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Office of Disability, Aging and Long-Term Care Policy

Descriptive Study of Three Disability Competent Managed Care Plans for Medicaid Enrollees

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Office of the Assistant Secretary for Planning and Evaluation

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DESCRIPTIVE STUDY OF THREE DISABILITY COMPETENT MANAGED CARE PLANS FOR MEDICAID ENROLLEES

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ABSTRACT

This report describes the organizational features of three disability competent health systems: Commonwealth Care Alliance (CCA) in Massachusetts; Community Health Partnership (CHP) in Wisconsin; and Independence Care System (ICS) in New York City. These programs integrate health and social services to deliver patient-centered care to Medicaid and Medicare beneficiaries with particularly complex chronic care needs. To provide program operators with useful information about these programs, we detail how staff deliver services and coordinate care for people with disabilities. We conducted two-day site visits to each program and discussed service delivery with program administrators and direct care staff.

The disability competent managed care plans in this study are committed to promoting independence and individualized care among their members, and to ensuring that members have the appropriate balance of medical and social supports. The plans also share four key features: (1) high-touch clinical interventions; (2) interdisciplinary teams to deliver care; (3) a strong emphasis on managing care transitions; and (4) investment in behavioral health resources. While the plans share these common features regarding how they are implemented, they differ on three other important operational features: (1) their level of integration with primary care and other providers; (2) the intensity of specialized services provided; and (3) the sophistication of information systems and data monitoring. The level of integration with primary care and other providers varies across the plans. CCA-Senior Care Option (CCA-SCO) recruits primary care practices and "wraps the care team around the practice" such that it is highly integrated with the practice. Less integrated operations are evident at Boston's Community Medical Group (BCMG), CHP, and ICS. BCMG and ICS primarily serve people with disabilities, whereas CHP and CCA-SCO serve broader populations. Although all the plans use member feedback to inform change, CCA-SCO and CHP employ a more data-driven approach to providing services and monitoring members. In addition, BCMG and CCA-SCO staff have access to patients' electronic medical records, which enhances care coordination activities with external providers.

The programs in this study incorporate features that define what it means to be an effective disability competent system, including coordinating services with providers across various settings, individualizing care based on members' needs, involving members in clinical decision-making, incorporating members' feedback into the program, and monitoring outcomes to drive change. Our study identified four factors, present in all of the programs, that helped the programs operationalize these core features: high-touch clinical interventions, the use of interdisciplinary teams, a strong emphasis on managing care transitions, and investment in behavioral health resources. However, programs must tailor their models based on the populations served and the complex settings in which they operate. Policymakers could play a critical role in the sustainability of these programs, because the state-specific policy environment and

reimbursement structure in which plans operate greatly affects their ability to deliver interventions and their financial viability. Although the plans must continue to explore cost-effective ways to deliver their interventions, in order to generate net savings, policymakers should consider removing the legal and regulatory limitations that increase administrative burden and reduce the effectiveness of plans.

These programs continue to adapt to both external changes, such as the changing health care landscape, and internal quality improvement changes based on data as well as their own experiences. This dynamic aspect is noteworthy because it is not only the facets of the programs, but also the continued refinement of their programmatic details and the adaptability of their leadership that contribute to their ability to meet the unique needs of individuals with disabilities.

ACRONYMS

The following acronyms are mentioned in this report and/or the appendices.

ACE	Alternative Configuration Experimentation
ADL	Activity of Daily Living
ASAP	Aging Services Access Point
BCMG	Boston's Community Medical Group
BMC	Boston Medical Center
BSN	Bachelor of Science in Nursing
BSW	Bachelor of Social Work
CCA	Commonwealth Care Alliance
CD-PAP	Consumer Directed Personal Assistance Program
CHA	Cambridge Health Alliance
CHP	Community Health Partnership
CHP-F	Community Health Partnership-Family Care
CHP-P	Community Health Partnership-Partnership
CMS	Centers for Medicare and Medicaid Services
D-SNP	Dual Eligible Special Need Plan
DCCO	Disability Care-Competent Organization
DCP	Disability Care Program
DME	Durable Medical Equipment
ED	Emergency Department
EMR	Electronic Medical Record
ER	Emergency Room
FFS	Fee-For-Service
GA	Geriatric Assessment
GI	Gastrointestinal
GSSC	Geriatric Social Service Coordinator
HEDIS	Healthcare Effectiveness Data and Information Set
HgbAlc	Glycated Hemoglobin
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, 9th edition
ICO	Integrated Care Organization
ICS	Independence Care System

IRIS	Include, Respect, I Self-Direct
IT	Information Technology
KCMU	Kaiser Commission on Medicaid and the Uninsured
LCSW	Licensed Clinical Social Worker
LICSW	Licensed Independent Clinical Social Worker
LTC	Long-Term Care
LTSS	Long-Term Support Services
MCO	Managed Care Organization
MCP	Member-Centered Care Plan
MD	Medical Doctor or Physician
MDS	Minimum Data Set
MLTC	Managed Long-Term Care
MS	Multiple Sclerosis
MSW	Master of Social Work
NHP	Neighborhood Health Plan
NP	Nurse Practitioner
OASIS	Outcome and Assessment Information Set
OT	Occupational Therapist
PA	Physician Assistant
PACE	Program of All-Inclusive Care for the Elderly
PCA	Personal Care Assistant
PCP	Primary Care Physician
PERS	Personal Emergency Response System
PHQ-9	Patient Health Questionnaire-9
PPOC	Physician Plan of Care
Project RED	Re-engineered Hospital Discharge Project
PT	Physical Therapist
RAD	Resource Allocation Decision
RN	Registered Nurse
SAAM	Semiannual Assessment of Members
SCI	Spinal Cord Injury
SCO	Senior Care Options
SNP	Special Needs Plan
SOFI	Statistics and Other Financial Information
SSC	Social Services Coordinator
SW	Social Worker
VP	Vice President

EXECUTIVE SUMMARY

Although people with disabilities make up 15 percent of the Medicaid population, they account for more than 40 percent of expenditures (Kaiser Commission on Medicaid and the Uninsured September 2012). These individuals often have unique health care and social needs, requiring care from multiple providers across a wide range of settings, which makes coordination of care particularly important. Although results are mixed, designating one provider or organization to coordinate care and facilitate patient self-management could be a promising approach to improving care for people with disabilities (Brown 2009; Gravelle et al. 2007; Smith et al. 2005). Despite the challenges of coordinating care for people with disabilities, a few programs have a long history of trying to better serve this population--these programs are referred to as disability competent managed care plans. This report describes the organizational features of three disability competent health systems: Commonwealth Care Alliance's (CCA) two plans, Boston's Community Medical Group (BCMG) and Senior Care Option (SCO) in Massachusetts, Community Health Partnership (CHP) in Wisconsin, and the Independence Care System (ICS) in New York City. We describe the organizational features of these plans and the ways in which staff deliver services and coordinate care for people with disabilities. This report also serves as a useful guide to program operators interested in refining or implementing a care coordination model for people with disabilities.

To better understand the facets of this model, we conducted two-day site visits to each program. The disability competent managed care plans described in this report are committed to promoting independence and individualized care among their members, and to ensuring that members have the appropriate balance of medical and social supports. The plans also share four key features: (1) high-touch clinical interventions; (2) interdisciplinary teams to deliver care; (3) a strong emphasis on managing care transitions; and (4) investment in behavioral health resources. Although contact varies based on need and is guided by clinical judgment, the plans generally provide frequent in-person contact between the provider and the member. In some cases, providers visit members once per month. Each plan uses a team made up of various staff members who have the knowledge and skills to best meet the needs of the population and to serve as a resource to other staff. The plans' emphasis on care transitions is supported in two ways: (1) all of the plans have established a formal protocol for managing care transitions; and (2) all have dedicated personnel to this role. In addition, the plans unanimously reported the prevalence of behavioral health problems among their members; three of four plans employ behavioral health personnel to work directly with members and care coordinators, and all plans encourage care coordinators to consult with behavioral health personnel, as needed.

While the plans share these common features regarding how they are implemented, they differ on three other important operational features: (1) their level of

integration with primary care and other providers; (2) the intensity of specialized services provided; and (3) the sophistication of information systems and data monitoring. The level of integration with primary care and other providers varies across the plans. CCA-SCO recruits primary care practices and "wraps the care team around the practice" such that it is highly integrated with the practice. Less integrated operations are evident at BCMG, CHP, and ICS. BCMG and ICS primarily serve people with disabilities, whereas CHP and CCA-SCO serve broader populations. Thus, ICS and BCMG devote considerable resources specifically to assist staff in working with individuals with disabilities. Although all the plans use member feedback to inform change, two of the plans employ a more data-driven approach to providing services and monitoring members; CCA-SCO and CHP use their information systems to generate sophisticated monitoring reports. In addition, BCMG and CCA-SCO staff have access to patients' electronic medical records, which significantly enhances care coordination activities with external providers.

The programs in this study incorporate features that define what it means to be an effective disability competent system, including coordinating services with providers across various settings, individualizing care based on members' needs, involving members in clinical decision-making, incorporating members' feedback into the program, and monitoring outcomes to drive change. Our study identified four factors, present in all of the plans, that helped the plans operationalize these core features: (1) high-touch clinical interventions; (2) the use of interdisciplinary teams; (3) a strong emphasis on managing care transitions; and (4) investment in behavioral health resources. The first three features are among those that have been found in programs that successfully reduced hospitalization for high-risk Medicare beneficiaries in a fee-for-service environment. However, programs must tailor their models based on the populations served and the complex settings in which they operate. Further, policymakers could play a critical role in the sustainability of these programs, because the state-specific policy context and reimbursement structure in which plans operate greatly affects their ability to deliver interventions and their financial viability. Although the plans must continue to explore cost-effective ways to deliver their interventions, in order to generate net savings, policymakers should consider removing the legal and regulatory limitations that increase administrative burden and reduce the effectiveness of plans. Policymakers could also consider compensating plans for care coordination activities to improve the financial viability of these relatively small plans. Program administrators should systematically monitor outcomes that are relevant for members of disability competent systems such as quality of life, member satisfaction, and functioning. Monitoring critical outcomes that are specific to individuals with disabilities would enable program operators to more fully assess their programs. Our study reinforces the importance of developing population-specific programs; program administrators must tap particular health and social services in order to improve the health and quality of life of individuals with disabilities.

These programs continue to adapt to both external changes, such as the changing state and federal health care landscapes, and internal quality improvement changes based on data as well as their own experiences. This dynamic aspect is noteworthy

because it is not only the facets of the programs, but also the continued refinement of their programmatic details and their leaders' adaptability that contribute to their ability to meet the unique needs of individuals with disabilities.

I. INTRODUCTION

People with developmental and physical disabilities comprise a significant portion of the Medicaid population. Although people with disabilities make up 15 percent of the Medicaid population, they account for more than 40 percent of expenditures (Kaiser Commission on Medicaid and the Uninsured [KCMU] September 2012).[1] Similarly, dual-eligible beneficiaries, many of whom have disabilities, comprise 21 percent of the Medicare population and 15 percent of the Medicaid population, while accounting for 31 percent of total Medicare costs and 39 percent of total Medicaid expenditures, respectively (Jacobson et al. 2012; Young et al. 2012). Collectively, these people often have unique health care and social needs, requiring care from multiple providers across a wide range of settings, making coordination of care particularly important. However, Medicaid faces significant challenges in implementing an efficient and effective health care delivery system for this population, which is further complicated by the history of distrust between the disability community and managed care plans. A history of mandatory enrollment in managed care plans resulted in restricted access to services and providers, under-treatment, and poor quality of care for this population. Some suggest that the comprehensive benefits and organizational structure of the physician multispecialty group model holds promise, but the coordination of various medical and social services might significantly improve the quality and effectiveness of care for this population. Although definitions of *care coordination* vary, the term is often used to mean case management, care management, and disease management (Beaman et al. 2004). Care coordination typically includes both medical and social support services and is provided in various settings (Gillespie and Mollica 2003). Coordinating care for people with disabilities is particularly challenging because chronic conditions frequently accompany a disability (Beaman et al. 2004) and these people see many providers with no one individual or organization responsible for integrating treatment (Pham et al. 2007). Although results are mixed, designating one provider or organization responsible for coordinating care and facilitating patient self-management could be a promising approach to improving care for people with disabilities (Brown 2009; Gravelle et al. 2007; Smith et al. 2005).

Despite the challenges of providing care for people with disabilities, a few programs have a long history of trying to better serve this population--these programs are referred to as disability care-competent organizations (DCCOs). Although there are no set standards for care coordination for people with disabilities, DCCOs facilitate a culture of quality, striking the appropriate balance between medical care and support services for those with complex health needs. Although members are eligible for benefits and services covered by Medicaid (and in some cases Medicare), DCCOs rethink medical necessity by offering supplemental benefits and services that facilitate independent living.

[1] KCMU/Urban Institute estimates based on data from fiscal year 2009 Medicaid Statistical Information System.

Guide to the Report

This report details three DCCOs--Commonwealth Care Alliance (CCA) in Massachusetts, Community Health Partnership (CHP) in Wisconsin, and the Independence Care System (ICS) in New York City--describing how these plans are structured to serve the disability population well. Chapter II provides an overview of the evaluation methods. In Chapters III through VI, we detail each plan's operational and clinical practices. Chapter VII compares and contrasts the plans' features and Chapter VIII concludes by summarizing key similarities and differences in the context of what is known about disability competent systems. We also provide important lessons from these programs for consideration by policymakers and program administrators.

II. BACKGROUND AND METHODS

A. Care Coordination for People with Disabilities

1. Features of Effective Care Coordination Models

Effective coordinated care interventions are multifaceted, incorporating delivery system redesign, increased clinician support, and self-management support, among other efforts, to improve outcomes. Certain activities are considered necessary for coordinating care among people with disabilities and are features of programs found to be successful, including risk screening, assessment, service plan development, service coordination, transition planning, monitoring, and reassessment (Gillespie and Molica 2003; Chen et al. 2000). Although many coordinated care programs implement these activities, they differ in how intensively and by whom they are implemented, how they are refined over time, the environmental context in which they are set, and the populations that they target (Mahoney 2010).

A multiyear evaluation of 15 coordinated care demonstration programs identified six features consistently found in programs that successfully reduced hospitalization for high-risk Medicare beneficiaries in a fee-for-service (FFS) environment. These features include: (1) *in-person contact with patients* approximately monthly, at least over the first year; (2) *behavioral change theory and motivational interviewing* to guide patient education and coaching and to support self-care; (3) *a collaborative and interdisciplinary approach* to medication management; (4) *facilitator of communication* with health and community providers when problems arise; (5) comprehensive approach to *managing care transitions*; and (6) *opportunities for face-to-face contact with patients' physicians* through, for example, care coordinators attending office visits, collocation with physicians, or regular contact during hospital rounds (Brown et al. 2012). These findings could be instructive for developing a cost-effective, integrated health care delivery system for Medicaid and dually eligible beneficiaries with disabilities. However, the extent to which programs targeting individuals with disabilities ascribe to these practices is not known. Furthermore, although important, these characteristics are only a few of the many features that must be implemented in a care coordination program.

2. Care Coordination in DCCOs

A qualitative evaluation of seven DCCOs[2] identified key components of care coordination for Medicaid beneficiaries with disabilities (Palsbo and Mastal 2006). Among the programs evaluated are those described in this report: CCA, CHP, and ICS. Three core components consistently appeared across all DCCOs: service coordination,

[2] Palsbo coined the phrase *disability care-competent organization (DCCO)* to describe the programs reviewed in this evaluation and differentiate them from managed care organizations (MCOs).

member education, and quality improvement (Palsbo and Mastal 2006). Findings indicated that all DCCOs conduct a comprehensive initial assessment and develop an individualized service plan in collaboration with members and their families or supports. The plan is a living document that is continuously updated as members' services, needs, or priorities change. Further, a key role of staff in all programs, regardless of discipline, is that of educator and coach. DCCOs invest time and resources into ensuring that clinical staff have the capabilities to assist members in a productive way (for example, to facilitate behavior change to improve health and functioning). The programs also emphasize the importance of quality management and many have dedicated resources for monitoring operational processes and clinical outcomes. In addition to these three core functions, the programs also had similar care coordination processes, including engaging members in developing self-directed, individualized care plans; ensuring cross-agency and provider collaboration and communication; communicating proactively with members based on their needs; attending clinical visits; and being readily accessible to members (Palsbo and Mastal 2006).

B. Overview of the Disability Competent Health System

Health systems operate within a context of policies (federal, state, and local) that are largely derived from a medical care model focused on acute care needs, as opposed to a psychosocial model that considers environmental needs (Palsbo and Kailes 2006). Further, well-documented traditional reimbursement policies in Medicaid and Medicare offer a different and somewhat limited view of medical necessity. Rather than focusing solely on medical solutions and medications to help patients reduce their need for hospital and institutional care, the disability competent care model places equal emphasis on providing member education and spurring behavior modification. The emphasis is on long-term goals, improving quality of life, and supporting community living. DCCOs are particularly adept at combining attributes of social service and health care agencies and accessing community resources. For example, a disability competent health system will work with community-based organizations to ensure that programs are held in physically accessible facilities.[3]

1. Health System Resources

The disability competent health system model, an adaptation of Wagner's chronic care model, redesigns care delivery and seeks to promote independent living for people with disabilities (Palsbo and Kailes 2006). To accomplish this, DCCOs have four key components: (1) delivery system design; (2) clinician support; (3) self-management support; and (4) clinical information systems. Next, we discuss the distinct features of this model.

[3] A best practice example is the initiative by the Special Olympics Health Athletes®.

2. Delivery System Design

The typical health maintenance organization (HMO) or primary care case management practice is designed to address acute health care needs, using the primary care physician (PCP) as a gatekeeper to specialty care, prescription medications, and durable medical equipment (DME). This system prioritizes care that is essential, rather than facilitating timely access to care and equipment that is beneficial but might not be essential for survival. On the contrary, DCCOs convert the gatekeepers into gate openers. Plans serve as gate openers by mediating among primary and specialty care, prescriptions, and DME, and establishing guidelines to expedite the care process, when it is appropriate. In addition, disability competent plans may visit the member in his or her home to address the member's needs if he or she is too ill to travel or could be adversely affected by making an office visit.

DCCOs encourage member accessibility to the provider panel by identifying and using physically accessible facilities, such as examination rooms that can accommodate a wheelchair. Preventive care is often underused by this population because of physical barriers, so these systems direct their members to diagnostic facilities that have equipment (such as mammography machines) that is appropriate for people with disabilities.

DCCOs strive to address both the medical and psychosocial needs of their members. Plans facilitate wraparound care such as mental health services and dental care and in some cases, offer wheelchair repairs, coordinate socialization, and accompany members to clinical appointments. DCCOs consider members to be active decision-makers; the member is highly involved in care-related decision-making and setting long-term goals.

Finally, disability competent systems focus on managing the members' needs, compared with a more traditional insurance model, which focuses on benefits management. Although cost is not absent from the decision-making process, there is less of a focus on saving money through service limitation. Given that people with physical disabilities often require periodic care to maintain their functional ability, this delivery system redesign is critical.

3. Clinical Support

DCCOs organize prepared practice teams whose clinical and disability-competency skills are regularly assessed. Plans typically offer some training to ensure staff are disability competent (that is, interact effectively and appropriately with people with disabilities). DCCOs may provide disability-specific in-service education or develop population-specific curricula and modules for training providers. Further, these providers are familiar with various conditions commonly observed among this population and maintain a level of clinical expertise in that specific area. Aligned with a more psychosocial model, DCCOs use various types of providers to ensure that the support

services and equipment are appropriate--for example, mental health personnel, and occupational and physical therapists.

4. Self-Management

People with disabilities are significantly less likely to access basic preventive measures and education about healthy lifestyle choices (Palsbo and Kailes 2006). DCCOs use the individualized, member-centered plan to engage participants in self-directed care. As part of this process, providers are expected to foster behavioral change among the members; they may work with clients to self-manage their diabetes or educate members about healthy eating. In addition to working one on one with members to teach self-management skills such as goal setting and progress monitoring, many DCCOs use websites to communicate with their members. Among some segments of the population, websites increase self-management functionality so that members can schedule an appointment, select or change a PCP, view test results, and refill prescriptions.

5. Clinical Information Systems

Finally, a key operational component of a DCCO is its clinical information system. This model relies on technology to organize provider orders, diagnostic testing results, and support services, rather than the traditional practice in which information systems are used to set appointments and collect fees. Many DCCOs have built their own management information systems to coordinate care or they use systems that maintain both medical and social support information on members. These information systems facilitate communication and efficiency among the interdisciplinary teams. DCCOs are driven by quality improvement and many clinical information systems serve as a resource in monitoring progress toward meeting their goals.

C. Overview of the Medicaid Managed Care Plans

This report examines the operational and clinical practices of CCA, CHP, and ICS; compares and contrasts plan features; and summarizes the extent to which the plans demonstrate components of the disability competent model. Although these long-running DCCOs[4] share the goal of improving the lives of their members while reducing their need for hospitalizations, emergency department care, and institutionalization, they are being implemented in distinct local and state Medicaid contexts. Table II.1 details the target population, service area, setting, capitation, and exclusion criteria for each program.

[4] CHP was in operation for 15 years. However, it closed in December 2012 due to state-level policy changes and continued financial difficulties.

TABLE II.1. Program and Member Characteristics					
	CCA-BCMG	**CCA-SCO**	**CHP-P**	**CHP-FC**	**ICS**
Service Area	Greater Boston	Essex & Suffolk, parts of Hampden, Middlesex, Norfolk, & Plymouth counties in Massachusetts	Chippewa, Dunn, Eau Claire, Pierce, & St. Croix counties in Wisconsin		Manhattan, Queens, Brooklyn, & Bronx
Year of Program Inception	1990s	2004	1997	2008	2000
Target Population	People with physical & developmental disabilities.	Dually eligible elderly with complex conditions.	People with physical or developmental disabilities, dually eligible elderly.		People with physical disabilities.
Enrollment	484[a,b]	4,440[b]	1,603[c]	1,201[c]	3,008[d]
Eligibility Criteria	MCO/NHP beneficiaries must be ages 18-64, enrolled in MassHealth, & have a disability that results in functional quadriplegia. Those 65 or older are enrolled through their SCO contract. All must reside within the service area.	Beneficiaries must be 65 or older, be MassHealth Standard or dually eligible, & reside within the service area.	Beneficiaries must be Medicaid eligible, be 65 or older or be 18-64 & have a developmental and/or physical disability, have long-term care needs, & reside within the service area.		Beneficiaries must be 18 or older, be Medicaid eligible, have long-term care needs,[e] & reside within the service area.
Capitated Services	Single capitation for all acute care & home & community-based long-term care services.[f]	Single capitation for all acute & long-term care services.[g]	Single capitation for all acute & long-term care services.[h]	Medicaid home & community-based long-term care services.	Medicaid long-term care services.
Percentage Dually Eligible	49	95	85	76	68
Population Characteristics					
Mean age	50	77	66	53	60
Median age	49	76	68	53	60

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.

NOTE: MassHealth is Massachusetts' Medicaid program.

a. 227 enrollees are covered by the capitated Medicaid plan; 211 enrollees are covered by Medicaid FFS; 46 enrollees are in the SCO plan.
b. As of September 2012.
c. As of January 2012.
d. As of October 2012.
e. Those who require more than 120 days of home care services/assistance with activities of daily living.
f. Until 2010, BCMG operated under a Medicaid risk-adjusted, capitated subcontract with NHP. Payments from Medicaid to NHP were risk-adjusted under a special rate and BCMG was paid a subcapitation of this capitated rate for the services BCMG directly provides. In 2010, the state stopped applying this rate.
g. CCA-SCO is an HMO-SNP. This term denotes both its Medicaid and Medicare funding designation. CCA-SCO enrollees do not have to be dually eligible; however, because all CCA-SCO members are 65 or older, almost all are dually eligible.
h. CHP-P is an HMO-SNP. For those enrollees who are dually eligible, CHP also receives a capitated Medicare payment, in addition to the capitated Medicaid payment.

BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP-FC = Community Health Partnership-Family Care; CHP-P = Community Health Partnership-Partnership; FFS = fee-for-service; HMO = health maintenance organization; ICS = Independence Care System; MCO = managed care organization; NHP = Neighborhood Health Plan; SCO = Senior Care Options; SNP = Special Needs Plan.

1. Commonwealth Care Alliance

CCA has provided comprehensive care to people with disabilities for over 20 years. It began as a stand-alone organization in the early 1990s contracting with the state's Medicaid program to provide care to working-age adults with disabilities. The plan was later absorbed into the Neighborhood Health Plan (NHP), a large Medicaid managed care plan. In its current form, CCA was launched in 2004 and operates two plans, Boston's Community Medical Group (BCMG) and Senior Care Options (SCO). Both programs have evolved to accommodate the shifts in the health care landscape; their success in doing so might be a testament to the consistency among leadership. During the 1990s, CCA's leadership were early innovators and continue to be thought leaders, implementing innovative health care delivery practices for this vulnerable population.

a. Boston's Community Medical Group

BCMG is a clinical practice that provides comprehensive care to approximately 500 adults throughout the greater Boston, Massachusetts, area. Many people enrolled in BCMG have severe physical conditions, including congenital anomalies, neuromuscular disorders, and spinal cord injuries. Although BCMG prioritizes people with physical and developmental disabilities, it no longer provides care to these populations exclusively. Until 2010, BCMG operated under a Medicaid risk-adjusted, capitated subcontract with NHP. Payments from Medicaid to NHP were risk-adjusted for people with physical disabilities and BCMG was paid a subcapitation of this capitated rate for all services provided. However, in 2010, the state stopped applying this risk-adjustment rate for enrollees with severe physical disabilities. Consequently, NHP has stopped enrolling any new members; BCMG continues to take new members with disabilities, but is directly reimbursed for services rendered to these members through Medicaid FFS, Medicare FFS, or other third-party payers. Despite this change in reimbursement, BCMG remains committed to directly providing acute care, preventive care, and long-term care services, which includes in-home care. In addition, care coordination is provided for support services, physical and occupational therapy, DME, behavioral health services, and nursing home care. Currently, 227 members are insured through NHP and 211 in Medicaid FFS. In addition, 46 members are enrolled in the SCO plan, as BCMG also contracts with the CCA-SCO plan (described later).

BCMG primarily identifies new members informally through word of mouth and referrals from Centers for Independent Living and other human service providers. The practice is reluctant to engage in marketing because it often has to turn referrals away due to a lack of capacity (for example, inadequate funding sources) or because the referred member lives outside the service area. However, BCMG anticipates expanding its network in 2013 through the integrated care organization demonstration in Massachusetts.[5]

[5] Integrated care organizations employ a new health care option for Massachusetts adults who are dually eligible for Medicaid and Medicare.

b. Senior Care Options

In 2004, the CCA launched SCO, an HMO-SNP[6] that serves people ages 65 and older. Currently, 4,440 members are enrolled in CCA-SCO, of whom 95 percent[7] are dually eligible. Seventy percent of members are nursing home certifiable. The plan receives a single capitation for all services, including acute care, preventive care, and long-term care services, including both in-home and nursing home care. Occupational, physical, and speech therapy; DME; social services; and behavioral health services are also covered.

Initially, CCA-SCO began enrolling members in what it termed delegated practices. These practices are delegated the responsibility for coordinating care for members and staff work for the practice directly. In 2006-2007, CCA-SCO developed a wraparound model and engaged so-called non-delegated practices to provide care. Staff at non-delegated practices work directly for CCA-SCO. Members voluntarily join CCA-SCO through referral from delegated or non-delegated primary care practices or through outreach and education meetings.

2. Community Health Partnership

CHP's structure has transformed over time, adapting to the political and health care climates in order to meet the needs of the population it serves. CHP began in 1997 as a waiver demonstration program modeled after the Program of All-Inclusive Care for the Elderly (PACE) with some variations (for example, the use of a nurse practitioner). However, it obtained an HMO license in 2005. In July 2012, plan leadership informed the state that it was not financially viable for CHP to operate the Family Care program. CHP closed in December 2012 due to state-level policy changes and continued financial difficulties.

At the time of the site visit, CHP operated two plans, Community Health Partnership and the Community Family Care program. Both plans serve adults with disabilities in five counties in central Wisconsin; however, Family Care serves a younger population[8] with fewer dual-eligible beneficiaries,[9] and is capitated for Medicaid long-term care services only, which includes in-home services (for example, nursing care, personal care, and medication assistance); transportation; occupational, physical, and speech therapy; DME; and behavioral health services. The Partnership program, on the other hand, is an HMO-SNP and, therefore, offers physician care, hospitalization, and

[6] This term denotes both its Medicaid and Medicare funding designation. *HMO* indicates its status as a Medicaid HMO, and *SNP* indicates its status as a Medicare SNP.

