vermonters and people with physical disabilities. The program assists people with everyday activities at home, in an enhanced residential care setting, or in a nursing facility. The SAMS database is an off-the-shelf software product from Synergy Software of Essex Junction, Vermont. DAIL/DDAS uses SAMS to manage Choices for Care and some other programs. It is accessible on the Internet though a secure website called: Agingnetwork.com. This website is hosted by Synergy and meets all HIPAA requirements for security. The CFC database in SAMS includes client demographics, enrollments and approved care plans SAMS action fields can be used to send client-specific messages to other SAMS users.

BUSINESS REQUIREMENTS

When MyCare Vermont is operational Participants will need to be clinically and financially eligible for the Department’s Choices for Care Waiver. Since the capacity already exists in SAMS for a centralized web based record and MyCare Vermont Participants are part of the Choices for Care Waiver we are proposing to modify the existing SAMS Database to meet the needs of MyCare Vermont. The Core planning team after extensive research agreed on the following data elements to be included in a centralized record. Some of capacity already exists in SAMS, some will require modifications. The following list identifies data elements to be included in a centralized electronic record for Participants in MyCare Vermont.

Data Elements:

1. Participant identifying information, including communication and service accommodations in response to the Participant's disability, and spiritual preference, if any;
2. Documentation of contacts with Participant, family members and persons giving informal support, if any;
3. Participant's goals;
4. A list of Participant's strengths and problems;
5. A summary of the Participant's medical and social history prior to joining MyCare Vermont;

6. Prescribed medications, including dosages and any known drug contraindications that are Participant-specific, and any discontinued medications and the rationale for the discontinuation.
7. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted;
8. Multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate provider;
9. Laboratory, radiology reports and reports from specialists;
10. Documentation about the services being received by the Participant from community agencies that are not part of the Provider Network;
11. Physician orders;
12. Disenrollment agreement, if applicable;
13. Participant's individual advance directives and health care proxy, recorded and maintained in a prominent place;
14. Plan for emergency conditions and Urgent Care, including identifying information about any emergency contact persons;
15. Emergency code list;
16. Allergies and special dietary needs;
17. Activities of Daily Living (ADLs) deficits, if any; and
18. HIPAA consent forms regarding who may access Participant's record.

The current SAMS database meets all functional and business process and data needs except for the following new areas needed for data capture:

1. Prescription Medications: (area to hold prescription meds, dosages etc. linked to client)
2. Allergies and special dietary needs (area to hold allergies linked to client)
3. Lab reports, x-rays etc. (area to hold images linked to client)
4. Emergency Codes: (area to hold emergency codes linked to client)

PROPOSED PROGRAM REQUIREMENTS

COMMUNITY-BASED PHYSICIANS

A. Introduction

Community-based physicians for MyCare Vermont refers to physicians in private or group practice who treat one or more MyCare Vermont Participants but are not directly employed by the MyCare Vermont Organizations. Doctors are eligible to become community-based physicians in MyCare Vermont if they are licensed in the State of Vermont specializing in family or internal medicine. If they so desire, the Participant may select a nurse practitioner to serve as their community-based physician.

Becoming a Participant in MyCare Vermont should not require the individual to give up their community-based physician and their well-established network of care providers, including supportive home care and personal care providers. Many individuals have long-standing relationships with these providers that have developed over years.

Long-term relationships with individuals will allow providers to gain important personal and medical knowledge about chronically ill consumers. This knowledge has been shown to increase the effectiveness of care and to make the care more individualized, or consumer-focused. Preserving these relationships is important.

In addition, due to the rural nature of the state and the desire to expand MyCare Vermont to Vermont's rural towns, the only practical solution is to engage community-based physicians. This will have the added benefit of providing a support team to assist physicians with providing care.

It is a challenge to develop community-based physician services. The medical director is a vital link to the community-based physician. She/he can help the physicians to better understand each other's practices and suggest strategies for the community-based physicians to work most effectively. The medical director has more "clout" with the physicians and can help problem-solve difficult relationships.

The medical director should be someone who is respected in the medical community, has experience or expertise with the target population, and, if possible, has a caseload of individuals who are eligible for MyCare Vermont. If a medical director is not included on the planning team during the pre-feasibility phase, then he/she will certainly need to be included when the Organization begins exploring relationships with potential providers.

B. Guidelines to Develop Individualized Community-Based Physicians

At a minimum a MyCare Vermont Organization shall incorporate the following concepts when developing contracts, policies and/or procedures concerning community-based physicians.

- ◆ MyCare Vermont is based on the belief that both high quality health and supportive care are necessary for the target population to maintain the highest level of health and quality of life and to remain engaged in the community as long as possible. The MyCare Vermont Team has the responsibility for integrating care across these two networks. Community-based physicians shall agree to delivering care as a member of the MyCare Vermont Team.
- ◆ Allow flexibility for Participants to select a specialist as their community-based physician. The specialist would have to agree to do certain things, and if they decline, the Participant must choose another person (specialist or not) as their community-based physician if they want to enroll in MyCare Vermont. Responsibilities the specialist would need to agree to include attending ICT meetings, interacting with the ICT, meeting all community-based physician and MyCare Vermont requirements, and providing acute and well care.
- ◆ Require accessibility of community-based physicians. Accessibility includes physical, technology, and Centralized Comprehensive Record. Each is discussed separately below.
 - MyCare Vermont Organizations will be required to ensure that all services provided are accessible and in compliance with the ADA.
 - A physician that wanted to be a community-based physician for MyCare Vermont would be required to have web-based access.
 - In a model using community-based providers, the community-based physician would be required to use an electronic centralized health record provided by the MyCare Vermont Organization.
- ◆ Community-based physicians are required to cooperate with systems developed by the MyCare Vermont Organization for regular monitoring.
- ◆ The Interdisciplinary Care Team will be composed of the Participant, the social worker, the nurse practitioner and community-based physician.
- ◆ The community-based physician shall participate in a daily meeting and the care planning meetings for their Participants, either in person or by conference call.
- ◆ The MyCare Vermont Organization will provide a central location where the other members of the Interdisciplinary Care Team can meet if the meeting does not happen in the physician's office.
- ◆ The MyCare Vermont Organization will develop a reimbursement schedule for community-based physicians that will provide reimbursement for acute and primary care. In addition, a monthly capitation payment will be developed to encourage maintaining the Participant at home, prescribing cost-effective care, and participation by the physician in managing the care with a team.

- ♦ The community-based physician will be responsible for on-call arrangements for Participants. It is the community-based physician's responsibility to educate Participants and on-call doctors of the requirements of MyCare Vermont.

PROPOSED PROGRAM REQUIREMENTS

CONSUMER/ SURROGATE DIRECTED CARE

A. Introduction

Consumer/ surrogate directed care is a service that gives individuals more flexibility in planning, and responsibility for directing, their services and supports, including hiring and managing direct care staff. Consumer/ surrogate directed care may include conventional goods and services, as well as self-designed services that provide needed support to enrollees. MyCare Vermont Organizations under contract with the Department of Disabilities, Aging and Independent Living must offer consumer/ surrogate directed care as a service option for all Participants interested in directing their own care.

The philosophy and process of person-centered planning provides the foundation for consumer/ surrogate directed care. Home and community-based services support people in everyday life. These services have an impact on the person's ability to participate as a member within their community, and to fulfill their own life-style choices. Person-centered planning can organize and direct resources in a manner that will make a difference in a person's quality of life, level of independence, and satisfaction with public services. While person-centered planning should be the foundation for all MyCare Vermont services, an explicit person-centered planning process is required when a Participant selects consumer/surrogate directed care.

Understanding person-centered planning processes is a key and necessary MyCare Vermont provider skill. Consumer/ surrogate directed care allows greater flexibility in tailoring services to meet individual needs and preferences. It is through a person-centered planning process that the Participant, along with self-selected friends, family, and providers, determines what, where, when, how, and from whom they will receive the assistance that is needed. The resulting plan reflects goods and services designed by the consumer to meet identified needs and achieve individually identified results or outcomes.

Person-centered planning is an ongoing activity that includes monitoring the effectiveness of the plan and progress toward achieving results, and changing the plan over time to incorporate new types of services or ways of delivering services, to address changed needs, or to support revised personal goals or desired results. There are various approaches to the person-centered planning process that have been put into public practice, and different approaches will be preferred by different Participants. Some people will choose to develop their consumer/ surrogate directed care plan with little or no assistance, while others may want more support in plan development. The MyCare Vermont provider must provide resources and information about the person-centered planning process and assist the Participant to the extent they desire.

B. Guidelines to Develop Individualized Consumer/ Surrogate Directed Care

In the Home-Based setting, the MyCare Vermont provider must offer three services that may be directed by the Participant (consumer-directed) or a surrogate employer. These services include:

- Personal Care
- Respite Care
- Companion Services

Being an employer is a big responsibility and should not be taken lightly. If a Participant in the MyCare Vermont program is able, willing and desires to be an employer for their own Personal Care, Respite or Companion services, they may apply to their MyCare Vermont provider for the consumer-directed option. However, if the individual is not able or willing to be the employer, a trusted friend or family member may apply to be the surrogate employer under the surrogate-directed option. Surrogate employers must live in close proximity to the individual and be available to perform all the responsibilities of the employer on an ongoing basis.

Whether consumer or surrogate directed, the MyCare Vermont Interdisciplinary Care Team must certify that the Participant or trusted friend or family member (surrogate directed care) can be the prospective employer. The Interdisciplinary Care Team must conduct a certification process for any Participant or surrogate who wishes to be an employer of services. The Certification process shall include:

1. Assessment of the Participant or surrogate-directed employer's cognitive ability to communicate effectively and perform the activities required as an employer. Cognition and communication are defined as follows:
 - i. Cognition: the ability to understand and perform the tasks required to employ a caregiver (including recruitment, hiring, scheduling, training, supervision, and termination). An individual who has cognitive impairments or dementia that prevent understanding and performance of these tasks, is not competent, or has a guardian, is not eligible to manage consumer/ surrogate directed services.
 - ii. Communication: the ability to communicate effectively with their team members and with the caregiver(s) in performing the tasks required to employ a caregiver. An individual who cannot communicate effectively, whether through verbal communication or alternate methods, is not eligible to manage consumer/surrogate directed services. In addition, the employer must live within close proximity to the individual in order to monitor services and supervise employees adequately. Employers must demonstrate over time that they have the ability to understand program rules and to reliably perform employer responsibilities. If the individual or surrogate is not able or willing to be the employer, the social worker will discuss other options.
2. Determination by the Interdisciplinary Care Team that the Participant or surrogate is able and willing to be the employer. The process includes:
 - i. The Social Worker on the Interdisciplinary Care Team assesses the Participant's or surrogate's ability and willingness to be an employer using the Employer Certification Form developed by the Department. Successful completion of this assessment process indicates the Participant or surrogate is able and willing to be the employer.

- ii. The Participant or surrogate develops a plan for services using the “Personal Care Worksheet” and “Service Plan” form developed by the Department. If requested by the Participant, the social worker on the Interdisciplinary Care Team will assist the Participant with completing these forms. The Personal Care Worksheet describes the specific tasks and services that shall be provided for the Participant. The Service Plan identifies the overall type and amount of services for the Participant. Signing of these forms by the Participant or surrogate indicates they agree to perform the required activities.

