

Clinical Design Services for Adult Mental Health Care Management System

Proposal Prepared for:

Vermont Department of Mental Health
Vermont State Hospital Futures Project

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Submitted by

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I. ORGANIZATIONAL CAPACITY

THE CENTER FOR HEALTH POLICY, PLANNING AND RESEARCH

Mission

The University of New England's Center for Health Policy, Planning and Research (CHPPR) is dedicated to improving the health status of populations. We identify, develop and evaluate innovations related to access, delivery and quality of health care and health policy.

Vision

To be a nationally recognized leader in planning and research on health policy and practice innovations.

Values

CHPPR believes that

- Strategies to improve healthcare access and delivery should be evidence-based and built upon the tenets of patient-centered care.
- Lasting improvements in health status occur when communities, families, patients and health providers participate in planning and implementing change.
- Successful innovations in health care at the community level inform effective policy innovations at state and national levels.

Previous Experience

The Waterbury Hospital Mental Health Services Report

Prepared for Waterbury Hospital

November 15, 1995

Public Health Resource Group (now CHPPR) and Choate Health Management (CHM) undertook an assessment of mental health services at The Waterbury Hospital (TWH) to determine its preparedness for future programming needs in a maturing managed care environment. In addition to extensive analysis of previously gathered and newly acquired data, we conducted a number of internal and external interviews. The former included the senior and unit level management team of the Division of Psychiatry and selected members of TWH's senior management. The latter included representatives of public and private community agencies, mental health service providers and payors. Through our assessment we provided recommendations for the design of an integrated mental health delivery system including: inpatient services, modifications of existing services, new/additional services, administrative practices, and staffing. We also provided recommendations for a managed care contracting strategy including: cooperative approach between psychiatry and finance, location of services/collaboration, utilization and revenue projections, approach to managed care organization, and overall strategy.

Cardiovascular Services Demand Needs

Prepared for Maine Department of Human Services
September 15, 2000

Public Health Resource Group (Now CHPPR) was contracted by the Maine Department of Human Services to perform a needs study of cardiovascular services in the State of Maine. The need and demand study was framed around a series of interrelated tasks including: Examining provider perspectives on the current adequacy of cardiovascular services in the State and the need for additional services, analysis of previous trends in utilization rates and comparing these with regional and national rates, forecasting future needs for services and the optimal distribution of these within the State, examining changes in medical technology that may influence future need and demand, evaluating current policies, rules, and regulations governing CON applications for services and making recommendations. CHPPR produced a final report with findings and recommendations to the Maine Department of Human Services.

Chronic Care Assessment and Planning Report

Prepared for Central Kenai Peninsula Hospital Service Area Board
April 14, 2005

In April of 2004, Public Health Resource Group (now CHPPR) delivered the Heath Care Service Needs Assessment of Central Kenai Peninsula report to the Central Kenai Peninsula Hospital Service Area Board (CKPHSAB). The goal of the study was to identify key health care service needs in those communities based on findings from a random digit dialed health survey of adults in the region. The CKPHSAB subsequently contracted with CHPPR to complete a Chronic Care Assessment and Planning study of Central Kenai Peninsula during winter 2004 – 2005. This study was designed to identify clinical and non-clinical (community and patient level) service gaps to persons diagnosed or at risk of developing chronic medical conditions. It provided the information necessary to plan prevention and management programs to improve the health status of the population. It assisted the CKPHSAB and local stakeholders in developing sustainable programs that built on existing chronic care services in the region.

Community Health Needs Assessment

CHPPR's Community Health Needs Assessment (CHNA) is a comprehensive process that identifies the salient health care and related social issues in the community through scientifically valid data analysis, input from local leadership, and comprehensive information. Specifically, the CHNA uses extensive secondary health related data, a random sample community household telephone survey and qualitative data from interviews with providers and key stakeholders in the study area to assess the healthcare needs and services in a given region. CHPPR (formerly PHRG) has conducted over 60 CHNAs over the past 17 years in 14 states and internationally.

For every CHNA, CHPPR develops a comprehensive planning report that presents research findings on the health status and service needs of local populations and makes concrete recommendations for each study region. Findings from CHPPR's health assessments addresses gaps in the healthcare system, and our recommendations assist local authorities in instituting

delivery system improvements for the area of study. Additionally, the CHNA report provides valuable data that can be used to highlight a region's health service need, should such data be required when seeking funds to implement community programs that improve the short-and long-term health status of area residents.

Recently CHPPR completed CHNA's in Middlesex County, CT, New London County, CT, Northern Eastern and Central Maine. Since 2006, CHPPR has completed comprehensive assessments in Massachusetts for MetroWest Medical Center, Jordan Hospital Community, and South Shore Hospital Community.

References

1. John Tobin, CEO, Waterbury Hospital, 64 Robbins Street, Waterbury CT, 06721, (203)573-6000
2. Susan Besio, Director of Healthcare Reform Implementation, 109 State Street, Montpelier VT, 05609, (802) 828-0566
3. Trish Riley, Director of the Governor's Office of Health Policy and Finance, Office of the Governor, #1 State House Station, Augusta ME, 04333, (207) 287-3531
4. Carol Crothers, Executive Director, NAMI Maine, 1 Bangor Street, Augusta ME, 04330, (207) 622-5767

HEALTH PARTNERS NEW ENGLAND

Health Partners New England (HPNE) is a psychiatric healthcare management and consulting firm located in Winchester, Massachusetts. The firm's expertise has been accessed by 35 healthcare organizations in 10 states serving over 17,000 inpatients and many more thousands of outpatients over the past 10 years. The company currently employs approximately 50 physicians, nurses, mental health workers and others serving our long term management contracts and several shorter term projects.