[7] To enroll in CCA-SCO, one must be MassHealth-eligible (that is, eligible for Medicaid). However, because all of CCA-SCO members are 65 or older, almost all are dually eligible.

[8] The mean age for enrollees in the Partnership program is 66, whereas the mean age for enrollees in the Family Care program is 53.

[9] Although dual eligibility is not required for enrollment, dual-eligible beneficiaries represent 85 percent of the Partnership population. Comparatively, dual-eligible beneficiaries make up 76 percent of the Family Care program.

prescription drugs,[10] as well as receiving a single capitation from Medicaid for providing full Medicaid coverage, including all the same long-term care services as the Family Care program. For dually eligible enrollees, CHP also receives a capitated Medicare payment, in addition to the capitated Medicaid payment. Both types of programs assist enrollees with access to community resources.

When both models are available in a geographic area, qualifying Wisconsinites self-select into Family Care or Partnership, or remain in FFS.[11] Adults ages 18-64 are eligible to enroll in CHP if they have a developmental and/or physical disability and are nursing home-certified and are enrolled in Medicaid. Adults ages 65 or older must be nursing home-certified and dually eligible for Medicare and eligible for enrollment. CHP does limited community outreach to vendors in order to identify new members, but members are primarily referred by the Aging and Disability Resource Centers of Wisconsin. The Aging and Disability Resource Centers administer long-term care functional screening to determine if a person needs a nursing home level of care. It then refers members to either the Partnership or Family Care program.[12]

3. Independence Care System

ICS began in 2000 and serves four boroughs in New York City. Unlike CCA and CHP, ICS does not provide care directly; rather, ICS attempts to coordinate all inpatient and outpatient care for members. Enrolled adults are eligible for Medicaid and require a nursing home level of care. Many enrollees are physically disabled and have complex care needs. Currently, ICS serves approximately 2,700 adults, of whom more than 70 percent are dually eligible for Medicare and Medicaid. The plan receives a capitated payment from Medicaid to manage the services provided; however, this capitated payment does not cover inpatient and physician services; rather, those services are billed to Medicaid or Medicare under FFS. The program strives to maintain a strong network of provider agencies and focuses on several areas, including wheelchair purchase and repair and pressure ulcer prevention and intervention.

ICS primarily identifies new members through outreach to community-based service agencies, with a substantial number (30 percent) of new members having been referred by members or other individuals. Secondarily, ICS receives new member referrals from existing members and providers. ICS recently partnered with agencies to attract more referrals in preparation for the implementation of state-mandated managed care, which is set for 2014.

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[10] Family Care does not include physician and hospital care.

[11] Managed care programs other than Partnership and Family Care, such as PACE, have plans operating in some parts of Wisconsin. However, the vast majority of Wisconsinites with long-term support service (LTSS) needs either self-select into Family Care or Partnership or remain in FFS.

[12] To be eligible for the Partnership, an individual must need a nursing home level of care. For Family Care, a nursing home level of care is not required. However, fewer than 100 members of its total population (2,700) are non-nursing home level-eligible. Those non-nursing home-certified members have documented LTSS needs.

D. Evaluation Methods

The qualitative evaluation is designed to describe the organizational features of the Medicaid managed care plans and how staff deliver services and coordinate care for people with disabilities. Designed to complement an evaluation of the plans' health care utilization, cost, and mortality outcomes (Mann et al. 2013), three key research questions guided qualitative data collection:

1. How do the plans emphasize managing enrollees' needs more than plan benefits?

2. What strategies do the plans use to ensure that members receive integrated care across various settings?

3. What strategies do plans use to support enrollees in living as independently as possible in the community?

Qualitative data collection and analysis offer an opportunity to provide a rich description of the context in which the managed care plans are set, operations and clinical service delivery that characterize them as disability competent systems, and commonalities and differences across the plans. If the quantitative analysis shows that the plans are successful at improving outcomes and can do so at a premium that yields net savings, an in-depth description of the plans' operational and clinical services is necessary to replicate the plans' interventions--and their favorable outcomes--successfully.

Data sources include site visits and program document and website review. We conducted a two-day site visit to each managed care plan between May and October 2012. Site visits included semistructured discussions with administrators and direct care staff and observations of team meetings.[13] We used semistructured discussion guides to indicate the type of information to collect while allowing for flexibility across plans in terms of respondent-specific questions asked. We organized the guides by the following topics (described in Appendix A) to facilitate straightforward analysis:

- Organizational features of the plan;
- Member outreach, intake, and participation;
- Program staff;
- Quality management and outcome measurement;
- Initial assessment, problem identification, and care planning;
- Service and resource arrangement;
- Ongoing monitoring;
- Communication and coordination;
- Member education;

[13] During the CCA-SCO site visit, we observed a post-hospitalization home visit with a nurse practitioner and registered nurse (RN); during the CCA-BCMG visit, we observed a home visit with a nurse practitioner.

- Management of care transitions;
- Medication management;
- Clinical information systems; and
- Facilitators and barriers to implementation.

Susan Palsbo's work on disability competent systems informed our questions, as did literature on effective care coordination programs. We tailored the guides to each plan before the site visit using available program documents.

We synthesized the qualitative data using a structured template organized by topic. To ensure scientific integrity of the data, we used two techniques, confirmability and credibility. Confirmability of data is defined as the degree of neutrality or the extent to which findings are shaped by the respondents and not by reviewer bias or interest. Triangulation of methods (for example, using discussions, document review, and observation) and including site visitors with diverse backgrounds on the review teams helped to ensure the confirmability of the data. We established credibility, or the truth of findings, by conducting respondent checks. This technique, described by Lincoln and Guba (1985) as critical to determining credibility, gives respondents an opportunity to correct errors and challenge what they perceive as faulty interpretations. Respondent checks occurred informally during the site visit process and formally after the site visit through follow-up email and/or telephone contact.

III. COMMONWEALTH CARE ALLIANCE-- BOSTON'S COMMUNITY MEDICAL GROUP

A. Context

CCA-BCMG directly provides comprehensive care to approximately 500 adults throughout the greater Boston area. BCMG's positive reputation is the result of long-term collaboration with numerous stakeholders, including the state Medicaid agency. Throughout BCMG's 20-year history, Massachusetts Medicaid has assisted in financing and developing pilot programs of prepaid systems of care. However, in the past decade the Medicaid landscape has significantly shifted in Massachusetts. Massachusetts implemented health care reform in 2006 that led to drastic changes to Medicaid eligibility and access to care. In addition, Medicaid payment rates took a 5 percent cut in 2010, with an additional 1 percent cut in 2011, placing financial burden on BCMG.

The most notable change occurred in 2010 when the state stopped applying the special risk-adjustment to the capitation rate for enrollees with severe physical disabilities. Before 2010, BCMG operated under a Medicaid risk-adjusted, capitated subcontract with NHP. Payments from Medicaid to NHP were risk-adjusted under a special rate and BCMG received a subcapitation for the services it provided directly. When the state stopped making this adjustment, NHP decided it would no longer subcapitate BCMG. Thus, for new enrollees, BCMG is now directly reimbursed through Medicaid FFS, Medicare, or other third-party insurance. Although NHP benefits from reduced hospitalizations among members', BCMG is not capitated for hospital services. However, BCMG incurs the associated costs for care coordination, which are not reimbursed under FFS. As a result, BCMG is operating at a loss this year and expects to see $1.5 million in losses by April 2013. To adapt to the state and federal policy environments, BCMG leadership has applied to participate in the integrated care organization demonstration in Massachusetts. Set to begin coverage in April 2013, the integrated care organizations employ a new health care option for Massachusetts adults dually eligible for Medicaid and Medicare. Although BCMG will continue to specialize in primary care for people with complex physical and developmental disabilities, the needs of its member population will undoubtedly change. Its coverage area will expand statewide and its enrollment stands to increase at least three-fold.

There is substantial competition for clinicians in the greater Boston area where BCMG operates. In particular, two large health systems (Partners Health Care and Care Group), as well as numerous academic medical centers (for example, Brigham and Women's Hospital, Massachusetts General Hospital, Tufts Medical Center, and Boston Medical Center) offer highly advanced facilities and substantially higher salaries compared with BCMG.

B. Organizational Features

1. Staffing and Team Structure

BCMG's approach to care coordination grew out of leadership's desire to address the specific needs of vulnerable populations, including adults with physical disabilities. Employing an interdisciplinary team model, BCMG is staffed with nurse practitioners and physician assistants[14] (known as mid-level providers), in addition to physicians. A registered nurse is a recent addition to the team and is tasked with providing clinical support to the mid-level providers. The registered nurse coordinates prescription refills, vaccinations, prior authorizations, and ordering supplies; the registered nurse also maintains the equipment shared by providers for use during home visits (such as the portable electrocardiogram machine). To complement the direct medical care provided by the practice, behavioral health, LTSS, and rehabilitation are coordinated by social workers and physical and occupational therapists who are employed by BCMG directly. A wound care specialist, DME coordinator, and psychiatrist are also available for consultation.

On average, mid-level providers have a caseload of 40-50 members. Those staff coordinating support services (that is, physical and occupational therapist, behavioral health, and LTSS) tend to have higher caseloads; however, that depends somewhat on acuity. For example, the ratio of behavioral health staff (that is, social workers) to members is about 1:100, though not all of those cases are active at the same time. Similarly, the average caseload of social workers coordinating LTSS varies from 30 to 75 members; staff noted that supporting LTSS for 75 members could be a comfortable caseload depending on member acuity.

To facilitate care delivery and coordination, each member is paired with a designated mid-level provider and a physician. The physician serves as the member's PCP, but the mid-level provider has primary responsibility for managing the member's needs. Clinical supervisors assign members to staff primarily based on geography, with caseload capacity as a secondary consideration. Although each member is assigned to a mid-level provider and physician, BCMG staff are highly collaborative: the entire clinical team meets on a weekly basis. Each meeting includes a comprehensive review of hospitalized patients and other topics discussed vary week to week. A key component of the model is provider access; thus, providers are available 24 hours a day, seven days a week through an on-call service. In addition to the call-in service, BCMG has some capacity for home visits on weekends and holidays.

Providers (that is, physician assistants, nurse practitioners, and social workers) are primarily masters-level employees and many have some background working with people with disabilities. Social workers must have a minimum of a bachelor's degree and behavioral health specialists must be a licensed clinical social worker (LCSW) or psychiatric clinical nurse specialist. To ensure that staff provide population-appropriate

[14] Physician assistants were hired for interdisciplinary teams 10 years ago.

care, orientation encompasses didactic and field training (that is, mentorship), with disability-competency training provided through lectures and case review. BCMG's team structure supports two clinical supervisors (nurse practitioners) who each oversee 5-6 mid-level providers. Clinical supervisors report to the executive director, who is also a nurse practitioner and has been with BCMG since its inception.

2. Information Technology

BCMG's current information technology infrastructure is somewhat limited. Logician, the electronic medical record (EMR), is used for documenting home visits, medication, and diagnoses and is capable of automated communication. For example, staff are prompted for medication interactions or allergies and can use the system to communicate with other staff. However, Logician lacks the ability to track outcomes, document support services, or generate claims. Despite the limitations of Logician, BCMG mid-level providers and physicians have access to Boston Medical Center's inpatient hospital notes and specialist consults via Sunrise Clinical Manager and CCA-SCO's system, CaseNet. The latter systems are advantageous in terms of coordination with outside providers (such as Boston Medical Center staff).

BCMG recognizes the limitations of Logician and is in the process of modifying its information technology infrastructure to improve communication and productivity. To facilitate workforce mobility, each staff member received a laptop that enables him or her to access the EMR in the field. However, the uptake of this technology is slow. Largely, providers do not document their home visits in real time. Further, BCMG will transition to the eClinicalWorks information system in the next six months, which will support a more sophisticated and comprehensive process for documenting member contacts, assessments, and treatment planning.

3. Quality Management

BCMG's approach to quality management has evolved over the past two decades as the organization has grown. Chart audits and consumer feedback have largely driven its current retroactive approach. Retrospective chart audits review Healthcare Effectiveness Data and Information Set (HEDIS) measures and glycated hemoglobin (HgbA1c), among other mandated measures, to identify issues in the quality of care. BCMG continues to use conventional methods of improving quality, such as member satisfaction surveys. BCMG cannot track members' service use. Subsequently, monitoring quality of care measures and the impact of care coordination services is limited. To address this gap, BCMG will implement a new clinical information system in the coming months (eClinicalWorks), which it will use to track outcomes.

Although BCMG's quality management is limited by Logician, several approaches to improving quality of care are noteworthy. In particular, BCMG implemented an inpatient pilot program whereby BCMG collaborates with Boston Medical Center family medicine attending physicians. As a result, nearly all BCMG inpatients are on one floor and seen by the Boston Medical Center family medicine service. BCMG recently

surveyed the members who had been admitted to Boston Medical Center (as part of an inpatient pilot) and 85 percent thought their discharge plan was clear and they understood their hospitalization.

BCMG has also increased focus on both preventive and end-of-life care. BCMG staff proactively discuss how members want to be cared for at the end-of-life and have implemented a model in which they can provide a la carte hospice. In addition to direct care, hospice participants can also receive other support services (for example, transportation and assistance with planning memorial services).

4. Recruiting Members and Initial Contact

BCMG relies on word of mouth and referrals from the Centers for Independent Living and other human service providers. Shortly after enrollment, a registered nurse (or in some cases the executive director, who is a nurse practitioner) contacts the member to collect basic clinical information, which facilitates triaging members by acuity. The initial call determines how urgently the member needs to be seen by a provider. The clinical supervisor assigns the new member to a mid-level provider and within two-days the nurse practitioner or physician assistant engages the participant to set up the initial visit.

C. Processes of Care

1. Initial Assessment

Providing individualized care is a core competency of BCMG and this is reflected throughout its care processes. The comprehensive initial assessment is critical to guiding care and occurs within two weeks of initial contact. It is completed in person by a nurse practitioner or physician assistant using the Initial Visit Documentation Form. The assessment includes a history and physical examination, the Patient Health Questionnaire-9 (PHQ-9), DME Inventory Checklist, and the Patient Medical Supply List. The provider assesses the member's supplies and equipment needs, support system (family), urgent health concerns, activities of daily living, medications, diagnoses, safety, and goals and preferences. The assessment typically lasts 90 minutes; however, duration varies based on the needs and complexity of members. Occasionally, the provider has to schedule a second visit to complete the initial assessment due to time constraints and/or member cooperation.

Following the initial assessment, the member's records are obtained from previous providers and the nurse practitioner or physician assistant presents the member's information and plan of care to the team. The clinical judgment of the provider largely drives the frequency of ongoing monitoring after the initial assessment.

2. Care Planning

Designed to support the member's medical and psychosocial needs, the care plan is developed during the initial assessment and is revised as frequently as is needed; there is no minimum frequency required by the contract. The process is ongoing; staff evaluate the member's needs at every in-person visit and revise the care plan when there is a change in status, setting, or diagnosis (such as a hospitalization). Contact varies based on need and is guided by clinical judgment, but on average members are seen once a month. This process enables the provider to: (1) have an up-to-date, comprehensive picture of the member's medical and psychosocial condition; and (2) tailor the care plan based on the members' needs and frequency of contact.

The primary care team (the physician assistant/nurse practitioner and physician) devises the care plan collaboratively with the member, detailing the member's medical needs, support services, end-of-life care preferences, goals and wishes, and other topics. The nurse practitioner or physician assistant typically spearheads this process, whereas the physician is more likely to be involved if the care plan involves complex issues (such as end-of-life care). BCMG does not have a formal care plan in its EMR; rather, it is detailed throughout the progress notes. The care plan is not accessible to outside providers, nor does BCMG share a copy of the care plan with the member's specialists.

3. Ongoing Monitoring

Consistent with BCMG's core belief that care should be individualized to the extent possible, provider's contact with members is: (1) guided by clinical judgment; and (2) tailored to the member's preferences; neither risk-stratification nor a protocol guides the frequency or mode of contact. At a minimum, members are contacted annually to complete the comprehensive assessment. Typically monitored in person, members are seen an average of once a month in their homes, where the nurse practitioner or physician assistant monitors their overall medical and psychosocial condition. When appropriate, providers check in through telephone calls. This may entail following-up on specific diagnoses (for example, diabetes) and/or making adjustments to medications. Similar to care planning, a change in condition, setting, or diagnosis may increase (or decrease) the frequency of contact with an individual member. Staff cited hospitalizations, psychosocial issues, and/or change in support structure as common reasons for changes in frequency of contact.

4. Communication and Coordination with Providers

BCMG physicians serve as the members' primary care provider, with an nurse practitioner or physician assistant playing a dual role, both providing direct care and serving as the care coordinator. Because BCMG's population typically requires care from multiple providers across a wide range of settings, BCMG nurse practitioners, physician assistants, and physicians communicate and coordinate with various providers; however, the extent to which they do this varies.

Staff are encouraged to work collaboratively with all providers, including specialty and support, and often accompany members to office visits and serve as their liaison and advocate. Mid-level providers use the member's medical records to facilitate coordination among a variety of providers, including internal behavioral health; LTSS; and physical and occupational therapists, and subspecialists, such as urologists, pulmonologists, gastroenterologists, and nephrologists.

5. Member Education

Although a less-structured aspect of member engagement, BCMG staff provide individually tailored education on various topics, including wound care, prevention of pressure ulcers, autonomic dysreflexia, nutrition, range of motion, and medication. Unlike some of the successful care coordination programs (Brown et al. 2012), BCMG staff do not rely on a standardized curriculum to educate members nor do they use behavior modification or motivational interviewing. To ensure effectiveness, providers observe members' use of equipment or supplies, ask them to demonstrate skills, and rely on verbal teach-back. For example, during in-person visits a provider will observe if a member uses a pressure-relieving device for pressure sore prevention properly.

6. Service and Resource Management

BCMG is committed to providing acute care, preventive care, and long-term care services, which include in-home care. In addition, staff coordinate care for support services, physical and occupational therapist, DME, behavioral health services, and nursing home care. As the primary provider, the nurse practitioner or physician assistant is responsible for monitoring the receipt of all services and making necessary referrals.

A key feature of the DCCO model is the care coordination provided for support services; BCMG embraces this role. For example, social workers spend a significant amount of time procuring housing because some members have tenuous housing situations, including those who are homeless or living in inaccessible apartments. In this role, staff may liaise with family, assist with applications, and follow up to ensure that the member is comfortable in his or her new setting. BCMG staff often assist members in filling out their MassHealth (Medicaid) eligibility applications to mitigate member confusion regarding this process and a lack of understanding from MassHealth staff regarding the needs of this population.

7. Management of Care Transitions

BCMG boasts two unique features that facilitate the management of care transitions: (1) strong integration with Boston Medical Center, in which a large majority of BCMG members receive emergency and inpatient care; and (2) staff encourage members to reach out to their mid-level provider (that is, a physician assistant or an nurse practitioner) before going to the emergency department, for any non-emergent issues. As a result, mid-level providers are notified regarding an emergency department

visit or inpatient admission in nearly all cases. This occurs via three mechanisms: (1) the mid-level provider calls the Boston Medical Center emergency department with an expected admission to identify the diagnosis and the member presenting to the emergency department; (2) the mid-level directly admits the member to the BCMG floor at Boston Medical Center; or (3) the member goes to the emergency department and/or is admitted to Boston Medical Center without consultation from the mid-level provider. If the member is admitted without consultation, the mid-level provider is notified by the Boston Medical Center floor team. Less commonly, a family member or case manager notifies the provider of an admission elsewhere.

During admission, there is daily communication between the Boston Medical Center hospital staff and the primary nurse practitioner or physician assistant to ensure that providers have a shared understanding of the member's condition (for example, baseline status), medications, and discharge plans. Although the nurse practitioner or physician assistant does not draft the discharge plan, he or she is involved in the discharge process. Specifically, providers must visit the member in person within 24-hours after discharge, primarily to reconcile medications and, more generally, to assess the member's physical condition. All discharges are discussed at the team meeting and providers must report on the member's status since discharge. BCMG's protocol, which outlines the aforementioned care transition flow, ensures a smooth transition between settings for its members. Currently, the nurse practitioner or physician assistant facilitates transitions across care settings; however, the registered nurse care coordinator will assist with care transitions in the future.

8. Medication Management

Similar to care transitions, medication management can be particularly challenging because the onus is often on the member to report side effects and/or changes in adherence. In addition, coordination with multiple providers is often required. However, staff organization and BCMG's integration with Boston Medical Center afford efficient processes. Although BCMG providers engage members regarding medication compliance, they also have access to Boston Medical Center's EMR. This system integration offers a distinct advantage in terms of medication management, particularly during care transitions (such as when a member is discharged from the hospital). In addition, the nurse practitioners and physician assistants practice their full license and scope (for example, writing orders).

Any time there is a change in setting or care, the nurse practitioner or physician assistant reconciles the member's medication. Typically, providers make adjustments based on clinical guidelines. For example, if someone has diabetes, the providers check the person's HgbA1c levels every three months. Although there is no formal requirement, medication reconciliation typically occurs a minimum of twice a year. In addition to fairly frequent medication reconciliation, pill boxes and medication support by a personal care assistant (PCA) are available to ensure adherence given the complexity of this population's medication regimen.

IV. COMMONWEALTH CARE ALLIANCE--SENIOR CARE OPTION

A. Context

Since its inception in 2004, CCA-SCO, an HMO-SNP that integrates Medicare and Medicaid funding, has been an innovator in health care, experimenting with capitation and team models that target individuals with complex needs. Initially, CCA-SCO began enrolling members in what it termed delegated practices. These practices use team models of care and are responsible for coordinating care for members. At delegated practices, staff work directly for the primary care practice and their business arrangements with CCA-SCO recognize this structure. However, in 2006-2007, CCA-SCO developed a wraparound model and engaged non-delegated practices to provide care. Non-delegated practices lack experience with care teams and capitated payments for services. Care coordination staff at non-delegated practices work for CCA-SCO directly and complement the care provided by the contracted primary care provider. Although termed non-delegated, these practices share CCA-SCO's mission and CCA-SCO teams are integrated into those practices. Currently, non-delegated practices are the predominant model, but CCA-SCO still retains six delegated practices (including BCMG).

Collaborations with practices and other stakeholders, including the state Medicaid agency, provide the foundation for the CCA-SCO model. The SCO plan in Massachusetts is a partnership between MassHealth (that is, Massachusetts Medicaid) and Medicare that provides integrated health care and social services for low-income seniors statewide. Massachusetts Medicaid and the Centers for Medicare and Medicaid Services (CMS) jointly contract with qualified managed care plans to provide a complete benefits package with a capitation structure that is responsive to a beneficiary's health status independent of the care setting. Seniors who are enrolled in both MassHealth and Medicare can choose a Medicare Advantage SCO-SNP, such as CCA, to provide and manage all of their Medicare and Medicaid benefits.

CCA-SCO must adhere to state requirements in order to continue its designation as a SCO. For example, Massachusetts requires that SCOs have a member services telephone number that is staffed at all times so that members always have access to a provider. Similarly, support services provided to CCA-SCO members are mandatorily coordinated through Aging Services Access Points, which are one-stop entry points for all support services and benefits available to seniors in Massachusetts (for example, home care services, housing options, public benefits, and legal assistance). As the liaison for Aging Services Access Points, geriatric social service coordinators collaborate with the CCA-SCO team whereby they provide information, applications, direct services, and referrals. In addition to the state-mandated requirements that accompany their designation as an SCO, CCA-SCO continues to adapt as a result of

the general shift in health care in Massachusetts over the past decade, which included reform in 2006 and cuts in Medicaid capitation rates in 2010 and 2011.

Finally, CCA-SCO must continue to be responsive to changes in demographic trends. Currently, many of the members do not speak English, with their primary languages being Spanish, Russian, Haitian Creole, and Vietnamese. CCA-SCO tries to recruit health care providers who are bilingual; however, a translator is used when that is not possible.

B. Organizational Features

1. Staffing and Team Structure

Although CCA-SCO has always used an interdisciplinary team model of care, over time the team structure has shifted somewhat. Initially, staff functioned as one large team and were familiar with all members. The current configuration uses several smaller primary care teams. The nurse practitioner spearheads care delivery through an interdisciplinary team model, which includes PCPs, nurse practitioners, registered nurses, and geriatric social service coordinators. Social workers who support the nurse practitioners and registered nurses coordinate behavioral health needs, as required. Physical and occupational therapists are also available for consultation.

The clinical group in Eastern Massachusetts has six care teams; ten care teams comprise the clinical group in Western Massachusetts. Teams consist of nurse practitioners, a registered nurse, and geriatric social service coordinators, all whom are familiar with the members assigned to the team. The registered nurse is a newer addition to the care team and supports nurse practitioners in care delivery and manages a panel of members who are less medically complex. The average caseload varies by provider type; geriatric social service coordinators support 90-120 members at a given time, whereas the registered nurses' caseloads are approximately 50 members. Nurse practitioners cover an average caseload of 65-75 members.

In addition, CCA-SCO created a transition coordinator role in June 2011. The transition coordinator oversees member transitions in various settings; he or she visits the hospital daily to interact with providers, attend rounds, and assist members into and out of skilled nursing facilities. In this role, he or she also carries a panel of members who live in nursing homes. Previously, the expectation was that the primary nurse practitioner/registered nurse would follow the member across settings; however, this practice became unmanageable.

Each member is assigned to a primary care team, whereby a nurse practitioner serves as the medical lead. The enrollment nurse and clinical director (a nurse practitioner) assign members to nurse practitioners primarily based on caseload, but they try to match members to staff based on their PCPs. To facilitate access to providers, CCA-SCO has an on-call service composed of support associates available

to members 24 hours a day, seven days a week. During business hours, CCA-SCO member services coordinates the response, whereas on-call clinicians provide support after hours.

CCA-SCO staff must meet state licensure requirements for their positions, but otherwise they do not have any minimum requirements. Many staff have some background in home care or working with the frail, elderly, or people with disabilities. New employee orientation is composed of both didactic and field training, which includes shadowing with a preceptor. Information is also provided regarding the history and uniqueness of CCA-SCO. Although disability education is informal, staff are expected to do a thorough functional and home safety assessment and be attentive to the member's culture and spoken language. Member complaints and/or frequent hospitalizations are used to assess gaps in the knowledge of the staff members. Recognizing opportunities for improvement, CCA-SCO recently created a position dedicated to staff orientation and education. A nurse practitioner is tasked with developing training materials and creating a more structured curriculum to train staff.

2. Information Technology

Currently, CCA-SCO uses Casenet, a case management system designed to monitor members' progress. In particular, it is used to document clinical notes, assessments, care plans, service authorizations, and tasks (such as reminders for new services). Casenet also monitors utilization using number of visits as a metric. Casenet is used by internal staff and is not accessible to other providers. CCA-SCO transitioned to CaseNet in 2008, previously using Wellogic.

In addition to their internal system (Casenet), CCA-SCO staff have access to external EMRs at the various primary care practices. When staff are credentialed with a particular practice (for example, the Cambridge Health Alliance [CHA]), they are able to access member records at that practice. SCO staff's access to primary care practices' EMRs facilitates information sharing and collaboration with other providers. CCA-SCO staff must work with many different EMRs; thus, having primary care practices develop an interface for their EMRs with CCA-SCO's system is a priority. To facilitate a more integrated system, CCA-SCO will transition to eClinicalWorks in 2013; eClinicalWorks offers a more sophisticated EMR system with some case management capability.

3. Quality Management

CCA-SCO employs a data-driven approach to quality management. Combing data available through Casenet and its claims data, CCA-SCO generates various reports that detail both productivity and adherence to state and CMS regulations. In addition, CCA-SCO produces practice-specific reports on a quarterly basis. Practice-specific reports include: (1) member information, such as the number of members, demographics, and risk scores; (2) total medical expenses; and (3) emergency department visits and inpatient admissions. Each report stratifies outcomes by member and by population (for example, ambulatory and nursing home).

Practice-specific reports are a large and sophisticated component of CCA-SCO's approach to quality management. Additional innovative approaches to improving quality include a recent focus on care transitions and implementing evidence-informed practices, including a palliative care program. Further, CCA-SCO implemented the Stanford Chronic Disease Self-Management Program and the Stanford Diabetes Self-Management Program in 2006 and 2012, respectively. CCA-SCO also assesses member satisfaction through surveys and focus groups. For example, CCA-SCO facilitates local consumer meetings to assess member satisfaction approximately monthly. Based on the feedback from those meetings, CCA-SCO implements changes to its program when appropriate.

