Care Bridge Framework

Proposal for Integrated Services for Individuals who are Dually Eligible for Medicare and Medicaid

Michigan Department of Community Health

September 5, 2012

Michigan's proposal for integrating services for individuals who are dually eligible for Medicare and Medicaid features the Care Bridge, a new model of services and supports coordination. The Centers for Medicare and Medicaid Services (CMS) requested additional details about the structure and functions of the Care Bridge as part of the review process. The Michigan Department of Community Health submitted the following documents to CMS on August 30 as a response to this request. These documents are drafts of the proposed concepts for the Care Bridge. The model will be updated as discussions with CMS and Michigan stakeholders continue.

The following documents were included as part of the packet to CMS:

- A letter from the Medical Services Administration Director Stephen Fitton to Director Melanie Bella of the CMS Medicare-Medicaid Coordination Office;
- A PowerPoint Presentation on the structure and functions of the Care Bridge;
- A narrative that describes the processes of the Care Bridge in detail; and
- Four vignettes that provide examples of how individuals who are dually eligible for Medicare and Medicaid and enroll in the demonstration would interact with the Care Bridge.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

August 30, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
2000 Independence Avenue, S.W.
Washington, DC 20001

Dear Ms. Bella:

Attached are materials that provide a more detailed description of the Care Bridge, a key component of Michigan's proposal on Integrated Care for People who are Medicare-Medicaid Eligible. These materials represent significant effort and collaboration by Medicaid and Behavioral Health staff in the Michigan Department of Community Health.

Our Department has convened two meetings with stakeholders on these Care Bridge materials, one with advocates and consumers and the second with provider associations and other service delivery interests. These meetings have generated a substantive response on certain elements of the Care Bridge with different points of concern from the different interests.

We recognize that changes will need to be made to the Care Bridge description and the associated processes and will continue to be engaged with stakeholders to design the best possible product for Michigan's dual eligible population. Rather than delay our presentation to CMS until we could conclude our deliberation with stakeholders, we are sharing the materials unchanged from their original form in order to get your reaction and include your feedback in our process. These documents are DRAFT materials.

We are anxious to more fully engage with CMS on not just the Care Bridge but the many other key elements of this initiative. We will be in touch soon to organize a process and schedule that will serve as a path to implementation.

We appreciate your partnership as we pursue this challenge knowing that our shared interest is a better service delivery system and health outcomes for this very vulnerable population.

Sincerely,

Stephen Fitton, Director
Medical Services Administration

cc: Tim Englehardt, Director of the Models and Demonstrations Group, CMS
Lynda Zeller, Deputy Director, BHDDA, MDCH

Michigan's Integrated Care for Dual Eligibles Proposal: The Care Bridge

Michigan Department of Community Health

Stakeholder Meeting

August 15, 2012

Michigan's Integrated Care Goals and Principles

Goals and Principles Development

- Shared at onset of stakeholder process
- Further evolved over the course of stakeholder events to reflect the thoughts of those who receive, provide and advocate for Medicare-Medicaid Eligibles
- Included in Michigan proposal to CMS submitted April 2012

Primary Goal

"The **primary goal** of integrating care and supports in Michigan is to design and implement an organized and coordinated delivery system that:

- Provides **seamless access** to all services for beneficiaries
- Creates a care and supports coordination model that **communicates** within its structures **by linking back to all domains** of the delivery system
- **Streamlines administrative processes** for beneficiaries and providers
- **Eliminates barriers** to home and community based supports and services
- **Improves quality** of services and **customer satisfaction**
- **Reduces the cost** of providing care to the state and federal government through improved care and supports coordination, financial realignment and payment reforms"

Core Principles

"They are:

- Above all else, the **person receiving services must be at the core** of the delivery model and the **principles of person-centered planning** developed in Michigan by advocates and people who receive services **must be preserved** and carried forward in any plan for a new care/supports coordination model
- The **components** of the existing service delivery model **that work well must be maintained** and not thrust aside for the sake of creating something new
- **Innovation** in a new system **must rely on evidence based practices**
- **Self Determination must be incorporated** into a new delivery model
- **Access** to all services **must be maintained and improved** upon in a new model

Core Principles

- **Quality standards and measurements** that are **not available in the existing delivery system must be developed** to demonstrate successes and opportunities for improvement
- A **standard risk and health assessment is essential** to eliminating redundancies and improving efficiencies in a new system
- Care and supports coordination is vital, with **a care/supports coordinator made available to every participant**

These goals and principles serve the dual purposes of preserving what is important and necessary in the current system while reaching for vastly improved integration across service domains and systems functions."

Michigan's Care Bridge

Goal/Purpose

- A care coordination framework to :
  - ***Identify*** Medicare/Medicaid dual eligible populations
  - ***Assess*** and, with the person, develop a person-centered care and supports plan based on health and social needs
  - ***Coordinate*** care and community support services
  - ***Ensure*** that person-centered health and life goals are met

Framework Assumptions

- Focus on care coordination across all settings
- Intensity of need varies by person
- Use of past service utilization to assess "dominant need"
- Lead coordinator serves as primary point of contact for person, family/caregivers, and providers
- Emphasis on maintaining existing relationships with providers
- Person is at the center of his/her integrated individualized plan

Functions of the Care Bridge

- Identify and stratify populations based on dominant need
- Develop Integrated Individualized Care and Supports Plan (IICSP)
- Ensure linkage to health and community services and supports
- Monitor the plan and occurrence of “trigger events”
- Engage in advocacy

Identify and Stratify Populations

- Many persons are currently receiving services from PIHP, LTCSS, and/or MHP
- Past utilization history applied as a "flag" to stratify populations
- Flag identifies preliminary "dominant need":
  - behavioral health/intellectual or developmental disability
  - long term care
  - complex medical
  - new enrollee/unknown
- Flag included in ICO enrollment file
- If person is a new eligible, pre-screen is conducted at time of enrollment and results passed to ICO