HPNE's company focus within psychiatry is to manage the clinical dimensions of care, as well as the financial and operational aspects of service delivery. Weaknesses in any of these critical components of a care delivery system invariability results in poorer community health. HPNE has been directly responsible for providing services across the full continuum of care, including initial assessment, triage, inpatient, outpatient, day treatment, and peer counseling for all ages, and for both substance abuse and psychiatry. The company has started units and services from scratch, has been retained to help systems emerge from serious regulatory problems stemming from poor care, and has served states and judicial systems by providing clinical "receivership" under court order and supervision.

Unlike many professionals and companies, HPNE has held on to its identity and belief in the terms and connotations of *psychiatry*, *mental health*, and *psychology*, rather than the more narrow, insurance-driven term "behavioral health". With the exception of our Chief Financial Officer, all members of HPNE's staff are licensed clinicians that provide some level of direct patient care in one or more settings.

HPNE's areas of experience and expertise include the following:

- All forms of reimbursement, billing, coding operations and compliance

- All forms of regulatory compliance including Joint Commission, state-level department of public health and mental health, CMS
- Financial modeling of Medicare, Medicaid (including Disproportionate Share Payments), and managed care payments
- Creating and launching new units in general hospitals including the CON process, budgeting, creating all policies and procedures, hiring and training all staff, Medicare compliance reviews through DPH, etc.
- Credentialing State-wide outpatient networks
- Creation of a internet-enabled bed-finding and quality of care tracking tool
- Staff training in all aspects of psychiatric and substance abuse care
- Quality management and peer review

Previous Experience

- Re-credentialing of statewide outpatient network of 200+ clinics and individual mental health care providers on behalf of an MCO (Commonwealth of Massachusetts)
- Statewide evaluation of the mental health system of care over 5 years (2002-07) to evaluate the state's progress in meeting the requirements of the improvement plan set forth by the department of justice and the state as a result of a CRIPA lawsuit (State of Hawaii)
- Statewide evaluation of the mental health system of care, meetings with consumers, advocates and providers across the state including rural mental health care needs (State of West Virginia)
- Evaluation of the acute care system of mental health care to make recommendations for system redesign regarding access to the state hospital beds, crisis services and appropriate state hospital bed capacity (State of Washington)
- Statewide evaluation of community mental health centers and state hospitals to make recommendations regarding state hospital bed capacity, facility needs, crisis services, rural mental health needs (State of North Carolina)
- Evaluation of state hospital as part of the initial Future's project, recommendations for future redesign of state hospital beds (State of Vermont)
- Population studies to predict number of inpatient psychiatric and substance abuse beds (New Hampshire, Massachusetts, Texas)
- Creation of all policies and procedures, plan of care, admission and discharge criteria all levels of inpatient psychiatric and substance abuse care
- Legislative testimony and committee work regarding mandatory nurse staffing levels, Department of Public Health substance abuse licensing requirements (Massachusetts)

References

1. Tom Clairmont, CEO, Henry Lipman, CFO, Ellen Wolff, CNO; LRGHealthcare, Laconia, NH. 603-527-2800.
2. Peter Davis, CEO, Richard Plamondon, CFO, Pam Duchene, CNO; St. Joseph Hospital, Nashua N.H. 603-595-3000
3. Elizabeth Cadigan, VP for Patient Services; Quincy Medical Center. 617-376-5745

4. Domenic Ciraulo, MD, Chairman, Department of Psychiatry, Boston Medical Center.
617-638-8141

ZIAPARTNERS

ZiaPartners (Christie A. Cline, MD, MBA, President and Kenneth Minkoff, MD, Senior System Consultant) have been providing system consultation in Vermont since 2003 on the implementation of an integrated system of care using the Comprehensive Continuous Integrated System of Care (CCISC) framework. During this time period, they have provided direct consultation onsite to each of the designated agencies and several of the inpatient units, including VSH, and have engaged with consumer and family stakeholders and representative stakeholders from other systems.

Previous Experience

In 2004-05, ZiaPartners provided consultation to a Juvenile Justice project to develop an integrated system of care for children and families and worked with a large number of stakeholders to contribute to the development of Vermont practice guidelines for developing integrated services in the children's system. Since 2006, the company has provided ongoing consultation in the Vermont Integrated Services Initiative (funded through a federal Co-occurring Disorders State Infrastructure Grant). Through these activities, ZiaPartners has developed considerable first-hand knowledge of the Vermont system of care, both in terms of regulatory and funding structures and in terms of service delivery structures (including acute care, VSH (Vermont State Hospital), Community Rehabilitation and Treatment (CRT), crisis management, and housing). The company also has worked with Vermont to conceptualize more effective management of complex populations that are frequently presenting in emergency, crisis, and acute care settings, including VSH and correctional settings, and are not currently well managed within scarce resources in Vermont.

In addition to the above activities, Dr. Minkoff provided consultation in Vermont to the re-design of the CRT program tiered funding system in 2000-2001, based on his experience with public sector managed mental health care, and as co-editor (with David Pollack, MD) of *Managed Mental Health Care in the Public Sector: A Survival Manual.* In addition, Dr. Minkoff served, along with Gail Hanson-Mayer, RNCS, MPH, and Paul Gorman, Ed.D., as a member of the Federal Court Evaluation Team that worked with the Hawaii Adult Mental Health Division (AMHD) from 2002-2006 to assist the Court, the Department of Justice, and Hawaii AMHD to emerge from the Department of Justice Civil Rights of Institutionalized Persons Act action that had been in place for over 15 years and affected both the state facility and the entire community system. In that role, Dr. Minkoff has developed considerable experience working with systems of care at all levels in relation to federal parameters for managing consumer responsive services at all levels of the system.