4. Engaging and Recruiting Providers

CCA-SCO recruits both primary care and specialty providers, as well as community-based long-term care vendors, such as personal care, home care, and nursing home care. CCA-SCO recruits providers through three main ways: (1) delegated practices; (2) non-delegated practices; and (3) word of mouth. CCA-SCO leadership emphasizes building strong collaborative relationships and believes that providers must support its philosophy and mission.

The CCA-SCO program director spearheads the recruitment of primary care practices. CCA-SCO undertakes a lengthy process before contracting with primary care practices to ensure that values are aligned. CCA-SCO leadership identified that the best practices are those that partner with CCA-SCO providers and that these practices believe that CCA-SCO is more than a traditional insurance plan. To ensure a collegial and productive relationship with practices, the program director has frequent calls (approximately one a month) with practices regarding enrollment and marketing, and to discuss any other pertinent issues. The practice-specific reports are used during quarterly visits with primary care practices to discuss quality and regulatory issues. Through this regular contact with the practices, CCA-SCO leadership monitors the cost and quality of services members receive.

5. Recruiting Members and Initial Contact

CCA-SCO relies mostly on primary care practices to identify potential members. If a provider identifies that a member is a candidate, the member may call member services or CCA-SCO's 24-hour line; CMS prohibits direct solicitation. Upon enrollment, the enrollment nurse contacts members to discuss their needs and to collect the basic clinical information outlined in the Minimum Data Set (MDS). The enrollment nurse and clinical director then assign the member to a nurse practitioner, who engages the participant to set up the initial visit.

C. Processes of Care

1. Initial Assessment

During the initial assessment the provider completes a physical exam and history, assesses vital signs, develops a list of prescribed medications and previous diagnoses, assesses activities of daily living and safety, and discusses the member's care preferences. The initial assessment is used to: (1) capture members' diagnoses for submission to Medicare; and (2) guide the care process. The initial assessment is conducted in person and takes approximately one hour to complete. A nurse practitioner must complete the initial assessment, although a registered nurse may provide assistance. The nurse practitioner uses the geriatric assessment form to conduct a physical examination, the foundation of which is *International Classification of Diseases*, 9th edition (ICD-9) codes. In addition to the diagnosis, other pertinent information is documented during the initial assessment, including supplies and equipment needs, support system, activities of daily living, medications, safety concerns, and preferences. Following the initial assessment, if the member is determined to be less medically complex he or she may be reassigned to the registered nurse, who will then serve as their primary care coordinator.

Monitoring after the initial assessment is driven primarily by the clinical judgment of the provider and member preference. For example, some nurse practitioners prefer to frontload the frequency of contact initially in order to establish a relationship with a member (for example, contact the member twice a week initially and then taper the frequency of visits). The nurse practitioner informally evaluates the member at every in-person visit and alters care when appropriate. However, a formal reassessment (that is, the geriatric assessment) must be completed in person by the nurse practitioner and/or PCP once a year.

2. Care Planning

Designed to support the members' health care and social needs, the care plan is based on the member's functional assessment, diagnosis, and living situation. Completed during the initial assessment, the nurse practitioner devises the care plan collaboratively with the member and other care team members (such as the geriatric social services coordinator [SSC]). The member's specific goals are the core of the care planning function, but care plans can be based on the geriatric assessment as well as the MDS. The care plan is revised as needed; typically this occurs when there is a status, setting, or diagnosis change. The plan is reviewed every six months, at a minimum, but many are revised more frequently. Members' physicians can receive a copy of the care plan. Further, PCPs are able to participate in the care planning process if they are available to do so.

3. Ongoing Monitoring

Contact with members varies and is guided by: (1) clinical judgment; (2) a change in condition; and (3) member preferences. At a minimum, the nurse practitioner has in-person contact with the member on an annual basis when completing the geriatric assessment. The MDS must be completed in person a minimum of two times a year by the registered nurse. Although mode of contact varies, typically members are monitored in person to assess their overall medical and psychosocial conditions. This may entail following-up on specific diagnoses (such as diabetes) or making adjustments to their medication regimens. A hospitalization, change in condition, or psychosocial issues were cited as the most common issues that trigger an increase in the frequency of contact with a member.

4. Communication and Coordination with Providers

Communication and coordination with providers varies by members' needs. Care coordinators often consult internal staff resources, who offer specialized expertise. For example, nurse practitioners regularly communicate with social workers regarding members' behavioral health needs and with geriatric social service coordinators for coordination of community resources and support services. Staff also communicate directly with providers by telephone, fax, or through email correspondence and occasionally attend appointments with members. Because nurse practitioners have access to members' EMRs, they are able to monitor members in real time and use the record to communicate with PCPs and specialty providers.

5. Member Education

As evidenced by their implementation of the Stanford Chronic Disease and Diabetes Self-Management Programs, member education is a focus of CCA-SCO's program. CCA-SCO's Health Education and Training department offers the aforementioned self-management programs, whereby Stanford provides the structure and curriculum content. Complementary to their self-management focus, nurse practitioners and registered nurses provide individualized education to members and their families on various topics, including medication management and consumer empowerment. Care coordinators emphasize education after hospital discharge to ensure that members understand discharge instructions. Staff rely on verbal teach-back to assess the effectiveness of education. To build upon their current practices, CCA-SCO leadership plans to integrate motivational interviewing into training.

6. Service and Resource Management

CCA-SCO is capitated for all services, including acute, preventive, and long-term care services. Health care services include physician care, surgical and intensive care, hospitalization, and prescription drug coverage. Physical and occupational therapy, DME, behavioral health services, and nursing home care are also covered.

A key feature of CCA-SCO's care model is the coordination between CCA-SCO nurse practitioners and/or registered nurses and the geriatric SSCs to ensure that members receive needed support services. Geriatric SSCs are experts in the community-based long-term care services available to enrollees and they are responsible for communicating with various vendors to set up any support needed. Community resources arranged for most frequently include home care (such as homemaker services or grocery shopping), personal care, non-emergency transportation, and adult day services. Although the geriatric SSC arranges community resources for members, nurse practitioner and/or registered nurses and geriatric SSCs work collaboratively to ensure complementary medical and support services. The nurse practitioner and/or registered nurse monitors the effectiveness of the services received and revises the member's service plan when needed.

7. Management of Care Transitions

In the past year, CCA-SCO has developed a more structured and efficient process for managing care transitions. In June 2011, CCA-SCO created the transition coordinator role to: (1) facilitate members' transitions across settings; (2) ensure more timely notification regarding member admissions and emergency department visits; and (3) relieve the primary nurse practitioner/registered nurse of following the member across various settings. Before the creation of the transition coordinator position, nurse practitioners and registered nurses were unable to consistently visit members in the hospital and communicate regularly with hospital staff, thereby impeding coordination across settings. As a result, the transition coordinator facilitates a more efficient and well-informed transition process.

Although CCA-SCO can be notified of emergency department and hospital admissions through member services or from the member's family, the primary mechanism for notification is through a fax from the hospital.[15] The transition coordinator receives a fax detailing emergency department visits or inpatient admissions Monday through Friday and then visits the hospital to interact with providers and attend rounds. During admission, there is daily communication between the hospital and the transition coordinator to ensure that providers have a shared understanding of the member's condition and discharge plans. The transition coordinator often participates in family meetings and discharge planning and relays any information regarding the discharge plan to the primary care team.

Currently, CCA-SCO employs the Situation Background Assessment Recommendation guidelines for communication between clinical handoffs and, in the near future, anticipates following Project RED[16] to standardize its approach to care transitions. Further, CCA-SCO policy dictates that a provider must visit the member in

[15] The largest cohort of CCA-SCO members (70 percent) receives inpatient services at CHA hospital.

[16] Project RED (the Re-engineered Hospital Discharge Project) was developed by researchers at Boston University and is designed to reengineer the hospital workflow process and improve patient safety by using a nurse discharge advocate to implement structured action steps that will improve the discharge process and decrease hospital readmissions.

person within 48 hours after discharge. This practice serves to mitigate any problem that could lead to readmission. During the visit, the nurse practitioner reviews the discharge summary, with a particular focus on diagnostic and medication changes. The visit is also an opportunity to observe the member's condition. Following the 48-hour visit, CCA-SCO individualizes its approach regarding contact. For example, follow-up might be conducted by telephone. For those members who require in-person contact, the first visit might be by the nurse practitioner, with the registered nurse conducting subsequent visits. The geriatric social service coordinator may attend the follow-up visit (or subsequent visits) to assess the member's activities of daily living needs because the setting change might trigger the need for additional or alternative support services.

8. Medication Management

CCA-SCO recognizes the importance of continuous medication management and frequent reconciliation. CCA-SCO staff regularly reconcile medications, believing that it should take place at every visit and should not be limited to transitions across settings. However, a formal protocol does not dictate reconciliation at every in-person visit or when a new prescription medication is prescribed. As the prescriber, the nurse practitioners regularly check members' medications and make adjustments within clinical guidelines. At a minimum, medication reconciliation occurs once a year.

Two practices bolster regular and frequent medication reconciliation: (1) the primary care teams' collaborative relationship with members' physicians; and (2) the nurse practitioners' ability to practice to the full extent allowed by his or her license and write orders directly into the EMR. In addition to accessing members' EMRs, CCA-SCO providers engage members and their families regarding medication adherence. CCA-SCO also provides medication adherence devices/supports such as pill boxes, Medicine-on-Time, and medication assistance by a PCA.

V. COMMUNITY HEALTH PARTNERSHIP

A. Context

Since its inception in 1997, CHP, based in Eau Claire Wisconsin, has operated the Partnership program;[17] however, as a result of a state mandate that all MCOs offer the Family Care benefit, it began offering Family Care as of 2009.[18] Initiated as a combination 1915(b)/(c) waiver, the Family Care benefit combines funding and services from a variety of existing programs into one flexible long-term care benefit. Because Partnership and Family Care competed against each other for members, CHP experienced financial stress, which increased over time. Partnership and Family Care had different capitation rates and CHP was losing money on Family Care members.[19] CHP leadership noted specifically that capitation was getting tighter.

Over time, CHP continued to face financial difficulties. To control costs, plan leadership implemented significant changes, including a workforce reduction in April and May 2011 that involved the release of 10 percent of staff and the elimination of the resource department--that is, the wound care nurse and the physical therapy and behavioral health departments. In January 2012, CHP launched a workforce mobility transition that included reducing floor space at the main office in Eau Claire and restructuring support staff functions. In July 2012, plan leadership informed the state that it was not financially viable for CHP to operate the Family Care program. The state interpreted this notice as withdrawal from the Family Care program and informed CHP that it would no longer operate the Partnership program either, if it terminated its Family Care program. CHP closed in December 2012 due to state-level policy changes and continued financial difficulties.

[17] The state Medicaid agency operates the Wisconsin Partnership Program. The Wisconsin Partnership Program contracts with community-based organizations such as CHP throughout the state to provide integrated health and long-term care for frail elders and people with physical disabilities.

[18] Family Care serves people with physical disabilities, people with developmental disabilities, and frail elders. There are two components: (1) aging and disability resource centers, designed to be a single entry point where older people and people with disabilities and their families can get information and advice; and (2) MCOs, which manage and deliver the Family Care benefit, which combines funding and services from a variety of existing programs into one flexible long-term care benefit.

[19] When a prospective member sought to enroll at the aging resource disability center in CHP's service area, he or she was able to choose between the Partnership and Family Care. If the prospective member chose Family Care, CHP was paid a lower capitation for the services it provided, compared with a scenario in which the prospective member enrolled in Partnership.

B. Organizational Features

1. Staffing and Team Structure

CHP Partnership and Family Care programs use an interdisciplinary team consisting of registered nurses and social service coordinators; however, Partnership teams include nurse practitioners, which is a key distinguishing feature between the two programs. Team designations include traditional facilities and alternative configuration experimentation (ACE). Typically, traditional Family Care teams include two pairings of a registered nurse and social service coordinator, whereas Partnership teams include these pairings and a nurse practitioner. The average caseloads for traditional teams are 18 members for a registered nurse, 35 members for a SSC, and 138 members for an nurse practitioner.[20]

Facilities teams were created in 2008 to provide dedicated staff to serve members residing in facilities such as nursing homes and residential settings. Because members residing in facilities typically have more supports than those living in the community, caseloads are higher, with registered nurses being responsible for approximately 60 members and social service coordinators working with about 45 members. ACE teams are structured differently in that either the registered nurse or social service coordinator is designated as the lead staff member for particular members (approximately 16); however, everyone on the team is familiar with all members. A nurse practitioner is also a member of the ACE team. ACE teams were established three years ago as a pilot project to examine the impact of team structure on member outcomes, such as reduced hospitalization. CHP has three functional ACE teams. Family Care caseloads are typically higher than Partnership caseloads. Assignments are based mostly on geography, although the ACE teams designate either the registered nurse or social service coordinator as the lead based on member complexity. For example, if a member is medically complex, the registered nurse is designated as the leader, whereas the social service coordinator is designated as the leader if a member has more mental health and social needs.

CHP created a transition planner role five years ago to reduce the burden on nurse practitioners who previously handled care transitions for all Partnership members as well as their regular caseloads. CHP also has an on-call service composed of support associates available to members 24 hours a day, seven days a week. Nurse practitioners work with a designated support associate.

CHP requires that registered nurses meet minimum state requirements and that social service coordinators have a four-year degree; a social work degree is preferred. New employee orientation includes didactic, online, and field training. Specialized disability education is provided by a developmental disability coordinator in a five-part series. Direct care staff are not assigned members until after one month of field observation. Clinical supervisors oversee 3-4 teams and meet weekly with their teams.

[20] Caseload varied widely based on team type.

CHP transitioned to supervising clinical staff by team rather than discipline about four years ago. Clinical supervisors report to program directors; CHP has seven program directors across its offices.

Other experts are available to staff for consultation, including a pharmacist, developmental disability coordinator, psychologist, geriatric psychiatrist, and physical therapist. CHP also has an employment services coordinator who provides staff training and serves as a resource for assisting members with vocational needs as well as staff dedicated to self-directed services. Before the workforce reduction, CHP had its own physical therapy and behavioral health departments and wound care nurse. Because data management and outcomes monitoring is an important aspect of CHP, the plan has a decision support services department that conducts technical and analytical aspects of data collection, management, and reporting.

2. Information Technology

Over the past year, CHP made a significant investment in information technology. On January 1, 2012, the organization launched a new EMR that comprises two separate systems: Allscripts and OnBase. The Allscripts system is the case management system used by case managers for documenting member contacts, assessments, and treatment planning. OnBase is a document management system that contains supporting documents such as medical records, treatment plans from providers, and prescriptions. The EMR is used for both documentation and outcomes monitoring. Before this, the plan used VPrime but upgraded its EMR to allow for improved documentation and reporting.

CHP offers staff innovative tools to improve communication and productivity. Each staff member received a tablet equipped with Lync, a Microsoft interactive communication software application with teleconference and instant messaging capabilities. The tablets were intended to support workforce mobility, enabling staff to work from any location. Staff have access to Store-In, a medication management software system. CHP also has an Intranet that provides staff with resources (for example, member-centered care plan) and serves as a vehicle for communication. For example, staff can access the Statistics and Other Financial Information (SOFI) data management system through the Intranet. All mangers have access to this dashboard whereby they can produce reports detailing quality indicators (for example, HEDIS), costs (for example, hospitalizations per 1,000 members), and administrative processes (for example, the next visit for a member or staff productivity.

The new EMR includes more discrete fields rather than narrative entry, a major improvement over VPrime. Data are extracted from the EMR to monitor member contacts and timeliness of assessments. The decision support services department generates reports using these data, such as reports that specify completed and uncompleted tasks. Allscripts includes automated capabilities such as prompts for appointment reminders for care managers. Although the EMR has improved operational and clinical performance monitoring, it is not integrated with hospital systems or primary

care practices and is not accessible to individuals outside of CHP. Copies of medical records from outside providers are stored in OnBase.

3. Quality Management and Outcomes Measurement

CHP leadership uses a data-driven approach to quality management and has dedicated quality management staff and a Decision Support Services department to ensure efficient clinical and operational performance. CHP's quality management, utilization management, clinical excellence, and peer review committees review quality data routinely and work with staff and management to address concerns as needed. For example, quality management staff work with teams on specific quality improvement projects. Directors also conduct chart audits quarterly and clinical supervisors conduct a home visit with staff at least annually to assess performance.

Consumer feedback is incorporated through satisfaction surveys, focus groups, and bimonthly input provided by a consumer advisory council. Approaches to making changes to improve quality are ongoing and data-based. For example, beginning in January 2012, CHP implemented a quality improvement project called the Nursing Home Initiative to reduce the number of days members spend in nursing homes. As part of this process, the CHP team communicates regularly with the nursing home staff, particularly around their transition home. The goal is to more quickly identify when the member is able to go home and the member's best options for transitioning into another setting.

CHP conducts a comprehensive review of its provider network as part of the annual contract recertification. Beginning in 2010, CHP developed a Provider Quality Standards and Performance Indicators manual for each of the following areas: residential services, daily living skills, and self-directed support services. These manuals provide guidance when in-network providers provide care and treatment to members. The Provider Quality Standards and Performance Indicators define minimum quality standards; performance benchmarks; and service definitions, descriptions, and requirements.

4. Engaging and Recruiting Providers

CHP has a provider relations department with staff members dedicated to contracting providers and assessing quality. At the time of the site visit, the department was in the process of hiring a person to specialize in provider credentialing and verification; providers most commonly recruited are personal care and home care agencies, residential and vocational settings, and nursing homes. CHP leadership emphasizes building strong relationships with providers and believes that providers must support its philosophy and mission. Most recruiting occurs through word of mouth. CHP implemented a provider advisory board in 2010 to create a forum to talk about working together to address changes. CHP uses the forum to explain upcoming changes to providers to ensure effective transitions in procedures (for example, changes in reimbursement).

5. Recruiting Members and Initial Contact

Members are referred by the aging and disability resource centers. A SSC initiates contact with a new member by telephone within three days of enrollment to schedule an in-person visit. Within ten days of enrollment, a SSC and registered nurse conduct an in-person visit with the member to identify major concerns, medications, and services for which the member qualifies. Staff complete the personal and home care task list assessment, initiate the member-centered care plan, and discuss the resource allocation decision[21] method, which assists with the identification of cost-effective and efficient services for members.

C. Processes of Care

1. Initial Assessment

All members receive a comprehensive assessment by a registered nurse and an SSC within 90 days of enrollment. A nurse practitioner completes a history and physical examination for all members in the Partnership program. The comprehensive assessment includes the following domains: physical and emotional health, cognitive functioning, caregiver information, legal directives, employment, environmental/safety, financial status, functional status such as activities of daily living and instrumental activities of daily living, medications, diagnoses, strengths and preferences, and supports.

The in-person assessment is usually conducted in the member's home, which enables the registered nurse and SSC to assess the safety of the home environment. The long-term care functional screen is also reviewed.[22] The assessment typically lasts 45 minutes; however, the duration varies based on the needs and complexity of members. Members are formally reassessed every six months in person. A mini-mental status examination is completed annually or with a change in cognition and the long-term care functional screen is conducted by a registered nurse functional screener annually or after a qualifying event (such as a hospitalization or fall).

2. Care Planning

The team develops a member-centered care plan that includes member outcomes as well as their strengths and preferences. The member-centered care plan is developed in collaboration with members and their families. It is an electronic template that is individualized to each member based on identified needs and goals. It is initiated

[21] Wisconsin has required all MCOs to use the resource allocation decision method since 1998.

[22] The long-term care functional screen is completed by an aging and disability resource center to assess eligibility for the program. In some cases, CHP staff determine that the findings are inaccurate and that the long-term care functional screen must be conducted again. CHP has a team of registered nurses who are certified to conduct the screening.

during the initial visit and completed within 90 days of enrollment. The member-centered care plan guides care and is reviewed during every in-person contact. It is updated whenever the member's care or condition changes (for example, if a service is reauthorized or if a member is hospitalized) or if a member requests a change in services; however, it must be updated at least every six months. Members receive a copy of the care plan every six months; physicians and other providers do not routinely receive a copy of the member's care plan unless requested. Physicians and other providers (for example, staff at day programs and residential facilities) vary widely in level of involvement with care planning; communication with the provider regarding care planning is encouraged, but some physicians do not want to engage, which can be problematic when trying to coordinating care.

3. Ongoing Monitoring

CHP requires a minimum of quarterly in-person contact by any member of the team; however, a registered nurse must assess members at least every six months to meet contract requirements. The frequency and mode of contact vary based on members' needs and could be as frequent as weekly. Risk-stratification is not used to guide the intensity of contact; rather, the team uses clinical judgment to determine contact frequency and mode. Contacts are member-driven, meaning that the team plans interventions based on the member's priorities and needs; however, medications are always reviewed during contacts. Hospitalization, sudden illness, and/or change in condition (for example, a fall, change in placement, and suspected abuse) are reasons for increased member contact. Although checklists indicate topics that should be covered during contacts; clinical judgment ultimately guides care.

4. Communication and Coordination with Providers

The frequency and mode of communication and coordination varies across CHP's two programs. Family Care staff most often communicate with nurses from physicians' offices, behavioral health providers, counselors, and physical therapists. They also request treatment plans from therapists working with members to ensure that everyone is working on the same goals. Some staff noted that getting return calls from providers is difficult; however, providers are largely responsive to staff when they share concerns about members. Family Care staff request members' medical records annually, whereas Partnership staff receive members' medical records from providers on a monthly basis through CHP's Health Information Management System. Partnership staff communicate directly with providers by telephone, fax, or email and attend appointments with members. One physician meets with a CHP nurse practitioner monthly to review care management for members he serves. Staff also attempt to review member-centered care plans with providers; if a member lives in residential facility, staff coordinate reviews of care plans with the facilities' reviews.

5. Member Education

Staff provide education on a range of topics, such as smoking cessation; condition-specific education (for example, diabetes, congestive heart failure, and chronic obstructive pulmonary disease); symptom management; prevention of rehospitalizations; medication management; end-of-life; coping skills; social outlet community education and resources; and stress reduction. Staff tailor education based on the specific needs of the member, drawing from the Krames on-demand program, which includes more than 3,000 topics of patient education. To assess the effectiveness of education provided, staff employ the teach-back method[23] and assess for symptom improvement. Staff do not consistently use behavior modification or motivational interviewing techniques to provide education.

6. Service and Resource Management

Both programs cover long-term care services such as in-home services (nursing care, personal care, and medication assistance); transportation; occupational, physical, and speech therapy; DME; social, and mental health, adult day, and vocational services; respite; supportive home care; assisted living; and nursing home care. Partnership also offers physician care; medical, surgical, and intensive care; hospitalization; prescription drugs and medications; dental, vision, and hearing services; labs; and X-ray. The state requires both programs to use the resource allocation decision method to identify services for members. This standardized decision-making process is composed of a series of questions designed to help the team and the member identify the specific goals and outcomes that would improve a member's quality of life. As of January 2008, all members are offered the Self-Directed Supports option, which enables them to direct their long-term care support services (that is, using an individualized budget to arrange services such as having a friend provide home-based personal care).

Community resources arranged for most frequently are home or personal care, transportation, and residential placement. Through regular contact, staff monitor the effectiveness of the services received and revise the member's individual service plan as needed. Striking the right balance between the cost and quality of services was a consistent theme identified during team meetings and discussions with management.

7. Management of Care Transitions

Partnership and Family Care staff vary in their approaches to managing transitions across care settings, with Partnership having a more structured approach and dedicated staff function than Family Care. For the past several years, transition planners have monitored Partnership members while hospitalized and have coordinated with teams for discharge planning. Transition planners contact the nurse practitioner within 24 hours of hospitalization, visit the member upon admission and while hospitalized, call the

[23] Teach-back is a way to confirm that the staff member has explained to the patient what he or she has to know in a manner that the patient understands.

hospital daily for updates on members, and relay information to the team through the EMR. In March 2012, the Partnership program required that the nurse practitioner complete a risk-assessment tool and action plan that categorizes members into high, moderate, or low risk for rehospitalization. After discharge, either the nurse practitioner or registered nurse visits the member within 24-72 hours to reconcile medications and assess clinical status. The nurse practitioner or registered nurse also accompanies the member to a follow-up visit within 14 days (the nurse practitioner tries to attend in most cases).

Additional post-discharge follow-up procedures vary by risk level: (1) high-risk requires minimum weekly contacts for six weeks, with the first three being face-to-face; (2) moderate risk requires minimum weekly contacts for four weeks, with the first two being face-to-face; and (3) low risk requires minimum weekly face-to-face contacts for two weeks. Staff attendance at the follow-up provider visit is optional but encouraged. Staff use clinical judgment to determine if regular monthly contacts are required for members at high and moderate risk.

In contrast, Family Care staff do not learn of hospitalizations in a timely manner and commonly find out during routine monitoring. The registered nurse or SSC collaborates with hospital staff as needed and visits the member within three days of discharge if they become aware of a hospital admission. Although encouraged, Family Care staff are not required to use the risk-assessment tool and action plan.

8. Medication Management

Partnership and Family Care vary in coverage of medications, which likely contributes to differences in medication management--that is, sources of information about medications and approach to reconciliation. Family Care does not cover medications, whereas the Partnership program includes a medication benefit. Family Care staff rely on the member and/or guardian as the primary source of information on medications, but also request a list of medications from members' PCPs annually. Staff reported reviewing medications during quarterly contacts. If they are concerned about members' medications, they may call the pharmacist.

Partnership staff conduct medication reconciliation every six months and after hospitalization to identify redundant medications and discrepancies between prescribed medications and medications actually taken. For example, staff reported examining medication bottles and discussing adherence with members. Staff also have access to pharmacy data so they can track refills and compliance.

VI. INDEPENDENCE CARE SYSTEM

A. Context

A Medicaid managed long-term care plan, ICS began in April 2000. ICS operates in a small geographic area encompassing four New York City boroughs (Manhattan, Queens, Brooklyn, and the Bronx) and serves approximately 3,000 people, many with complex chronic care needs. The plan serves a relatively high percentage of working-age people who use wheelchairs and many members with multiple sclerosis and spinal cord injuries. Nearly 70 percent of the plan's current members are dually eligible for Medicaid and Medicare, an increase from 50 percent in May 2012 as a result of the state's transition to mandatory managed care.

New York State is implementing mandatory managed care for all Medicaid recipients, which will result in the expansion and diversity of ICS's membership. Currently, there are approximately 100,000 eligible beneficiaries for long-term social supports in New York City. As of July 2012, approximately 35,000 of these beneficiaries were in managed long-term care, 45,000 were in FFS personal care, and 20,000 in the long-term home health care program.[24] As of September 2012, the CMS has given approval to convert the two FFS programs to managed long-term care plans through mandatory enrollment; as a result, ICS anticipates enrolling more senior adult (those ages 65 or older) Medicaid beneficiaries.[25]

ICS projects that nearly half of its members will be senior adults following these state regulatory changes. In terms of care need, only 15-20 percent of new members are similar to ICS's current population, which is mostly younger members with disabilities. Subsequently, ICS will have to accommodate the needs of the incoming members, rather than stay exclusively focused on those with disabilities. Fundamentally different from the other plans in this report, ICS is capitated for Medicaid LTSS, but it does not provide primary or acute care. Rather, its focus is on providing specialized support services. However, ICS expects to be capitated for acute and primary care services, as well as LTSS, in the next two years.

[24] The long-term home health care program offers a coordinated plan of medical, nursing, and rehabilitative care provided at home to disabled people who are medically eligible for placement in a nursing home. This program is available to individuals who choose to receive services at home. These individuals must have care costs that are lower than the nursing home cost in the county.

[25] Currently, ICS enrolls more than 300 members per month. In May 2012, ICS reported 2,200 total enrollees (50 percent of whom were dual eligible beneficiaries). As of October 2012, ICS had 3,008 members enrolled (68 percent of whom were dual eligible beneficiaries).

B. Organizational Features

1. Staffing and Team Structure

Throughout its 12-year history, ICS has implemented several different care models. However, care management has always been characterized by a combined, if not integrated, social-medical approach. This is reflected in the use of both social workers and nurses as the core staff. ICS also has a fundamental belief that long-term care social needs are more dominant on a daily basis compared with medical needs for most people with disabilities. Both types of expertise are needed; however, for most members social support is required on a regular basis, whereas medical support is required episodically. Consequently, social workers' skill sets and perspectives are seen as equally or more valuable than nurses.