After the above certification process is complete, the Interdisciplinary Care Team meets and reviews the Personal Care Worksheet and Service Plan presented by the Participant or surrogate. The Interdisciplinary Care Team approves, modifies or denies the request from the Participant or surrogate. If approved, the Participant or surrogate then becomes the employer. It is the responsibility of the Interdisciplinary Care Team to monitor the employer’s ongoing eligibility to manage their services. If the Interdisciplinary Care Team denies the Participant’s request to receive consumer/surrogate directed care, the Participant will have the same appeal rights as for other MyCare Vermont Services.

Once certified, the employer agrees to perform the following ongoing tasks:

- Understand and follow program requirements.
- Recruit and select qualified employee(s) that are 18 years of age or older.
- Notify selected employee(s) of their responsibilities.
- Enroll in an independent payroll agent approved by the MyCare Vermont Organization.
- Assure that employment forms are completed and submitted to the payroll agent.
- Train employee(s) to perform specific tasks as needed.
- Develop a work schedule based on the approved Service Plan.
- Maintain updated copies of approved waiver Service Plan.
- Arrange for substitute or back-up employees as needed.
- Develop and maintain a list of tasks for the employee(s) to perform based on the Personal Care Worksheet.
- Authorize employee(s) timesheets (based on the approved Service Plan and actual time worked).
- Maintain copies of all employee(s) timesheets.
- Perform supervisory visits in order to assure that tasks are performed by the employee(s) correctly and completely.
- Evaluate employee(s) performance.
- Provide ongoing performance feedback to employee(s).
- Terminate employee(s) employment when necessary.
- Notify the payroll agent of any necessary changes.
- Participate in the assessment and reassessment of eligibility.
- Communicate with the Interdisciplinary Care Team on a regular basis
- If applicable, assure a monthly patient share is paid to the payroll agent.
- Avoid conflict of interest with employees, the individual and/or other participating agencies.

PROPOSED PROGRAM REQUIREMENTS

DECISION METHOD

The Organization will develop a decision methodology for use by the Interdisciplinary Care Team for determining which services are necessary or more appropriate to meet the Participant's needs than are traditional Medicare or state plan Medicaid Services.

The State of Wisconsin in collaboration with the Wisconsin Partnership program has developed a "Resource Allocation Decision Method" (RAD). This Method was developed to clarify that consumer preference is not the only determinant of services, and to provide a methodology for organizations to balance outcomes with cost. The Organization can use the process developed in Wisconsin or elect to use an alternative method that has been approved by State. The Wisconsin RAD tool has been attached as a sample.

At a minimum, the decision methodology should include consideration of the following questions:

1. What is the need, goal, or problem for the Participant?
2. Does it relate to the Participant's assessment, service plan or desired outcomes?
3. How else could the need be met, goal achieved or problem solved?
4. Are there policy guidelines to guide the choice of option?
5. Which option does the member (and/or their family) prefer?
6. Which option(s) is/are the most effective and cost-effective in meeting the desired outcome(s)?
7. Have all the options been explained, discussed, and negotiated with the Participant?

In particular, this Decision Method is intended to:

- Instill person-centered values and consumer outcomes into daily case management practices.
- Identify circumstances in which an organization could decline to provide a service requested by a member.
- Maximize appropriate resource allocation decisions.
- Assure cost-efficiency in all resource expenditures, large and small.
- Assure consistency across sites, interdisciplinary teams, and time.
 - This ensures fairness or equity (i.e., like cases are treated alike).
- Facilitate team meetings with steps and questions to guide teams.
 - This increases teams' efficiency and reduces stress (by providing a clear structure focusing on outcomes).
- Train managers and staff.
- Educate consumers and families.
 - This demystifies decisions, and reduces power struggles and misunderstandings.
- Preserve the flexibility and creativity critical to quality and program success.
 - A standardized decision process can allow for greater flexibility than specific rules or criteria and is more outcomes-based.
- Provide guidelines for hearing officers in the state fair hearing appeal process.

SAMPLE TOOL

WISCONSIN RESOURCE ALLOCATION DECISION METHOD

1. *What is the need, goal, or problem?*
 - The member and team staff together identify the core issue. To do so, keep asking “Why?”
 - Whose problem is it? Does the member see it as a problem, or do (some) staff?
 - If the member/family is asking for an item or service, explore the reasons for the request.
2. *Does it relate to the person’s assessment, service plan and desired outcomes?*
 - “Desired outcomes” are those in the person’s assessment and service plan.
 - Is it essential to the person’s health or safety? (What would happen if the needs weren’t met?)
 - How does it relate to ADLs or IADLs, independence and other desired outcomes in the plan?
 - Whose responsibility is it to address this particular need or problem?
3. *How could the need be met?*
 - What’s been tried in the past? How do people usually address similar needs?
 - How could the member help solve this need/problem? What ideas does s/he have? Could adaptations in people, environment, or equipment help member meet this need? Can s/he afford to pay for this, or share cost if appropriate?
 - What informal resources (family, friends, volunteers) might be able to help?
 - What other community resources (e.g., thrift stores, senior center, organizations) could be sought?
 - What options could the organization consider (e.g., loaner program, rental vs. purchase, incremental goals)?
4. *Are there policy guidelines to guide the choice of option?*
 - If yes, those should be followed. If related policies seem to lead to unacceptable conclusions in a particular case, the policy needs to be corrected or amended with criteria to allow exceptions.
5. *Which option does the member (and/or family) prefer?*
6. *Which option(s) is/are the most effective and cost-effective in meeting the desired outcomes?*
 - “Effective” means it works to achieve a desired outcome. Consider both short-term and long-term outcomes.
 - “Cost effective” means “effectively achieving a desired outcome (meeting a need) at reasonable cost and effort.”
 - “Reasonable” alternatives are those that:
 - Would probably solve the problem, i.e., are effective in meeting the desired outcome for peers (with similar needs).
 - Would not have significant negative impact on desired outcomes.
 - Note that “cost effective” is always tied to outcomes, and that it does not always mean “least expensive” or “inexpensive.”
 - How will we measure success/outcomes in order to gauge cost-efficiency?
 - Is member committed to using the suggested service/product?
7. *Explain, Dialogue, Negotiate.* Consumer can appeal the Organization’s decision.

PROPOSED PROGRAM REQUIREMENTS

EXTRA SERVICES

In order to offer Participants benefits not found in the existing Medicare and Medicaid programs, the Organization would be allowed to offer additional, “Extra Services” to all program Participants. For example, the Organization could elect to cover the cost of expand dental benefits. Unlike Flexible Services, which would be determined on a case-by-case, situation-by-situation basis, Extra Services would be uniformly available to all Participants.

In the delivery of Extra Services the Organization would be required to pay providers in a manner that would reward their adherence to the program’s objectives for coordination, person-centeredness, and quality.

PROPOSED PROGRAM REQUIREMENTS

FLEXIBLE SERVICES

The Organization will be expected to provide Flexible Services that provide alternative, resourceful ways to meet the Participant's needs. Flexible Services would be services outside those provided in the Medicaid benefit package, in the 1115 Choices for Care Demonstration Waiver and by Medicare. The Interdisciplinary Care Team with the Participant would be responsible for determining appropriate and necessary Flexible Services required to meet the Participant's needs on a case-by-case basis. The Flexible Services would be Participant-specific, culturally appropriate, and fiscally and professionally sound. For example, the Organization might find that the use of a local bicycle shop to repair a wheelchair tire may be more convenient for the Participant and less costly than returning the wheelchair to the manufacturer.

Principles

The principles to be used by the Organization to deliver Flexible Services will be:

1. Deliver and coordinate health and social services through an interdisciplinary care team.
2. Treat Participants as individuals who are accountable for decisions and responsibilities and entitled to their rights.
3. Allow Participants to manage their own services to the greatest extent possible or to the extent they desire.
4. Offer Participants the information necessary to make informed decisions.
5. Deliver quality services that are both Participant- and provider-friendly, on a timely basis.
6. Educate health care professionals regarding frail elders and people with disabilities.
7. Maintain physical and mental health standards to ensure optimal levels of health and functioning for each Participant.
8. Encourage Participants to develop and maintain friendships and to participate with their friends and families in their communities.
9. Consider the changing needs of Participants and flexibly adapt services as necessary.
10. Emphasize Participants' dignity, self-reliance and sense of self worth.
11. Carry out the Participant's care plan by effectively and equitably utilizing the available public and private resources.

PROPOSED PROGRAM REQUIREMENTS

INTERDISCIPLINARY CARE TEAM

Each Organization contracting with the Department of Disabilities, Aging and Independent Living (DAIL) to provide services to MyCare Vermont Participants shall provide services through a comprehensive interdisciplinary services delivery system that addresses both health care and long term care needs.

Interdisciplinary Care Team Members

The Organization shall establish an Interdisciplinary Care Team (ICT) consisting of, at a minimum, the Participant (or designee selected by the Participant), a Primary Care Provider¹, Case Manager/Social Worker, and Registered Nurse. The team members will be employed or staff under contract with the Organization. The team will operate in accordance with the MyCare Vermont program requirements and the Organization's policies and procedures. It is the responsibility of the Organization to ensure Participant and/or designee involvement with the team to the extent needed or desired by the Participant. If appropriate, other members may be added to an individual Participant's team, based on the Participant's condition and/or needs.

Decisions are made jointly by all team members, including the Participant and/or designee. Each team member is responsible for communicating his or her position on issues and preferred course(s) of action. In practice, Participant participation in decision-making is on a continuum. Although joint decision making may be ideal, participation should be considered satisfactory when the individual is participating to the degree he or she desires and at his or her comfort level. If there is disagreement between the Participant and the other team members, the Participant has a right of appeal.

I. Interdisciplinary Care Team Responsibilities

A. Team:

- Educate, empower and facilitate the Participant to exercise his or her rights and responsibilities.
- Involve the Participant as an active team member and stress Participant-centered collaborative goal setting.
- Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active.
- Establish a set of guidelines or care responsibilities for the entire team and distribute these responsibilities to all team members.
- Provide information and support to the Participant in making choices within the parameters of the Organization.
- Develop, monitor and review the Participant's care plan with the Participant.

¹ This may be either a primary care physician or a nurse practitioner.

- Ensure Participant's goals and preferences are identified, documented in the care plan and addressed.
- Provide case management, including assessing needs, and authorizing and coordinating services.
- Evaluate the effectiveness of the current plan of care and implement modifications as needed in collaboration with the Participant and other providers as appropriate.
- Provide in-home assessment of safety issues, and work with the Participant to manage identified risks.
- Provide education to the Participants and families regarding health and social needs.
- Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs.
- Report information to team, Participant and other appropriate health care providers as needed.
- Assess and assist the Participant in identifying and addressing quality of life issues.
- Meet documentation and reporting requirements in a timely and accurate manner.
- Provide links/coordination/integration with care providers across settings.
- As appropriate, represent the Participant's point of view when the member is unable to participate in decisions.
- Provide Participant with necessary equipment and supplies.

II. Individual Team Members' Responsibilities

A. Participant and/or designated representative:

1. Understand the disease process, chronic illness, and/or disability.
2. Realize his/her role as the daily self-manager.
3. Engage family and caregivers in the Participant's self-management.

B. Primary Care Provider:

- Provide initial history and physical exam.
- Provide periodic re-evaluation of medical status.
- Provide, in the member's residence or in an office/clinic setting, evaluation of episodic acute illness.
- Provide prevention and health maintenance education to Participant.
- Assume leadership role in collaborating with appropriate providers prior to, during, and at discharge from hospital, rehabilitative and nursing facility settings.
- Order diagnostic or therapeutic interventions.