DESIGN TEAM

Researcher: Ronald Deprez, Ph.D., MPH

Primary Role: Primary Investigator, identify options for management structures for Clinical Care Management Systems, identify design options for quality assurance, quality improvement and utilization review for the Clinical Care Management System and final report detailing and program elements.

Qualifications: Dr. Deprez is the Executive Director for the center for Health Policy, Planning and Research. He and his colleagues at the Center are leaders in the development of population-based healthcare needs assessment and planning technologies. An example is the Center's Community and Institutional Assessment Process (CIAP), a set of research based planning tools for prioritizing and restructuring health services.

Researcher: Nancy Brossoie, Ph.D.

Primary Role: Identify options for management structures for Clinical Care Management Systems, identify key system gaps and redundancies based on the program descriptions developed, identify design options for quality assurance, quality improvement and utilization review for the Clinical Care Management System, staffing support for the Care Management design and develop process, and final report detailing and program elements.

Qualifications: Dr. Brossoie has professional expertise in the oversight of behavioral health services at the program and administrative level. Her background as a quality improvement administrator has provided her with experience in developing systems over large rural areas in Virginia, strategic planning, implementation of electronic medical records, regulatory oversight including JCAHO and CARF, and consumer rights. Dr. Brossoie's relevant research experience has included work on evaluating the quality of Virginia's Elderly and Disabled waiver services and the status of Virginia's Public Guardianship program.

Researcher: Michael P. Krupa, Ed.D.

Primary Role: Create consistent, written program descriptions for the specified levels of care, create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions, develop uniform protocols to operationalize the following functions and activities in the care management system, based on the overall principles developed, examine and quantify sources of financial support for all levels of care and for coordination of care staffing and associated operational costs.

Qualifications: Dr. Krupa is the Founder and Chief Executive Officer of Health Partners New England. His areas of professional interest and experience include coordination and delivery of mental health and substance abuse services at all levels of care including assessment, triage, inpatient, outpatient; operational systems for delivering care including staffing, all processes, billing and reimbursement; clinical training; public policy; and systems for tracking quality.

Researcher: Gail Hansen Mayer, APRN, BC, MPH

Primary Role: Create consistent, written program descriptions for the specified levels of care, create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions, develop uniform protocols to operationalize the following functions and activities in the care management system, based on the overall principles developed, examine and quantify sources of financial support for all levels of care and for coordination of care staffing and associated operational costs.

Qualifications: Ms. Hansen Mayer has extensive consulting experience in behavioral health at the system and state levels. As a consultant for Health Partners New England, she assists in providing evaluation and management of psychiatric services to a wide range of acute care providers. She has worked for the State of Vermont, Division of Developmental Disabilities and Mental Health Services Futures Project to evaluate the role of the State Hospital in the mental

health system and provide consultation to the clinical staff regarding treatment planning in preparation for Medicare Survey.

Researcher: Ken Minkoff, MD/ Christie Cline, MD, MBA

Primary Role: Review document of written program descriptions for the specified levels of care, create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions.

Qualifications: Dr. Minkoff is a Psychiatrist with current hospital appointments in Psychiatry at Winchester Hospital and Saints Memorial Hospital. He previously held the position of Chief of Psychiatry at Choate-Symmes Health Services, Inc and Choate Health Systems, Inc. Dr. Minkoff co-founded ZiaLogic and ZiaPartners with Christie Cline, MD, and is currently contracted to work with approximately 25-30 county, state, and provincial systems in the US and Canada. He has published extensively on a variety of subjects including co-occurring disorders and strategies for system change.

Researcher: Edie Barrett, RN

Primary Role: Create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions.

Qualifications: Ms. Barrett has clinical expertise in mental health and addictions care and professional work in inpatient, crisis assessment and crisis stabilization, long term care, outpatient, homecare settings, and in private practice. Her administrative skill set includes leadership experience, knowledge of quality improvement, program planning and evaluation, developing new programs, JCAHO and CARF standards, and managed care environments.

II. SCOPE OF WORK AND EXPECTED OUTCOMES

IDENTIFY OPTIONS FOR MANAGEMENT STRUCTURES

Transforming Vermont's statewide mental health service system from a service-oriented approach to a consumer-driven model presents many challenges. Few existing system change models can provide a 'road map' for making this change. The transformation process should be viewed as intentional and congruent with the physical, emotional, and social needs of consumers. The end result should be a system that reflects the needs of Vermonters and not simply a replicate of other systems.

To develop our care management system, we will first review the recommendations and strategies provided by the Institute of Medicine, the President's New Freedom Commission report, SAMHSA Federal Action Agenda, and previous system change studies in Vermont. We are also prepared to work closely with the Future's Plan Project team, mental health providers and professionals, and community stakeholder groups to identify processes that will work for Vermont. The development of our plan will take into account the current system's strengths and weaknesses, and the key issues and concerns of the stakeholder groups.

We will design a care management system by adapting the Balanced Scorecard (Kaplan & Norton, 1996) business strategic planning approach to help us understand and account for all of

the identified competing demands on mental health services. Our model is centered on the individual who is surrounded by the recursive relationships among programs, agencies, payors, and clinical standards that influence the delivery of services. The needs, goals, and standards within each competing domain are placed in the framework to help us be mindful of the needs that must be addressed and accommodated in each area of service delivery to reach our goal. Based on our initial work, key domains in our Balanced Scorecard framework will include community stakeholders, community-based programs, clinical programs, funding sources, communities, and government. Our work within this framework will guide us in developing a patient-oriented system that is desirable, effective, and efficient while balancing the needs of each domain.