To accommodate the shift in focus and growth, ICS recently implemented an interdisciplinary team model; previously, there was limited coordination between nurses and social workers and the two disciplines operated in silos. The interdisciplinary model was piloted in July 2011 and rolled out throughout 2012 and 2013. Each interdisciplinary team serves 500 members, who are stratified based on their level of need for care management. Members' needs range from minimal to crisis. ICS teams consist of a team leader, care managers (that is, social workers), nurses, care management coordinators, a home care aide coordinator, and a senior home care aide. Member stratification is used to gauge the right ratio of staff to members; on average, a care manager has a caseload of 50 members. Members are stratified into four basic categories of low, moderate, high, and transition, with the notion that the members designated as low have less complex care needs and need less attention from staff than those with higher designations. In addition to an on-call nurse available 24 hours a day, seven days a week, staff are accessible to members on weekdays from 8:00 a.m. to 6:00 p.m.

The role of staff is two-fold. First, staff are expected to provide discipline-specific assessments and interventions. Second, staff collaboratively coordinate services and support for members. However, a care manager (that is, a social worker) typically spearheads service coordination and nurses are responsible for completing the assessments (for example, initial assessment, six-month reassessment, and significant change in condition assessment).[26] However, teams meet on a weekly basis to solve issues as they arise.

ICS employs both bachelors-level and masters-level staff. For nurses and social workers, a registered nurse and bachelors in social work certifications are required, respectively. In addition, one year of home experience is required for nurses. ICS employs a stepwise approach to train new employees. During the first phase, the department heads orient staff to ICS processes and procedures. Following this two-

[26] The Semi Annual Assessment of Members, administered by nurses, is the comprehensive assessment tool currently used by all Medicaid managed long-term care plans to establish clinical eligibility for managed long-term care and to provide baseline data for managing a beneficiary's care.

week orientation, staff transition to the second phase, in which they receive role-specific training for approximately four weeks. For example, a nurse will spend time with the nurse educator in the field and also with peers. During this phase, nurses receive education regarding field documentation requirements. Finally, new staff transition into the third training phase, whereby they are paired with a mentor for 12 weeks; during this phase, staff are assigned members and practice in the field. Further field training and condition-specific training are offered, as needed.

ICS employs many staff with condition-specific expertise who are available for consultation, including an nurse practitioner with multiple sclerosis certification, a certified wound care nurse, behavioral health specialists, and physical and occupational therapists with specialization in wheeled mobility. ICS also developed resource teams to supplement the work of the care managers and to fill critical gaps in the service delivery system for the population it serves. ICS staff recognized that certain cohorts of members required more specialized expertise and relationships with physicians. As a result, ICS formed specialized care management teams for members with multiple sclerosis and then later for members with spinal cord injuries. The latter team provides care management services focused on preventing secondary complications from spinal cord injuries and providing links to specialists. Other resources include behavioral and women's health, rehabilitation services, and wound care.

2. Information Technology

ICS began using Care Compass in April 2011. Care Compass is a multifunctional electronic care management record system. Its capabilities include storing member contact medical information and staff notes, storing provider information, generating reports (stratified by member or by provider), and producing a task list. Member assessments are recorded in Care Compass and are accessible to staff and designated contract agencies, as appropriate.

The member complexity tool (that is, risk-stratification) and various decision pathways are built into Care Compass. For example, if a member has a urinary tract infection, the care manager receives automated prompts that detail the condition-specific care that should be provided by the PCA or other provider. Issues that require provider attention are automatically flagged and remain so until appropriately resolved. To ensure the provision of timely services and interventions, managers are alerted if a care manager does not follow up on an open issue.

3. Quality Management and Outcome Measurement

ICS uses a data-driven approach to quality management whereby performance indicators are measured at both the organizational and individual levels. ICS employs dedicated quality management staff and has a performance improvement committee that reviews all administrative, clinical, and support services to ensure efficient and effective functioning. Performance indicators are used to assess the timeliness and quality of services and to manage compliance with programmatic and regulatory

requirements. The reports generated include information used to monitor service provision, timeliness of assessments, and adherence to contract requirements, and to manage member grievances and appeals. Measures are also used to gauge staff performance. On a monthly basis, management receives the aforementioned reports and is encouraged to discuss issues or exemplary work with staff. Further, nurses and care managers regularly monitor their own performance through reports generated by the program's software application. Regular chart and care plan reviews complement data-driven performance monitoring.

ICS implements comprehensive quality improvement initiatives across its departments. To ensure ongoing improvement, each department develops targets and goals in collaboration with the president and chief operating officer. Member feedback is incorporated through satisfaction surveys, which are administered every two years. Additionally, the vice president for advocacy regularly reviews grievances and appeals and plays a key role in resolving any issues. Grievance and appeal information is also used to monitor provider and staff performance, and is reported to the New York State Department of Health each quarter.

4. Engaging and Recruiting Providers

ICS uses external providers for many of the services provided; thus, it emphasizes maintaining a broad network of provider agencies. ICS recruits various community-based long-term care vendors, including personal care, home care, and nursing homes, using geography, certification, and service area as criteria. ICS seeks home care contractors committed to employer best practices, such as providing workers with a fair hourly wage and health insurance. ICS believes that these types of incentives for paraprofessionals are critical to good home care. Initially, it was challenging to identify providers that were able to provide appropriate services and meet ICS's standards regarding employer best practices (such as fair wages and fringe benefits).

Home care aide services, whether agency models or consumer-directed personal assistance services, are viewed as the primary vehicle for enabling members to live independently. Therefore, ICS invests considerable resources in ensuring the provision of high quality services, preferring to contract with particular home care agencies. Specifically, ICS plays an active role in matching paraprofessionals to ICS members. ICS uses a number of factors to match; most importantly, the coordinators look at the member's needs. ICS considers members' clinical needs as well as the paraprofessionals' clinical strengths and personalities. However, the member is the ultimate decision-maker; if a member enrolls in ICS and prefers a particular home care worker (that is, there is a long-standing relationship), ICS supports the member's choice and ensures continuity of care. ICS also selectively chooses equipment suppliers. Although it has contracts with seven suppliers, it works primarily with two preferred suppliers.

5. Recruiting Members and Initial Contact

ICS relies on several mechanisms for member referral. Although most members are referred to ICS from community-based service agencies, existing members refer a substantial proportion of new members (30 percent). When it receives a referral, the ICS intake team conducts an initial telephone screen, verifies Medicaid enrollment and eligibility for services,[27] and schedules a nurse to visit the applicant and perform the intake screen. If qualified for services, the applicant is enrolled and assigned to a care team. The care manager (social worker) meets with the member in person during the first two months of enrollment.

C. Processes of Care

1. Initial Assessment

The nurse conducts the initial in-person assessment using the semiannual assessment of members (SAAM), a state-developed tool for assessing managed long-term care needs. The initial assessment lasts 1-2 hours, with some variation based on members' needs and complexity. The initial assessment typically takes place in a member's home, in order to assess the equipment and other supports needed at the time of enrollment.

The SAAM index is a functional assessment scoring system developed by the Department of Health. It is composed of 13 items, including activities of daily living, incontinence, and cognitive functioning. The SAAM is readministered every six months and at any point at which there is a significant change in the member's condition. During the six-month reassessment, members are assessed for: (1) changes in medical and functional status; (2) stability in family and social supports; and (3) receipt of appropriate services.

A companion tool (to the SAAM) is used to determine PCA service hours. The personal care assistance tool is also completed during the initial assessment and at least semiannually thereafter to determine the type and amount of personal care assistance needed. Additionally, the tool can be completed if the member has a significant change in condition that affects his or her need for home care services. The behavioral health complexity tool is completed every three months for members receiving behavioral health services.

Since implementation of the interdisciplinary team pilot, risk-stratification is used to guide the care of ICS members. Members are stratified into four basic categories of low, moderate, high, and transition. The transition categorization is temporary and the member will be recategorized after the crisis is resolved. Members are stratified based

[27] If a member is enrolled in any waiver program, ICS enrollment is prohibited. Anyone age 18 or older who is enrolled in Medicaid, lives in the four-county service area, and has long-term care needs (those who require more than 120 days of home care services) is eligible.

on the level of intervention required by the social worker and nurse. More complex members typically have a combination of medical conditions and/or behavioral health issues. Stratification ensures that higher-risk members receive the appropriate level of attention.

2. Care Planning

ICS believes in person-centered care whereby providers individualize care based on members' needs. For example, ICS views the member as the ultimate decision-maker and not just as a member of the care management team. A member's goals and preferences are a critical part of care planning and ICS goes to considerable lengths to satisfy member's preferences. For example, ICS offers a full wheelchair assessment clinic, which is designed to be a consumer purchasing experience and supports two chairs for every member.[28]

ICS staff create two individualized plans: the service plan and the care plan. The service plan is developed by the nurse and signed by a physician immediately following the initial assessment. The service plan details available services and changes to services (that is, initiate, discontinue/continue, or increase/decrease); the authorization period; the authorization frequency and schedule; and the provider. The service plan also serves as a physician order. The care plan is developed by the social worker after reviewing the service plan. The social worker spearheads the creation of a member-centered care plan, which is developed during the second month following enrollment. The care manager uses the nurse's assessment, conversations with the member, and clinical judgment to develop a care plan tailored to the member's needs and goals. The care plan describes covered and non-covered benefits, which include members' needs in terms of accessing services authorized through the service plan. The care plan is an internal document, but can be made available to external stakeholders that the member authorizes. The care plan is updated every six months and at any point at which there is a significant change in condition.

3. Ongoing Monitoring

The frequency and mode of contact vary based on the member's needs and personal preferences. Care managers are required to visit the member in person quarterly and call the member monthly. Topics covered include those detailed in assessments and/or issues identified during previous visits. If more frequent contact is appropriate, care managers will visit the member more as needed. The nurse visits members in person once every six months for reassessment. Hospitalization and/or change in condition (physical or psychosocial) are reasons for increased contact. In general, the frequency of contact is consistent with the members' stratification level; members in crisis or high-risk receive more frequent contact compared with those in the lower stratification levels. Although in-person and telephone contact are the most

[28] ICS supports two chairs for members who use powered chairs. Typically, when a member is ready for a second chair, ICS will keep the first chair functioning in case the new second chair needs repair.

frequent modes of communication, staff will correspond with members through text messages and email on occasion.

Frequency of contact is generally guided by risk-stratification; however, monitoring of specific conditions is driven by the protocols established for each condition and by the willingness of the member to accept an intervention. For example, there are protocols and standard interventions for members identified to be at risk of developing a wound. If appropriate, interventions are discussed with the member during the care planning visit and the appropriate frequency of ongoing monitoring is determined in collaboration with the member.

4. Communication and Coordination with Providers

Consistent with other aspects of ICS's care coordination process, the frequency and coordination with providers is member-dependent. Interactions with physicians were described as somewhat limited because ICS is not capitated for primary or acute care. However, nurses, social workers, and rehabilitation staff will reach out to physicians when appropriate. For example, an assessment nurse might call a physician regarding a member's high blood pressure. In addition, ICS staff are expected to facilitate coordination with physicians regarding prescription medications and DME evaluations. The latter is a source of delay in obtaining approval for Medicare-paid equipment for dually eligible beneficiaries. If the equipment is for dually eligible beneficiaries, ICS facilitates the completion of the seven-page evaluation that must accompany that order. For Medicare, the member has to have a face-to-face complex rehabilitation evaluation with the physician. Obtaining the paperwork could involve going with the member to ensure it is filled out accurately according to Medicare guidelines. Often, additional notes are needed because the physician failed to fill in elements correctly or did not sign the document legibly. As a result, the approval can take up to one year; during that period, ICS staff continue to follow up (through calls, faxes, letters, and in-person visits) with the physician to ensure the request is completed accurately according to Medicare guidelines.

ICS staff will occasionally attend medical visits with the member. This may occur for wound care, a nurse may attend a visit with a member to help facilitate service coordination; and care managers may attend a visit to address a medication management issue. The staff's role as a liaison between multiple providers is limited to acute problems or immediate needs. Although the members' PCP (that is, an external provider) must sign the service plan as it serves as a physician order, staff do not regularly communicate with providers regarding new member information. As described previously, staff reach out to physicians and other care providers in certain circumstances when they believe that it benefits the member. However, some ICS staff reported that the providers are not always responsive.

5. Member Education

Education is adapted to meet member's specific needs. The nurse, social worker, or the resource team staff provide tailored education on various topics. Typically, this includes medication, wound care, and equipment. The education curriculum and materials are somewhat structured and staff use the teach-back method to assess effectiveness. Health education materials related to prevention of secondary conditions (such as flu and pneumonia vaccines) are provided on a regular basis and at the point of a new diagnosis. Additionally, all members receive educational materials related to advance directives.

6. Service and Resource Management

ICS is capitated for Medicaid LTSS,[29] but it does not provide primary or acute care. In addition to providing LTSS, ICS offers a vast array of specialized services,[30] including care management, a community-based wheelchair repair program, a seating and mobility evaluation program, pressure ulcer prevention and intervention, a consumer-directed personal assistance home care program, socialization and recreational activities, behavioral health services, an advocacy department, and a health care program specifically for women with disabilities.

The community resource arranged for most frequently is home care; on average, ICS members received 6-8 hours a day of such care, seven days a week. Through regular contact, the care manager monitors any services the member receives and revises the member's care plan as needed.

7. Management of Care Transitions

ICS uses a structured approach to care transitions. Its policy dictates that the care manager contacts the discharge planning staff as soon as they become aware of a member's hospitalization. The care manager typically visits the member within one day of becoming aware of the hospitalization, as care managers are tasked with coordinating services and planning for discharge. A transitions team, which includes a clinical nurse supervisor and a social worker, collaborates with the care manager and the hospital discharge staff to determine the need for skilled and other social support services at the point of discharge. Care managers also ensure that services start again after hospitalization. It is common practice that the care manager visits the member

[29] Adult day health care; care coordination; consumer-directed personal assistance program; dental care; DME; vision services; hearing exams and aids; home care (for example, home health aides, home attendants, or personal assistants); home delivery of meals; home safety modifications/accessibility improvements; housekeeping/chore services; medical and surgical supplies; nurse on-call (24 hours a day, seven days a week); nursing home care; nutrition services; personal emergency response system; physical, occupational and speech therapies (at home or in the community); podiatry, orthotics, and management); social day care; and transportation.

[30] Member-centered care coordination; consumer-directed personal assistance home care program; specialized senior adult services; specialized care management services for people with spinal cord injuries and multiple sclerosis; a community-based wheelchair repair program; a seating and mobility evaluation program; a women's health care program; an advocacy department; social, educational, and artistic activities; and behavioral health services.

within one week after discharge. In addition, a nurse visits the member in person within five days after discharge to assess changes in medication, DME, and medical supplies. The nurse will note functional changes and amend the service plan as needed. He or she can order skilled services to manage new medications and to educate on new diagnoses. Nurses communicate any changes that require service modification through the electronic member record to the care manager.

Despite ICS's well-intentioned and structured approach to transition management, notification regarding emergency department visits and hospitalization is challenging. Only half of ICS's members self-report an event. Notification is more frequent if a home care agency provides services to a member. If the member is discharged before notification, the care manager will schedule an in-person visit upon notification of the event.

8. Medication Management

Both the member and his or her family are expected to inform the nurse regarding medication adherence and any side effects. Nurses are also expected to examine medication containers and consult with the prescriber as needed. Formal medication reconciliation during the six-month assessment, at a minimum, complements member education regarding medications. During the six-month visit, nurses are responsible for updating and reconciling the list of medications. Additional reconciliation may occur following an emergency department visit or inpatient admission; the nurse and/or care manager will contact the physician regarding changes in a member's medication regimen.

All ICS members have prescription coverage under the state Medicaid program or Medicare if dually eligible. To ensure that medication remains affordable, ICS works with its members and physicians when medications are off formulary. In addition, pill boxes are available to ensure adherence to medications.

VII. SIMILARITIES AND DIFFERENCES ACROSS PLANS

The CCA programs--CCA-SCO and CCA-BCMG in Massachusetts, CHP in Wisconsin, and ICS in New York City--are deeply committed to promoting independence among people with disabilities and ensuring that the right balance of medical and social supports are in place. Although the programs share this guiding principle and some clinical practices, they differ significantly in state-specific contexts and reimbursement structures that ultimately influence their operations. In this chapter, we describe the plans across a range of organizational and process features and identify similarities and differences in how they deliver care.

A. Context

Although plans operate in various contexts and settings described in previous chapters, a theme consistently identified is the continuous adaptation to shifts in state-level policy and economic climates. The Medicaid landscape in Massachusetts changed over the past decade due to shifts in health care delivery and reform (for example, Massachusetts implemented health reform in 2006). In 2010, BCMG shifted from a Medicaid risk-adjusted, capitated subcontract payment structure to direct reimbursement through Medicaid FFS, Medicare, or other third-party payers. This resulted in an operating loss and projected continued losses through early 2013. To adapt to this environment, BCMG leadership applied for the Integrated Care Organization demonstration, which would employ a new health care option for Massachusetts adults who are eligible for both Medicaid and Medicare. Further, in 2012, Medicaid experienced a 5 percent rate reduction followed by an additional 1 percent reduction in 2011. As a result, CCA-SCO currently operates at 2006 rates and is continuously trying to identify strategies to improve efficiencies.

Similarly, when Wisconsin mandated that all MCOs offer the Family Care benefit in 2009, CHP's two programs (Family Care and Partnership) began to compete with each other for members. CHP experienced significant financial stress as a result of several factors. First, due to different capitation rates (in Family Care and Partnership), CHP was losing money on Family Care members. Staff reported that the Family Care program also enrolled members with more developmental disabilities than did the Partnership program, a population with complex needs for which it did not have substantive in-house expertise. In July 2012, CHP leadership notified the state that the Family Care program was no longer financially viable. The state interpreted this notice as withdrawal from the Family Care program and informed CHP that it would no longer be allowed to operate the Partnership Program if it dropped its Family Care plan, forcing CHP to close.

ICS also struggled with financial viability and has experienced challenges at the state level since the program's inception. About five years ago, ICS nearly went out of business, necessitating a reduction in salaries and benefits along with provider rates to remain afloat. ICS has since recovered from this setback but leadership noted that the plan is always trying to identify ways to become more efficient. Most recently, ICS is preparing to transition to Medicaid managed care according to New York's mandate. ICS projects that approximately half of its members will be older than 65 after the change (only about 15-20 percent of the new members 65 and older have needs similar to ICS's current member base). Although ICS would have preferred to focus exclusively on the individuals with disabilities, state regulatory changes prohibit this. Despite these demands, CCA-BCMG, CCA-SCO, and ICS continue to operate, refining their programs to adapt to unexpected changes.

B. Organizational Features

Organizational features include staffing and team structure, information technology, quality management and outcomes measurement, and provider engagement and recruitment. Table VII.1 illustrates key organizational features for each program.

1. Staffing and Team Structure

All plans use interdisciplinary teams; however, team composition and functionality vary across the plans. CCA-SCO, BCMG, and CHP Partnership have nurse practitioners/physician assistants on the care team. The nurse practitioner/physician assistant serves as the team leader directing care for a panel of members in CCA-SCO and BCMG. Comparatively, the nurse practitioner in CHP Partnership has a more functional role--that is, completing histories and physicals, facilitating communication between providers and team registered nurses, and serving as a medical resource for teams. Further, CHP nurse practitioners do not function as autonomously as CCA nurse practitioners and are limited to ordering only over-the-counter prescriptions. These varying roles could be attributable to Massachusetts' progressive use of nurse practitioners and other mid-level providers. Another difference in structure is that CCA-SCO works with geriatric social service coordinators[31] to coordinate care, whereas CHP Partnership and Family Care programs teams include social service coordinators who work directly for CHP.

[31] Massachusetts mandates that geriatric social service coordinators coordinate services for CCA-SCO through aging services access points, which is a one-stop entry point for all support services and benefits available to seniors. Geriatric social service coordinators are employed through aging services access points, but are participants in service delivery and care planning as part of the CCA-SCO interdisciplinary team.

TABLE VII.1. Organizational Features				
	CCA-BCMG	**CCA-SCO**	**CHP**	**ICS**
Staffing and Team Structure				
Model of Care	Interdisciplinary	Interdisciplinary	Interdisciplinary	Interdisciplinary[a]
Staff Availability	24/7	24/7	24/7	24/7
Training	Didactic & field training; population-specific training is provided.	Didactic & field training; disability education is informal.	Didactic, online, & field training; disability education is provided.	Multiphase didactic & field training; condition-specific training is provided.
Expert Staff & Consultants	Behavioral health, psychiatrist, PT/OT, LTSS, wound care specialist (NP).	Behavioral health, PT/OT.	Pharmacist, developmental disability coordinator, geriatric psychiatrist, psychologist PT.	NP with multiple sclerosis certification, certified wound care nurses, behavioral health, PT/OT with specialization in wheeled mobility.
Quality Management and Outcomes Measurement				
Reports Clinical Indicators/Outcomes	No	Yes	Yes	Yes
Dedicated Quality Staff	No	No	Yes	Yes
Monitors & Reports ED Visits & Hospitalizations	Yes	Yes	Yes	Yes
Current Quality Improvement Initiatives	Inpatient pilot program,[b] increased focus on preventative & end-of-life care.	Focus on care transitions considering stratifying members implemented evidence-informed practices.	Nursing Home Initiative to reduce the number of days members spend in nursing homes, evaluation of the ACE model.	Department-specific targets & goals.
Assess Staff Performance	Yes; annual performance reviews for staff & chart audits.	Yes; annual performance reviews.	Yes; observe home visits at least annually, annual performance reviews, chart audits.	Yes; staff-level performance indicators, annual performance reviews, & chart reviews.
Provider Engagement and Recruitment				
Types of Providers Recruited	n.a.[c]	Primary care practices, community-based long-term care vendors such as personal care & home care.	Personal care, home care, residential, vocational, nursing homes.	External providers provide most services; emphasis on recruiting home care & equipment providers.
Use of Provider Advisory Board	Yes	Yes[d]	Yes	No

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.

NOTES:

a. ICS implemented the interdisciplinary model in July 2011 and rolled it out throughout 2012 and 2013.
b. BCMG implemented an inpatient pilot program whereby BCMG collaborates with Boston Medical Center family medicine attending physicians.
c. BCMG is a clinical practice and provides care directly to members. It does not recruit external providers and/or practices like the other plans.
d. CCA-SCO uses a board of directors.

24/7 = 24 hours a day, seven days a week; ACE = alternative configuration experimentation; BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP = Community Health Partnership; ED = emergency department; ICS = Independence Care System; LTSS = long-term support services; NP = nurse practitioner; PT = physical therapy; OT = occupational therapy; SCO = Senior Care Options.
n.a. = not applicable.

All plans reported restructuring care teams several times to identify the most efficient and effective approaches. CHP created facilities teams in 2008 to provide dedicated staff to serve members residing in facilities such as nursing homes and

residential settings. CHP leadership also implemented ACE teams three years ago as a pilot project to examine the impact of team structure on member outcomes, such as reduced hospitalization. CCA-SCO also recently added a registered nurse to its care teams because leadership identified opportunities for nurse practitioners to delegate certain tasks to registered nurses. Thus, ongoing restructuring reflects plan leaderships' adaptability to an ever-changing environment and search for efficiency.

The most significant difference in team structure and function is that CCA-SCO recruits primary care practices and wraps the care team around the practice in an effort to integrate with the practice. Practice integration was reported as time-consuming; however, it was viewed as essential to effective care coordination. Within this model, CCA-SCO leadership tried to have exclusive relationships with primary care practices so that the practice would not have other CCA-SCO contracts. Such exclusive partnerships ensured mission alignment as CCA-SCO looks to build a clinical program and aims to be recognized as more than an insurance plan. In addition, CCA-SCO staff are credentialed with the practice, which enables them to access patients' medical records in real time.

ICS teams include social workers and registered nurses, which could be due in part to the services they provide--LTSS. ICS social workers functioned as care coordinators[32] and registered nurses primarily conducted assessments and reassessments according to contractual requirements (for example, significant change in condition assessments after hospitalization). This team structure reflects ICS leadership's core belief that social needs and issues are generally more dominant than medical ones in long-term care and that social support is required for most members on a regular basis. However, ICS recognized that staff functioned in silos and at the time of our site visit it was piloting a different care model that integrates social workers and registered nurses.

A notable difference across BCMG, CHP, and ICS[33] is that ICS and BCMG have considerable resources available to assist staff in working with people with disabilities. ICS's resources include a disability coordinator, wound care nurse, behavioral health specialists, and an in-house rehabilitation department staffed with physical and occupational therapists. Similarly, BCMG has a wound care specialist, physical and occupational therapists, a DME coordinator, a newly added clinical education coordinator, and a psychiatrist available for consultation. Although CHP had similar resources previously, the workforce reduction in 2011 eliminated the resource department. However, CHP retained the disability coordinator position and made available consultation by a psychiatrist.

[32] Although the plans used various terms for referring to staff, we use the term *care coordinator* to describe the person with the primary responsibility for coordinating care.

[33] CCA-SCO is not included in this comparison because the program did not specifically target people with physical or developmental disabilities.

The plans provide structured orientation of new staff that combines didactic training and field observation. BCMG, CHP, and ICS also provide training in disability-competency skills.

2. Information Technology

All plans use information management systems to document care management activities and offer some level of automated communication and decision support capabilities. However, plans use different systems and accessibility to other sources of patient information varies (Table VII.2). BCMG uses Logician, which documents home visits, medication, and diagnoses and is capable of automated communication. Logician lacks the ability to track outcomes, document support services, or generate claims. As a result, BCMG leadership is transitioning to eClinicalWorks in 2013. Despite the limitations of Logician, BCMG mid-level providers and physicians have access to Boston Medical Center's inpatient notes and specialist consults via Sunrise Clinical Manager, which enables them to communicate with other providers in real time.

CCA-SCO uses Casenet, which documents clinical notes, assessments, care plans, service authorizations, and tasks. Although Casenet is for internal use only, CCA-SCO staff have access to patients' medical records through primary care sites. This capability enables CCA-SCO staff to access patient information in real time and facilitates care coordination activities. ICS has used Care Compass since April 2011. It is a multifunctional information system that stores member and provider information and clinical assessments and documentation. Care Compass generates reports and task reminders and facilitates staff communication and coordination. CHP's information management system, launched in January 2012, was the most sophisticated of all the plans. CHP uses an EMR that comprises two separate systems: Allscripts and OnBase. Allscripts is the case management system used by case managers for documenting member contacts, assessments, and treatment planning. OnBase is a document management system that contains supporting documents such as medical records, treatment plans from providers, and prescriptions.

BCMG, CCA-SCO, and CHP also offered staff innovative tools to improve communication and productivity, namely a laptop computer or tablet to facilitate documentation and communication in the field. However, availability of innovative tools did not always correspond with uptake of technology. Despite having laptops, BCMG and CCA-SCO staff reported that they continued to document home visits on paper and transfer their handwritten notes to the EMR following the visit; mid-level providers (physician assistants and nurse practitioners) reported that documenting in the EMR in real time can be cumbersome and in some cases prohibits connecting with the member. CHP staff received tablets equipped with Lync, an application with teleconference and instant messaging capabilities. CHP staff seemed more receptive to documenting in the field; staff reported that entering member information into the EMR in real time resulted in more detailed notes and assisted in caring for members. For example, staff enter a member's vital signs as they measure them and can pull up their previously recorded vital signs as a comparison.

TABLE VII.2. Clinical Information Systems										
	CCA-BCMG		CCA-SCO		CHP					ICS
	Logician[a]	Sunrise Clinical Manager	Casenet[b]	Epic[c]	Allscripts[d]	OnBase[e]	Lync	Store In	SOFI	Care Compass[f]
Internal EMR	X		X		X					X
External EMR[g]		X		X						
Member Contacts	X		X		X					X
Member Assessment	X		X	X	X					X
Document Management						X				X
Medication Management	X							X		
Case Management			X		X					X
Claims Generation			X							
Service Authorizations			X							
Automated Communication/ Reminders	X		X							X
Tracking Clinical Indicators/Outcomes			X		X				X	X
Generating Reports			X		X				X	X
Internal Provider Communication	X		X		X		X			X
External Provider Communication		X		X						

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.