C. Registered Nurse:

- Assess physical health status and response to illness and/or disability.
- Assess effectiveness of medications including intended effect, side effects, and Participant knowledge and method of administration.
- Provide in-home assessment to identify functional limitations and adaptations to environment.

- Provide face-to-face skilled nursing services as required to manage care and maintain current knowledge of Participant needs.
- Delegate appropriate aspects of Participant care to supportive home care service providers including Personal Care Attendants (PCAs), Homemakers, or Licensed Nursing Assistants (LNAs); and supervise and evaluate the effectiveness of care given.
- Provide, in conjunction with the Primary Care Provider, prevention and health maintenance education to Participant.
- Assess the need for and coordinate supportive home care services provided to Participant.
- Ensure that the supportive home care provider's written plan is reflective of Participant needs, is current, and provides sufficient direction to the supportive home care provider.
- Communicate acute changes in health status to Participant in a timely manner and collaborate with Participant in implementing interventions.

D. Case Manager/Social Worker:

- Complete basic psychosocial, environmental and economic assessments.
- Provide on-going coordination of psychosocial services.
- Explore financial options and eligibility for services, including employment services.
- Provide information about and assist Participant in maintaining and establishing community links.
- Provide information about and assist Participant with housing and transportation issues.
- Assist in crisis intervention.
- Provide assessment and coordination of mental health, alcohol and/or drug abuse services.
- Coordinate supportive counseling as appropriate.

PROPOSED PROGRAM REQUIREMENTS

PERSON-CENTERED CARE

A. Values and Principles Underlying Person-Centered Care

Person-Centered Care is customized care that is respectful of and responsive to an individual Participant's circumstances, preferences, needs and values. Person-Centered Care starts with Person-Centered Planning. Key attributes of Person-Centered Planning and Care include:

1. Collaborative decision-making;
2. An informed and educated care team;
3. Coordination and integration of care among providers and across all settings;
4. Promotion of well-being including physical comfort and emotional support;
5. Involvement of the Participant or a representative selected by the Participant (For any Participant with dementia or other organic impairments, person centered care must include spouses, guardians or other primary care givers who are likely to be involved in treatment or support plan implementation.); and
6. Involvement of members of the Participant's chosen support circle.

The values and principles underlying the Person-Centered Care approach include the following:

1. Person-Centered Care recognizes the value of each Participant.
2. Person-Centered Care maximizes the Participant's independence, and creates desired community connections.
3. The Participant will participate in the Person-Centered Care process to the extent that he or she desires.
4. Each Participant has the right to express preferences and make choices and these shall be actively sought and respected.
5. Each Participant has the right to choose how supports, services and/or treatment are used to maximize his or her personal well-being.
6. The Participant has the right to request a meeting with their Interdisciplinary Care Team.
7. Accommodations for communication will be made to maximize the Participant's ability to express his or her needs and/or desires.

8. A Participant's cultural background and lifestyle shall be recognized and valued in the decision-making process to the extent desired by the Participant.

B. Guidelines for Developing Individualized Person-Centered Care

The Participant can decide if they desire to be involved in planning their care and if so, to what extent. The Organization must document the Participant's decision concerning their involvement. The Participant may reconsider their decision regarding their level of involvement at any time.

Development of Individualized, Person-Centered Care occurs in two steps:

Step 1: Hold a Preparation Meeting followed by a Discovery Meeting. The purpose of these meetings is to prepare for the Care Planning Meeting in Step 2.

Within three months of the Participant's enrollment, the Organization is required to conduct a person-centered Preparation Meeting and an initial Discovery Meeting with the Participant and members of their ICT. The frequency of additional Discovery Meetings shall be determined by the Participant and the team.

A. Preparation Meeting

If the Participant is interested in actively participating in the process, a Preparation Meeting will be held with the social worker/case manager and the Participant. The purpose of this meeting is to plan for the Discovery Meeting. At the Preparation Meeting the Participant will:

- Set the agenda and the priorities for the Discovery Meeting;
- Identify topics he/she would like to speak about (e.g., dreams, goals, desires and any other topics for discussion) at the Discovery Meeting;
- Identify who to invite to the Discovery Meeting (e.g., specialists, family members, members of a chosen support circle, etc.);
- Determine where and when the Discovery Meeting will be held; and
- Select the person who will facilitate the Discovery Meeting.

B. The Discovery Meeting with the Interdisciplinary Care Team

The purpose of this meeting is to focus on the Participant:

- to identify the Participant's dreams, goals and desires;
- to identify the Participant's strengths, which are used as the starting point for developing a care plan; and

- to provide the Participant the opportunity to meet and get to know the members of their Team.

It is important for all ICT members to have an understanding of strengths, dreams, goals and desires of the Participant so that person-centered planning and care can be incorporated in the delivery of all services to the Participant.

The Organization must ensure there is a commitment from all ICT members to honor the process, to take action and to follow through on agreements.

The Organization must develop or adopt a person-centered planning tool to use at person-centered Discovery Meetings. Examples of tools include: *Essential Lifestyle Planning*, *MAPS*, *Personal Future Planning*, and *PATH*.

Step 2: Conduct Care Planning Meeting and deliver care.

1) Conduct Care Planning Meeting

The Organization is required to regularly convene Interdisciplinary Care Team (ICT) meetings with the Participant and/or their family members in order to complete or update a Participant's Integrated Individual Care Plan. These meetings shall be held no less frequently than every six months and more often as needed or as conditions change. All meetings shall be held at a location and time that is convenient for the Participant and/or their family members.

The care planning process to be used at ICT meetings includes the following:

1. The Participant and/or their family members and other members of the ICT work collaboratively to define the Participant's care plan.
2. The care planning process shall honor the Participant's preferences, choices and abilities which were identified during the Discovery Meeting.
3. Development of goals for the care plan is informed and guided by the Participant's strengths dreams, goals and desires as well as by their medical needs.
4. All supports, services and treatment options to meet the expressed needs and desires of the Participant are identified and discussed with the Participant. This includes all standard Medicare and Medicaid services, as well as Extra and Flexible services.
5. All potential sources of volunteer support are considered, including the Participant, their family, friends, guardian and significant others.
6. The Participant may express a need or make a request for support, services and/or treatment at any time.
7. Health and safety concerns are identified in partnership with the Participant, and support services needed to mitigate risks are identified. All members of the ICT shall proactively anticipate potential crisis or emergency situations and develop steps to mitigate identified risks.
8. In addition, for each Participant risk factors for chronic disease or increased disability will be identified. Condition-specific opportunities for self-management services will be

made a part of the individual's care plan. These services will respond to Participants' personal and environmental circumstances. At a minimum, the following risk factors will be assessed: tobacco abuse, nutrition, lack of physical activity, excessive alcohol consumption, drug abuse and reduction in range of motion/fall risk.

9. Strategies, supports, services and/or treatments are selected and the care plan developed to achieve desired goals.

The Individual Integrated Care Plan:

The Individual Integrated Care Plan shall be written from the perspective of the Participant (e.g., "I will receive 3 hours of Personal Care Assistant services daily to help me meet my goal of ___") and shall include the following components:

- The Participant's goals.
- The services that will be provided to assist the Participant in meeting his or her identified goals.
- Support services that have been identified to proactively address health and safety concerns.
- Documentation of progress made by the Participant toward achieving goals, which shall serve as the basis for subsequent Individual Integrated Care Plans.
- The Participant's and/or family members' signature(s) indicating agreement with the care plan

2) Deliver care and services using a person-centered approach

The Participant shall have ongoing opportunities to provide feedback on how he or she feels about the services, supports and/or treatment he or she is receiving from the ICT and individual providers, and the progress being made toward attaining their goals.

The Organization shall develop and utilize a system to routinely contact Participants to determine if they are receiving person-centered care and to obtain suggestions on what improvements can be made. The Organization shall take corrective steps as necessary to ensure that person-centered care is being delivered.

The Participant shall have the opportunity, to the extent possible, to explore available care options prior to making a choice or decision about that care option.

In a medical emergency, when a Participant is unable to exert his or her autonomy, the ICT shall act to respond to and stabilize the Participant's situation in a manner that is consistent with the Participant's expressed values and goals.

C. Assurances and Indicators of Person-Centered Care Implementation

It is the responsibility of the Organization to assure that the Individual Integrated Care Plan is developed and implemented utilizing a Person-Centered Care process. In addition, the Organization is responsible for monitoring the delivery of services to ensure that services are

person-centered. Below is a listing of prospective and retrospective indicators that would demonstrate that Person-Centered Care is being provided. The methods of gathering information regarding these indicators may vary, and may include the review of administrative documents, clinical policy and guidelines, case record reviews, and interviews or focus groups with Participants and members of their chosen support circle.

Prospective Indicators:

The Organization shall measure the following indicators:

1. Each Participant is provided with a copy of the Participant's Bill of Rights.
2. The concepts of the Participant's Bill of Rights are reiterated at each planning meeting with the Participant and their family members.
3. The Organization has a Participant advisory council that actively engages Participants in oversight of the Organization.
4. The Organization and all contracted providers document that they routinely ask Participants if their services are person centered.
5. The ICT members, staff and providers receive training to use language that encourages individuals to openly state dissatisfaction. For example, use phrases such as: "You will help me by telling me what is not going well."
6. The Organization conducts quarterly reviews of the Flexible services that are being provided, including type and frequency.
7. The Organization creates and follows protocols that address the following areas of activity:
 - a. That the ICT informs Participants of their right to Person-Centered Care
 - b. That the ICT always includes the Participant (or a designee) in ICT meetings (if desired).
 - c. That the ICT identifies someone who will be responsible for helping the Participant express his or her needs, as necessary.
 - d. That the Individualized Care Plan be written from the Participant's perspective.
 - e. That centralized records will be updated within 24 hours when new information is obtained.
 - f. That the ICT asks each Participant at every Team meeting if s/he is getting what s/he needs.
8. The Organization creates a culture of continuous improvement by:
 - a. Starting with top management. Evidence is provided that top management embraces the concept of person-centered care.
 - b. Identifying barriers to person-centered care and developing steps to address them, including:

- attitudinal barriers (e.g., fear that an Participant's and families' suggestions will be unreasonable.),
- educational barriers (e.g., lack of provider skills for collaborating), and
- organizational barriers (e.g., competing priorities)

Retrospective Indicators:

1. The Organization shall measure the following indicators: The Organization obtains Participant input by conducting an annual Participant survey using an outside evaluator.
2. Participants are informed about the State Ombudsman.
3. The Organization conducts internal evaluations and audits regarding:
 - a. The frequency and type of flexible services being provided.
 - b. Whether all Participants know about the state health care ombudsman.
 - c. Whether care plans meet required format and style.

PROPOSED PROGRAM REQUIREMENTS

QUALITY MANAGEMENT

Introduction

The Organization must operate an ongoing Quality Management program (QM) which includes quality assessment and performance improvement, in accordance with federal and State requirements. If the Organization chooses to become a PACE program, they must comply with the Quality Management Requirements of PACE. The requirements of this section explain the program requirements of the Organization if the decision is made to operate a Medicare Special Needs Plan (SNP) and/or contract with the Department of Disabilities, Aging and Independent Living (DAIL) to operate as Medicaid MyCare Vermont Provider.