In addition to using the Balanced Scorecard as a framework to raise our awareness of the needs of different groups, a review of the professional and academic literature will be conducted to identify transformative models of care and their respective strengths and weaknesses. While the concept of person-centered services is not new, service delivery models that completely embrace the concept are in their infancy. A paucity of literature exists, as it is too soon for states that have received federal transformation grants to report on their successes and failures. Therefore, we will rely on our professional contacts to alert us of current strategies underway in other mental health systems. We will also make contact with representatives of those programs to inquire about the strengths and challenges of implementation, including financing.

A few strategies based on person-oriented community-based services for children, older adults, and people with developmental disabilities will inform development of our system. They include 'wraparound services' for children (coordinated services with medical providers, family, school, and community-based programs), Medicaid waiver consumer-directed services (services directed by the service recipient with the help of an agency coordinator), and ITNAmerica transportation networks (door to door transport funded primarily by healthcare providers for their patients).

Behavioral health program models that provide support for our work include traditional managed care organizations, case rate (vs. fee for service) systems in Colorado and California, Pro-covery (Campbell & Lama, 2006), San Diego Serial Inebriate Program (Dunford, Castillo, Chan, Vilke, Jenson, & Lindsay, 2006) and basic transformation change efforts and challenges identified by human service agencies in North Carolina, New Jersey, and California.

We will also expand our search of the literature to include service delivery models designed to meet the needs of incarcerated adults, returning Iraq war veterans, and those with co-occurring disorders such as chronic conditions, substance abuse, and mental retardation.

By engaging in the activities outlined above, we will produce a care management system that is person-centered, yet responsive to the competing demands of the diverse group of stakeholders involved in the delivery of services.

WRITTEN PROGRAM DESCRIPTIONS FOR LEVELS OF CARE

- *Inpatient Care: General hospital care, intensive inpatient care and specialized care*
- *Crisis Stabilization Bed/Inpatient Diversion bed care*

- *Secure Residential Recovery*
- *Community Residential Recovery*
- *Other Community residential programs*

We propose to bring our experience and expertise budgeting, starting, staffing, and running services in inpatient, crisis stabilization/diversion, and non-inpatient levels of care, including Intensive Residential Treatment Programs (IRTP), to the process of developing each of the required program area descriptions, including admission and discharge criteria for each level of care. We will emphasize the goal of making as many programs dual diagnosis capable as practical.

Our goal will be to work with the existing continuum of services in each catchment area in Vermont, including CRT services (emergency evaluation and continuing care), crisis stabilization capacity, and acute inpatient capacity, to help design a framework for a continuum of services that is recovery oriented, that is dual diagnosis disorder capable, and that emphasizes consumer choice, self determination, and use of the least restrictive level of care possible at any moment in time. The team has experience in working with case rate systems, not only through consultation in Vermont, but in designing a public managed care case rate continuum of acute and continuing care services in Massachusetts (Minkoff & Regner, 1999).

The goal of this continuum is to minimize acute and long term hospital utilization, as well as to maximize community recovery and rehabilitation for individuals with complex needs of all types, including co-occurring substance abuse disorders and medical conditions. Some of these individuals would be considered current CRT clients, while others might not be eligible for CRT as presently designed but would need varying levels of intensive community intervention for an extended period (up to several months) to manage a crisis and to promote engagement in community-based services at a more routine level.

Program descriptions for all levels of care will include statements of populations served and conditions treated, therapeutic modalities offered, admission (and rule out) criteria, staffing expertise, training, education and discipline mix, and sample job descriptions. Project staff have written care descriptions for each of these levels of care and have established staffing plans including job descriptions, required training and expertise, and competency mixes (e.g., RN, Mental health counselor, SW, etc.) for each.

In addition to the levels of care cited in the RFP, we propose consideration of intensive crisis case management for individuals with cod, partial hospital, supported (but not 24 hour staffed) sober living, and varying levels of crisis diversion residential capacity that creates a flexible range of costs for clients with varying levels of service intensity. Different models can be adapted to the needs of diverse communities in Vermont. Intensive case management, day programming and residential support can be flexibly combined to meet each client exactly where they are for as long as they need, and reinforce community placement to avoid hospitalization.

Expected client outcomes will be articulated along both the dimensions of adjustment to current level and setting of care (e.g., new inpatient admission, newly in Community Residential Recovery, etc.) and criteria and treatment planning for moving to any other modality of care.

Each of these settings will include a focus on consumer education about physical and psychological health and adjustment, including psychotropic medications and substance use and abuse. Materials will also focus on staff and patient safety at each level of care to reduce staff and patient risk for injury.

Finally, indices of patient progress and satisfaction, as measured by stake-holder selected measures (TOPS, etc.), will be employed at each level of care and over pre-defined time frames within each level.

Our experience both directly providing these materials and managing a cooperative process with Vermont stakeholders is grounded in both our consultation and management experience with existing programs (including many within general hospitals) and in our experience starting new programs and units. Each of these projects has required statements and descriptions of admission criteria, statements of the scope of care, and continuing care criteria that satisfy regulators and both governmental payors such as Medicaid and Medicare, and many Managed Care Organizations (MCO's). We have also provided extensive MD, RN and other staff training on UM, proper coding, and billing for each of these sets of payors.

IDENTIFY KEY SYSTEM GAPS AND REDUNDANCIES

Reviewing the identified program descriptions for gaps and redundancies in services is one step in ensuring coverage of mental health services throughout the system. However, we will also revisit information learned about service delivery from our work on this project and will seek feedback from the community stakeholders and program administrators in identifying gaps in service delivery that are not apparent on paper. As the challenges of rural service delivery (e.g., long distance and lack of transportation) become apparent, we will use that information to refine development of our system model and program descriptions.