NOTES:

a. Logician documents home visits, medication, and diagnoses.
b. CaseNet is primarily a case management tool used for claims generation and as a repository for clinical notes, entering service authorizations, documenting home visits, and detailing tasks.
c. Epic is the external EMR to which many CCA-SCO staff have access. However, some staff have access to other primary care sites' EMRs.
d. Allscripts is a case management system used for documenting member contacts, assessments, and treatment planning.
e. OnBase is a document management system. It contains medical records, providers' treatment plans, and prescriptions.
f. Care Compass serves as the electronic care management record for members, as well as a data repository. It houses documentation of the assessments, care plans and gaps in care activities. It also generates reports by members, provider, or cohort and tracks key performance measures.
g. BCMG, CCA-SCO, and CHP staff all have access to external electronic health records. BCMG mid-level providers and physicians are able to access Boston Medical Center and CCA-SCO records through Sunrise Clinical Manager and CaseNet, respectively. CCA-SCO providers become credentialed with a practice and then can access records via Epic or another EMR. CHP receives a copy of Partnership members' medical records monthly.

BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP = Community Health Partnership; EMR = electronic medical record; ICS = Independence Care System; SCO = Senior Care Options; SOFI = Statistics and Other Financial Information.

3. Quality Management and Outcomes Measurement

Each plan focuses on improving quality but varies in the extent to which data are used for monitoring and to drive change. Because BCMG cannot track its members use of services, monitoring quality of care measures and the impact of care coordination services is limited, with BCMG's approach relying largely on findings from chart audits and consumer feedback. Conversely, CCA-SCO uses a data-driven approach to quality management by combing data available through its care management system, Casenet, and claims data. A feature that distinguishes CCA-SCO from the other plans related to quality management is the use of quarterly practice-specific reports generated and discussed with primary care practices working with CCA-SCO enrollees. These reports include specific outcomes, such as emergency department visits and inpatient admissions, so that each practice can assess its performance. CCA-SCO leadership has used these reports since the inception of the program.

CHP also uses data to inform quality initiatives and has dedicated quality management staff and a Decision Support Services department to ensure efficient clinical and operational performance. Quality management staff work with teams on specific quality improvement projects--for example, reducing the number of days members spend in nursing homes. Similarly, ICS employs dedicated quality management staff and has a performance improvement group that reviews all administrative, clinical, and support services to assess performance, such as timeliness and quality of services. In addition, the plans assess member satisfaction regularly through surveys and/or focus groups and an advisory council.

4. Provider Recruitment and Engagement

Leadership across the plans consistently identified the importance of building strong collaborative relationships with providers that support the plans' philosophies and missions. In particular, CCA-SCO and ICS leaders noted that it is important for providers to recognize that the plan operates more like a program rather than a traditional insurance plan. CCA-SCO, CHP, and ICS recruited similar providers, such as personal care, home care, nursing homes, residential, and DME providers. CCA-SCO also recruits primary care practices because its model is based on practice integration. At the inception of the program, CCA-SCO had a dedicated site manager to carry out this function. On the other hand, CHP and ICS have provider relations departments that are largely responsible for recruiting providers. The CHP and ICS provider relations departments are responsible for contracting and credentialing provider networks. Currently, ICS has 250 providers, but its network will have to triple in size to accommodate ICS's growth strategy. Notably, BCMG provides primary care directly and does not recruit outside providers. However, it serves fewer patients than the other plans.

C. Process Features

Programs' process features are the specific actions performed by staff, such as assessment, care planning, monitoring, facilitating communication with and among providers, providing member education, arranging services, and managing care transitions and medications. Plan staff conducted comprehensive assessments, corralled resources, and served as liaisons between providers and members. Staff consistently emphasized individualized care guided by members' needs and preferences.

1. Initial Assessment

All four programs' care coordinators performed initial assessments in a member's home within a few weeks after a patient's enrollment and conducted periodic reassessments thereafter. In-person contact was viewed as important for assessing home and environmental safety.

Although all of the plans conducted comprehensive assessments, the assessment tools used varied widely, in part due to regulatory requirements and capitation. Further, qualifications of staff conducting initial assessments also varied across programs. A nurse practitioner or physician assistant conducted the initial assessment for BCMG and CCA-SCO members, whereas a registered nurse and social worker/or SSC conducted the assessment for CHP Family Care and ICS members. A nurse practitioner completed a history and physical examination for members enrolled in CHP Partnership. A distinguishing feature of the programs is the use of risk-stratification by ICS for ongoing monitoring. ICS stratifies members into four risk groups as a way to ensure that members receive the proper level of care and that staff assignments are balanced. However, ICS only recently began using this four-level risk-stratification method as part of its team restructuring efforts. Previously, ICS used a three-level risk-stratification method whereby enrollees were allocated the same number of case management hours regardless of their risk level; case managers would then retroactively stratify clients based on their needs, rather than proactively allocate resources based on risk.

2. Care Planning

Care planning is an ongoing and dynamic process for identifying members' service needs, priorities, and preferences. Care coordinators initiate the care plan during the initial assessment and continue to modify it as needed with a significant change in condition (for example, after hospitalization or change in diagnosis) or services and at least every six months. Care plans address a wide range of topics, including medical, mental health, and social needs; functioning; living arrangements; personal relationships; and services authorized. Although programs used care plans with various formats, care coordinators consistently noted that care plans are member-driven and individualized based on members' changing needs and priorities. Table VII.3 shows each plan's process for initial assessment and care planning.

TABLE VII.3. Initial Assessment and Care Planning				
	CCA-BCMG	**CCA-SCO**	**CHP**	**ICS**
Initial Assessment				
Time to Initial Assessment	Within 2 weeks of enrollment.	Within 1 month of enrollment.	Within 10 days of enrollment.	Within 1 month of enrollment.
Initial Assessment In Person	Yes	Yes	Yes	Yes
Patient Stratification	No	No	No	Yes
Assessment Tools Used	Initial visit form, PHQ-9, DME Checklist, Patient Medical Supply List.	MDS, geriatric assessment.[a]	Home safety assessment & mental status examination, history & physical examination.	The SAAM,[b] the personal care assistance tool, behavioral complexity tool.
Staff Conducting Assessments	NP or PA	RN & NP	RN & SSC NP for Partnership	RN & SW
Formal Reassessment	Annually	The MDS is completed every 6 months; the geriatric assessment is completed annually.	Every 6 months; the mini-mental status examination is completed annually or with change in cognition; the long-term care functional screen is reviewed after the first 90 days & then conducted annually.	Every 6 months & if a significant change in condition occurs. The personal care assistance tool is completed at least twice per year. The behavioral health complexity tool is completed every 3 months for members who are in receipt of services.
Care Planning				
Time to Development	Developed during the initial assessment.	Developed during the initial assessment.	Developed during the initial assessment.	The service plan is developed immediately after the initial assessment. The care plan is developed after the service plan.
Care Plan Updated	Staff evaluate needs at every in-person visit.	Care plan must be reviewed every 6 months; however, many are revised more frequently.	Care plan is reviewed during every in-person contact; it is formally updated every 6 months.	Care plan is reviewed during each contact & revised as needed; at a minimum, it is updated every 6 months.
Common Reasons for Update	A status, setting, or diagnosis change.	A status, setting, or diagnosis change.	If a service is reauthorized, if member identifies another goal, and/or if there is a change in condition.	A significant change in the member's condition.

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.
NOTES:
a. ICD-9 codes are the foundation of the geriatric assessment, which captures diagnoses for submission to Medicare.
b. The SAAM is a functional assessment scoring system developed by the Department of Health.

BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP = Community Health Partnership; DME = durable medical equipment; ICD-9 = International Classification of Diseases, 9th edition; ICS = Independence Care System; MDS = minimum data set; NP = nurse practitioner; PA = physician assistant; PHQ-9 = Patient Health Questionnaire-9; RN = registered nurse; SAAM = semiannual assessment of members; SCO = Senior Care Options; SW = social worker.

3. Ongoing Monitoring

Monitoring includes regular assessment of members' physical, mental, and social functioning and responding quickly to physiological, behavioral, and other changes that could lead to a hospitalization or an emergency department visit. All plans' care

coordinators monitored their patients through regular contacts; however, frequency of contact varied widely and was driven by members' needs and preferences.

Despite the annual minimum requirement for contacting members, BCMG staff typically contact members personally each month. All CCA-SCO members must have the MDS completed twice a year by a registered nurse and the geriatric assessment annually by an nurse practitioner; however, members were monitored as needed. CHP members are seen in person by a registered nurse or social service coordinator at least quarterly; however, members must be assessed by a registered nurse every six months. Despite these requirements, staff reported that the frequency of monitoring varies based on members' needs, with some seen as frequently as weekly. Similarly, ICS required care coordinators (social workers) to visit members at least quarterly, with nurses assessing members at least every six months or after hospitalization. However, staff reported that members in crisis could be seen daily if needed. Further, although ICS used risk-stratification to guide frequency of monitoring, clinical judgment always overrules established guidelines. Allowing clinicians to use judgment was a consistent theme across all plans. Although the programs provided clinicians with guidelines and protocols to guide care, the clinicians had the autonomy to go beyond those guidelines. Further, none of the plans imposed a limit on the number of times members could be contacted and/or visited. Table VII.4 details plans' processes for ongoing monitoring.

TABLE VII.4. Ongoing Monitoring

	CCA-BCMG	CCA-SCO	CHP	ICS
Minimum Frequency of Contact	Once a month, on average; contact varies based on need & is guided by clinical judgment.	Contact varies based on need & is guided by clinical judgment.	Quarterly at a minimum, but contact varies based on need & is guided by clinical judgment.	Care manager: monthly at a minimum, but contact varies based on need. Nurse: contacts for assessment or reassessment.[a]
Contacts Based on Members' Needs & Clinical Judgment	Yes	Yes	Yes	Generally, risk-stratification guides contact.[b]
Location of In-Person Contacts	Home, office visit, hospital.	Home, office visit, hospital, nursing home.	Home, office visit, hospital, nursing home, residential setting.	Home, office visit, hospital, ICS office, nursing home.
Reasons for Changes in Contact Frequency	Hospitalization and/or change in condition, psychosocial issues, change in support structure.	Hospitalization and/or change in condition, psychosocial issues.	Hospitalization, sudden illness, and/or change in condition.	Hospitalization and/or a change in member's status (mental, physical, or situational).
Education Provided	Yes	Yes	Yes	Yes

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.
NOTES:
a. Contact frequency describes the care model before implementation of the interdisciplinary team pilot.
b. Risk-stratification was implemented in 2011 with the interdisciplinary team pilot.

BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP = Community Health Partnership; ICS = Independence Care System.

4. Communication and Coordination with Providers

One of the challenges facing people with disabilities is that the communications among their many providers are fragmented and often non-existent. Plan staff consistently noted their role as a liaison among multiple providers; however, responsiveness to staff's communication efforts varied widely. Staff occasionally attended appointments with members that served as an opportunity for informal communication with providers. However, the frequency with which they attended appointments varied across plans and clinical judgment guided the decision to do so. Access to members' medical records differentiated BCMG and CCA-SCO from CHP and ICS. BCMG and CCA-SCO staff have access to patients' medical records, which significantly enhances communication and care coordination activities. Although CHP Partnership staff receive patients' medical records on a monthly basis, they do not use the same electronic system for communicating and are not aware of a member's status or needs in real time.

TABLE VII.5. Communication and Coordination with Providers

	CCA-BCMG	CCA-SCO	CHP	ICS
Formal Communication with Providers	BCMG physicians participate in care planning.	Physicians are encouraged to participate in the care planning process; members' physicians can receive a copy of the care plan.	Physicians are encouraged but not required to participate in the care planning process.	Service plans are reviewed and signed by a physician. Frequent communication with LTSS network providers. DME approval documents are both faxed & mailed to the providers.[a]
Common Mode of Interactions with Providers	In-person, electronic.	In-person, electronic.	In-person, telephone, fax, & email.	In-person, telephone, fax, & email.
Opportunities for Informal Communication	Attend office visits with members; PAs/NPs access members' medical records & use the EMR to communicate with providers.	Attend office visits with members; NPs access members' medical records & use the EMR to communicate with providers.	Attend appointments with members.	Attend office visits with members.

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.
NOTES:
a. Required for dually eligible members only. For Medicare, the member must have a face-to-face complex rehabilitation evaluation with the physician.

BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP = Community Health Partnership; DME = durable medical equipment; EMR = electronic medical record; ICS = Independence Care System; LTSS = long-term supports and services; NP = nurse practitioner; PA = physician assistant.

Communication with providers (primary care and specialists) is more limited for CHP Family Care staff and ICS staff and focuses mostly on problems that need immediate attention. Staff noted that it can be difficult to receive a return telephone call from a provider. However, it is notable that ICS staff take a proactive approach to interacting with physicians pertaining to DME. Because incomplete or incorrect Medicare paperwork often leads to long delays in approval of equipment, ICS rehabilitation staff frequently attend a physician visit with the member to ensure that the

paperwork is completed accurately. Table VII.5 shows each plan's process for communicating and coordinating with providers.

5. Member Education

Plans recognized the importance of educating members but varied in their use of structured materials. BCMG and ICS staff did not report adhering to a structured curriculum, whereas CHP staff used the Krames on-demand system and CCA-SCO drew from its Health Education and Training Department, which offers the Stanford Chronic Disease Self-Management and Diabetes Self-Management programs. Education was provided on a range of topics and plan staff noted that education was individualized based on specific members' needs. Although none of the plans provided formal training in motivational interviewing or behavior change theory, CCA-SCO leaders were in the process of integrating motivational interviewing into staff training.

6. Service and Resource Management

The plans provide services consistent with those covered under Medicaid capitation rates; however, the extent to which plans provided and coordinated uncovered services varied. BCMG provides acute care, preventive care, and long-term care services; staff also coordinate care for support services, physical and occupational therapist, DME, behavioral health services, and nursing home care. BCMG physician assistants and nurse practitioners monitor the receipt of all services and make necessary referrals. Similarly, CCA-SCO is capitated for acute care, preventative care, and long-term care services and plan staff arrange and monitor theses services. Moreover, CCA-SCO nurse practitioners have the ability to authorize needed services. CCA-SCO staff also work collaboratively with geriatric SSCs, who are experts in community-based long-term care services, to ensure members receive complementary medical and support services.

CHP Family Care is capitated only for long-term care services such as in-home services; transportation; occupational, physical, and speech therapy; DME; social, mental health, adult day, and vocational services; respite; supportive home care; assisted living; and nursing home care. The Partnership program also offers physician care; medical, surgical, and intensive care; hospitalization; prescription drugs and medications; dental, vision, and hearing services; labs; and X-rays. Both programs use the resource allocation decision method, which is composed of a series of questions designed to help the team and the member identify the specific goals and outcomes that would improve the member's quality of life. CHP care teams ensure that members receive the most appropriate services.

Similar to CHP Family Care, ICS provides LTSS. However, ICS also offers a vast array of specialized services, including care management, a community-based wheelchair repair program, a seating and mobility evaluation program, pressure ulcer prevention and intervention, a consumer-directed personal assistance home care program, socialization and recreational activities, behavioral health services, an

advocacy department, and a health care program specifically for women with disabilities. These specialized services go beyond what ICS is required to cover and make ICS unique in its care for people with disabilities.

7. Management of Care Transitions

Plans emphasized prevention of hospitalization and emergency department visits by developing a proactive approach to managing care transitions through ensuring notification of emergency department visits and hospital or other facility admissions and adhering to protocols during care transitions.[34] Because BCMG is integrated with Boston Medical Center--from which a large majority of BCMG members receive emergency and inpatient care and to which members are encouraged to reach out to their mid-level provider before going to the emergency department--BCMG providers are notified of their patients' emergency department visits and inpatient admissions in a timely way in nearly all cases. Similarly, because the largest cohort of CCA-SCO members receives inpatient services at CHA hospital, notification is almost always timely. CCA-SCO also has a dedicated transition coordinator[35] who visits the hospital daily and communicates with CCA-SCO staff about hospitalized members. As with CCA-SCO, CHP has a dedicated staff to ensure effective transition planning. Transition planners monitor Partnership members while hospitalized and coordinate with teams for discharge planning. ICS becomes aware of hospitalizations through members' self-reports and personal home care agencies. Although notification of such events is not as timely as in BCMG, CCA-SCO, and CHP Partnership, ICS has a policy that requires care managers to contact hospitalized members within three days of admission, although notification is not always timely.

Although specific practices vary, plans have policies or protocols in place to ensure that staff visit members after their hospital discharge. The focus of the visit is on preventing readmission and ensuring that members understand discharge instructions, such as how to take prescribed medications, and attend post-discharge follow-up visits.

8. Medication Management

Although all program staff acknowledged the importance of medication management, procedures for the frequency and approach to medication reconciliation varied widely. BCMG providers reported that reconciliation occurs when there is a change in setting or care. Although there is no formal requirement, medication reconciliation typically occurs a minimum of twice a year. Further, BCMG providers have prescriptive authority, so they can make medication changes when needed. CCA-SCO staff reported that medication reconciliation should take place at every visit and not only during transitions in care. Although a formal protocol does not dictate reconciliation at every in-person visit, because CCA-SCO nurse practitioners have prescriptive authority,

[34] Because CHP Family Care program is capitated for LTSS, staff did not receive timely notifications of hospitalizations. Although staff were encouraged to use the post-hospital risk-assessment tool used by Partnership staff, it was not required.

[35] The transition coordinator position has been in place since July 2011.

they regularly monitor members' medications and make adjustments as needed. However, medication reconciliation must occur at least once a year.

TABLE VII.6. Care Transitions and Medication Management

	CCA-BCMG	CCA-SCO	CHP	ICS
Care Transition Management[a]				
Use of Formal Protocol for Managing Care Transitions	Yes; anyone discharged must be seen in person within 24 hours.	Yes; anyone discharged must be seen in person within 48 hours.	Yes; partnership uses a risk-assessment tool to guide post-discharge contact.	Yes; care manager contacts the discharge planner within 24 hours & visits within 1 day.
Process for Identifying Whether Members Had ED Visits & Hospitalizations	PA/NP notifies the hospital regarding an ED visit or admission.	The transition coordinator receives a fax, which lists members who have been hospitalized or visited the ED.	Partnership: The NP is contacted by the transition planner within 24 hours of hospitalization.[b]	Staff are informed through member self-report & home care agencies.
Provides Relevant Information to Hospital Staff	Yes	Yes	Partnership: Yes. Family Care: If informed of admission.	If informed of admission.
Hospital Visits	Yes	Yes	Yes	Yes
Frequency of Contact with Hospital Discharge Planners	Daily communication.	Daily communication.	Daily communication.	Varies.
Post-Discharge Care	Home visit by PA or NP within 24 hours after discharge.	Home visit within 48 hours after discharge.	Partnership: NP or RN visits member within 24-72 hours of discharge. Family Care: Home visit within 3 days of discharge if aware of an admission.	Home visit by RN within 5 days of discharge; care coordinator commonly visits members within 1 week of discharge.
Medication Management				
Sources of Information on Medications Taken	Member self-report; Boston Medical Center's EMR.	Member self-report; families or caregivers; primary care site's EMR.	Member self-report; providers; partnership receives medical records & has access to pharmacy data.	Member self-report; member's family; medication containers.
Minimum Frequency of Medication Reconciliation	No formal minimum requirement; clinical judgment.	Annually.	Every 6 months or after hospitalization.	Every 6 months or after hospitalization.
Provision of Medication Adherence Devices & Supports	Pill boxes & medication support by a PCA are available.	Meds-on-Time, a medication dispenser, & medication support by a PCA.	Pill boxes, med-drops, and locked medication planners are available.	Pill boxes are available.

SOURCE: Discussions with program staff and program data, Mathematica Policy Research, 2012.
NOTES:
a. Currently, the NP or PA facilitates all transitions for CCA-BCMG. The RN care coordinator is expected to assist with care transitions in the future. CCA-SCO, CHP, and ICS all have personnel dedicated to care transitions.
b. Typically, Family Care staff are not informed in a timely manner.

BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; CHP = Community Health Partnership; ED = emergency department; EMR = electronic medical record; ICS = Independence Care System; NP = nurse practitioner; PA = physician assistant; PCA = personal care assistant; RN = registered nurse.

Whereas BCMG and CCA-SCO staff have access to patients' EMRs, CHP Family Care staff rely on the member and/or guardian as the primary source of information on medications and request a list of medications from members' PCPs annually. Staff reported reviewing medications during quarterly contacts. CHP Partnership staff conduct medication reconciliation every six months and after hospitalization to identify redundant medications and discrepancies between prescribed medications and those

actually taken. Staff also have access to pharmacy data so they can track refills and compliance. In contrast to BCMG and CCA-SCO nurse practitioners, those working on CHP Partnership teams do not typically change medications. At a minimum, ICS registered nurses conduct formal medication reconciliation during the six-month assessment when they are required to update and reconcile medications. Additional reconciliation may occur following an emergency department visit or inpatient admission. Table VII.6 shows each plan's process for managing care transitions and medications.

VIII. DISCUSSION AND CONCLUSIONS

A. Plans Share Four Key Features

Our analysis has identified four key features shared by the plans: (1) high-touch clinical interventions; (2) interdisciplinary teams to deliver care; (3) a strong emphasis on managing care transitions to prevent rehospitalization and emergency department use; and (4) a focus on the behavioral health needs of the population served and the investment in resources to meet those needs.

1. High-Touch Clinical Interventions

Plans facilitate in-person contact because it is critical to: (1) establishing effective relationships with members; and (2) reducing hospitalizations and emergency department use. Almost immediately after new members enroll, plan staff contact them to schedule the initial assessment, which is conducted in the member's home. Staff uniformly work hard and creatively to establish collaborative relationships and address members' immediate needs during the initial engagement. One care coordinator noted that she frontloads the frequency of contact in order to establish a strong relationship with the member; this care coordinator visited members 2-3 times a week during the first few weeks after enrollment. Frequency of contact varies and is largely driven by members' stated needs and preferences, thus, reflecting the individualization of care.

Plans' procedures support the practice of up-front contact (that is, through the initial assessment); however, they also emphasize continued high-touch clinical interventions. Staff have the flexibility to contact members as frequently as needed and reported visiting members in their homes or in residential settings, accompanying members to physician appointments, and, in many cases, visiting members during hospitalizations or temporary nursing home stays. This type of elastic, individualized response capacity (that is, episodic care response capacity) is critical to reducing hospitalizations and emergency department visits and could result in subsequent cost savings. For example, an in-person visit might bring a pressure sore or high blood pressure to the attention of the provider, whereas if left untreated, such conditions can escalate and result in preventable hospitalizations. Research supports the need to design interventions that include relatively frequent face-to-face contact with high-needs patients (Brown et al. 2012; Bott et al. 2009; Brown 2009). In particular, a recent study (Brown et al. 2012) of 11 programs that were part of the Medicare Coordinated Care Demonstration found that the four programs that succeeded in reducing hospitalizations for high-risk patients had more frequent in-person contacts than the seven unsuccessful plans--about once a month, on average, during the first year.

2. Interdisciplinary Team

Consistent with the DCCO model, plans emphasized the use of interdisciplinary teams to ensure holistic treatment. All plans noted that their interdisciplinary team structures have evolved over time, and two plans (CCA-SCO and ICS) implemented variations in team structure and function as recently as 2011. The plans employ numerous types of clinicians within teams, including physician assistants, nurse practitioners, registered nurses, and LCSWs, to ensure that members receive comprehensive care. Clinicians are expected to bring their clinical expertise and experience to the team and collaborate with one another to help members achieve optimal outcomes. Given the complexity and comorbidity of conditions among people with disabilities, the interdisciplinary team is critical to providing comprehensive care to this population. As was true for the high-touch feature, this finding is supported by the literature on other successful care coordination interventions. For example, Counsell and colleague's (2007, 2009) GRACE model takes a similar approach, with a geriatrician, nurse practitioner, and social worker on the team, and finds significant reductions in hospital use.

3. Management of Care Transitions

One of the most challenging aspects of coordinating care is the management of care transitions. Although plans' capacities and procedures for managing transitions vary, all three have developed a proactive approach to managing transitions by designating personnel to facilitate this process. In this role, the staff coordinating transitions follow members across various settings to ensure that providers have a shared understanding of the member's condition and functioning, that members' medications and discharge plans are communicated among collaborating providers, and that members understand and follow through with discharge plans.

BCMG, CCA-SCO, and CHP Partnership receive timely notification of hospitalizations because a large majority of their members receive emergency and inpatient care at hospitals with which the plans have established a process for learning about such events. Although ICS does not have a similar process in place for timely notification of such events, it has a policy that requires care coordinators to contact hospitalized members within three days of admission, once notified. Despite differences in notification of events and procedures for visiting members while hospitalized and post-discharge, all plans have devoted substantial attention to implementing and improving practices to reduce rehospitalizations.

4. Investment in Behavioral Health Resources

Another similarity across the plans is the focus on the behavioral health needs among members and the investment in behavioral health resources to assist staff in working with members. The plans unanimously echoed the prevalence of behavioral health problems among their members and noted the challenges of tackling the comorbidities of medical and mental health conditions. Given this considerable need,

plans noted the importance of having adequate in-house capacity in this area and/or experts available for consultation. Three of four plans employ behavioral health personnel to work directly with members and care coordinators. All plans encourage care coordinators to consult with both internal and external behavioral health personnel, as needed. For example, providers increasingly attend members' appointments with psychologists and psychiatrists. Consistent with the DCCO model, the plans emphasize behavioral health as an important part of caring for the member holistically and take steps to help staff become more comfortable working with members who have behavioral health issues.

B. Three Key Features Distinguish the Plans

While the plans share the aforementioned features regarding how they are implemented, they differ on three other important operational features: (1) level of integration with primary care and other providers; (2) intensity of specialized services provided; and (3) sophistication of information systems and data monitoring.

1. Integration with Primary Care and Other Providers

The level of integration with primary care and other providers varies widely across the plans. By design, CCA-SCO is more integrated than CHP and ICS.[36] Specifically, CCA-SCO recruits primary care practices and wraps the care team around the practice in an effort to integrate with the practice. CCA-SCO staff then become credentialed with the practice, which enables them to access patients' medical records in real time. Similarly, BCMG staff have access to patients' medical records, which significantly enhances communication and care coordination activities. Although CHP Partnership staff receive patients' medical records on a monthly basis, they do not use the same electronic system for communicating and are not aware of what is happening with members in real time. However, one of the PCPs who provides care to members served by the Partnership program meets with a CHP nurse practitioner monthly to review the status of members. ICS care coordinators are not integrated with primary care practices through any of the aforementioned mechanisms because it is capitated solely for Medicaid LTSS coverage.

2. Intensity of Specialized Services Provided

BCMG and ICS primarily serve people with physical disabilities, whereas CHP and CCA-SCO serve broader populations. Thus, a notable difference across BCMG, CHP, and ICS[37] is that ICS and BCMG devote considerable resources specifically to assist staff in working with individuals with disabilities (such as a disability coordinator/ educator), which is a key feature of disability competent systems (Palsbo and Kailes

[36] BCMG is not included in this comparison because it is the primary care practice.

[37] CCA-SCO is not included in this comparison because the program did not specifically target people with physical or developmental disabilities. Note that CHP did have more resources devoted specifically to individuals with disabilities at one time, but then eliminated those resources because of its financial condition.

2006). ICS and BCMG also have a wound care nurse and physical and occupational therapists on staff. ICS provides unique additional services not covered by FFS Medicaid that are focused on the specialized needs of some plan members. First, ICS has behavioral health specialists on staff who are available to work with members to address behavioral health issues and to serve as a resource for staff. Second, ICS has a wheelchair repair clinic on site that offers a weekly maintenance workshop. Repair technicians are also available to go to members' homes to repair damaged equipment. Further, ICS offers social and recreational activities for its members.

3. Information Systems and Data Monitoring

Plans' information systems and data monitoring capabilities varied significantly. One feature that distinguishes the programs is that BCMG and CCA-SCO staff have access to patients' medical records, which significantly enhances communication and care coordination activities. Research shows that nursing-led care management without collaboration from PCPs does not yield positive patient and cost outcomes (Leibel et al. 2007). Sharing the same EMR provides opportunities for collaboration and is not burdensome for primary care providers.

In addition, CCA-SCO and CHP use their information systems to generate sophisticated monitoring reports. Each CCA-SCO practice receives a practice-specific report that includes member information, such as the number of members in the program at that particular practice; demographic information; members' risk scores; and total medical expenses and outcomes (for example, hospitalizations and emergency department visits per 1,000 members per year). CCA-SCO stratifies outcomes by member and by populations (for example, ambulatory, nursing home, and serious mental illness). A three-month update is completed for each practice and reports are used to review acute care admissions per 1,000 members per year and emergency department visits per 1,000 members per year. Because acute care admissions are typically due to complications, CCA-SCO focuses on reducing such complications, which can result in emergency department visits, in addition to hospitalizations. Similarly, CHP uses EMR data to assess the quality of services delivered and health outcomes and has a robust Decision Support Services department that generates reports for ongoing monitoring of clinical and operational performance. For example, reports detail screening tests, follow-up visits after a hospital discharge, and HEDIS data.