The Organization must protect, maintain, and improve the quality of care provided to MyCare Vermont Participants. The vision of any quality improvement program is to insure the right care for every Participant every time. The Organization shall provide for the delivery of quality services to Participants with the primary goal of improving the health status and well-being of Participants. Where the Participant's condition is not stable, the Organization shall arrange for services that will seek to maintain the Participant's current health status and well-being, to the extent desired by the Participant, by implementing measures to prevent any further decline in condition or deterioration of health status or well-being.

The DAIL defines quality of services for MyCare Vermont as follows:

The degree to which services for individuals and populations:

- increase the likelihood of desired health outcomes;
- increase the likelihood of desired independence and quality of life;
- are Person-Centered; and
- are consistent with current professional knowledge about effective care.

The Organization shall have a Quality Management Program for:

- a) measuring the Organization's performance of its contractual responsibilities,
- b) identifying opportunities for improving performance,
- c) developing and implementing action steps to improve performance, and
- d) measuring whether the targeted improvements have been achieved.

If the Organization operates a SNP and contracts to be a MyCare Vermont provider, the DAIL will make every effort to coordinate program and reporting requirements with Medicare SNPs requirements. Below is a crosswalk of Medicare Requirements for SNPs and Medicaid regulatory requirements. Medicaid citations are noted. The Organization will be required to report all items listed below to the DAIL. Items 1-6, 8-10, 13-14 are required by both Medicare and Medicaid. Items 7, 12-13 are Medicare-only requirements.

1. Assess the quality and appropriateness of care and services furnished of all contracts and to individuals with special health care needs §438.204, §438.240(b)(4), §438.208(c)(2)
2. Identify the race, ethnicity and primary language spoken and submit to State §438.204(2)
3. Regularly monitor and evaluate the health plans for compliance §438.204(3)
4. Arrangements for annual, external independent reviews of the quality outcomes and timeliness of and access to the services covered under the contract §438.204(3)(d)
5. Appropriate use of intermediate sanctions §438.204(3)(e)
6. An information system that supports initial and ongoing operation and review of the State's quality strategy §438.204(3)(f)
7. Have a chronic care improvement program that includes methods for identifying the enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program
8. Conduct quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction that focus on specified clinical and non-clinical areas and that involve measurement of performance, system interventions including the establishment or alteration of practice guidelines, improving performance, systematic and periodic follow-up on the effect of the intervention §438.240(b)(1)
9. Follow written policies and procedures that reflect current standards of medical practice §438.236
10. Have in effect mechanisms to detect both under-utilization and over-utilization of services §438.240(b)(3)
11. Measure and report performance using the measurement tools required by CMS and report performance to CMS §438.350(e), §438.352
12. Make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them
13. PPO plans must have a provider network that has agreed to a contractually specified reimbursement for covered benefits regardless whether the benefits are provided within the network of providers
14. Annual review, at least, for a formal evaluation of the impact and effectiveness of the quality improvement program §438.240(d)
15. The Organization must correct all problems that come to its attention through internal surveillance, complaints or other mechanisms §438.364(a)(5)

Quality Management Program

The Organization shall have on file with the DAIL an approved written plan describing the QM Program, including how the Organization will accomplish the activities required by this section.

The Organization shall approach all clinical, functional, personal experience and administrative aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement and shall:

- rely heavily on Participant input;
- recognize that opportunities for improvement are unlimited;
- be data driven;
- rely heavily on input from all staff of the Organization and its subcontractors;
- require measurement of effectiveness, continuing development, and implementation of improvements as appropriate;
- evaluate Provider and Organization performance using objective quality indicators;
- support continuous ongoing measurement of clinical, functional, personal experience and administrative effectiveness and Participant satisfaction;
- support programmatic improvements of clinical, functional, personal experience and administrative processes based on findings from ongoing measurements; and
- support re-measurement of effectiveness and Participant satisfaction, and continued development and implementation of improvement interventions as appropriate.

The QM Program shall include annual goals for planned projects or activities, including clinical, functional, personal experience and administrative or initiatives and measurement activities. Each goal shall have associated timelines and quantitative measures for evaluation.

The Organization shall submit a semi-annual QM Program evaluation in a format and timeframe specified by the DAIL. The evaluation shall evaluate the effectiveness of clinical, functional, personal experience and administrative QM initiatives using, in whole or in part, the quality measures defined in the Quality Program Initiatives section.

The Organization shall include in subcontracts a requirement securing cooperation with the QM Program. The Organization shall keep participating physicians and other Network Providers informed about the QM Program and related activities.

QM Program Structure

The Organization shall maintain a well-defined QM structure that includes a planned systematic approach to improving clinical, functional, personal experience and administrative processes and outcomes. The Organization must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. The Organization will require that Participants, ICT members, employees and contract providers are involved in the development and implementation of all quality management activities. The Organization shall designate:

Quality Management Director: an identified senior-level director who will oversee all quality management and performance-improvement activities. The quality management director must have expertise in the Integrated Care Model.

Medical Director: a medical director licensed by the State of Vermont with geriatric expertise and/or disability expertise and experience in community and institutional long

term care, who will be responsible for establishing medical protocols and practice guidelines to support the QM program described in this section.

Physician: a qualified physician, licensed by State of Vermont in Medicine and further board certified in family practice or internal Medicine, who will be responsible for establishing and monitoring the implementation and administration of geriatric and disability management protocols.

Behavioral Health Clinician: a qualified behavioral health clinician, with expertise in geriatric and disability service, who will be responsible for establishing behavioral health protocols and providing specialized support to the ICT.

The QM Program shall include a set of functions, roles, and responsibilities for the oversight of QM Program activities that are clearly defined and assigned to appropriate individuals, potentially including administrative staff, subcontractors, ICT members, other clinicians, and non-clinicians.

The QM Program shall include:

Participant Advisory Committee: The Organization must establish an advisory body that represents the interests of Participants and caregivers of MyCare Vermont. The Participant Advisory Committee guides key decision-making in the areas of Participant satisfaction and quality improvement. This committee provides quarterly reports to the Organization's Board of Trustees overseeing the operation of MyCare Vermont.

Ethics Committee: The Organization must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including delivery of services, end-of-life issues and advance directives.

Professional Advisory Committee: The Organization must establish a Professional Advisory Committee to advise the Organization in the development and implementation of program policies and the ongoing review and evaluation of program performance in light of established goals and objectives. This committee provides quarterly reports to the Organization's Board of Trustees overseeing the operation of MyCare Vermont.

Clinical Practice Guidelines

The Organization shall adopt not fewer than six evidence-based clinical practice guidelines. The six evidence-based clinical practice guidelines must be distributed as follows: at least two specific quality goals in the acute/primary care¹, long-term care², and behavioral health³ areas. Such practice guidelines shall be based on valid and reliable clinical evidence, consider the needs

¹ Acute/primary care medical services include comprehensive care for routine, urgent and chronic medical needs.

² Long term care includes social, housekeeping and support services to improve or maintain function, health, and/or activities of daily living.

³ Behavioral health includes a continuum of services aimed at providing an array of mental health and substance abuse services, including prevention, treatment, and interventions that promote recovery and social well-being.

of Participants, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate, but not less than every other year.

The Organization shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QM Program.

The Organization shall coordinate the development of clinical practice guidelines with the DAIL to avoid providers receiving conflicting practice guidelines from the Organization and the DAIL.

The Organization shall disseminate the practice guidelines to all affected Providers, Participants and potential Participants. The Organization shall take steps to implement adoption of the guidelines, and to measure continuous Provider compliance with the guidelines.

Quality Measurement – Program Level

The Organization shall engage in the collection of quality measurement data. Quality measures are defined to include statistical assessments of the structure and process of medical, long-term care delivery and the personal experience of the Participant, as well as assessments of the impact or outcome of care on the health status and well-being of Participants.

Quality measures should be selected from nationally adopted or endorsed evidence-based measurement sets wherever possible. When such measures are not available, quality measure selection should be informed by a consensus process involving providers and Participant of services, in Vermont or elsewhere.

The Organization shall assess the quality of care delivered to Participants using measures and measurement methodologies, including:

- ♦ measurement of access to care and access to the ICT using a Participant survey;
- ♦ measurement of Participant involvement in the interdisciplinary care team;
- ♦ measurement of the provision of Person-Centered Care, of Participant goal attainment, and of care that is consistent with the Department’s “Desired Outcomes of Services” as defined in the Quality Management Plan;
- ♦ measurement of Participant experience and level of satisfaction using periodic telephone calls to Participants;
- ♦ measurement of program ICT performance through review of Individual Care Plans and minutes of ICT meetings, observation of ICT meetings and survey of ICT members;
- ♦ measurement of effective management of common chronic care conditions (e.g., asthma, depression) identified by the DAIL and other appropriate measures required by the DAIL;
- ♦ measurement of effective management of: dementia; alcohol and drug abuse prevention and treatment Initiative; abuse and neglect identification appropriate measures required by the DAIL;

- ♦ measurement of effective provision of preventive services (e.g., periodic recommended screenings, health promotion and wellness activities) using appropriate HEDIS measures identified by the DAIL and other appropriate measures required by the DAIL;
- ♦ measurement of incidence and appropriate use of ambulatory care-sensitive hospitalizations, hospital admissions and readmissions, nursing facility institutionalization and emergency room visits; and
- ♦ measurement of the effectiveness of Organization and ICT efforts to support Participants in managing chronic conditions using appropriate measures required by the DAIL.

The Organization shall use such quality measurement data in the development, assessment, and modification of its QM Program.

Annual Quality Program Initiatives

Using information obtained through the previous section, Quality Measurement - Program Level, the Organization shall annually define and develop at least two specific quality goals in the primary care, long-term care, and behavioral health areas. The Organization must provide documentation on each project, describing:

- a. the objective;
- b. the expected outcomes;
- c. a brief justification with background on each objective;
- d. how each quality goal will be measured;
- e. the target population;
- f. the method of evaluating change in the quality goals;
- g. communication processes; and
- h. documentation requirements.

Quality program initiatives shall be proposed to the DAIL for approval at least thirty (30) days prior to the start of each Contract Year and shall address identified opportunities for quality improvement for which a quality program initiative can positively impact care in a meaningful way for a significant percentage of Participants.

Quality initiative evaluations shall be included within the annual QM program evaluation submitted to the DAIL.

Quality Management Monitoring

The Organization shall develop written policies and procedures approved by the DAIL for selection and qualifications of clinical staff and contracted providers. Upon termination of any contracted providers the Organization must notify the DAIL concerning the reason for termination. The Organization will be required to perform competency reviews of all clinical staff and any network providers.

Collaboration with the Department of Disabilities, Aging and Independent Living (DAIL) Quality Management Plan

The DAIL maintains a Quality Management Plan to assure quality assurance and improvement. The DAIL Quality Management Unit performs ongoing assessment of the quality of certain long-term care services provided to Vermonters served by the DAIL, including services delivered by Home Health providers, Area Agencies on Aging, and Adult Day Services providers. The Organization as a MyCare Vermont provider will be subject to comply with the DAIL Quality Management Plan.

Collaboration with the External Quality Review Organization (EQRO)

The Organization will collaborate with the DAIL's external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Participants and to identify opportunities for Organization improvement. The Organization shall work collaboratively with the DAIL and the EQRO to annually perform quality measurement activity.