We will also look for the gaps and overlaps when clients move in and out of services. After leaving a program and resuming care, some services may be unnecessarily duplicated and conversely, some may be overlooked. We propose to identify strategies for meeting these challenges in programs where this appears to be a frequent problem. The completion of this task will be an iterative process. We recognize the competing needs of the consumer, the programs, and responsive to the unique needs of rural life.

CREATE CLINICAL ADMISSION, CONTINUED STAY AND DISCHARGE CRITERIA

We propose that the LOCUS tool as well as other measures cited in the SAMHSA co-occurring Center for Excellence summary report be reviewed with Vermont providers for utility, ease of use, and cost. The overview cited in *Screening, Assessment, and Treatment Planning with Persons with Co-Occurring Disorders* includes the following key concept: "Integrated screening, assessment, and treatment planning...begins at the earliest point of contact with the client (and) continues through the relapse prevention stage. Information regarding a client's substance abuse and functional adjustment is gathered throughout the treatment process, along with the evidence regarding the effects of the intervention (or lack thereof). Treatment plans are then modified accordingly (Mueser et al., 2003. p. 49).

This report summarizes each of the current, most commonly employed assessment measures including the Addiction Severity Index (ASI), Alcohol Use Disorders Identification Test (AUDIT), Beck Depression Inventory II (BDI-II) and others. The advantage of the LOCUS measure is its focus on level of care placement or match across the most commonly used levels of care as well as its ease of application.

As noted in Section B, our team has experience developing specific admission, continued stay and discharge criteria for each level of care in a care management continuum for individuals with complex needs, including developing criteria for both Dual Diagnosis Capable (DDC) and Dual Diagnosed Enhanced (DDE) programs. In addition, our team members have participated in the design and development of both the LOCUS, and the ASAM PPC 2R criteria, and are familiar with the strengths and limitations of both tools within a continuum of care. In fact, Dr. Minkoff chairs an annual symposium at the Institute for Psychiatric Services entitled Innovations in Level of Care Assessment for Co-occurring Disorders in which both David Mee Lee, MD (lead developer of ASAM) and Wesley Sowers, MD (lead developer of LOCUS) participate. In this symposium, participants explore the benefits and limitations of each tool in making level of care assessments for complex individuals.

From the perspective of what is needed in Vermont, the LOCUS is an excellent starting place for a common language about the multidimensional criteria for establishing service intensity and level of care requirements within a continuum. However, while the LOCUS describes general levels of care, it does not specify in detail the full flexible continuum of services that are described in Section B. It would be the job of our team to begin with the general LOCUS criteria and then create more specific instructions for how concrete models and examples of different types and mixes of services would actually be created, implemented and utilized in Vermont.

Further, the ASAM PPC 2R remains a viable tool for understanding level of care assignment within the continuum of addiction services. It is less adaptable than the LOCUS for application across the whole system. Our goal would be to create a Vermont specific cross walk between ASAM PPC 2r and the LOCUS so that, in those components of the system in Vermont where ASAM is currently utilized, there can still be a common language about how to create service intensity criteria (admission, continued stay, and discharge) that fit both the LOCUS and the ASAM. The starting place for doing this is recognizing the overlap of significant dimensions on both tools, such as acuity, co-morbidity, readiness to change, and support system availability.

DEVELOP UNIFORM PROTOCOLS TO OPERATIONALIZE FUNCTIONS AND ACTIVITIES

- *Crisis/emergency screening (not just for involuntary treatment)*
- *Census management (at each level of care)*
- *Transportation*
- *System-wide discharge planning for a person not connected to community services*
- *Payment for services for people with no insurance, or for care that is not covered by insurance*
- *Conflict resolution between entities*
- *Client rights and dissemination of this information*

Developing uniform protocols to operationalize the system of care is akin to creating a policy and procedure manual for care. Unlike policy and procures for an individual level of service, these standards will articulate both what currently exists and what will likely be future evolutions of services. As indicated in the RFP, these standards should not be prescriptive to the point of causing undue legal risk for services that are unable to comply with ideal treatment conditions due to resource scarcity.

The specific protocols identified in this section of the RFP are important component protocols of a larger care management system which we are proposing to help the state to design. This care management system needs to function in the state at three levels simultaneously, and each level needs to be designed to be interactive with the others. Our team has had experience in developing this type of population-based care management system within a fixed amount of resources in a variety of other public and private systems.

At the first or highest level of the care management system, the system needs to adopt methodologies for overseeing the “flow” of high need and complex clients through all of the available resources and levels of the care of the service system, both within each community catchment area and across the state. This involves not just the existing care management capacity related to CRT but also a larger capacity that includes non-CRT clients who use critical and costly high end resources, including state hospitalization. The component protocols at this level of care management include census management (as through a centralized coordinator of all inpatient beds), centralized and coordinated discharge planning in partnership with all state mental health and substance abuse program resources, formal mechanisms for assigning case responsibility and mediating disputes (clinical, administrative, and financial), and mechanisms for specifically addressing the acute and long term needs of individuals who are uninsured (including protocols for maximizing access to Medicaid eligibility, as well as maximizing utilization of flexible funding in existing state waivers).

At the second level of care management, there need to be specific standards and guidelines for critical clinical practice components: crisis evaluation, short term crisis intervention, short term crisis case management for complex co-occurring individuals, discharge planning from acute care or diversion settings, and so on. Our team has experience with these service models and criteria in other systems in other states (e.g., Michigan), and can adapt these models in Vermont. Further, we propose including a peer support component into crisis case management based on some initial findings that peer support can be a cost effective component of a community based hospital diversion process.