C. Conclusions

The programs in this study incorporate features that define what it means to be an effective disability competent system, including coordinating services with providers across various settings, individualizing care based on members' needs, involving members in clinical decision-making, incorporating members' feedback into the program, and monitoring outcomes to drive change. Our study identified four factors, present in all plans, that helped the plans operationalize these core features: (1) high-

touch clinical interventions; (2) the use of interdisciplinary teams; (3) a strong emphasis on managing care transitions; and (4) investment in behavioral health resources. The first three features are among those that have been found in programs that successfully reduced hospitalization for high-risk Medicare beneficiaries in an FFS environment.

Policymakers can also play a critical role in the sustainability of disability competent programs, as the state-specific policy contexts and reimbursement structures in which plans operate greatly affects their ability to deliver interventions and financial viability. Program administrators may want to systematically monitor outcomes that are relevant for members of disability competent systems such as quality of life, member satisfaction, and functioning. Monitoring critical outcomes that are specific to individuals with disabilities would enable program operators to more fully assess their programs. Our study reinforces the importance of developing population-specific programs; program administrators may consider tapping particular health and social services in order to improve the health and quality of life of individuals with disabilities.

Although all of the plans are committed to promoting individualized care among their members, the plans must operate within the framework of the services included in their capitation, which ultimately affects their operations. Discussions with plan leadership suggest that those with a single capitation covering all acute and long-term care services may have more flexibility to employ the aforementioned facets of a successful care coordination model.

These programs continue to adapt to both external changes, such as changing state and federal health care landscapes, and internal quality improvement changes based on data as well as their own experiences. This dynamic aspect is noteworthy because it is not only the programs' facets, but also the continued refinement of their programmatic details and their leaders' adaptability that contribute to their ability to meet the unique needs of individuals with disabilities.

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APPENDIX A. DISCUSSION GUIDE TOPICS

Master Discussion Guide Topics	
Topic	**Description**
Organizational Features	Details respondents' years of experience in current role and their experience providing services for individuals with functional limitations.
Member Outreach, Intake Process, and Participation	Details outreach approaches for target populations (and sub-populations), eligibility criteria, and effectiveness of the outreach process.
Program Staff	Describes staff roles, responsibilities, and qualifications; staff training and supervision; and staff structure.
Quality Management and Outcome Measurement	Describes performance improvement process; particularly approaches used to assess and monitor staff performance, procedures used for receiving and resolving member complaints, and any changes made to improve the quality of care coordination.
Initial Assessments	Describes the initial assessment process including the assessment tools used and the processes by which staff and members identify initial needs and goals.
Problem Identification and Care Planning	Questions probe staff on care plans including reasons why care plans may be revised or updated, the frequency with which care plans are formally revised, and the role that a member's providers may play in the care planning.
Service and Resource Arrangement	Details resources and services that are offered to members.
Ongoing Assessments and Monitoring	Describes the general process, medium, and frequency of member contact; notes the use of risk-stratification; details medication management.
Communication and Coordination	Describes provider engagement and management of care transitions.
Member Education	Details teaching strategies and techniques used to educate members about self-care and the approaches used to assess education effectiveness.
Integration of Long-Term Care and Acute Care Services	Describes the process of communicating with primary care providers who refer members to the plan for long-term care services. Also reports on how member information is exchanged between care managers, primary care providers, and specialists.
Integration of Long-Term Care, Acute Care, and Behavioral Health Services	Describes how care managers communicate with providers who authorize behavioral health services.
Clinical Information Systems	Describes the clinical information system and how it is used.
Facilitators and Barriers to Implementation	Details the general successes and challenges that plans have encountered in implementing their programs.

APPENDIX B. SITE PROFILES

Commonwealth Care Alliance--Boston's Community Medical Group

Boston's Community Medical Group (BCMG) provides care for Commonwealth Care Alliance's Disability Care Program (DCP). BCMG provides comprehensive care to approximately 500 adults in the greater Boston area. It specializes in primary care for individuals with involved physical and developmental disabilities, providing both preventative and episodic care. The current model is interdisciplinary and medically focused with a mid-level provider (physician assistant or nurse practitioner) leading the team. Notably, BCMG anticipates expanding its network in 2013 via the Integrated Care Organization (ICO) demonstration in Massachusetts.

Overview	
Target Population	
Service area	Greater Boston[1]
Types of counties served by the plan	Urban
Eligibility criteria	MCO/NHP beneficiaries must be age 18-64, enrolled in MassHealth, and have a disability that results in functional quadriplegia. Although BCMG prioritizes people with physical and developmental disabilities, it no longer adheres to the strict MCO/NHP criteria. Further, BCMG is able to accept people age 65 years and older through its SCO contract. Exclusions include those with end-stage renal disease.
Estimated number of eligible beneficiaries[2]	484 enrollees in "team care" either through NHP, CCA/SCO, or FFS.
Capitation	Until 2010, BCMG operated under a Medicaid risk-adjusted, capitated subcontract with NHP. Payments from Medicaid to NHP were risk-adjusted under a special rate and BCMG was paid a sub-capitation of this capitated rate for all care provided to enrollees for the services BCMG directly provides. In 2010, the state stopped applying this rate for enrollees with severe physical disabilities. Subsequently, NHP stopped enrolling any new members in the DCP. NHP continues to serve as the insurer for the "grandfathered" disability care plan members and BCMG continues to enroll new patients. For new enrollees, BCMG is directly reimbursed through Medicaid FFS, Medicare, or other third-party insurance.
Member Outreach, Participation, and Characteristics	
Total number of enrollees	484 total enrollees; 227 enrollees are in the capitated Medicaid plan (NHP), 211 enrollees are covered by Medicaid FFS, and 46 members are enrolled in the SCO plan.
Percentage dual-eligible status	49%
Primary method of identifying members	BCMG relies on word of mouth and referrals from Centers for Independent Living and other human service providers. The practice is reluctant to engage in marketing because it often has to turn referrals away due to a lack of capacity (i.e., inadequate funding sources and limited FFS reimbursement) or because the referred patient lives outside the service area.
Planned change in approach to identifying members	Yes
When/why planned change will be made	BCMG anticipates expanding its network in 2013 via the ICO demonstration in Massachusetts.
Demographic characteristics[3]	Mean age: 50. Median age: 49.

Overview (*continued*)	
Context	
Local/state/federal policy context	Massachusetts implemented Healthcare Reform in 2006. In 2010, Medicaid took a 5% cut. In 2011-2012, there was another 1% cut. In 2010, Massachusetts Medicaid stopped applying the specific risk-adjustment rate for enrollees with physical disabilities. As a result, NHP discontinued enrollment of CCA disability care plan members.
Local health care labor market	BCMG operates in the greater Boston metro area. There is substantial competition for clinicians in the region. The Boston area has 2 very large health care systems (Partners Health Care and Care Group), as well as many academic medical centers (e.g., Brigham and Women's Hospital, Massachusetts General Hospital, Tufts Medical Center, Boston Medical Center, Children's Hospital, Mass Eye and Ear, the Dana Farber Cancer Institute, and the Joslin Diabetes Center). Further, there are several large provider organizations in the metro area.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. **NOTES**: 1. Arlington, Bedford, Belmont, Boston, Braintree, Brockton, Brookline, Burlington, Cambridge, Canton, Chelsea, Cohasset, Dedham, Everett, Hingham, Holbrook, Hull, Lexington, Lynn, Lynnfield, Malden, Marshfield, Medford, Melrose, Milton, Nahant, Needham, Newton, North Reading, Norwell, Norwood, Quincy, Randolph, Reading, Revere, Saugus, Scituate, Somerville, Stoneham, Stoughton, Swampscott, Wakefield, Waltham, Watertown, Wellesley, Weston, Westwood, Weymouth, Wilmington, Winchester, Winthrop, Woburn. 2. As of September 1, 2012. 3. 15% of enrollees are ages 65 or older. BCMG = Boston's Community Medical Group; CCA = Commonwealth Care Alliance; DCP = Disability Care Program; FFS = fee-for-service; ICO = Integrated Care Organization; MCO = managed care organization; NHP = Neighborhood Health Plan; SCO = Senior Care Options.	

Organizational Features	
Staff/Team Structure	
Types of personnel delivering services	Interdisciplinary team model, including physicians (MD), physician assistants (PA), nurse practitioners (NP), social workers (behavioral health and long-term services and supports [LTSS]), and physical therapy/occupational therapy (PT/OT). Each member is paired with a primary PA/NP (known as a mid-level provider) and a physician. The patient also has an assigned "back-up" mid-level provider. The mid-level provider has primary responsibility for managing that caseload. The physician serves as the patient's PCP. Two clinical supervisors (NPs) who have teams of 5-6 mid-level providers each. Recently hired an RN care coordinator. Entire clinical team meets weekly. The hospital team (i.e., Boston Medical Center family medicine attending) attends the BCMG team meeting to discuss hospitalized patients. NP teams have mini-clinical meetings once per month.
Staff roles and responsibilities	
Executive Director	Oversees all of the operations of BCMG with a particular emphasis on the clinical operations; recruits clinical staff; serves as a resource for clinical supervisors; ensures compliance with internal quality standards and state and federal standards; facilitates site development; oversees budget with the Administrative Director; participates in EMR initiative; board member; oversees ICO expansion.
Medical Director	Oversees all clinical aspects of program; facilitates care model; serves as resource for clinical staff; spearheads the inpatient pilot program.
Administrative Director	Oversees non-clinical functions including: human resources, accounts payable, billing, IT, and the DME department. Participating in ICO expansion activities.

Organizational Features (*continued*)	
Physician Assistant	Serves as lead primary care provider; administers initial assessment and annual comprehensive assessment; attends to primary care needs and care coordination; conducts ongoing monitoring; provides medication assistance (e.g., administration, education, reconciliation); monitors members post-hospitalization; attends physician appointments with members. Position is half patient care and half case management.
Nurse Practitioner	Serves as lead primary care provider; administers initial assessment and annual comprehensive assessment; attends to primary care needs and care coordination; conducts ongoing monitoring; provides medication assistance (e.g., administration, education, reconciliation); monitors members post-hospitalization; attends physician appointments with members. Position is half patient care and half case management.
Registered Nurse	Supports PAs/NPs; coordinates prescription refills, vaccinations, prior authorizations, supply ordering, and home health referrals; provides clinical support to office practice; maintains equipment shared by NPs/PAs for home visits. New addition to care model.
Social Worker	Includes behavioral health and LTSS.
Behavioral Health	Supports the PAs and NPs as needed and conducts behavioral health assessments. Coordinates behavioral health services provided through contracted network including: inpatient care and discharge planning for psychiatric admissions. Can provide "bridge" therapy that is home-based until network services are available or patient is receptive or able to participate.
LTSS	Supports the PAs and NPs as needed; refers members to social supports/community services; coordinates community services.
PT/OT	Overall rehabilitation case managers, which includes liaising with other settings (e.g., day programs, nursing homes, workplaces); sets up exercise programs and regular PT/OT services; conducts physical assessment of patients relative to DME; provides range of motion education; does not provide PT/OT services directly.
DME Coordinator	Serves as the liaison between PT/OT staff, the vendor, and the insurance company (e.g., NHP); assists patients with ordering and delivery of equipment and supplies.
Clinical Education Coordinator	New addition to care model; staffed by a PA; responsible for formalizing and scaling up staff clinical training.
Staff background and education	
Physicians	Medical doctor; board certified in family medicine or internal medicine.
Physicians Assistant	Masters-level staff.
Nurse Practitioner	Masters-level staff; board certified in Adult or Family Medicine.
Registered Nurse	RN license; Bachelors-level staff.
Social Workers	Bachelors-level and Masters-level staff; social workers must have a minimum of a bachelor's degree; behavioral health specialist must be a LICSW or psych clinical nurse specialist. Many staff have some background working with people with disabilities.
Caseload (ratio)	
PA/NP	Average: 40-50. Ideal: approximately 40-45.
PT/OT	Average: 35-40 true actives. Ideal: varies based on acuity.
Behavioral Health	Average: 1:100. Not all active; mix of assessments, support to team, coordination, and short-term treatment.
LTSS	Average varies between 30 and 75. Ideal: 75 could be ideal/comfortable depending on acuity.
Staff/team assignments	Geography is the primary consideration followed by caseload capacity. Clinical supervisors determine the final assignment.
Days/hours staff are available to members	24/7 availability. MD +/- an NP/PA is on call/available outside of business hours (i.e., nights and weekends with capacity for home visits on weekends and holidays).
Availability of experts for consultation	Behavioral health (LICSW), psychiatrist, PT/OT, LTSS; wound care specialist (NP).

Organizational Features (*continued*)	
Training and supervision	Orientation encompasses didactic and field training (i.e., mentorship). Population-specific training is provided via lecture and case review. Future training will include learning modules.
Information Technology	
Major systems used and their primary functions	Logician: BCMG system used for documenting home visits, medication, and diagnoses. Sunrise Clinical Manager: BCMG has access to inpatient team's notes and specialist consults via Sunrise Clinical Manager. CaseNet: BCMG has access to this CCA-SCO system. CaseNet is used as a case management tool for claims generation and as a repository for notes; used for entering service authorizations, documenting home visits, and detail tasks (e.g., reminders for new services). BCMG will be transitioning to eClinicalWorks in the next 6 months.
Use of automated communication/reminders for upcoming contacts and decision support capabilities	Yes. Prompt for medication interactions or allergies; flag system for internal correspondence.
Process for tracking member contacts and assessments	NA
Accessibility of system	All clinicians (including PT/OT, social workers, and RN) have access to Logician. Logician is for internal use only but mid-level providers and MDs are able to access BMC and CCA-SCO records through other systems.
Quality Management and Outcome Measurement	
Efforts to provide data and other types of feedback to staff and providers	Annual performance reviews for staff; chart audits to ensure quality; assessment of inpatient pilot program includes review of costs, readmission rates, and overall hospitalizations.
Reports generated	
Care manager task reminders	No
Member behaviors	No
Clinical indicators/ outcomes	No
Productivity	Yes
Other	Reports from NHP and CCA and some other insurers on HEDIS measures. Manually review charts; some measures are required reporting for BMC credentialing such as HgbA1c, which BCMG manually reviews and reports.
Approaches to making changes to improve quality	Member services department with various processes set up to monitor complaints. Implemented inpatient pilot program. Increased focus on preventative care. Increased focus on end-of-life care; implementing Medical Orders for Life-Sustaining Treatment. Expects that new EMR (i.e., eClinicalWorks) will be used to track outcomes to improve quality. Member services department with various processes set up to monitor complaints.
Assessing member satisfaction	Recently surveyed the patients who had been admitted to BMC (as part of inpatient pilot) and 85% thought their discharge plans were clear and they understood their hospitalization. Recently surveyed entire patient population and 96% reported that they would recommend BCMG to others.

Organizational Features (*continued*)	
Engaging/Recruiting/Retaining Providers	
Types of providers recruited	BCMG is a clinical practice and provides care directly to members. It does not recruit external providers/practices like the other plans.
Approach to recruiting providers	n.a.
Use of advisory board	Yes
Difficulties encountered when recruiting/retaining providers	n.a.
Initial Contact with Member	
Process for making initial contact with member	Patient is contacted regarding basic clinical information and then triaged based on acuity. The referral is given to a mid-level provider who has 2 days to call the patient. The patient should be seen within 2 weeks. The initial visit takes about 1½ hours. After initial assessment, the mid-level provider obtains the patient's records from previous provider, determines the care plan, and presents the patient to the team. Occasionally, the mid-level provider has to schedule a second visit to complete the physical due to time constraints and/or patient cooperation.
Process for and extent of follow-up on initial contact	Clinical judgment.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. BCMG = Boston's Community Medical Group; BMC = Boston Medical Center; CCA = Commonwealth Care Alliance; DME = durable medical equipment; EMR = electronic medical record; HEDIS = Healthcare Effectiveness Data and Information Set; HgbA1c = glycated hemoglobin; ICO = Integrated Care Organization; IT = information technology; LICSW = Licensed Independent Clinical Social Worker; LTSS: long-term care support services; MD = medical doctor; n.a. = not applicable; NA = not available; NHP = Neighborhood Health Plan; NP = nurse practitioner; OT = occupational therapy; PA = physician assistant; PCP = primary care physician; PT = physical therapy; RN = registered nurse; SCO = Senior Care Options.	

Processes of Care	
Initial Assessment	
Tools used	Initial visit documentation form; Patient Health Questionaire-9; Durable Medical Equipment Inventory Checklist; Patient Medical Supply List. Completed by the mid-level provider.
Use of risk-stratification	No
Mode (in-person, telephone, online) and duration of assessment	In-person by the mid-level provider; duration is about 1 hour.
Topics covered during assessment:	Physical exam and history; supplies and equipment needs; supports (e.g., family); urgent health concerns; activities of daily living, medications, diagnoses, safety, preferences.
Formal reassessment	Comprehensive assessment done annually by mid-level provider.
Approach to identifying member needs and goals and tailoring interventions to meet those needs	Somewhat through the traditional physical exam and history, which is tailored to the population. During the initial assessment, the mid-level provider checks in regarding the patient's goals and wishes. The mid-level providers stay in touch with the patients and are accessible.
Care Planning	
Time from assessment to care plan development	Developed during the initial assessment and revised as needed; evaluating the patient needs at every in-person visit.
Who provides input?	The primary care team (i.e., NP/PA and the physician) and the patient. The physician is more involved if care plan involves complex issues (e.g., end-of-life care).
Primary purpose of care plan	The care plan is designed to support the patient's medical and psychosocial needs.

Processes of Care (*continued*)	
Care plan format	The care plan is not formally documented in the EMR but is based on the initial assessment and comprehensive exams that are conducted by the mid-level provider. The plan is documented in the progress note.
Topics covered in care plan	Medical needs; support services; end-of-life care; patient's goals and wishes.
How often/under what circumstances are care plans updated?	Revised when there is a status, setting, or diagnosis change (e.g., a hospitalization).
Accessibility of care plans	Members' care plans are accessible to internal staff only.
Ongoing Monitoring	
Minimum frequency of contacts with member	Comprehensive assessment is completed by mid-level provider annually.
Typical frequency of contact with member	On average, patients are seen once a month. Contact varies based on need and is guided by clinical judgment. Change in condition guides the frequency of contact.
Use of risk-stratification to guide frequency of contact	No. PAs/NPs use clinical judgment.
Mode of member contact (mail, phone, in-person, online)	Varies by member, but typically in-person.
Average duration of real-time contact	Varies depending on members' needs.
Most common topics covered during monitoring contact	Follow-up on specific diagnoses (e.g., diabetes), make adjustments to medication regimen, and monitor medications.
Communication and Coordination with Providers	
How (formal/informal, telephone/in-person, group meetings/individual conversations), how often, and with whom (e.g., physicians, other providers) staff communicate about the member	Communication varies by member. A PA/NP may communicate with internal behavioral health personnel, LTSS personnel; PT/OT and/or the MD. PAs/NPs also communicate with specialists. PAs/NPs have access to members' medical records and use the record to communicate with providers.
Attends appointments with members?	PAs/NPs will often attend the specialist visits.
Role as communications hub across physicians and other care providers (e.g., specialists, home care, community agencies, skilled nursing facilities, assisted living facilities)	Mid-level provider communicates with subspecialists, most commonly urologists, pulmonologists, and GI and renal specialists. Staff are encouraged to work collaboratively.
Programs' expectations of physicians and other providers	
Participate in care planning (provide input to or review care plans)	BCMG physicians participate in care planning.
Respond to requests	Yes
Call staff with new member information	No
Member Education	
Topics covered in member education (particularly concerning medication adherence, disease education, symptom and self-care monitoring, and consumer empowerment)	Wound care; prevention of pressure ulcers; autonomic dysreflexia; nutrition education; range of motion; medication.
Who provides education?	Mid-level, PT/OT.
Degree of structure in curriculum and materials	None

Processes of Care (*continued*)	
Efforts to tailor education to individual members	Yes
Use of behavior modification or motivational interviewing	No
How program assesses effectiveness of education	Demonstration, verbal teach-back, outcomes (e.g., proper use of pressure-relieving devices will result in prevention of pressure sore).
Service and Resource Management	
Range of services offered	Acute care, preventative care, and long-term care services, including in-home services. Care coordination for PT/OT, durable medical equipment, social services, mental health services, nursing home care, and support services.
Community resources arranged for/referred to most frequently	Housing; assisting with MassHealth applications.
Role in monitoring receipt of services and for making referrals (or arrangements)	Yes. Mid-level provider makes the referral.
Management of Care Transitions	
How program learns about adverse events such as ED visit or hospital, skilled nursing facility, or rehabilitation admission	The mid-level providers are notified regarding an ED visit or admission via 2 mechanisms: (1) The mid-level provider calls into the ED with an "expect" to identify the diagnosis and the patient is subsequently admitted; or (2) the mid-level directly admits the patient to the BCMG floor. If patient goes to the ED/is admitted to BMC without consultation from the mid-level, the mid-level is still notified. If the patient goes to the ED/is admitted to another hospital, the mid-level may not be notified; the patient, a family member, or case manager may notify the mid-level of an admission elsewhere. BCMG has a board in the office that is updated daily regarding discharges. The primary mid-level is also notified by the floor team.
Overall approach to transition management	BCMG highly encourages the patients to reach out to their mid-level provider prior to coming to the ED for any non-emergent issues. The mid-level is expected to be involved regarding the discharge. Currently, the mid-level facilitates all transitions. The RN care coordinator is expected to assist with care transitions in the future.
Does program visit members in hospital or communicate with hospital staff during admission? If so, for what purpose?	Yes, there is daily communication between the floor staff and the primary mid-level provider to ensure that providers have a shared understanding of the member's condition (e.g., baseline status), medications, and discharge plans. The mid-level provider does not draft the discharge plan.
Does program visit members at home after discharge?	Yes
Does program follow-up with member subsequent to initial post-discharge visit? If so, where, when, and for what purpose?	Yes, mid-level providers must visit patients in their home within 24 hours after discharge. The primary purpose of this visit is medication reconciliation and to see the patient's condition. The frequency of future contact varies depending on the member's condition.
Does program use a care transitions protocol? If so, what is included?	Yes. The program has a policy in place that anyone discharged needs to be seen in person within 24 hours. The care transition "flow" is a documented protocol.
Does program assess whether protocol is followed and if so, how?	No data collection is possible from the EMR. However, all discharges are discussed at the team meeting and the NP/PA must report on the member's status following discharge.
Medication Management	
Sources of information on medications taken	Members; BMC EMR.
Approach to updating information on medications taken	Any time there is a change in care, the mid-level provider does medication reconciliation. PA/NP can write orders directly.

Processes of Care (*continued*)	
Approach to medication reconciliation to identify redundant medications and discrepancies between prescribed medications and medications actually taken	PAs/NPs make adjustments within clinical guidelines (e.g., if someone has diabetes, the NPs check their HgA1C every 3 months). At a minimum, medication reconciliation occurs "a few" times per year. There is no formal minimum requirement.
Approach to reconciling medications following ED visit or inpatient admission	Medication reconciliation should take place after any ED visits or inpatient admissions.
Does program provide medication adherence devices and supports?	Yes. Pill boxes and medication support by a PCA are available.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. BCMG = Boston's Community Medical Group; BMC = Boston Medical Center; ED = emergency department; EMR = electronic medical record; GI = gastrointestinal; HgbA1c = glycated hemoglobin; LTSS: long-term care support services; MD = medical doctor; NP = nurse practitioner; OT = occupational therapy; PA = physician assistant; PCA= personal care assistant; PT = physical therapy; RN = registered nurse.	

Major Changes Over Time
Started as a small pilot in 1980 and became BCMG in 1988. Now is a 501(c)(3) affiliate of CCA.
PAs were brought on approximately 10 years ago. Previously model supported NPs as mid-level providers.
BCMG has continually added in more supports to the basic home care model including behavioral health, housing supports, and other long-term support systems.
In 2010, Massachusetts stopped applying an increased reimbursement rate for enrollees with severe physical disabilities. Subsequently, NHP stopped enrolling any new members and BCMG now supports care for some enrollees via FFS reimbursement.
In 2010, BCMG implemented the inpatient pilot program. BCMG now collaborates with BMC family medicine attending. Nearly all BCMG inpatients are seen by the family medicine service.
In 2012, an RN care coordinator was added to the care model.
BCMG anticipates expanding its network in 2013 via the ICO demonstration in Massachusetts.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. BCMG = Boston's Community Medical Group; BMC = Boston Medical Center; CCA = Commonwealth Care Alliance; FFS = fee-for-service; ICO = Integrated Care Organization; NHP = Neighborhood Health Plan; NP = nurse practitioner; PA = physician assistant; RN = registered nurse.

Unique Features
PAs/NPs are the patient's primary provider. They assess, diagnose, intervene (e.g., write prescriptions) and evaluate.
PAs/NPs are making the referral to subspecialists so they are able to track and follow-up with the patient.
Implemented inpatient pilot program; nearly all BCMG patients are seen by same service. PAs/NPs have access to EMRs at BMC. Relationship with BMC helps to ensure smoother care transitions.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. BCMG = Boston's Community Medical Group; BMC = Boston Medical Center; EMR = electronic medical record; NP = nurse practitioner; PA = physician assistant.

Commonwealth Care Alliance--Senior Care Option

Commonwealth Care Alliance-Senior Care Option (CCA-SCO) serves six Massachusetts counties. The plan offers both acute and long-term care services and targets individuals with complex needs. The first SCO enrollment was in 2004. Although the model of care has evolved over time, the current model is interdisciplinary and medically focused, with a nurse practitioner leading the team. Since its inception in 2004, CCA-SCO has always integrated care teams led by nurse practitioners into primary care practices that share its philosophy of care.

Overview	
Target Population	
Service area	Essex and Suffolk counties, parts of Hampden, Middlesex, Norfolk, and Plymouth counties in Massachusetts.
Number of counties served by the plan	6
Types of counties served by the plan	Urban
Eligibility criteria	Beneficiaries must be 65 years of age or older, qualify for MassHealth Standard or be dually eligible, and reside within the service area. Exclusions include: people with MassHealth Basic, Limited, and Essential, those with end stage renal disease, and undocumented immigrants.
Program's estimate of number of eligible beneficiaries[1]	Approximately 77,000.
Capitation	Capitated for all services (Medicare D-SNP).
Member Outreach, Participation and Characteristics	
Total number of enrollees	4,440. Over 70% of members are nursing home certifiable.
Percentage dual-eligible status	95% are dual-eligible; approximately 5% are MassHealth only.
Primary method of identifying members (identify state restrictions if applicable)	All members have indicated that they are interested in learning more about the program prior to solicitation. This information is obtained through providers, outreach and education meetings, etc. CMS regulations prohibit direct solicitation.
Planned change in approach to identifying members	No
When/why planned change will be made	n.a.
Demographic characteristics	Mean age: 77. Median age: 76. English-speaking members are the minority. Members' primary languages include: English (35-40%), Spanish (35-40%), and Russian (5-8%). Some members speak Haitian Creole or Vietnamese.
Local/state/federal policy context	Massachusetts implemented Healthcare Reform in 2006. In 2010, Medicaid took a 5% cut. In 2011-2012 there was another 1% cut. Currently, SCO is running at 2006 rates. Massachusetts requires that the CCA-SCO program has 1 Member Services telephone number. The "team" model of care is a contractual requirement of the state. ASAPs are one-stop entry points for all of the support services and benefits available to seniors in Massachusetts (e.g., home care services, housing options, public benefits, legal assistance). These agencies provide information, applications, direct services, and referrals. GSSCs work for ASAPs.

Overview (*continued*)	
Local health care labor market	Since the majority of members do not speak English, SCO tries to recruit health care providers who are bilingual. A translator is used when that is not possible.

SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012.
NOTE:
1. As of September 1, 2012.

ASAP = Aging Services Access Point; CCA = Commonwealth Care Alliance; CMS = Centers for Medicare and Medicaid Services; D-SNP = Dual Eligible Special Need Plans; GSSC = Geriatric Social Service Coordinator; n.a. = not applicable; SCO = Senior Care Options.