Outcomes of the Quality Management Program

The DAIL will use the measures listed below to evaluate and measure the success of the QM program. The outcomes of a Quality Management Program are met when the Organization:

- a. Demonstrates that it has an internal quality improvement system described in an annual report to the DAIL;
- b. Provides documentation that it has reviewed and if appropriate, taken steps for improving the quality of services provided by subcontractors as reported in the annual delegation of authority report to the DAIL;
- c. Provides documentation that it has reviewed and if appropriate, taken steps for improving, access to health care in an annual report to the DAIL;
- d. Provides documentation of the results of physician credentialing in an annual report to the DAIL;
- e. Provides the results of member satisfaction survey indicating overall Satisfaction of at least eighty (80) percent in an annual report to the DAIL;
- f. Achieves demonstrable improvement in significant aspects of clinical, functional, personal experience areas that can be expected to have a favorable effect on health outcomes and Participant satisfaction, as evidenced in the two annual project reports to the DAIL; and
- g. Demonstrates improvement in the support provided to Participants in achieving their desired outcomes.

PROPOSED PROGRAM REQUIREMENTS

WORKFORCE INITIATIVE TO PROMOTE STAFF RETENTION AND HIGH QUALITY PERFORMANCE

Workforce Initiative

- A. The Organization must establish an on-going process for creating and maintaining a positive work environment for all Staff. To do so, the Organization must demonstrate through its policies, procedures and programs governing its employees and through its provider contracts that it has created a work environment that has the following characteristics:
1. Fosters open and clear communication within the Organization and with other providers and health care facilities. The Organization's mission and annual goals are understood and supported by all staff involved with the Participant's care. Questioning is encouraged whenever there is uncertainty or confusion about responsibilities or next steps. Different communication styles are understood and respected.
 2. Fosters shared decision-making and a supportive environment among all staff involved with the Participant's care. All staff involved with the Participant's care, regardless of educational background or professional licensure, contribute to Individual Care Plans, program policies, operations, and program evaluations. The contributions of all staff involved with the Participant's care are recognized and respected.
 3. Encourages the expression of different opinions and out-of-the-box thinking. There is no retribution toward any staff involved with the Participant's care who ask challenging questions or propose unconventional solutions.
 4. Establishes a clear understanding of decision-making responsibilities among all staff involved with the Participant's care. There are clear ground rules on how decisions are made and how policy and programs are implemented.
 5. There is clear accountability within the Organization as to who is responsible for leading initiatives to create and maintain the above-stated characteristics.

A work culture with the above-listed characteristics will be referred to as "Positive Work Culture." The Organization must establish an on-going process to develop a Positive Work Culture. To develop this process the Organization must demonstrate attention to each of the following areas of best practice:

1. Staff recruitment
2. Orientation and training
3. Staffing levels and work hours
4. Professional development and advancement
5. Supervision training and practices
6. Team approaches
7. Staff recognition and support

The Organization, with the approval of the DAIL, must develop an individualized plan to address a Positive Work Culture. This Individualized Plan shall:

- Include Self-assessment (must include employee satisfaction survey) of challenges or barriers their Organization faces with recruitment and retention of their workforce.
- Identify a new Best Practice or a substantial addition and continuation of a previous Best Practice that the Organization will develop.
- Bring together a planning team and have them become familiar with the charts and forms (they can do this as a group or individually).
- Develop a Work plan for implementing change.
- Develop feedback loops to ensure any change implemented becomes a sustainable change in the Organization's organization.
- Develop Outcome Measures. At a minimum, the DAIL requires the measurement of the following outcome measure:
 1. Employee satisfaction
 2. Turnover rates
 3. Staff position vacancy rates
 4. Years of service

The Organization must also on a regular basis and no less frequently than annually reassess and identify a new Best Practice or a substantial addition and continuation of a previous Best Practice that the Organization will develop to address Positive Work Culture.

- B. On on-going basis, the Organization must submit to the DAIL for approval details regarding how it will operationally implement a Positive Work Culture using the process described above. It must include:
1. Identification of who at the staff level will be responsible for providing guidance, resources, encouragement and other types of support to each of the Interdisciplinary Care Teams regarding Positive Work Culture.
 2. The content and use of the Organization's self assessment tools that identifies potentially successes and challenges faced in the work culture.
 3. The content and use of an orientation program covering information new staff need to understand about MyCare Vermont, Positive Work Culture, and the Organization's other policies and procedures.
 4. Content and use of cross-disciplinary training programs regarding best practices concerning Participant care.
 5. Content and use of training programs regarding communication styles, listening skills, conflict resolution and team development.
 6. Content and use of training programs for senior management on cultural competence, problem solving, communication and coaching skills.
 7. Mechanism for communicating positive feedback from Participants and staff.
 8. Recognition and reward for Positive Work Culture achievement.
 9. How the Organization will internally evaluate its successes in achieving Positive Work Culture through use of outcome measures.

A CONSUMER'S PERSPECTIVE ON PATIENT-CENTERED PLANNING AND CARE

Presentation to MyCare Vermont Contractors Seminar

August 28, 2007

by

Sarah Littlefeather

In 1988, the term “patient-centered care” was coined by the organization now known as the Picker Institute. Surveys developed by this institute and conducted in health care organizations in the United States, Canada and Europe showed that the most important aspects of care, according to the patient and their families were these:

1st. Safety... proper dosage of medication will be given, the that the right body part will be surgically treated and that we will be safe from facility or staff induced infection and injury;

2. Excellent care... the most technologically advanced treatment by the most qualified individual that is available.

3. Accessibility... both for mobility reasons and **accessible** in that the treatment would be delivered in a reasonable period of time and waiting time for appointments with the practitioner not be lengthy.

4. Respect... the consumer would be both respected as an individual and that culture, ethnicity and customs would be given their appropriate consideration in care planning.

5. That it be **coordinated**, that various individuals and services would work together sharing the same relevant details about care and that transitions be as seamless as possible.

6. Information ... That it would provide the facts that are needed for the consumer to make appropriate informed decisions, and that the appropriate information regarding the consumer would be available to all those who need access to it.

7. Physical comfort... in addition to having adequate pain relief, that the healthcare facilities be pleasant, comfortable and health affirming.

8. Emotional support. Illness brings a lot of fears ...from fear of death to fear of financial catastrophe. This needs to be acknowledged and supported.

9. It's important that the care **involve family members and friends**, recognizing that they are a primary aspect of well-being and likely to be intimately involved in the consumer's care. And

10. That there be adequate **preparation for discharge** from an acute care facility or ... translated into the ongoing care situation... that care and planning inform the day to day living of a healthy and satisfying life.

In addition to those ten, of personal importance to me is that I get to **know my providers** and see how they interact with one another. Another is that they get to know me better and in emergency situations can **advocate** for me more knowledgeably. With a team in place, my family members are **relieved of the worry** that I am alone in orchestrating my care and that if something occurs and I am unable to speak for myself, my team will be able to seamlessly act on my behalf until they arrive. And last but certainly not least is the importance of the potential for saving significant amounts of money.

My own circumstances in one episode alone could have saved 10's of thousands of taxpayer dollars to say nothing of my own money and that of my family. I speak from personal experience about why person-centered planning and care is important.

In 1971, I suffered a basilar skull fracture that remained undiscovered though not unsuspected for almost 30 years. During those 30 years, I experienced repeated episodes of meningitis. From the recurrent insults to the membranes around my spinal cord and brain and the many invasive tests and examinations to try to locate the cause, these membranes became scarred, producing a somewhat rare condition called arachnoiditis. I also experience from time to time another rare condition called post-infectious polyneuropathy. While stable much of the time now, these conditions and a non functioning pituitary gland produce symptoms which are occasionally of an acute nature and put me into the category of the complex patient who is a prime candidate for the type of health care that MyCare Vermont aspires to be.

Last year, I experienced one of those occasions. I was admitted to a very high-tech hospital out of state where they were not yet practicing person-centered care. The staff was not trained to listen and respect the patient. Because of that, I experienced the negative side to nearly all of those 10 survey answers.

A team that knew of my complexities and who could have helped during the acute and transitioning phases would have been such a blessing for my family and me as I went from acute to long-term care and back to acute, then into rehab then finally back home to inch my way back to my baseline.

I believe that the second hospital admission and subsequent rehab need not have occurred and was exacerbated by the stress of not having a team in place that could have helped during that crucial initial post acute phase. I also believe that I would have been back to my life at least six months before I was.

The rewards for **consumers** of person-centered planning and care are many. Some of those are:

- **Faster recuperation periods**
- **Fewer prescription and treatment errors**
- **Lower incidents of infection**
- **Fewer incidences of Emergency Room visits,**
- **Fewer hospital admissions**

- **Fewer cases of depression**
- **Higher level of confidence in healthcare in general**
- **If I am living well with my condition, another reward might be that my providers are more satisfied with their jobs and I don't have to worry about my town not having enough providers**
- **Then there is reward of happier people living with difficult circumstances being as active in our communities as we choose to be**
- **The biggest reward however, for ME, would be PEACE OF MIND; my team would be in place, and the information most important about me would be available to others when it is needed. My family wouldn't worry as much and I could put my energy into the things I need and like to do**
- **"Everybody wins"**

That person-centered care and planning is important is why we should attempt to deliver our healthcare in this way; the rewards I just spoke about are what we might reap if we succeed in doing so.

But ... and here is the Vermont perspective. "You can't get there from here. "

Person centered or what others are calling patient-centered or family-centered method of care delivery is a work in progress around the country and that progress has not been easy. There are successes. The Dana Farber Institute in Boston is a big one. Their launch into person-centered care was a tragic one but they took the ball and now have a successful model of patient centered care that is one we can all look to.

They have taken patient centered care to the highest levels by creating patient advisory councils, patient/family educators. Patients and family are on the boards and involved in projects from hiring staff to planning building modifications.

The Medical College of Georgia is another huge success but we can still count these successes easily. The numbers are not that great.

A report that came out in 2001 written by the INSTITUTE OF MEDICINE, called Crossing the Quality Chasm: a New Healthcare System for the 21st Century, makes the following powerful statement:

"the burden of harm conveyed by the collective impact of all of our health care quality problems is Staggering. It requires the urgent attention of all stakeholders."

With strong statements like this one around now for several years, we still have such difficulty getting this model operating in more than just a relatively few places.
WHY?

In order for this person centered care model to be successful, there are two main stakeholders that must be on board; the **individual receiving the care** and the **primary care provider**. Without the solid support of these two, ventures such as MyCare Vermont will fail. The other

folks involved in person-centered care are of course vital but these two are the core of this model and there is a problem.

What I am here to talk about today is what can prevent these players from coming together and what we might do to bring them into a working relationship.

In the past few years I have been a consumer representative and advocate on several boards and councils and a number of projects that involve healthcare and independent living.

The providers and the consumers **are** on the same page. Our goals are aligned without question. The consumer's and the primary care provider's hopes and aspirations are the same.

- We both want delivery of the best care possible.
- We both want to get the most for our dollar with as little waste as is reasonable.
- The *consumers* want the healthiest most productive life we can have. The *compassionate provider* wants that for us.
- The *provider* wants to earn a living commensurate with his or her education and expertise and to be of service. The *reasonable and understanding consumer* wants that for them.

Yet nearly every time when identified consumers are present at the meetings where there are both consumers and providers, there is an elephant in the room, whether it is the consumer speaking or the provider speaking. If it is the consumer, the providers' antenna goes up, if it is the provider, the consumers are on guard. That elephant in the room is mistrust.