At the third level of care management, we would design protocols for basic components of consumer support services for clinical care. These would include: access to transportation, (including peer support transport); education regarding consumer rights and choices (including use of advance directives, if appropriate); development of peer advocates and educators to assist with medical and psychiatric adherence; etc.

We would meet with representatives of the stakeholders that have first-hand knowledge of the needs in the system to obtain their input for critical features about how these various components and protocols should be designed and interlinked, and then use this input to adapt our general

knowledge about these services from other systems to the specific goals and objectives of the care management system in Vermont.

We assume that program operation and system standard setting will be conducted in concert with the development of quality improvement (QI) activities and strategic planning. Standards for accepting clients not in crisis and living out of the catchment area, for minimum and maximum census counts, and for the rate of indigent clients accepted into care needs to be considered as part of the QI plan. Identifying who will be served (and to what extent they should be served) is a system level decision and should not be made by individual programs. Additionally, we propose that conflict resolution and client rights training and education cross programming and falls under the work of the QI director and Clients Rights Advocate (see next section).

Lack of transportation has long been recognized as the reason why community-based programs fail. Transportation challenges faced by Vermonters are similar to other rural communities with small populations. Strategies for operationalizing transportation in the care management system will be dependent on many variables (e.g., funding, vehicles, service area, staff, and maintenance support) and cannot be identified at this early stage. We propose to gather information about the current state of transportation in Vermont before outlining a strategy. We are aware of transportation systems such as ITNAmerica and Dynacorp from which we can draw comparisons for our work.

Standards of care will be based on best practices within the professional and clinical field. Standards will be created in a common format to maximize continuity of evaluation across levels of care. Each standard will identify the level of care, the provider, a brief name of the standard (e.g. Intake Evaluation Process), a narrative of the standard, and a check-off list for required and suggested elements. Standards of care that affect client record documentation will also be presumably developed in conjunction with individuals responsible for managing and overseeing client records and the QI director (see next section).

Evaluation of standards will include timeframes for review and consumer satisfaction with services. Evaluation timeframes will be developed in accordance with rules of outside regulatory agencies, system policy and procedure, and guided by recommendations from stakeholder focus groups. We propose to build in an ongoing evaluation process of standards and consumer satisfaction be conducted in conjunction with the QI plan and QI staff. Criteria for adopting any given measures will include ease of use and, in the case of proprietary system such as LOCUS, cost.

Many of the activities listed above are influenced by payor source. We have significant experience understanding public and third party payors and will work with the department to understand pay sources not tied to traditionally reimbursed services from Medicaid and Medicare.

In support of consumer-directed services, we propose to integrate family and peer support participation into our work. We recognize that a social network is a source of support for individuals working towards recovery; especially in times of crisis. We propose to develop a protocol to include peer and family support during times of crisis. Care plans will be created with

the consumer's consent at a time when they are functioning well and proactive in their treatment. The pre-designed plans will then be operationalized during times of crisis and will include the necessary information for family and friends to participate in appropriate interventions across levels of care.

IDENTIFY DESIGN OPTIONS FOR QUALITY ASSURANCE, QUALITY IMPROVEMENT AND UTILIZATION

Our experience in implementing systems within established and new healthcare systems provides us with the necessary insights to develop effective and achievable quality improvement (QI) strategies for a care management system in VT. We propose to develop a plan that provides the structure to facilitate growth of a comprehensive plan that interfaces well with other State reporting systems in the future. Key structural components will include:

- QI plan for the entire care management system
- QI director position
- Peer-review quality assurance (QA) structure
- Standardized QA activities across each program
- Centralized client record
- Utilization review plan
- Credentialing program
- Consumer rights advocate position

QI plan for the entire care management system. We propose developing components of an initial QI plan for our proposed system to help facilitate the growth of the system in the early years of implementation. Our QI plan will include system and program goals, objectives, and performance outcome measures (short and long-term) based on system management and participating program descriptions. The collaboration of clinical and non-clinical services will be highlighted, as both are integral to consumers' success in recovery. Suggested focus areas in the plan for clinical services include prevention or care of acute or chronic conditions, strategies for providing high risk services, and continuity and coordination of care. Areas of focus for non-clinical aspects of programs or services will include availability, accessibility, cultural competence of staff and programs, consumer rights, and program management, all of which affect a significant portion of consumers served and have a potentially significant affect on quality of care, services, or satisfaction.

QI Director position. We believe that an effective QI program requires a leader who is dedicated to ensuring the quality of service delivery from intake through discharge from the present into the future. We propose establishing a dedicated QI position that will work as part of the system's administrative team and provide leadership in integrating the regulatory and policy components into the formal QI plan.

The Director will also oversee a peer-reviewed QA structure developed by program. Based on our findings, additional dedicated staff may be recommended to assist in the ongoing review of records and services. The QI Director will also be responsible for leading the collection of data for state reporting efforts, including the report and review of sentinel events that may involve the consumer rights advocate. The QI Director will act as the liaison to State officials and represent

the system at the State reporting level. More details about the responsibilities of the position will be identified during the project period.

All dedicated QI positions will be primarily proactive in nature, assisting staff in understanding the regulations, policies, and procedures that dictate service delivery (42CFR, HIPPA, Medicaid, Medicare, 3rd party payors, JACHO, CARF, internal policies and procedures). This process may require developing and offering ongoing training sessions to staff across the system. The QI staff will also need to be reactive and responsive to identified problems within the system and work with staff to resolve the problem as quickly as possible. A designated portion (e.g., 10%) of QA activities conducted at the program level will also be reviewed by QA staff on a regular basis.

The QI director will also be responsible for overseeing the distribution and analysis of an annual system consumer satisfaction survey and participate in regular community meetings where community members are encouraged to voice their opinions.