Organizational Features	
Staff/Team Structure	
Types of personnel delivering services	Care is delivered through an interdisciplinary team model, including PCPs, NPs and/or RNs, and GSSCs. The NP is the team lead. GSSCs work as part of the interdisciplinary care team. The clinical group in the East has 6 SCO teams; the West has 10 teams. The overall team model has not changed since 2004.
Staff roles and responsibilities	
Senior Vice President	Ensures continued focus on and success of SCO program during the expansion via the ICO demonstration; facilitates site development.
Clinical Director	Ensures compliance with internal quality standards and state and federal standards; ensures site is appropriately staffed; facilitates site development; serves as resource for clinical supervisors.
Provider Network Manager	Recruits and maintains the provider network; works with other senior leaders regarding strategy/decisions to expand to additional sites.
Nurse Practitioner	Serves as medical lead on care teams; administers GA, conducts care planning and ongoing monitoring; provides medication assistance (e.g., administration, education, reconciliation); monitors members post-hospitalization; may attend physician appointments with members.
Registered Nurse	Administers MDS; can assist NP with the administration of GA; conducts ongoing monitoring; supports NPs; newer addition to care model.
Social Worker	Part of the behavioral health team; supports the NPs and RNs as needed; assists in referring members to community-based behavioral health resources; conducts behavioral health assessments.
GSSC	Assesses members' psychosocial and ADL needs. Provides expertise on community-based long-term care services that are available for the enrollees. GSSCs do not work with members who are residing in nursing homes. All staff may make home visits as appropriate.
Staff background and education	
Nurse Practitioner	Masters-level staff (some are board certified as Adult NPs).
Registered Nurse	RN license (usually BSN).
Social Worker	Masters-level staff (some are licensed counselors).
GSSC	Bachelors-level staff. Several GSSCs are working toward social work licensure. However, a specialized/masters-level degree is not required. Many staff have some background in home care or working with the frail, elderly, and/or people with disabilities. There are no minimum requirements.

Organizational Features (*continued*)	
Caseload (ratio)	
GSSCs	Ideal: approximately 50. Average 90-120.
NP	Ideal: 60-100. Average: 65-75.
RN	Approximately 50.
Social workers	Fluid caseload
Staff/team assignments	At the first of the month, the enrollment nurse and clinical director review the caseloads of all NPs. They try to match members to a staff member based on their PCP. Fit with the NP is also important.
Days/hours staff are available to members	On-call service, 24/7; during business hours, calls go to CCA Member Services, and after hours calls go to on-call clinicians.
Availability of experts for consultation	Behavioral health, PT/OT.
Training and supervision	Orientation encompasses didactic and field training (i.e., shadowing with a preceptor). Information is also provided regarding the history of SCO and the uniqueness of the SCO program. Disability education is informal. Plan leadership expects staff to have the ability to do a thorough functional and home safety assessment and be attentive to the members' culture and their spoken language. Complaints and/or frequent hospitalizations are used to assess gaps in the knowledge of the staff members.
Information Technology	
Major systems used and their primary functions	CaseNet: mainly a case management tool used for claims generation and as a repository for clinical notes; used for entering service authorizations, documenting home visits, and detail tasks (e.g., reminders for new services). Epic/Primary care site EMR: providers use for documenting assessments and treatment. Staff obtain credential for a site (e.g., CHA) and then can access records via Epic.
Use of automated communication/reminders for upcoming contacts and decision support capabilities	Yes
Process for tracking member contacts and assessments	Yes
Accessibility of system	CaseNet is for internal use only. However, staff are able to share records with primary care sites.
Quality Management and Outcome Measurement	
Efforts to provide data and other types of feedback to staff and providers	Site-specific reports that are reviewed on a quarterly basis. Report includes patient information (e.g., number of patients, demographics, risk scores), total medical expenses, hospitalizations (per 1,000 per year), and ED visits (per 1,000 per year). Reports detail outcomes by patient and by population (e.g., ambulatory, nursing home).
Reports generated	
Care manager task reminders	No
Member behaviors	No
Clinical indicators/outcomes	Yes
Productivity	Yes
Other	HEDIS measures by site annually; adherence to CMS regulations.

Organizational Features (*continued*)	
Approaches to making changes to improve quality	Member services department with various processes set up to monitor complaints and disenrollment. Recent focus on care transitions. Considering stratifying members. Implemented evidence-informed practices including palliative care program, Stanford Chronic Disease Self-Management Program (as of 2006), and Stanford Diabetes Self-Management Program (as of 2012).
Assessing member satisfaction	Local consumer meetings to assess member satisfaction (about 12 per year).
Engaging/Recruiting/Retaining Providers	
Types of providers recruited	All types of health care providers; additionally, community-based long-term care vendors such as personal care, home care, and nursing homes.
Approach to recruiting providers	Uses 3 methods to recruit providers: (1) delegated sites; (2) non-delegated sites;[1] and (3) word of mouth. Primary care sites are offered an aligned financial incentive. There is an emphasis on building strong relationships. Providers must support the philosophy and mission of SCO.
Use of provider advisory board	Board of Directors, not an advisory board.
Difficulties encountered when recruiting/retaining providers	Reimbursement may be less generous. Tries to engage providers and primary care sites in conversation regarding the benefits of the program.
Initial Contact with Member	
Process for making initial contact with member	Enrollment nurse makes contact to discuss the case and complete the MDS.
Process for and extent of follow-up on initial contact	Clinical judgment and NP preference. Some NPs increase the frequency of contact initially to establish the relationship (i.e., see the member 2-3 times per week for the first few weeks of enrollment).

SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012.

NOTE:

1. Delegated sites were the original SCO sites. These sites had team models of care and were delegated the responsibility for delivering the program. At these sites, staff work directly for the primary care site; business arrangements recognize this structure. Non-delegated sites lacked experience with the aforementioned model of care (i.e., care teams and capitated payments for services). The care management staff at non-delegated sites work for CCA directly (e.g., Cambridge Health Alliance) and complement the care provided by the contracted PCP. These sites are mission aligned and there are SCO teams integrated into those practices.

ADL = activities of daily living; BSN = Bachelor of Science in Nursing; CCA = Commonwealth Care Alliance; CHA = Cambridge Health Alliance; CMS = Centers for Medicare and Medicaid Services; ED = emergency department; EMR = electronic medical record; GA= Geriatric Assessment; GSSC = Geriatric Social Service Coordinator; HEDIS = Healthcare Effectiveness Data and Information Set; ICO = Integrated Care Organization; MDS = minimum data set; NP = nurse practitioner; OT = occupational therapy; PCP = primary care physician; PT = physical therapy; RN = registered nurse; SCO = Senior Care Options.

Processes of Care	
Initial Assessment	
Tools used	MDS: completed by enrollment nurse. GA: ICD-9 codes are the foundation; used as a tool to capture the members' diagnoses for submission to Medicare. The GA must be completed by an NP; the RN may assist the NP in completing the GA.
Use of risk-stratification	No
Mode (in-person, telephone, online) and duration of assessment	In-person by the NP; duration is about 1 hour.

Processes of Care (*continued*)	
Topics covered during assessment	Physical exam, vital signs, activities of daily living, medications, diagnoses, safety, preferences.
Formal reassessment	GA is done annually.
Approach to identifying member needs and goals and tailoring interventions to meet those needs	All care team members ask members if they have specific goals. These goals are the center of the care planning function.
Care Planning	
Time from assessment to care plan development	The care plan is done during the GA visit and revised as needed (e.g., a setting or life change).
Who provides input?	The member and all staff on the care team; NP is the lead.
Primary purpose of care plan	The care plan is designed to support the members' health care needs based on their functional assessment, diagnosis, and living situation. There is 1 care plan.
Care plan format	Care plans can be based on the GA as well as the MDS.
Topics covered in care plan	GSSCs organize the support services with various vendors.
How often/under what circumstances are care plans updated?	The care plan is revised when there is a status, setting, or diagnosis change. The care plan must be reviewed every 6 months; however, many are revised more frequently.
Accessibility of care plans	Members' physicians can receive a copy of the care plan.
Ongoing Monitoring	
Minimum frequency of contacts with member	The GA is completed at least once per year. This is in-person and must be done by the NP and/or PCP. The MDS is completed 2 times per year. The MDS must be done by an RN.
Typical frequency of contact with member	Contact varies based on need and is guided by clinical judgment; any change in condition also guides the frequency of contact.
Use of risk-stratification to guide frequency of contact	No, NPs use clinical judgment.
Mode of member contact (mail, phone, in-person, online)	Varies by member, but typically in-person.
Average duration of real-time contact	Varies depending on members' needs.
Most common topics covered during monitoring contact	Follow-up on specific diagnoses (e.g., diabetes), make adjustments to medication regimen, and monitor medications.
Reasons for changes to frequency or mode of contact	Hospitalization and/or change in condition (e.g., fall, change in placement); psychosocial issues may increase the frequency of contact.
Use of protocol for ongoing monitoring	Clinical judgment.
Communication and Coordination with Providers	
How (formal/informal, telephone/in-person, group meetings/individual conversations), how often, and with whom (e.g., physicians, other providers) staff communicate about the member	Communication varies by member; an NP may communicate with behavioral health personnel and the PCP. NPs have access to members' medical records and use the record to communicate with providers. The GSSC will most often email the NP. Communication between GSSC and NP varies based on member acuity.
Attends appointments with members?	NPs accompany member on a physician visit occasionally. If there is a complication, an NP will go with the member to the visit. More often, NPs go to a specialty appointment.
Role as communications hub across physicians and other care providers (e.g., specialists, home care, community agencies, skilled nursing facilities, assisted living facilities)	Staff attempt to communicate with providers and are encouraged to work collaboratively.

Processes of Care (*continued*)	
Programs' expectations of physicians and other providers	
Participate in care planning (provide input to or review care plans)	PCPs are always welcome to participate in the care planning process if/when they have time and are available, either virtually or in-person. Communication is often via technology.
Respond to requests	Yes, providers are responsive.
Call staff with new member information	No
Member Education	
Topics covered in member education (particularly concerning medication adherence, disease education, symptom and self-care monitoring, and consumer empowerment)	Medication; self-monitoring of chronic conditions; consumer empowerment.
Who provides education?	NP and RN; the Health Education and Training department offers the Stanford Chronic Disease Self-Management and Diabetes Self-Management programs.
Degree of structure in curriculum and materials	Stanford provides structure and content for this program that CCA follows.
Efforts to tailor education to individual members	Yes, observed NP and RN tailor education to member and educate family.
Use of behavior modification or motivational interviewing	Not currently; integrating motivational interviewing into training.
How program assesses effectiveness of education	NPs assess education using teach-back method.
Service and Resource Management	
Range of services covered	SCO is capitated for everything; thus, it covers all services including acute care, preventative care, and long-term care services including in-home services (nursing care, personal care, medication assistance), occupational/physical/ speech therapy, durable medical equipment, social services, mental health services, and nursing home care. GSSC coordinates the community-based support services including: homemaker services, life-line service, grocery shopping, laundry, non-emergency transport, and adult day services.
Community resources arranged for/referred to most frequently	The GSSC plays a large role in arranging community resources. The most commonly requested GSSC service is homemaking.
Role in monitoring receipt of services and for making referrals (or arrangements)	Yes. In particular, the GSSC typically communicates with the vendors recruiting support services.
Management of Care Transitions	
How program learns about adverse events such as ED visit or hospital, skilled nursing facility, or rehabilitation admission	The NP receives a fax including a list indicating a hospitalization or ED visit; list is received Monday through Friday at 7:30 a.m.; this process began recently.
Overall approach to transition management	As of June 2011, transition coordinator visits the hospital daily to interact with providers and attend rounds. Previously, the expectation was that the primary NP/RN would follow the patient across settings. The NP and GSSC collaborate regarding transition management. The NP and GSSC would likely do a joint visit after a setting change.
Does program visit members in hospital or communicate with hospital staff during admission? If so, for what purpose?	Yes, to ensure that providers have a shared understanding of the member's condition (e.g., member's baseline status), medications, and discharge plans; to ensure that members understand plans for discharge follow-up.
Does program visit members at home after discharge?	Yes

Processes of Care (*continued*)	
Does program follow-up with member subsequent to initial post-discharge visit? If so, where, when, and for what purpose?	Yes, visit members in their home within 48 hours after discharge to anticipate problems that could lead to an unexpected readmission. The primary purpose is medication reconciliation and to see their condition.
Does program use a care transitions protocol? If so, what is included?	Yes. The program has a policy in place that anyone discharged needs to have a 48-hour visit. Policy was implemented in about 2007.
Does program assess whether protocol is followed and if so, how?	Yes
Medication Management	
Sources of information on medications taken	NPs can access members' EMR; members; members' families or caregivers.
Approach to updating information on medications taken	NPs interact with the members' physicians regarding medications. NPs can write orders directly in the EMR.
Approach to medication reconciliation to identify redundant medications and discrepancies between prescribed medications and medications actually taken	NPs check/make adjustments within clinical guidelines (e.g., if members have diabetes NPs check their HgA1C every 3 months). At a minimum medication reconciliation is done annually. Medication reconciliation could be done by the RN. There is no formal protocol for ensuring it is done at every visit.
Approach to reconciling medications following ED visit or inpatient admission	Medication reconciliation should take place during every visit and is not specific to ED visits or inpatient admissions.
Does program address medication affordability problems? If so, how are they identified and how are they addressed?	There is no charge to any member for any medication.
Does program provide medication adherence devices and supports?	Yes. "Meds on Time," a medication dispenser, and medication support by a PCA are available.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. CCA = Commonwealth Care Alliance; ED = emergency department; EMR = electronic medical record; GA= Geriatric Assessment; GSSC = Geriatric Social Service Coordinator; HgbA1c = glycated hemoglobin; ICD-9 = International Classification of Diseases, 9th edition; MDS = minimum data set; NP = nurse practitioner; PCA= personal care assistant; PCP = primary care physician; RN = registered nurse; SCO = Senior Care Options.	

Major Changes Over Time
In 2004, CCA began looking at "model" primary care sites (e.g., PACE). It effectively reached out to these model primary care sites. CCA "delegated" the SCO program at only these model sites initially. CCA has since partnered with "non-delegated" sites (as of 2005-2006).
In 2006, CCA hired its first NP who eventually transitioned to the team lead and site manager. An NP is the clinical director.
In 2011, CCA hired a care transition manager who facilitates transition across various settings (e.g., hospital to home or hospital to skilled nursing facility).
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. CCA = Commonwealth Care Alliance; NP = nurse practitioner; PACE = Program of All-Inclusive Care for the Elderly; SCO = Senior Care Options.

Unique Features
The first SCO enrollment was in 2004 and at that time all sites were "delegated," meaning they were already offering "model" care.[1]
NPs are able to practice their full license. For example, they assess, diagnose, intervene (e.g., write prescriptions) and evaluate.
NPs have access to EMRs at primary care practice sites/hospitals.
The values of CCA and the non-delegated sites must be aligned.
SCO tries to have exclusive relationships with its non-delegated primary care sites (i.e., CCA is the primary SCO contracted with CHA).
Each primary care site has a PCP(s) who support(s) the program (i.e., a champion).
Pays careful attention to enrollment to ensure that the SCO program is appropriate for the potential member and family.
Offers evidence-based programs (e.g., diabetes program).
ICD-9 codes are the foundation of the main assessment tool (i.e., GA).
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. **NOTE**: 1. In this context, "model" care is defined as an integrated model of care designed to enable Medicare and Medicaid to serve older beneficiaries more effectively by offering a more comprehensive (and even tailored) set of services. In other words, sites that were providing continuous care and services, offering individuals eligible for nursing home care the option of continuing to live in the community. CCA = Commonwealth Care Alliance; CHA = Cambridge Health Alliance; EMR = electronic medical record; GA= Geriatric Assessment; ICD-9 = International Classification of Diseases, 9th edition; NP = nurse practitioner; PCP = primary care physician; SCO = Senior Care Options.

Community Health Partners

Community Health Partners (CHP) serves five counties in central Wisconsin: Chippewa, Dunn, Eau Claire, Pierce, and St. Croix. CHP is expected to close as of January 2013 as the state will not renew its contract. At the time of the site visit, CHP operated 2 health plans: Partnership Program and Family Care. The Partnership Program offered both acute and long-term care services while Family Care offered long-term care services only. CHP began in 1997 as a waiver demonstration program modeled after the PACE program with some variations such as the use of a nurse practitioner. CHP obtained an HMO license in 2005. Although CHP wanted to exclusively maintain its Partnership model, the state pushed the development of the Family Care model. As of 2009, CHP has implemented both models (Partnership and Family Care). The Family Care benefit currently includes individuals who have a nursing home level of care and those who have a non-nursing home level of care.[38]

Overview	
Target Population	
Service area	Chippewa, Dunn, Eau Claire, Pierce, and St. Croix counties in Wisconsin
Number of counties served by the plan	5
Types of counties served by the plan	Rural and some urban
Eligibility criteria	Enrollees must be at least 65 years old, or 18 years old and have a developmental and/or physical disability and have long-term care needs; meet functional and financial requirements; be Medicaid eligible; and reside in 1 of the 5 counties above.
Program's estimate of number of eligible beneficiaries	6,888[1]
Capitation	Capitated for both Medicaid and Medicare, if applicable.[2] CHP is responsible for nursing home care but members can withdraw at any time.
Member Outreach, Participation and Characteristics	
Total number of enrollees	2,804[3]
Percentage dual-eligible status:	Partnership (85%); Family Care (76%).
Primary method of identifying members	Members are referred by the Aging and Disability Resource Centers; limited community outreach to vendors.
Planned change in approach to identifying patients	No, state restrictions preclude marketing.
When/why planned change will be made	n.a.
Demographic characteristics	Mean age: Partnership (66); Family Care (53). Median age: Partnership (68); Family Care (53).

[38] Less than 100 members enrolled in CHP are non-nursing home level of care members.

Overview (*continued*)	
Context	
Local/state/federal policy context	Wisconsin is a strong county-based state with 72 counties. Wisconsin requires the use of the Resource Allocation Decision (RAD) method to ensure that services are effective and cost-efficient. Self-Directed Services have been available since 2001. The "Self-Directed Option" rests within the mainstay of Family Care managed care program. CMS required that the state establish an alternative to the Family Care program. As a result, IRIS (Include, Respect, I Self-Direct) was launched in the summer of 2008 as an alternative to a managed care organization that features self-direction. In 2009, members who were eligible for non-nursing home level of care were enrolled in Family Care. This transition was made across all managed care organizations in Wisconsin.
Local health care labor market	Nurse practitioners are difficult to recruit.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. **NOTES**: 1. Estimate reported by program staff, includes both members and eligible non-members in the service area. 2. If dual-eligible, then CHP gets a capitated Medicare payment, in addition to the capitated Medicaid payment. 3. As of January 1, 2012. CHP = Community Health Partners; CMS = Centers for Medicare and Medicaid Services; IRIS = Include, Respect, I Self-Direct; n.a. = not applicable; RAD = resource allocation decision.	

Organizational Features	
Staff/Team Structure	
Types of personnel delivering services	Both Partnership and Family Care use an interdisciplinary team. Partnership includes NPs, RNs, and SSCs. Family Care does not include NPs. Team designations include: Traditional, Facilities, and ACE. Typically, Family Care teams include 2 pairings of an RN and an SSC. Partnership teams include these pairings as well as an NP. Facilities teams serve members residing in facilities such as nursing homes and residential settings. ACE teams have a different structure in that RNs and SSCs are not paired and everyone on the team is familiar with all members. CHP has 40 care teams.
Staff roles and responsibilities	
Program Director	Oversees care provided by teams, serves as resource for clinical supervisors, and ensures compliance.
Clinical Supervisor	Manages and supports teams in the provision of direct care; ensures cost-effectiveness of teams' interventions.
Nurse Practitioner	Serves as medical lead on care teams, conducts annual history and physical, monitors members post-hospitalization and temporarily in nursing homes, attends physician appointments with members, and provides wound care as needed.
Registered Nurse	Conducts assessment, care planning, ongoing monitoring, medication assistance (e.g., administration, education, reconciliation), post-hospitalization monitoring, care coordination, and long-term care functional screening.
Social Services Coordinator	Conducts assessment, care planning, ongoing monitoring, and care coordination; identifies and arranges community resources.
Transition Planner	Facilitates transitions across care settings. Position has been in place for the past 5 years.
Associate	Formerly referred to as team assistant; functions in member support, clinical support, or clinical information; NPs have designated associates.
Employment Services Coordinator	Provides staff training and serves as resource for addressing members' vocational needs.

Organizational Features (*continued*)	
Self-Directed Services staff	Serves as resource for teams in assisting members with self-directed care options.
Decision Support Services staff	Conduct technical and analytical aspects of data collection, management, and reporting.
Wound Care Nurse	Provided wound care coordination for members from 2008-2011.
Staff background and education	SSCs must have a 4-year degree, social work preferred; RNs must meet minimum state licensure requirements and have an active license.
Caseload (ratio)	
Traditional Team	Ideal: RN 17-18, SSC 30-35, NP 90-100. Average: RN 18, SSC 35, NP 138.
Facilities Team	Ideal: RN 40, SSC 45. Average: RN 60, SSC 45.
ACE Team	Ideal: SSC/RN 30. Average: SSC/RN 30 (lead member responsible for 16-20 members), NP 84-125. Family Care caseloads are typically higher than Partnership caseloads.
Staff/team assignments	Mostly based on geography; RNs and SSCs work in pairs on Traditional and Facilities teams; ACE teams designate either an RN or SSC as the lead for members. These designations are based on member complexity and needs.
Days/hours staff are available to members	On-call service available outside of business hours.
Availability of experts for consultation	Pharmacist, developmental disability coordinator, transition planners, medical director, psychologist, geriatric psychiatrist, and physical therapist.
Training and supervision	Orientation includes didactic, online, and field training. Disability education is provided in a 5-part series. Direct care staff are not assigned members until after 1 month of field observation. CHP transitioned to supervising by team rather than by discipline about 4 years ago.
Information Technology	
Major systems used and their primary functions	EMR includes 2 separate systems: Allscripts, a case management system, and OnBase, a document management system. Prior to January 2012, used VPrime. Allscripts: generally used for documenting member contacts, assessments, and treatment planning. OnBase: program that contains supporting documents such as medical records, providers' treatment plans, and prescriptions. Lync: a Microsoft interactive communication software application available on tablets that has teleconference and instant messaging capabilities. Store-In: medication management software system. Statistics and Other Financial Information (Sofi): data management system. CHP Intranet: provides staff with resources and serves as a vehicle for communication.
Process for tracking member contacts and assessments	Data are pulled from the EMR to assess contacts and timeliness of assessments, and reports that specify completed and uncompleted tasks are generated.
Use of automated communication/reminders for upcoming contacts and decision support capabilities	Appointment reminders for care managers.
Accessibility of system	Internal access to EMR.
Quality Management and Outcome Measurement	
Efforts to provide data and other types of feedback to staff and providers	Quality management committee; clinical excellence committee; chart audits conducted by directors; and annual quality review. Clinical supervisors conduct a home visit with staff at least annually; feedback provided during team meetings.
Reports generated	
Care manager task reminders	Yes

Organizational Features (*continued*)	
Member behaviors	No
Clinical indicators/outcomes	Yes
Productivity	Yes
Other	Adherence to CMS regulations; HEDIS measures.
Approaches to making changes to improve quality	Nursing Home Initiative to reduce the number of days members spend in nursing homes (January 2012). Evaluation of the ACE model.
Assessing member satisfaction	Satisfaction surveys; address complaints with team and member.
Engaging/Recruiting/Retaining Providers	
Types of providers recruited	Personal care, home care, residential, vocational, nursing homes.
Approach to recruiting providers	Word-of-mouth, emphasis on building strong relationships, providers must support philosophy and mission of CHP.
Use of provider advisory board	Yes, since 2012.
Difficulties encountered when recruiting/retaining providers	CHP explains upcoming changes to providers to ensure effective transitions (for example, changes in reimbursement); as long as providers understand the rationale for the changes, they are supportive.
Initial Contact with Member	
Process for making initial contact with member	SSC contacts member via telephone within 3 days of enrollment to schedule an in-person visit.
Process for and extent of follow-up on initial contact	Within 10 days of enrollment, SSC and RN conduct in-person visit with the member to identify major concerns, medications, and services for which member qualifies; complete personal and home care task list assessment.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. ACE = Alternative Configuration Experimentation; CHP = Community Health Partners; CMS = Centers for Medicare and Medicaid Services; EMR = electronic medical record; HEDIS = Healthcare Effectiveness Data and Information Set; NP = nurse practitioner; RN = registered nurse; SSC= social service coordinator.	

Processes of Care	
Initial Assessment	
Tools used	Comprehensive assessment including home safety assessment and mental status examination is completed by RN and SSC. NP completes a history and physical examination for Partnership members.
Use of risk-stratification	No
Mode (in-person, telephone, online) and duration of assessment	In-person; 45 minutes to a few hours depending on member.
Topics covered during assessment	Physical health, emotional health, cognitive functioning, employment, environment/safety, activities of daily living/instrumental activities of daily living, vocational interests, medications, diagnoses, supports, strengths, and preferences.
Formal reassessment	Mini-mental status examination completed annually or with change in cognition; long-term care functional screen is reviewed after the first 90 days and then is conducted annually or after a qualifying event (e.g., hospitalization, fall); comprehensive reassessment is completed every 6 months.
Approach to identifying member needs and goals and tailoring interventions to meet those needs	Teams identify outcomes in collaboration with the members; this process is ongoing.
Care Planning	
Time from assessment to care plan development	The MCP is developed during initial visit.
Who provides input?	Member; providers if medical order is required. At 6-month review, staff try to discuss MCP with providers, day service providers, and family members.

Processes of Care (*continued*)	
Primary purpose of care plan	To identify member outcomes and guide care.
Care plan format	The MCP is an electronic template that is individualized to each member. The template is available on the CHP intranet.
Topics covered in care plan	Frequency of team contact, personal outcomes, services and supports necessary to achieve outcomes, providers, living arrangements, relationships, physical health and wellness, and date of most recent long-term care functional screen.
How often/under what circumstances are care plans updated?	MCP is reviewed during every in-person contact and revised as needed, if a service is reauthorized, if member identifies another goal, or if change in condition occurs.
Formal reassessment	Every 6 months and annually.
Accessibility of care plans	Member receives copy of care plan every 6 months and annually. Physicians do not routinely receive a copy of the member's care plan unless they request it.
Ongoing Monitoring	
Minimum frequency of contacts with member	Quarterly by either SSC or RN. RN must visit member every 6 months and annually.
Typical frequency of contacts with member	Quarterly, but varies based on members' needs; members can be seen as frequently as weekly.
Use of risk-stratification to guide frequency of contact	No, determined by clinical judgment.
Mode of member contact (mail, phone, in-person, online)	Quarterly visits are in-person; other modes are used as needed.
Average duration of real-time contact	Varies depending on members' needs.
Most common topics covered during monitoring contact	Review of MCP and needed services and medications; assessment of physical and mental health and living situation; driven by member.
Reasons for changes to frequency or mode of contact	Hospitalization, sudden illness, and/or change in condition (e.g., fall, change in placement, suspected abuse).
Use of protocol for ongoing monitoring	Checklists indicate topics that should be covered; clinical judgment.
Communication and Coordination with Providers	
How (formal/informal, telephone/in-person, group meetings/individual conversations), how often, and with whom (e.g., physicians, other providers) staff communicate about the member	Family Care staff most often communicate with nurses from physicians' offices regarding changes in condition and behavioral health providers; they request medical records from providers annually, and request treatment plan from therapists; getting return calls from providers is difficult. Partnership staff communicate with providers by telephone, fax, and email; they receive members' medical records on a monthly basis.
Attends appointments with members?	NPs and RNs attend appointments with members enrolled in Partnership. Attending appointments with members in Family Care is less common; however, RNs try to attend when possible.
Role as communications hub across physicians and other care providers (e.g., specialists, home care, community agencies, skilled nursing facilities, assisted living facilities)	Yes. Staff attempt to review MCPs with providers. If a member lives in residential facility, staff coordinate reviews of treatment plans with the facilities' reviews.
Programs' expectations of physicians and other providers	
Participate in care planning (provide input to or review care plans)	Not an expectation, but is encouraged.
Respond to requests	Yes
Call staff with new member information	No

Processes of Care (*continued*)	
Member Education	
Topics covered in member education (particularly concerning medication adherence, disease education, symptom and self-care monitoring, and consumer empowerment)	Smoking cessation, condition-specific education (e.g., diabetes, congestive heart failure, and chronic obstructive pulmonary disease), symptom management, prevention of rehospitalization, medication management, end-of-life, coping skills, social outlet community education and resources, and stress reduction.
Who provides education?	RNs, SSC, (NP if Partnership program).
Degree of structure in curriculum and materials	Use of KRAMES educational materials.
Efforts to tailor education to individual members	Yes
Use of behavior modification or motivational interviewing	No
How program assesses effectiveness of education	Teach-back method; assessment of symptom improvement.
Service and Resource Management	
Range of services covered	Both programs offer long-term care services such as in-home services (nursing care, personal care, and medication assistance), transportation, occupational/physical/speech therapy, durable medical equipment, social services, mental health services, adult day services, and nursing home care. Partnership also offers health care services such as physician care, medical/surgical/intensive care, hospitalization, prescription drugs and medications, dental services, vision and hearing services, and labs and X-ray. Program uses the RAD method to identify effective and efficient services for members.
Community resources arranged for/referred to most frequently	Home care, personal care, transportation, residential placement.
Role in monitoring receipt of services and for making referrals (or arrangements)	Yes
Management of Care Transitions	
Process for learning about and addressing adverse events such as ED visit or hospital, skilled nursing facility, or rehabilitation admission	Partnership and Family Care staff vary in their approach to managing transitions. Transition planners monitor Partnership members while hospitalized and coordinate with teams for discharge planning.
How program learns about such events	Partnership: the NP is contacted by the transition planner within 24 hours of hospitalization. Family Care: staff do not learn of hospitalizations in a timely manner; they most commonly find out during routine monitoring.
Overall approach to transition management	Partnership: NP completes a risk-assessment tool and action plan that categorizes members into high-risk, moderate-risk, and low-risk for rehospitalization; began using tool in March 2012. If a member is temporarily admitted to a nursing home, the RN or SSC contacts the facility by telephone within 1 business day of admission and then meets facility point of contact within 3 business days.
Does program visit members in hospital or communicate with hospital staff during admission? If so, for what purpose?	Partnership: transition planners visit the member upon admission, call the hospital daily for updates on members, visit the members while they are in the hospital, and relay information to the team through the EMR; member's MCP is sent to the hospital. Family Care: RN or SSC collaborates with hospital staff as needed.

