

Health and Long-Term Care Integration Project

MyCare Vermont: Resources for Independence through Coordinated Health and Long-Term Care

OVERVIEW

November 28, 2006

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:

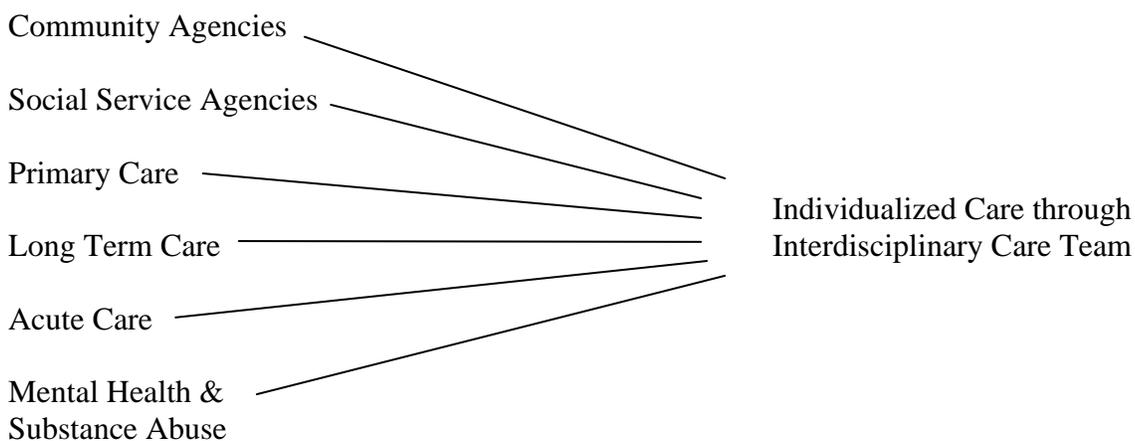
1. Integrated Services
2. Health Promotion and Risk Assessment/Reduction Services
3. Flexible Services

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, Certified Case Manager², 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.

² Certified by the Vermont Department of Disabilities, Aging and Independent Living

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. Certified Case Manager:

- 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.

Drafted 9-19-06; revised 9-26-06, 10-24-06, and 11/21/06 by the Core Planning Team.