Standardized QA activities across each program. To achieve consistency across the system, core sets of QA activities will be identified for the system and within each program. Activities will address components such as service access, service delivery, service authorization, quality of documentation (presence and content), internal record review process, customer service, and consumer satisfaction. Some programs may have additional levels of review, based on requirements from regulatory agencies or federal code (i.e., 42CFR).

Centralized client record. Our experience has shown that QA activities can best be conducted across programs and locations within a broad geographical area, when a centralized medical record (paper or electronic) is established for each client. The record has a designated 'home' and, when necessary (if paper), is physically transferred to the location providing services through the use of internal system couriers. Couriers can include staff who routinely travel between clinic sites.

A centralized record requires the use of a standardized chart format, which can be developed based on our findings. While a person-centered approach suggests that a person should not be judged on their past history, the benefit of a centralized chart is that the history and status of the consumer can be viewed in one place. Effective service planning with consumers with comorbidities begins with understanding the range within which the consumer functions emotionally and physically. Thereby, a centralized record is useful in coordinating and planning goals to establish a clear road for recovery.

For consumers enrolled in substance abuse programs or federal probation activities which may limit access to a client record, a process will be proposed that keeps the necessary documentation separate and retains the confidentiality and rights of the consumer.

We also propose to identify a chart management (documentation and handling) system that works best within our proposed care management system. Components will include staffing, housing of records, storage, access, and documentation. Standardized documentation will need to be developed for each program including treatment plans, reviews and discharge summaries. Intakes may be modified to reflect the need of the program.

It has been our experience that the use of electronic medical records (internal and interagency) has lessened some of the burdens frequently associated with QA activities and providing services in a timely manner. Systems can be built to red-flag inconsistencies or omitted information at the time they occur as well as prompt for follow-up. Based on our findings, we will identify how QI/QA activities can be integrated into current methods of recordkeeping and can support the introduction of electronic medical records in the future.

Utilization review plan. Operating within a continuum of care requires that many administrative tasks are centralized; the largest component being reimbursement activities. Therefore we propose centralizing client accounts and conducting reimbursement processes from a central location in the system. This will maximize billing as consumers move from one program to another in the middle of treatment.

Like the proposed standardized QA strategies, the QA activities conducted with utilization will be standardized across the system. Based on our findings, a designated position filled by an experienced and knowledgeable reimbursement specialist may be proposed to maximize reimbursement dollars. Many health plans have gaps and overlaps in coverage of which most patients and providers are unaware. Navigating the nuances of crisis and non-crisis treatment can result in increased billables for the program which ultimately can lead to better access to services, reducing unnecessary healthcare utilization, and reducing bad debt. We propose to develop a utilization plan that builds upon the systems currently in place to maximize billable and reduce duplicative services.

Credentialing program. Part of a QI program includes the credentialing process of providers. We propose to examine current efforts in addressing the process and make recommendations for centralizing and simplifying the process as much as possible across the system.

Consumer rights advocate position. An adjunct position we propose in our QI plan is that of a designated consumer rights advocate. The position will be separate from that of QI staff but will work with the QI director in meeting the needs and concerns of the consumers. Further development of this position will be based on our findings.

STAFFING SUPPORT FOR CARE MANAGEMENT DESIGN AND DEVELOPMENT PROCESS

Consumer-driven services are more effectively developed with the ongoing support and input from consumers and community stakeholders. Therefore, we propose to

- Make ourselves available to receive comments and suggestions from the stakeholders throughout the project period.
- Conduct semi-structured interviews and focus groups with stakeholders to inform and discuss the development of our care management strategy.

Stakeholders will also be provided the opportunity to read and critique the final drafts of our written documents. Their suggestions will be addressed and incorporated in subsequent revisions as appropriate.

FINAL REPORT DETAILING SYSTEM DESIGN AND PROGRAM ELEMENTS

The final report for this project will include

- A management framework for a care management system.
- Consistent policies and protocols to implement the system.
- Quality improvement, assurance, and utilization review systems that facilitate a design for continued improvements in the system and effective allocation of resources.
- Products that will be readily usable and appropriate for Vermont.

The final report will include sections that provide information about the development process and the activities associated with each section in the proposal narrative. Stakeholder comments offered during interviews and focus group sessions will also be listed (or summarized if needed) to demonstrate their level of involvement in the development process.

The Futures Project team and other designated persons will be provided with a final draft of the report for their review, comments, and suggestions. Once all comments, additions, and corrections have been received, we will make the requested revisions and submit a hard copy and an electronic copy (.pdf file) of the final report to the designated persons.

III. PROPOSAL WORK PLAN

SCOPE OF WORK ALLOCATION

Key Research Deliverables	Lead Person	Effort	Time (days)	Budget
Identify Options for Management Structures for Clinical Care Management Systems	NB*, RD	Review of current system, contact other systems, Lit review, Internet search, write	13	\$13,140
Create consistent, written program descriptions for the specified levels of care	MPK(GHM; review by KM)	Review other descriptions, Search and identify, current program descriptions, write, Work w/stakeholders by reviewing current VT-based descriptions with edits, circulate electronically, meet in user groups organized geographically	5.5	\$10,200
Identify Key system gaps and redundancies based on the Program Descriptions Developed above	NB	Discussion, Analysis, Compare to other systems, write, Work w/stakeholders	7	\$6,090
Create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions	MPK GHM, KM, CC, EB	Review other HPNE descriptions, Search and identify, current program descriptions, write, Work w/stakeholders by reviewing current VT-based descriptions with edits, circulate electronically, meet in user groups organized geographically	28	\$57,993
Develop uniform protocols to operationalize the following functions and activities in the care management system, based on the overall principles developed, examine and quantify	MPK (GMH, MC)	Convene stakeholders to operationalize scope, budgets, etc. for coordinating care and resolving disputes.	8	\$14,400