Processes of Care (*continued*)	
Does program visit members at home after discharge?	Family Care: staff visit member within 3 days of discharge if they become aware of a hospital admission. Partnership: either NP or RN visit member within 24-72 hours of discharge to reconcile medications and assess clinical status; NP or RN accompanies member to a follow-up visit within 14 days (the NP tries to attend). SSC conducts post-hospital visit for behavioral health admissions.
Does program follow-up with member subsequent to initial post-discharge visit? If so, where, when, and for what purpose?	Partnership: Post-discharge follow-up procedures vary by risk level: (1) high-risk requires minimum weekly contacts for 6 weeks with the first 3 being in person; (2) moderate-risk requires minimum weekly contacts for 4 weeks with the first 2 being in person; and (3) low-risk requires minimum weekly in-person contacts for 2 weeks. Staff attendance at the follow-up provider visit is optional. Staff use clinical judgment to determine whether regular monthly contacts are required for members at high and moderate risk.
Does program use a care transitions protocol? If so, what is included?	Partnership uses a Hospitalization Risk Assessment tool that categorizes members into high-risk, moderate-risk, and low-risk for rehospitalization. The tool outlines minimum requirements for contacting members during the post-hospital period. Family Care does not use the tool.
Does program assess whether protocol is followed and if so, how?	Yes, chart audits are conducted by directors.
Medication Management	
Sources of information on medications taken	Member; Family Care staff request list of medications from providers annually; Partnership staff receive medical records monthly.
Approach to updating information on medications taken	Review medications with member during in-person visits.
Approach to medication reconciliation	Partnership: reconciliation is done every 6 months and after hospitalization to identify redundant medications and discrepancies between prescribed medications and medications actually taken (for example, examine medication bottles and discuss with member); track refills and compliance.
Approach to identifying medication side effects and assessing potentially dangerous drug interactions	Staff has access to Store-In, a medication management software system.
Sources of additional information/ consultation about medication problems	Consult with pharmacist or primary care providers. Staff can request a medication utilization review from the pharmacy.
Approach to reconciling medications following ED visit or inpatient admission	Review of the post-hospitalization PPOC; pharmacy data for some members.
Does program address medication affordability problems? If so, how are they identified and how are they addressed?	Affordability is discussed with members; staff assist members with budgeting if needed.
Does program provide medication adherence devices and supports?	Yes, pill boxes, med-drops, and locked medication planners are available.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. CHP = Community Health Partners; ED = emergency department; EMR = electronic medical record; MCP= member-centered care plan; NP = nurse practitioner; PPOC = Physician Plan of Care; RAD = resource allocation decision; RN = registered nurse; SSC= social service coordinator.	

Major Changes Over Time
In 2008, CHP created facilities teams which provided dedicated staff to facilities such as nursing homes, residential care apartment complexes, and community-based residential facilities.
In 2009, members who were eligible for non-nursing home level of care could be enrolled in Family Care.
During a workforce reduction in March/April 2011, 10% of staff were released and the Resource Department was eliminated, which included the physical therapy and behavioral health departments.
In January 2012, a workforce mobility transition included reduced floor space in Eau Claire and restructuring of support staff (associates).
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. CHP = Community Health Partners.

Unique Features
CHP recently invested in multiple technology enhancements including tablet computers for case management staff equipped with face-to-face teleconferencing, instant messaging capabilities, and network resources. Internet and secured intranet access allows for full mobility and information syncing for all data collection.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. CHP = Community Health Partners.

Independence Care System

Independence Care System (ICS), a Medicaid managed long-term care plan that began in April 2000, serves Manhattan, Queens, Brooklyn, and Bronx. The plan has a relatively high percentage of people who use wheelchairs, and people with multiple sclerosis (MS) and spinal cord injury (SCI), most of whom are of working-age. In addition to providing long-term care support services (LTSS), ICS offers an array of specialized services including care management, a community-based wheelchair repair program, a seating and mobility evaluation program, pressure ulcer prevention and intervention, socialization and recreational activities, behavioral health services, an advocacy department, and a health care program for women with disabilities.

Overview	
Target Population	
Service area	Manhattan, Queens, Brooklyn, and Bronx
Number of counties served by the plan	4
Types of counties served by the plan	Urban
Eligibility criteria	Enrollees must be age 18 or older, be enrolled in Medicaid, live in service area, and have long-term care needs.[1] ICS tends to serve/attract individuals with complex chronic care needs.
Program's estimate of number of eligible beneficiaries[2]	There are approximately 100,000 eligible beneficiaries for LTSS in New York City.[3]
Capitation	Medicaid LTSS, including in-network nursing home stays.
Member Outreach, Participation, and Characteristics	
Total number of enrollees	3,008[4]
Percentage dual-eligible status	68%[4]
Primary method of identifying members	A majority of referrals come from outreach to community-based service agencies. A substantial number (30%) come from members or other individuals referring others. ICS is currently enrolling more than 300 members a month.[4]
Planned change in approach to identifying patients	Anticipating more senior adult (65+) Medicaid beneficiaries.
When/why planned change will be made	New York State is implementing mandatory managed care for all Medicaid recipients; thus, demand for services will grow substantially, especially for dual-eligibles.
Demographic Characteristics	Mean age: 60.4.[4] Median age: 59.5.[4]
Context	
Local/state/federal policy context	New York State is implementing managed care for all Medicaid recipients, which will result in expansion and diversity in membership. ICS projects that approximately half of its members will be age 65+ after the change (only about 15-20% of the new age 65+ members are similar to ICS' current younger disabled members in terms of care needs). ICS also expects to be capitated for acute and primary care services, as well as LTSS, in the next 2 years.

Overview (*continued*)	
Local health care labor market	Not reported.

SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012.

NOTES:

1. Those who require more than 120 days of home care services.
2. As of September 1, 2012.
3. As of July, approximately 35,000 of these beneficiaries were in Managed Long-Term Care, 45,000 were in FFS personal care and 20,000 were in the Long-Term Home Health Care Program. As of September, the Center for Medicare and Medicaid Services had given approval to convert the 2 FFS programs to Managed Long-Term Care plans through mandatory enrollment. ICS expects to grow substantially over the next 3 years, as part of the transition to a managed care framework.
4. As of October 1, 2012.

FFS = fee-for-service; ICS = Independence Care System; LTSS: long-term care support services.

Organizational Features	
Staff/Team Structure	
Types of personnel delivering services	An interdisciplinary team model is currently being used. This model was started with a pilot project in July 2011 and is being rolled out in 2012-2013. Each team serves 500 members. Consists of a team leader, social workers, nurses, care management coordinators, a home care aide coordinator, and a senior home care aide. A care manager social worker (SW) coordinates services. Registered nurses (RNs) primarily do assessments. ICS also has several specialized teams that care for members with specific conditions, including the MS and SCI unit. Other resources include behavioral health, women's health, rehab/DME, and wound care. Staff meet weekly.
Staff roles and responsibilities	
President	Provides overall strategic vision and direction.
Chief Operating Officer	Provides overall direction of day-to-day operations including the information infrastructure, staff training operations of intake and enrollment, provider relations, member services, compliance and performance improvement, and human resources.
Sr. VP, Care Management	Leads development of overall care management system including the restructuring from multidisciplinary team model to interdisciplinary team model.
Sr. VP, Administration	Develops and manages most administrative functions including intake and enrollment, provider relations, outreach, transportation, member services, and facility management/office services.
Sr. VP for Rehabilitation Services	Develops and manages wheeled mobility program, including evaluation, purchase, and repair. Develops and directs training activities.
VP, Management Information Systems	Develops and manages electronic management information systems and use of information technology. Responsible for compliance and quality improvement.
VP, Advocacy	Responsible for problem-solving with care managers on member issues and grievances, and development of health program for women with disabilities.
Director, Independent Living Services	Oversees consumer-directed personal assistance services and advisor in building supports to increase members' independence into care management system.
VP, Community Relations	Develops and manages all communication (internal and external) and marketing activities.
Staff background and education	Nurses: RN required (most BSN), 1 year home care experience required; SW: BSW required (most MSW).
Caseload (ratio)	Average: 1:50; varies by stratification.
Days/hours staff are available to members	Monday through Friday, 8:00 a.m. to 6:00 p.m. Evening and weekend emergency service.
Availability of experts for consultation	NP with MS certification; certified wound care nurses; behavioral health specialists; PT/OT with specialization in wheeled mobility.

Organizational Features (*continued*)	
Training and supervision	The 2-week orientation phase is experiential and run by department heads. New staff are then moved into the trainee phase. In the 2 week classroom training phase, staff receive role-specific training. Nurses will then learn the documentation requirements in field (for about 4 weeks). Staff transition into mentee phase of training and they are paired up with an appropriate mentor. When staff members move to mentee phase, they are assigned members and in the field (12 weeks). Field training is done at the individual level completed by groups. Condition-specific training is provided as needed.
Information Technology	
Major systems used and their primary functions	Care Compass is an electronic care management record system which has been in use since April 2011. Care Compass serves as the electronic care management record for members, as well as a data repository. It houses documentation of the assessments, care plans and gaps in care activities. It also generates reports by members, provider or cohort and tracks key performance measures.
Process for tracking member contacts and assessments	Member contacts and assessments are all recorded in Care Compass and are available at any time to staff.
Use of automated communication/reminders for upcoming contacts and decision support capabilities	Automatic alerts to staff when certain items need their attention.
Accessibility of system	Staff and designated contract agencies as appropriate.
Quality Management and Outcome Measurement	
Efforts to provide data and other types of feedback to staff and providers	Performance indicators are used to assess timeliness and quality of services and to manage compliance with programmatic and regulatory requirements. Performance indicators are measured both at the organizational level and at the individual staff and member level. Each staff member has an annual performance review.
Reports generated	Monitoring reports are available to managers include monitoring of service provision, timeliness of assessment, adherence to contract requirements, and management of member grievances and appeals.
Approaches to making changes to improve quality	Each department has its own targets and goals. ICS has a Performance Improvement Committee that reviews all administrative, clinical, and support services to ensure that they are functioning effectively. ICS has at least 1 staff dedicated to quality improvement.
Assessing member satisfaction	Member satisfaction is monitored via a member satisfaction survey, which is administered every 2 years. The VP for Advocacy regularly reviews grievances and appeals and plays a key role in resolving member issues. Grievance and appeal information is also used to monitor provider and staff performance and is reported to the New York Department of Health on a quarterly basis.
Engaging/Recruiting/Retaining Providers	
Types of providers recruited	The plan uses external providers for most of the services that it provides. Care management and wheelchair evaluation, purchase, and repair are the major exceptions. A focus is placed on maintaining a broad network of provider agencies and, at the same time, developing preferred provider relationships with select agencies in major service areas.
Approach to recruiting providers	ICS seeks home care contractors that are committed to best practices such as providing workers with a fair hourly wage and health insurance. ICS also supports member choice. If a member comes to ICS and wants to keep his or her particular home care worker, then ICS will generally accommodate the request.
Major equipment providers	ICS works primarily with 2 preferred suppliers, although it has contracts with 6-7 contractors. ICS chooses providers based on geography, certification, and service area.
Use of provider advisory board	n.a.
Difficulties encountered when recruiting/retaining providers	It was initially challenging to identify providers that were able to provide appropriate services and meet ICS' standards regarding fair wages, fringe benefits, and other practices.

Organizational Features (*continued*)	
Initial Contact with Member	
Process for making initial contact with member	The intake team does an initial telephone screen after receiving a referral, verifies Medicaid enrollment and eligibility for services, and schedules a nurse to visit the applicant and perform the intake assessment. If qualified for services, the applicant is enrolled and assigned to a care manager. The care manager contacts the member within the first week of enrollment to schedule a home visit to develop a care plan.
Process for and extent of follow-up on initial contact	The care manager meets with the member in person within the first 2 months of enrollment.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. BSN = Bachelor of Science in Nursing; BSW = Bachelor of Social Work; DME = durable medical equipment; ICS = Independence Care System; MS = multiple sclerosis; MSW = Master of Social Work; n.a. = not applicable; NP = nurse practitioner; OT = occupational therapy; PT = physical therapy; RN = registered nurse; SCI = spinal cord injury; SW = social worker; VP = Vice President.	

Processes of Care	
Initial Assessment	
Tools used	The SAAM is a state tool that is completed at intake, every 180 days and at any point when there is a significant change in the member's condition. Every in-person ICS nurse visit requires completing a SAAM. The responses to SAAM questions prompt other ICS-developed assessments such as bladder, diabetes, respiratory, and wound risk among others. A companion tool to the SAAM is used to determine personal care assistant service hours. It is completed at intake and at least semiannually thereafter. The tool may be completed if the member has a significant change in condition that impacts his or her need for home care services. The behavioral health complexity tool is completed every 3 months for members who are receiving services from the Behavioral Health Unit.
Use of risk-stratification	Members are stratified into 4 basic categories: low, moderate, high, and transition. Stratification is about complexity related to care management. The complexity is usually related to the member's combination of medical conditions and/or behavioral health issues. It is used to ensure that members at higher levels of risk receive appropriate levels of attention and for assigning staff.
Mode (in-person, telephone, online) and duration of assessment	In-person; typically takes 1-2 hours.
Topics covered during assessment	The SAAM (Semi Annual Assessment of Members) is the comprehensive assessment tool currently used by all Medicaid MLTC plans. It is a modified version of the Medicare Outcome & Assessment Information Set (OASIS-B), which is used to establish clinical eligibility for managed long-term care and to provide baseline data for managing a beneficiary's care. The SAAM index is a functional assessment scoring system developed by the Department of Health. It is comprised of thirteen items for the SAAM instrument, including Activities of Daily Living, incontinence and cognitive functioning. Points are allocated to the different levels of functioning with the number of points increasing as the functional limitation increase.
Formal reassessment	The SAAM is completed every 6 months or when there is a change in status. Members are assessed for changes in medical and functional status, stability in family and social supports, and to ensure appropriate services are in place.
Approach to identifying member needs and goals and tailoring interventions to meet those needs	Clinical judgment and input from the member. The service plan is shared with the member's PCP, to obtain orders for covered services.

Processes of Care (*continued*)	
Care Planning	
Time from assessment to care plan development	The care plan is developed by the social worker after reviewing the service plan developed by the nurse and signed by a physician, and discussing the member's goals and needs with the team and the member. The care plan is updated every 6 months and as needed.
Who provides input?	The member and the ICS care team staff provide input into the care plan.
Primary purpose of care plan	To create an individualized plan of care for each member, which includes listing services that are needed and assisting members in accessing services that are authorized through the service plan.
Care plan format	Electronic care plan template, paper document.
Topics covered in care plan	Describes covered and non-covered benefits, preferences, and goals of member.
Topics covered in service plan	Available services and changes to services, the authorization period, authorization frequency/schedule, and provider.
How often/under what circumstances are care plans updated?	Every 6 months and when there is a significant change in condition.
Accessibility of care plans	Available to staff and member (and others that the member authorizes).
Ongoing Monitoring	
Minimum frequency of contacts with member	Care manager: at least monthly, but contact varies based on need. Nurse: contacts for assessment or reassessment.
Typical frequency of contacts with member	Generally, risk-stratification guides contact.
Use of risk-stratification to guide frequency of contact	Yes
Mode of member contact (mail, phone, in-person, online)	Phone or in-person (home or office visit); sometimes text message, regular correspondence, and email.
Average duration of real-time contact	45-60 minutes for in-home visit.
Most common topics covered during monitoring contact	Items covered in assessments and/or issues identified through care planning or in visit.
Reasons for changes to frequency or mode of contact	Hospitalization and/or a change in member's status (mental, physical, or situational).
Use of protocol for ongoing monitoring	Monitoring of an issue is determined by the protocols established for each issue and by the willingness of the member to accept an intervention.
Communication and Coordination with Providers	
How (formal/informal, telephone/in-person, group meetings/individual conversations), how often, and with whom (e.g., physicians, other providers) staff communicate about the member	There are extensive daily/weekly interactions with LTSS network providers usually by phone or e-mail. In-person and/or group meetings occur as needed. Interactions with physicians are fairly limited. ICS is not capitated for primary or acute care, so physicians are not in ICS' provider network and are not compensated by ICS. Service plans are reviewed and signed by a physician. Staff often communicate with providers regarding DME. DME approval documents are both faxed and mailed to the providers.
Attends appointments with members?	Yes
Role as communications hub across physicians and other care providers (e.g., specialists, home care, community agencies, skilled nursing facilities, assisted living facilities)	Communication is limited to those providers providing covered services. Staff reach out to physicians and other care providers (of non-covered services) as appropriate.
Programs' expectations of physicians and other providers	
Participate in care planning (provide input to or review care plans)	Physicians must sign service plan which also serves as an MD order.
Respond to requests	Yes, but physicians are not always responsive.
Call staff with new member information	No

Processes of Care (*continued*)	
Member Education	
Topics covered in member education (particularly concerning medication adherence, disease education, symptom and self-care monitoring, and consumer empowerment)	Education varies based on the member's needs and could include a range of topics.
Who provides education?	Primarily the nurse or social worker. Resource unit staff also provide education.
Degree of structure in curriculum and materials	Health education materials related to prevention of secondary conditions (such as flu and pneumonia vaccines), depending on member's condition. All members receive educational materials related to advance directives.
Efforts to tailor education to individual members	Yes
Use of behavior modification or motivational interviewing	Yes, use harm reduction techniques.
How program assesses effectiveness of education:	Ongoing assessments and use of teach-back.
Service and Resource Management	
Range of services covered: Social Day Care; Transportation	Medicaid LTC services: adult day health care; care coordination; Consumer-Directed Personal Assistance Program (CD-PAP); dental care; durable medical equipment (e.g., wheelchairs, prosthetics); eye exams, glasses and other vision services; hearing exams, hearing aids and hearing aid batteries; home care (e.g., home health aides, home attendants, personal assistants); home delivery of meals and meals in group settings (e.g., senior centers); home safety modifications/accessibility improvements; housekeeping/chore services; medical and surgical supplies; nurse on call (24/7); nursing home care; nutrition services; Personal Emergency Response System (PERS); physical, occupational, and speech therapies (at home or in the community); podiatry, orthotics, and orthopedic footwear; respiratory therapy; skilled services (including nursing and medication management).
Specialized services	Member-centered care coordination; a person-centered home care aide model; a well-established consumer-directed personal assistance home care program; a nationally recognized disability care coordination model; specialized care management services for people with spinal cord injury and multiple sclerosis; a community-based Wheelchair Repair Program; a Seating and Mobility Evaluation Program; Women's Health Care Program; specialists in pressure ulcer prevention and intervention; an Advocacy Department; social/educational/artistic activities; behavioral health services.
Community resources arranged for/ referred to most frequently	Home care; the typical ICS member receives 6-8 hours per day/7 days per week.
Role in monitoring receipt of services and for making referrals (or arrangements)	ICS staff directly monitor the receipt of services.
Management of Care Transitions	
How program learns about adverse events such as ED visit or hospital, skilled nursing facility, or rehabilitation admission	Member self-report (50%); home care agencies (90%).
Overall approach to transition management	ICS' policy is that the care manager contacts member as soon as ICS becomes aware of a hospitalization.
Does program visit members in hospital or communicate with hospital staff during admission? If so, for what purpose?	The care manager contacts the hospital discharge planner within 24 hours and visits the hospital usually the day after becoming aware of the hospitalization to coordinate services and to plan for discharge. If members are discharged before that, the care manager visits them in the home. Members in a nursing home are visited monthly.
Does program visit members at home after discharge?	Yes

Processes of Care (*continued*)	
Does program follow-up with member subsequent to initial post-discharge visit? If so, where, when, and for what purpose?	The assessment nurse visits the member in person within 5 days after discharge. Nurses communicate any changes that require service modification via the electronic member record to the care manager. It is also common practice that the care manager visits members 1 week post-discharge.
Does program use a care transitions protocol? If so, what is included?	A care manager calls the discharge planning staff as soon as they become aware of a member's hospitalization. The care manager visits the member within 24 hours of admission to hospital to coordinate discharge. A transitions team collaborates with the care manager and the hospital discharge staff to determine the need for skilled and other social support services at the point of discharge and to determine whether there is a need to modify the care/service plan. An RN will visit within 5 days of return to the home and review any changes in medication, durable medical equipment, or medical supplies and any functional changes and amend the service plan as needed, which can include increasing home care services. The RN can order skilled services to manage new medications and to educate on new diagnosis. The social work care manager will follow up as needed and make any needed changes to the care plan.
Does program assess whether protocol is followed and if so, how?	Yes, through supervision of Transition Team.
Medication Management	
Sources of information on medications taken	Resources available to nurse during in-home visit (member, member's family, prescriptions, medication containers, etc.).
Approach to updating information on medications taken	Medications are reviewed during the 180-day assessment. The nurses' role is to make sure there are no duplications or countervailing interactions.
Approach to medication reconciliation to identify redundant medications and discrepancies between prescribed medications and medications actually taken	During the 6-month visit, nurses teach the members about their medications and are responsible for updating the list of medications.
Sources of additional information/ consultation about medication problems	Staff consult with prescriber as needed.
Approach to reconciling medications following ER visit or inpatient admission	An RN will visit member within a few days of discharge and will reconcile medications during that time.
Does program address medication affordability problems? If so, how are they identified and how are they addressed?	All ICS members have coverage under the state Medicaid program. ICS works with members and their physicians when medications are off formulary.
Does program provide medication adherence devices and supports?	Yes, pill boxes. Also, skilled nursing services are used to preparing medication and monitoring of adherence to regimen.

SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012.

CD-PAP = Consumer Directed Personal Assistance Program; DME = durable medical equipment; ED = emergency department; ER = emergency room; ICS = Independence Care System; LTC = long-term care; LTSS: long-term care support services; MD = medical doctor; MLTC = managed long-term care; OASIS = Outcome and Assessment Information Set; PCP = primary care physician; PERS = Personal Emergency Response System; RN = registered nurse; SAAM = semiannual assessment of members.

Major Changes Over Time
ICS has tried several different care models over time. Throughout its 12-year existence, however, care management has been characterized by a combined, if not integrated, social-medical approach. This is reflected in the use of both social workers and nurses as the core staff. ICS has also had a core belief that, in long-term care, social needs and issues are generally more dominant on a daily basis than medical ones. Expertise is needed in both, but social support is required for most members on a regular basis and medical support is required episodically for most members.
ICS also developed resource teams to supplement the work of the care managers and to fill critical gaps in the service delivery system for the population it serves. The resources include wheelchair evaluation and repair, wound care and home care aides specialist.
ICS staff recognized that certain cohorts of members required more specialized expertise and relationships with physicians than others. This led to the formation of a specialized care management team for members with MS and SCI.
ICS is now in the process of restructuring from a multidisciplinary model in which there was limited coordination between RNs and SWs to an interdisciplinary team model.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. ICS = Independence Care System; MS = multiple sclerosis; RN = registered nurse; SCI = spinal cord injury; SW = social worker.

Unique Features
It is a home and community-based model, in contrast to the dominant focus on care management through primary care medical homes.
It is a social-medical model based on the premise that many of its members' problems are either social issues or both social and medical. Social workers, in this context, are considered as valuable as nurses with different skills and perspectives.
Home care aide service, whether agency model or consumer-directed personal assistance services, are viewed as the primary vehicle for enabling members to live independently, and considerable resources are invested in ensuring that high quality services are provided. In addition, the perspectives and skills of aides in the home are being integrated into the care management process through the inclusion of a senior home care aide on the team.
ICS started a mobile wheelchair repair service for services in the home. Weekly maintenance workshops are also held at ICS offices.
ICS believes in person-centered care in a way that is not generally conceptualized or practiced. It sees the member as the ultimate decision-maker, and not just a member of the care management team.
SOURCE: Plan documents and data; interviews with program staff and program data, Mathematica Policy Research, 2012. ICS = Independence Care System.

CENTER OF EXCELLENCE IN RESEARCH ON DISABILITY SERVICES AND CARE COORDINATION AND INTEGRATION (CERDS)

REPORTS AVAILABLE

Abstracted List of Tasks and Reports

HTML	http://aspe.hhs.gov/daltcp/reports/2014/CERDS.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/CERDS.pdf

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Association between NCQA Patient-Centered Medical Home Recognition for Primary Care Practices and Quality of Care for Children with Disabilities and Special Health Care Needs

HTML	http://aspe.hhs.gov/daltcp/reports/2014/ChildDisV3.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/ChildDisV3.pdf

Children with Disabilities and Special Health Care Needs in NCQA-Recognized Patient-Centered Medical Homes: Health Care Utilization, Provider Perspectives and Parental Expectations Executive Summary

HTML	http://aspe.hhs.gov/daltcp/reports/2014/ChildDisES.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/ChildDisES.pdf

Descriptive Study of Three Disability Competent Managed Care Plans for Medicaid Enrollees

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2014/3MCPlanses.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2014/3MCPlans.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/3MCPlans.pdf

Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2014/PACEeffectes.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2014/PACEeffect.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/PACEeffect.pdf

Effectiveness of Alternative Ways of Implementing Care Management Components in Medicare D-SNPs: The Brand New Day Study

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2014/OrthoV2s.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2014/OrthoV2.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/OrthoV2.pdf

Effectiveness of Alternative Ways of Implementing Care Management Components in Medicare D-SNPs: The Care Wisconsin and Gateway Study

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2014/OrthoV1es.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2014/OrthoV1.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/OrthoV1.pdf

Evaluating PACE: A Review of the Literature

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2014/PACELitReves.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2014/PACELitRev.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2014/PACELitRev.pdf

Factors Predicting Transitions from Medicare-Only to Medicare-Medicaid Enrollee Status

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Impacts of Waiting Periods for Home and Community-Based Services on Consumers and Medicaid Long-Term Care Costs in Iowa

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Parent Perspectives on Care Received at Patient-Centered Medical Homes for Their Children with Special Health Care Needs

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Physician Perspectives on the Influence of Medical Home Recognition on Practice Transformation and Care Quality for Children with Special Health Care Needs

HTML	http://aspe.hhs.gov/daltcp/reports/2014/ChildDisV1.shtml
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Strategies for Integrating and Coordinating Care for Behavioral Health Populations: Case Studies of Four States

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Transitions from Medicare-Only to Medicare-Medicaid Enrollment

HTML	http://aspe.hhs.gov/daltcp/reports/2014/MMTransV1.shtml
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To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

NOTE: All requests must be in writing.

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