I believe that in every instance where the attempts at implementation of the person-centered healthcare delivery system have failed, it is the lack of trust between these two players. Even though the reasons given may be that the failure was financial or the system took too much time to implement or lacked strong enough leadership, under it all is the element of **trust** between the practitioner and the consumer. We have yet to establish faith that when the going gets tough we can look to each other for that boost that will get us going again. That *reliance* on each other requires that we **trust** each other, but we have yet to be convinced that we really do want the same things.

A paper prepared by The Institute of Family-Centered Care supported by the Robert Wood Johnson Foundation for the 2006 invitational meeting convened by the Institute reports that a few of the barriers to the implementation of this partnership that are often heard from the providers standpoint are that:

- **suggestions from consumers will be unreasonable**
- **confidentiality will be compromised**
- **a customer service program is sufficient to ensure patient satisfaction and involvement**
- **or this partnership isn't necessary because "we are already patient centered, we know what is best" or... another commonly heard argument is "we are all patients."**

And another is

- **it is time-consuming and costly**

Some **CONSUMER** fears that create problems are that they:

- **won't be respected**
- **won't be given enough information to participate fully in the process**
- **will be double-teamed or strong-armed into capitulating to a treatment or process that doesn't feel right for them**

I believe that there is something else. In the forward of the book *Patients as Partners; How to Involve Patients and Families in Their Own Care* put out by *Joint Commission Resources*, the writer addresses clearly what he refers to as the “default answer” to the question of why the **provider** balks at including the patient in the decision making process. He says that default answer is fear of **LIABILITY**.

In my experience as a patient and of being around other patients, the biggest fear of the **consumer** in trying to be part of the decision making process is that they will not be heard.

The author of the forward in *Patients as Partners* feels, and I agree wholeheartedly, that underlying both of these is the **fear** that we will not have the *communications skills* needed to negotiate these difficult waters.

So how *do* we begin to bring these two untrusting potential partners to creating a successful system?

Perhaps first by recognizing and articulating that we actually have such a problem. There **is** an elephant in the room. We do **not** trust each other and we do not trust ourselves enough that we could communicate well through the hard times. Just like correctly diagnosing the illness brings the possibility of curing it, we have to acknowledge **this** problem in order to cure what ails this process.

Having done so, we can apply certain principles to problem solving and this is where I believe Vermont has an edge in making this partnership work:

Vermonters can speak plainly to one another because that is first of all what we **do** here in Vermont. So the partnership might begin with this conversation. “Provider (doctor or whoever) Joe, we don't trust each other. You may be afraid of me suing you and I am afraid you won't hear me when I need most to be heard.” Having said that, we can begin with all the things Vermonters have to offer one another:

- As Vermonters, we *ARE* person-centered ... that's how we like to work... *person to person*

As Vermonters we offer:

- Tolerance
- Practicality
- Neighbor to neighbor collaboration
- Our *individualism* which makes us creative in problem solving
- We are a rural mountainous area and our geography makes us even more aware than others might be of the difficulties fragmentation in healthcare can bring

- We might be the first to say “you can’t get there from here” but we will also be the first to do everything we can to see that you **do** get there.

Because of these attributes, we as Vermonters are uniquely qualified to tackle such a challenging task.

To develop trust takes time and REPETITION, REPETITION, REPETITION... that **I** will do what **I** say and that **you** will do what **you** say.

Here are a few things that might help in encouraging a trusting relationship:

To help build trust for the **provider** we might:

- Designate staff people who are already **skilled at communicating** in person-centered collaborations to act as liaisons in decision making sessions
- We might **invest in orientation and training** for effective collaboration in person-centered care
- We might **invest in educational and planning** activities for providers AND patients to engage in **with each other**
- We might present hard data to them that supports the conclusions that person centered care **is cost effective** and returns **will be measurable in dollars** as well as **patient satisfaction** and **market share**
- We could have an **experienced consumer** come talk to a meeting of providers and relate their personal positive experience of person-centered care

To raise trust for the consumer some things we could do, in addition to their involvement in their care planning are:

- Invite the consumer to be involved in **every** aspect of healthcare endeavors ...from the planning of the building, to administration aspects... to policy making and aesthetics and even include them in the staff hiring process.
- The consumer could be invited to have positions on boards and councils
- We could have **paid** consumer advocates, not just an advocate **FOR** the consumer but an advocate who **IS** one
- We could create **consumer advisory councils**
- We might have **consumer educators** involved in training programs from medical students to medical technicians. And have training programs for whoever has patient contact.
- Invite the consumer to participate in the **hiring of staff**

These are some of the things that have been practiced by the successful organizations practicing person-centered planning and care and have been shown to produce positive results in bridging the trust gap.

A person who trusts his or her provider is more likely to adhere to prescribed treatments; they will panic less, be more relaxed and competent in the management of their day-to-day medical regimens and therefore have more successful treatment outcomes.

A provider who trusts the patient is more likely to **want** to involve them in the decision making process and enjoy the fact that they are truly fulfilling their desire to be of service because the consumer will tell them ***personally*** that they are.

If they are invited, there are **consumers** here in our state who have wisdom to offer, and who are available to assist in every aspect of healthcare and planning. There are **providers** here who are already quite experienced and skilled at person-centered care. Let us hope they find each other on this MyCare Vermont adventure and that once again Vermont is on the leading edge in healthcare reform.

I would like to quote again from the report Crossing the Quality Chasm:

...“Our present efforts resemble a team of engineers trying to break the sound barrier by tinkering with a MODEL T FORD. We need a new vehicle or perhaps many new vehicles. The only alternative is not to change.”

Vermont is taking up that challenge. MyCare Vermont may be one of those new vehicles.

I would like to leave you with a few of the lofty possibilities put forth in the conclusion of *Through the Patient’s Eyes*, a wonderful book sponsored by the Picker/ Commonwealth Program for Patient Centered Care. They say:

“An expanded concept of the purpose and value of the practitioner-patient interaction could lead the medical payment system to **revalue the TIME** practitioners spend with patients. ... the Physician Payment Review Commission has begun to push the rewards in the direction of more time with patients. Insurers could follow suit, placing greater relative **monetary value on time** spent with patients. ...

It could also change how medical care is valued. By ushering in a system in which the patient’s values regarding risks and rewards are central to determining the *‘appropriate’* course of treatment.”

It could even alter the course of medical education by integrating knowledge of disciplines such as psychology and sociology. And finally, this book offers... “the sum of these changes could restore public esteem for medical professionals and institutions.” They also say:

“The extent to which Americans are willing to invest in the healthcare system in the future may depend more on the level of public trust and confidence built through a *better response to the needs of patients* than to any other factor.”

I think we can do this.

Sarah Littlefeather
August 28, 2007

DATA ANALYSIS

Health and Long Term Care Integration Project

Review of Medicaid Data

Prepared by

Pacific Health Policy Group

For

State of Vermont

Office of Vermont Health Access

And

Department of Disabilities, Aging and Independent Living

September 26, 2006

State of Vermont Review of Medicaid Data

<i>Table of Contents</i>	<i>Page #</i>
Overview	71
<i>Section 1 - Duals</i>	
Table 1 – Average Number of Eligibles, by Gender and Age	72
Table 2 – Number of Recipients, by Program	73
Table 3 – Medicaid Expenditures, by Age and Service Category	74
Table 4 – Group 1: Individuals Eligible for Long-Term Care, Living in the Community	75
Table 5 – Group 2: Individuals Residing in Nursing Facilities	76
Table 6 – Group 3: Dual Eligibles Not Receiving Long-Term Care, Developmental Services or CRT Services	77
<i>Section 2 - Medicaid Only</i>	
Table 7 – Group 1: Individuals Receiving LTC Home and Community-Based (HCBS) Services	78
Table 8 – Group 2: Individuals Receiving Nursing Facility Services	79
<i>Section 3 - Demographic Summary</i>	
Table 9 – Demographic Summary by County	80
Table 10 – Demographic Summary by Region	81

Overview

Data Sources

Eligibility data and paid claims data for SFY 2004 (July 1, 2003 – June 30, 2004)

*Analysis includes only transactions in claims system

Approach

1 Evaluation of Eligibility Data

- Excludes eligibles who did not receive full Medicaid benefits
- Eligibility based on monthly enrollment during SFY04

2 Evaluation of Claims Data

- Excludes eligibles who did not receive full Medicaid benefits
- Excludes individuals who participate in the Traumatic Brain Injury (TBI) Waiver

Definitions

“Recipient” is an individual person receiving that service

“Average number of eligibles” is the total member months of that group, divided by 12

“Average cost per month” is the total expenditure amount of that group, divided by the number of member months in that group

Section 1 - Duals

Table 1
Average Number of Eligibles, by Gender

Gender	Average Eligibles	Percent of Total
Male	4,421	37.6%
Female	7,328	62.4%
Total	11,749	100.0%

Average Number of Eligibles, by Age

Age Range	Average Eligibles	Percent of Total
0-21	67	0.6%
22-45	2,403	20.4%
46-55	1,574	13.4%
56-65	1,366	11.6%
66-74	1,948	16.6%
75+	4,392	37.4%
	11,749	100.0%

Notes:

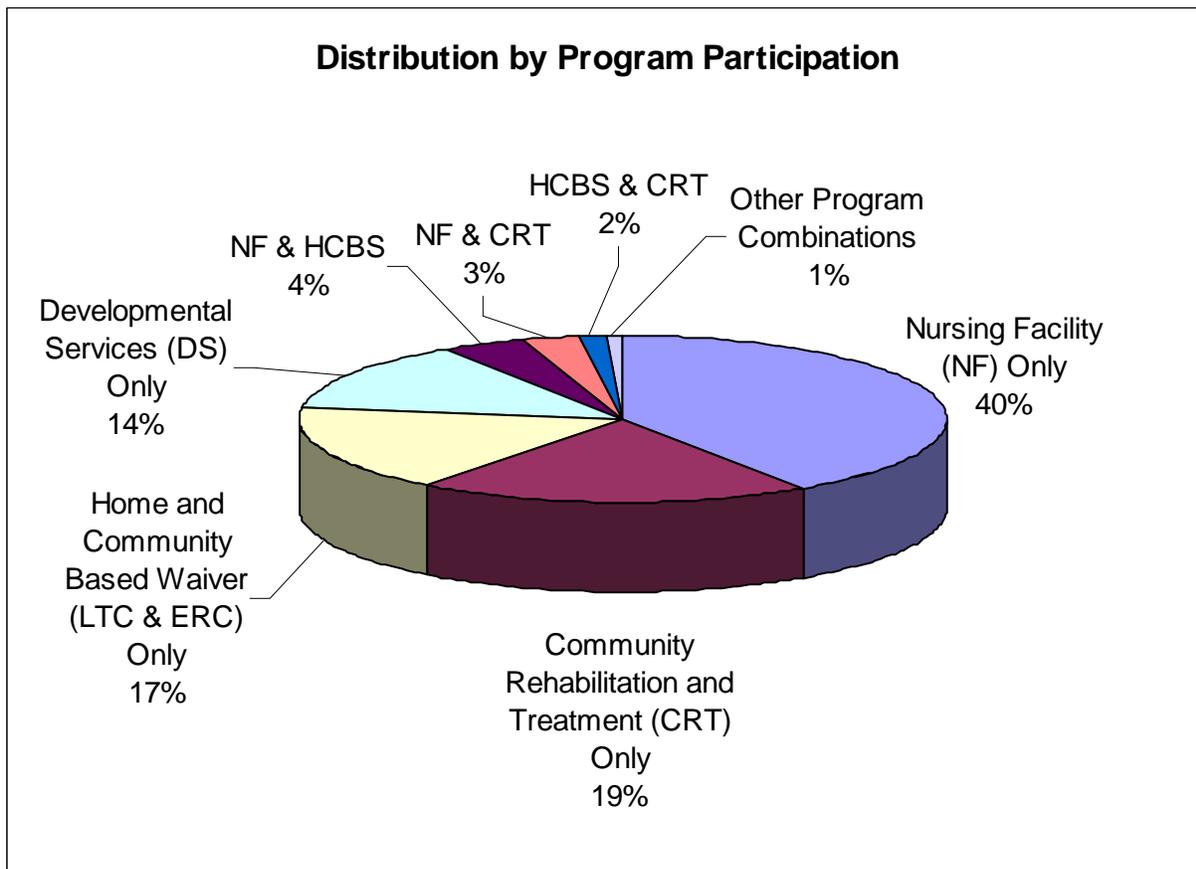
Average number of eligibles calculated by dividing total member months by 12