sources of financial support for all levels of care and for coordination of care staffing and associated operational costs		Examine internet-accessible means both to track bed and service availability and to share care-plans developed with consumers and treaters		
Identify Design Options for Quality Assurance, Quality Improvement and Utilization Review for the Clinical Care Management System	NB, RD	Identify service delivery process - ID points of entry, data collected, billing system. Identify state mandated data, Create internal evaluation process, plan – entry to discharge. Work w/stakeholders	26	\$22,531
Staffing Support for the Care Management design and Development Process	NB	Develop schedule for working with stakeholders	12	\$8,607
Final Report Detailing and Program Elements	NB, RD	Discussion & Writing	19.9	\$14,944
Total Professional Fees (CHPPR)				\$46,004
Total Consulting Costs (including travel and supplies \$8,600)				\$110,500
Travel and Supplies (CHPPR)				\$3,906
Total Costs				\$160,410

* The assumption is being made that the lead will work with all team members to accomplish each objective.

RD: Ron Deprez, Ph.D., MPH

NB: Nancy Brossoie, Ph.D.

GHM: Gail Hansen Mayer RN, CNS

KM: Ken Minkoff MD

CC: Christie Cline MD

MPK: Michael P. Krupa, Ed.D.

EB: Edie Barrett, RN

A. Staffing**\$ 29,676**

Name	Role	Total % Effort
Ronald Deprez, Ph.D., MPH	PI	2.69%
Nancy Brossoie, Ph.D.	Senior Researcher	17.35%
Jia Ling Loo	Research Assistant	7.31%
Mary Louie	Administrative Assistant	3.65%

B. Fringe Benefits**\$ 7,122**

Fringe Benefits = 24% of Total Salaries

- Retirement
- Health insurance
- Dental insurance
- Basic life insurance
- Retiree health insurance

C. Indirect Costs**\$ 9,206**

12% of all salary costs = Indirect costs

D. Office Operations**\$786**

General office supplies will be used by staff members to carry out the daily activities of the project. The supplies account for paper, envelopes, letterhead, and other supplies (\$200 requested). Printing is 15 cents per copy (\$250 requested). The printing will include all reports to the internal team and stakeholders. Telephone amount requested is 20% of the monthly \$210 telephone expense (\$336 requested).

E. Travel**\$3,120**

Two senior staff will make 3 trips to Vermont. Staff will travel to Vermont during the beginning of the project for a kickoff meeting and develop a communication plan with project advisors and agency personnel involved in the project. The trip is 500 miles at 44 cents a trip (\$220 per trip per person). Lodging is \$300 per night for 6 nights per budget period (3 nights and 2 staff members).

Travel	Amount Request
3 trips to Vermont	
Ground Transportation (500mi/ \$0.44)	\$1,320
Lodging/ meals (\$300 per night)	\$1,800

Total	\$3,120
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F. Consultant

\$ 110,500

Health Partners New England (HPNE) will lend clinical expertise in specified sections. HPNE costs include professional fees, supplies and travel.

Name	Total % Effort
Michael Krupa, Ed.D	2.74%
Ken Minkoff, MD	2.40%
Christie Cline, MD	2.40%
Gail Hanson Mayer, APRN, BC, MPH	11.87%
Edith Barrett, RN	4.11%

ID	Task Name	Start	Finish	2008											
				May	Jun	Jul	Aug	Sep	Oct	Nov	Dec				
1	Project Start-up	5/1/2008	5/6/2008												
2	Draft work plan	5/1/2008	5/2/2008												
3	Team kickoff meeting	5/5/2008	5/5/2008												
4	Finalize work plan and communication plan	5/6/2008	5/6/2008												
5	Task 1 – ID Options for Management Structures	5/7/2008	5/30/2008												
6	Review current system	5/7/2008	5/13/2008												
7	Lit review and internet search	5/15/2008	5/22/2008												
8	Draft options	5/22/2008	5/30/2008												
9	Task 2 – Written Program Description for Levels of Care	5/7/2008	5/30/2008												
10	Draft descriptions	5/7/2008	5/19/2008												
11	Meet with stakeholders	5/23/2008	5/23/2008												
12	Revise descriptions	5/26/2008	5/30/2008												
13	Task 3 – ID System Gaps and Redundancies	6/2/2008	6/16/2008												
14	Perform Analysis	6/2/2008	6/6/2008												
15	Meet with stakeholders	6/11/2008	6/11/2008												
16	Revise descriptions	6/12/2008	6/16/2008												
17	Task 4 – Create clinical admission, continued stay, and discharge criteria for each level of care	6/16/2008	7/23/2008												
18	Review previous HPNE work and draft	6/16/2008	7/11/2008												
19	Meet with stakeholders	7/14/2008	7/14/2008												
20	Revise criteria	7/15/2008	7/23/2008												
21	Task 5 – Develop Uniform protocols to operationalize activities in care management systems	8/1/2008	9/12/2008												
22	Convene stakeholders	8/1/2008	8/1/2008												
23	Draft protocols	8/4/2008	9/12/2008												
24	Task 6 – ID design options for quality improvement and utilization review	9/22/2008	10/27/2008												
25	ID state mandated data	9/22/2008	10/3/2008												
26	Create internal evaluation process	10/6/2008	10/20/2008												
27	Meet with Stakeholders	10/27/2008	10/27/2008												
28	Draft Report	11/3/2008	12/3/2008												
29	Draft report	11/3/2008	11/24/2008												
30	Meet with Stakeholders to review draft	12/3/2008	12/3/2008												
31	Final Report	1/2/2009	1/2/2009												