Excludes state programs that do not provide comprehensive Medicaid benefits (e.g., pharmacy, QMB)

Section 1 - Duals

**Table 2
Number of Recipients, by Program**

Nursing Facility (NF) Only	2,714
Community Rehabilitation and Treatment (CRT) Only	1,324
Home and Community Based Waiver (LTC & ERC) Only	1,129
Developmental Services (DS) Only	924
NF & HCBS	277
NF & CRT	176
HCBS & CRT	101
Other Program Combinations	54



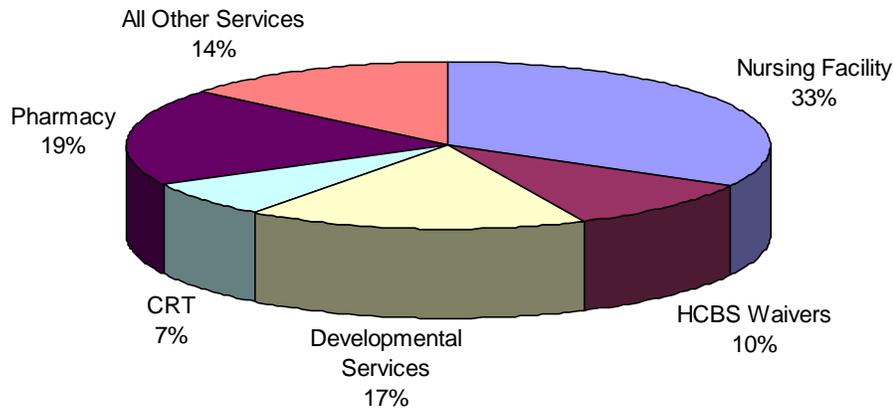
*Notes:
Counts based on claims history for SFY 2004*

Section 1 - Duals

**Table 3
Medicaid Expenditures, by Age and Service Category**

Service Group	Age <18	18-44	45-64	65+	Total
1 Inpatient	\$ 31,065	\$ 163,381	\$ 586,216	\$ 366,270	\$ 1,146,932
2 Inpatient-Behav	-	141,471	69,000	3,749	214,221
3 Inpatient-NF	-	-	1,394	137,945	139,339
4 Outpatient	14,753	270,027	401,744	52,247	738,771
5 Physician	7,403	302,788	389,256	138,212	837,659
7 Home Health	-	778,372	758,388	1,072,847	2,609,606
8 Hospice	-	-	4,263	219,871	224,135
9 Nursing Facility	-	730,844	3,706,726	80,576,742	85,014,312
10 HCBS Long Term Care	-	1,920,007	3,769,440	20,179,819	25,869,266
11 Adult Day Treatment	-	11,874	71,449	808,383	891,706
12 Targeted Case Mgmt	-	264,966	319,072	145,480	729,517
13 Ambulance	-	6,986	11,497	5,854	24,336
14 Non-Med Residential	-	289,795	1,001,032	3,954,624	5,245,451
15 Optometrist/Optician	137	7,466	10,553	7,656	25,813
16 Podiatrist	-	449	475	1,738	2,662
17 Psychologist	-	92,108	71,074	8,583	171,766
18 MR Clinic	-	67,089	63,451	137,923	268,463
19 Mental Health Clinic	34,635	227,002	166,912	243,462	672,011
20 CRT	24,854	7,443,042	7,655,350	2,845,378	17,968,623
21 Alcohol Subs Abuse	-	193,791	78,884	9,791	282,466
22 Dental	4,245	332,022	271,588	175,596	783,451
23 Transportation	3,319	346,890	661,969	1,154,847	2,167,024
24 Vocational Rehab	-	-	-	-	-
25 Developmental Services	21,299	20,298,527	19,465,424	5,098,481	44,883,731
26 Case Mgr/Soc Worker	-	100,712	84,730	10,753	196,196
27 Licensed Nurse	-	-	53,274	-	53,274
28 Audiologist	-	1,632	5,719	57,420	64,772
29 Med Supplies,DME	16,318	531,570	300,753	442,255	1,290,896
30 Inpatient Crossovers	876	522,386	963,361	3,328,708	4,815,331
31 Prof Crossovers	2,317	847,321	1,467,865	2,160,570	4,478,074
32 Other	25,678	1,822,944	2,046,738	3,818,003	7,713,362
TOTAL	\$ 186,899	\$ 37,715,463	\$ 44,457,597	\$ 127,163,207	\$ 209,523,166
Pharmacy	\$ 42,604	\$ 9,784,340	\$ 15,344,593	\$ 23,372,519	\$ 48,544,056

Distribution of SFY04 Spending by Service Category



Section 1 - Duals

**Table 4
Group 1: Individuals Eligible for Long-Term Care, Living in the Community**

Service Group	<18	18-44	45-64	65+	Total
1 Inpatient	-	16,969	89,138	38,119	144,225
2 Inpatient-Behav	-	-	11,374	-	11,374
3 Inpatient-NF	-	-	127	26,242	26,368
4 Outpatient	-	1,047	16,312	3,281	20,640
5 Physician	-	8,145	56,697	10,009	74,851
7 Home Health	-	454,989	298,283	500,012	1,253,284
8 Hospice	-	-	-	18,795	18,795
9 Nursing Facility	-	-	-	-	-
10 HCBS Long Term Care	-	1,651,988	3,270,467	16,488,115	21,410,570
11 Adult Day Treatment	-	-	20,821	94,872	115,693
12 Targeted Case Mgmt	-	-	-	7,998	7,998
13 Ambulance	-	832	2,497	675	4,004
14 Non-Med Residential	-	-	35,215	1,219,482	1,254,696
15 Optometrist/Optician	-	112	285	817	1,214
16 Podiatrist	-	-	-	117	117
17 Psychologist	-	-	-	-	-
18 MR Clinic	-	-	-	-	-
19 Mental Health Clinic	-	2,064	766	13,442	16,273
20 CRT	-	-	-	-	-
21 Alcohol Subs Abuse	-	212	-	4,088	4,300
22 Dental	-	4,257	7,071	16,330	27,658
23 Transportation	-	23,404	225,202	404,835	653,441
24 Vocational Rehab	-	-	-	-	-
25 Developmental Services	-	-	-	3,797	3,797
26 Case Mgr/Soc Worker	-	689	2,006	-	2,695
27 Licensed Nurse	-	-	7,931	-	7,931
28 Audiologist	-	-	1,158	7,547	8,705
29 Med Supplies,DME	-	210,800	84,353	206,146	501,300
30 Inpatient Crossovers	-	86,581	101,355	458,301	646,237
31 Prof Crossovers	-	19,601	117,525	263,175	400,301
32 Other	-	74,680	221,525	580,391	876,596
TOTAL	-	2,556,370	4,570,107	20,366,587	27,493,064

Total Recipients	0	56	146	976	1,178
Average Number of Eligibles	0	51	126	735	908
Average Cost per Month	\$0	\$4,218	\$3,107	\$2,310	\$2,523

Age 18 to 64

Total Recipients	202
Average Number of Eligibles	173
Average Cost per Month	\$3,431

Note:

Excludes individuals who also received Nursing Facility care, Developmental Services or CRT Services

Section 1 - Duals

**Table 5
Group 2: Individuals Residing in Nursing Facilities**

Service Group	<18	18-44	45-64	65+	Total
1 Inpatient	-	-	209,744	56,505	266,249
2 Inpatient-Behav	-	-	-	-	-
3 Inpatient-NF	-	-	1,268	29,426	30,693
4 Outpatient	-	6,542	4,606	6,386	17,534
5 Physician	-	1,579	23,079	13,907	38,566
7 Home Health	-	2,785	6,658	27,954	37,396
8 Hospice	-	-	939	113,052	113,991
9 Nursing Facility	-	573,058	2,788,367	73,015,537	76,376,962
10 HCBS Long Term Care	-	-	-	-	-
11 Adult Day Treatment	-	-	15,287	73,749	89,036
12 Targeted Case Mgmt	-	-	-	6,528	6,528
13 Ambulance	-	-	4,412	3,036	7,447
14 Non-Med Residential	-	167	-	108,113	108,280
15 Optometrist/Optician	-	-	55	869	924
16 Podiatrist	-	-	29	1,067	1,097
17 Psychologist	-	-	1,624	1,494	3,118
18 MR Clinic	-	16,096	10,497	93,956	120,549
19 Mental Health Clinic	-	-	3,112	21,981	25,093
20 CRT	-	-	-	-	-
21 Alcohol Subs Abuse	-	-	-	-	-
22 Dental	-	2,043	4,637	38,612	45,292
23 Transportation	-	31	15,982	56,860	72,873
24 Vocational Rehab	-	-	-	-	-
25 Developmental Services	-	-	-	-	-
26 Case Mgr/Soc Worker	-	316	-	5,022	5,338
27 Licensed Nurse	-	-	-	-	-
28 Audiologist	-	-	-	7,783	7,783
29 Med Supplies,DME	-	1,041	1,238	25,776	28,054
30 Inpatient Crossovers	-	5,838	136,915	1,256,889	1,399,642
31 Prof Crossovers	-	5,905	56,434	407,527	469,866
32 Other	-	36,052	52,962	590,488	679,502
TOTAL	-	651,452	3,337,845	75,962,517	79,951,814

Total Recipients	0	16	90	2,635	2,741
Average Number of Eligibles	0	15	76	1,997	2,088
Average Cost per Month	\$0	\$3,744	\$3,676	\$3,169	\$3,192

Age 18 to 64

Total Recipients	106
Average Number of Eligibles	90
Average Cost per Month	\$3,687

Note:

Excludes individuals who also received Developmental Services and CRT services

Section 1 - Duals

**Table 6
Group 3: Dual Eligibles Not Receiving LTC, DS, or CRT Services**

Service Group	<18	18-44	45-64	65+	Total
1 Inpatient	1,803	116,427	181,511	182,934	482,675
2 Inpatient-Behav	-	19,719	24,699	-	44,417
3 Inpatient-NF	-	-	-	81,390	81,390
4 Outpatient	767	189,111	327,422	42,155	559,455
5 Physician	3,073	229,294	255,497	103,017	590,881
7 Home Health	-	220,675	245,021	326,541	792,237
8 Hospice	-	-	3,324	85,683	89,007
9 Nursing Facility	-	-	-	-	-
10 HCBS Long Term Care	-	-	-	-	-
11 Adult Day Treatment	-	11,874	23,857	597,131	632,861
12 Targeted Case Mgmt	-	2,240	13,876	2,722	18,838
13 Ambulance	-	5,133	2,924	2,003	10,060
14 Non-Med Residential	-	13,931	110,496	1,750,272	1,874,699
15 Optometrist/Optician	-	3,380	6,792	4,547	14,719
16 Podiatrist	-	306	235	465	1,007
17 Psychologist	-	58,375	47,428	5,415	111,218
18 MR Clinic	-	7,037	1,395	-	8,432
19 Mental Health Clinic	1,720	124,941	72,341	26,424	225,426
20 CRT	-	-	-	-	-
21 Alcohol Subs Abuse	-	118,643	42,557	1,310	162,510
22 Dental	2,809	175,903	144,090	99,456	422,258
23 Transportation	2,242	180,773	227,477	424,595	835,087
24 Vocational Rehab	-	-	-	-	-
25 Developmental Services	-	-	-	-	-
26 Case Mgr/Soc Worker	-	66,794	72,260	3,115	142,170
27 Licensed Nurse	-	-	-	-	-
28 Audiologist	-	67	3,098	32,538	35,703
29 Med Supplies,DME	13,178	113,325	98,872	129,444	354,819
30 Inpatient Crossovers	-	221,914	437,608	952,759	1,612,281
31 Prof Crossovers	749	554,561	987,820	1,208,687	2,751,817
32 Other	12,277	1,073,209	1,315,017	2,190,505	4,591,008
TOTAL	\$ 38,620	\$ 3,507,632	\$ 4,645,618	\$ 8,253,109	\$ 16,444,978

Total Recipients	16	1,671	2,296	3,828	7,811
Average Number of Eligibles	15	1,271	1,807	3,101	6,194
Average Cost per Month	\$214	\$230	\$214	\$223	\$221

Age 18 to 64

Total Recipients	3,967
Average Number of Eligibles	3078
Average Cost per Month	\$221

Section 2 – Medicaid Only

**Table 7
Group 1: Individuals Receiving LTC Home and Community-Based (HCBS) Services**

Service Group	<18	18-44	45-64	65+	Total
1 Inpatient	\$ -	\$ 66,579	\$ 496,128	\$ 98,267	\$ 660,974
2 Inpatient-Behav	\$ -	\$ 17,127	\$ 20,119	\$ -	\$ 37,246
3 Inpatient-NF	\$ -	\$ 8,746	\$ 23,238	\$ 1,521	\$ 33,505
4 Outpatient	\$ -	\$ 59,724	\$ 221,334	\$ 74,116	\$ 355,174
5 Physician	\$ -	\$ 26,373	\$ 136,031	\$ 62,036	\$ 224,440
7 Home Health	\$ -	\$ 398,239	\$ 273,623	\$ 35,656	\$ 707,518
8 Hospice	\$ -	\$ -	\$ 2,935	\$ 2,246	\$ 5,181
9 Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -
10 HCBS Long Term Care	\$ -	\$ 1,112,733	\$ 1,427,858	\$ 418,108	\$ 2,958,698
11 Adult Day Treatment	\$ -	\$ -	\$ -	\$ -	\$ -
12 Targeted Case Mgmt	\$ -	\$ 771	\$ -	\$ -	\$ 771
13 Ambulance	\$ -	\$ 3,957	\$ 30,493	\$ 5,666	\$ 40,116
14 Non-Med Residential	\$ -	\$ 833	\$ 50,394	\$ 20,008	\$ 71,234
15 Optometrist/Optician	\$ -	\$ 223	\$ 354	\$ 128	\$ 706
16 Podiatrist	\$ -	\$ 224	\$ 642	\$ -	\$ 866
17 Psychologist	\$ -	\$ 2,516	\$ 240	\$ -	\$ 2,756
18 MR Clinic	\$ -	\$ -	\$ -	\$ -	\$ -
19 Mental Health Clinic	\$ -	\$ 33,289	\$ 3,778	\$ -	\$ 37,067
20 CRT	\$ -	\$ 36,298	\$ 14,706	\$ 9,455	\$ 60,459
21 Alcohol Subs Abuse	\$ -	\$ -	\$ 569	\$ -	\$ 569
22 Dental	\$ -	\$ 6,480	\$ 3,481	\$ -	\$ 9,961
23 Transportation	\$ -	\$ 23,306	\$ 60,829	\$ 3,435	\$ 87,569
24 Vocational Rehab	\$ -	\$ 12,570	\$ -	\$ -	\$ 12,570
25 Developmental Services	\$ -	\$ -	\$ 3,797	\$ -	\$ 3,797
26 Case Mgr/Soc Worker	\$ -	\$ 1,594	\$ 302	\$ -	\$ 1,896
27 Licensed Nurse	\$ -	\$ 85,240	\$ 24,895	\$ -	\$ 110,135
28 Audiologist	\$ -	\$ -	\$ -	\$ -	\$ -
29 Med Supplies,DME	\$ -	\$ 85,830	\$ 167,988	\$ 19,200	\$ 273,018
30 Inpatient Crossovers	\$ -	\$ -	\$ -	\$ 876	\$ 876
31 Prof Crossovers	\$ -	\$ -	\$ 48	\$ 2,185	\$ 2,232
32 Other	\$ -	\$ 24,748	\$ 4,165	\$ 2,421	\$ 31,334
TOTAL	\$ -	\$ 2,007,398	\$ 2,967,945	\$ 755,323	\$ 5,730,666

Total Recipients	0	47	90	21	158
Average Number of Eligibles	0	32	56	14	103
Average Cost per Month		\$5,174	\$4,384	\$4,496	\$4,648

Age 18 to 64

Total Recipients	137
Average Number of Eligibles	89
Average Cost per Month	\$ 4,672

*Note:
Excludes individuals who also received nursing facility care*

Section 2 – Medicaid Only

**Table 8
Group 2: Individuals Receiving Nursing Facility Services**

Service Group	<18	18-44	45-64	65+	Total
1 Inpatient		\$ 152,335	\$ 632,078	\$ 94,977	\$ 879,390
2 Inpatient-Behav		\$ 23,886	\$ 52,853	\$ -	\$ 76,738
3 Inpatient-NF		\$ -	\$ 1,957	\$ -	\$ 1,957
4 Outpatient		\$ 36,708	\$ 138,287	\$ 15,514	\$ 190,509
5 Physician		\$ 40,118	\$ 156,042	\$ 27,599	\$ 223,759
7 Home Health		\$ 50,229	\$ 79,128	\$ 1,641	\$ 130,998
8 Hospice		\$ 1,285	\$ 7,747	\$ -	\$ 9,033
9 Nursing Facility		\$ 696,342	\$ 2,417,617	\$ 1,288,039	\$ 4,401,998
10 HCBS Long Term Care		\$ 109,831	\$ 198,232	\$ 13,190	\$ 321,253
11 Adult Day Treatment		\$ -	\$ 4,561	\$ -	\$ 4,561
12 Targeted Case Mgmt		\$ -	\$ -	\$ 2,794	\$ 2,794
13 Ambulance		\$ 16,842	\$ 59,127	\$ 9,740	\$ 85,709
14 Non-Med Residential		\$ -	\$ 222	\$ -	\$ 222
15 Optometrist/Optician		\$ -	\$ 528	\$ 134	\$ 662
16 Podiatrist		\$ 63	\$ 557	\$ 457	\$ 1,076
17 Psychologist		\$ 359	\$ 2,546	\$ -	\$ 2,905
18 MR Clinic		\$ 9,248	\$ 7,225	\$ 12,802	\$ 29,275
19 Mental Health Clinic		\$ 3,286	\$ 8,026	\$ 1,686	\$ 12,998
20 CRT		\$ 5,709	\$ 153,892	\$ 43,492	\$ 203,093
21 Alcohol Subs Abuse		\$ -	\$ -	\$ -	\$ -
22 Dental		\$ 1,058	\$ 2,385	\$ 806	\$ 4,249
23 Transportation		\$ 3,277	\$ 9,448	\$ 88	\$ 12,812
24 Vocational Rehab		\$ 720	\$ 11,813	\$ -	\$ 12,533
25 Developmental Services		\$ 3,693	\$ -	\$ -	\$ 3,693
26 Case Mgr/Soc Worker		\$ 80	\$ 925	\$ -	\$ 1,005
27 Licensed Nurse		\$ 19,208	\$ -	\$ -	\$ 19,208
28 Audiologist		\$ 100	\$ -	\$ -	\$ 100
29 Med Supplies,DME		\$ 59,463	\$ 37,600	\$ 1,798	\$ 98,861
30 Inpatient Crossovers		\$ -	\$ -	\$ 6,558	\$ 6,558
31 Prof Crossovers		\$ -	\$ -	\$ 1,710	\$ 1,710
32 Other		\$ 10,163	\$ 3,674	\$ 3,959	\$ 17,796
TOTAL	\$ -	\$ 1,244,001	\$ 3,986,467	\$ 1,526,984	\$ 6,757,452

Total Recipients	1	25	123	49	198
Average Number of Eligibles	1	13	60	33	106
Average Cost per Month		\$7,632	\$5,568	\$3,895	\$5,317

Age 18 to 64

Total Recipients	148
Average Number of Eligibles	72
Average Cost per Month	\$5,950

Notes:

Includes all individuals who received nursing facility services

One individual was under Age 18; for confidentiality purposes, expenditure data was moved to the 18-44 group

Section 3 – Demographic Summary

Table 9
Demographic Summary by County

County	Nursing Facility	HCBS	LTC Subtotal	Percent of Total	Other	Total Duals
Addison	96	111	207	5.0%	300	507
Bennington	326	40	366	8.8%	545	911
Caledonia	143	49	192	4.6%	489	681
Chittenden	421	250	671	16.1%	1308	1979
Essex	5	9	15	0.3%	136	151
Franklin	193	135	328	7.9%	630	958
Grand Isle	3	9	12	0.3%	91	103
Lamoille	100	36	136	3.3%	275	411
Orange	51	60	111	2.7%	364	475
Orleans	200	46	247	5.9%	535	782
Rutland	390	118	508	12.2%	1168	1676
Washington	344	94	438	10.5%	717	1155
Windham	157	80	238	5.7%	492	730
Windsor	310	140	450	10.8%	745	1195
Out of State	0	0	0	0.0%	16	16
Grand Total	2,741	1,178	3,919	94.0%	7,811	11,730



Section 3 – Demographic Summary

**Table 10
Demographic Summary of Region**

Region	Counties	Nursing Facility	HCBS	LTC Subtotal	Percent of Total	Other	Total Duals
Champlain Valley	Addison, Chittenden, Franklin and Grand Isle	713	505	1,219	31%	2,329	3,548
Central Vermont	Lamoille, Orange and Washington	495	190	685	17%	1,356	2,041
Northeast Vermont	Caledonia, Essex and Orleans	349	104	453	12%	1,160	1,613
Southwest Vermont	Bennington and Rutland	716	158	874	22%	1,713	2,587
Southeast Vermont	Windham and Windsor	468	220	688	18%	1,237	1,925
Out of State		-	-	-	0%	16	16
Total		2,741	1,178	3,919	100%	7,811	11,730