Assign Preliminary Lead Coordinator

- ICO responsible for assigning Preliminary Lead Coordinator (PLC)
- ICO PLC gathers initial information and identifies core integrated team members, i.e. PIHP/CMH, LTC, PCP
- A team member is designated to initiate contact with the person to begin the integrated person-centered planning process
- The PLC initiates an electronic Individualized Care Bridge Record-ICBR

Individual Integrated Care and Supports Plan (IICSP)

- A face-to-face, person-centered planning meeting is scheduled with the individual, his/her chosen allies, and the integrated care/supports team
- Individual selects Lead Coordinator (LC) who serves as primary point of contact
- Planning Process:
  - Incorporates existing assessments, plans of service, and other relevant documents
  - Identifies strengths, gaps, and needs for further assessments, services, and supports
  - Identifies who does what and when
- Result is the person-centered IICSP

Individual Care Bridge Record (ICBR)

- Secure web-based portal on which documents and messages can be posted and pushed
- Operated by ICO with access by person and team
- Used by the team to update plan and communicate among team members
- Components:
  - History, lab results, current issues list, medications
  - IICSP
  - Notes and messages about updates/changes

Linkage to Services

- LC or other designated team member(s) assist person with appointments and access to services and supports
- Person is aided in navigating the healthcare and supports neighborhood
- Formal and informal community supports are arranged
- Team members communicate via ICBR regarding progress

Monitoring the IICSP

- Lead Coordinator
  - Assures services and supports occur as planned and approved
  - Monitors for “trigger events” that change status (ED visit, crisis)
  - Follows up with individual regarding satisfaction with services, supports, life situation
  - Communicates results in ICBR
  - Monitors care and services on a regular basis as noted in IICSP or as needed or requested by the individual

Advocacy

- Identify and address barriers that prevent the person from achieving life goals
- Includes investigation, problem-solving, communication, service authorization, and other activities to remediate problems and improve the member's experience

Summary of Care Bridge Key Features

- Assures fidelity to integrated person-centered planning across all care and support team members
- Establishes role of Lead Coordinator responsible for assessment, IICSP management and monitoring, and communication
- Supported by web-based technology that maintains centralized integrated care and supports record accessible by person and his/her team members

Questions?

THE CARE BRIDGE

Introduction

Michigan's proposal to integrate services for persons who are dually eligible for Medicare and Medicaid employs two contracts as the foundation of the demonstration. The state and CMS will contract with Integrated Care Organizations (ICOs) and the state's Prepaid Inpatient Health Plans (PIHPs) to deliver services and supports: ICOs will be responsible for the provision of medical and long term care services to the program participants, while PIHPs will deliver behavioral health and developmental disabilities services. While this model differs from the original CMS guidance, the arrangement is entirely suited to Michigan's unique public system, in which public behavioral health and developmental disabilities services and Medicaid medical services are provided through well-developed, mature, but separate managed care systems.

This document describes the Care Bridge, which is the pivotal component of the Demonstration and enables, supports, and assures integration and coordination of all services and supports. Through the Care Bridge, all aspects of each member's service and support planning and delivery will be effectively integrated.

Definition

Michigan's Care Bridge is a care coordination platform through which a member, his or her allies, care coordinators, and providers will interact in conducting assessments, care and supports planning, linkage to and coordination of supports and services, service and satisfaction monitoring, and advocacy. The Care Bridge assures fidelity to Michigan's face-to-face person-centered planning processes across all providers and parties. The Care Bridge unites communication tools, current and historic data, roles and responsibilities, planning processes, and reporting requirements to enable members to receive individualized, person-centered, and seamless services and supports.

The platform will be supported by web-based technology that allows secure access to data and enables all parties to use and (where appropriate) update the member's Individual Integrated Care and Supports Plan (IICSP), issues list, medication list, and other documents. The technology also allows team members to notify one another of changes in the member's condition or plan in real time. The Care Bridge facilitates all of the following:

- Identification of the Medicaid system supports and services used by each dually eligible person prior to enrollment, to accurately recognize the individual's dominant service needs as behavioral health, developmental disability, medical, long-term care, or a combination thereof. This function is crucial in assuring that ICOs engage long-term care and behavioral health providers at the point of enrollment and throughout membership.

- Assessment of the health and social needs and development of a person-centered IICSP based on those social support needs. The Care Bridge supports the collaboration of all parties in assessment and planning processes and in appropriate periodic re-evaluation.
- Real-time coordination of all care and community support services throughout membership, across the full continuum of supports and services, during all care transitions, and as the member's needs and person-centered plan changes.
- Assurance that each person's health and life goals, as identified in the person-centered IICSP, are pursued and achieved.

Identifying Dominant Needs

During enrollment, the new member signs a consent form permitting the ICO to actively evaluate the member's historic use of Medicaid funded services and to interact with providers of behavioral health and developmental disabilities, long-term care, and MI Choice and Habilitation Supports Waiver services[1].

As the first step in the enrollment process, the state provides the enrollment broker with a file indicating whether the dually eligible person has been or is being served by a PIHP, nursing home, or the MI Choice or HAB waiver programs. The enrollment broker flags the enrollment record to indicate the systems with which the member interacts, if any. Based on that information, the enrollment broker renders a preliminary determination of the dominant need of the member: acute care, behavioral health, developmental disability, or long-term care.

If the person is newly eligible, the enrollment broker conducts a brief screening to identify possible conditions and preliminary dominant need, if there is one.

The enrollment broker enters its findings into the enrollment file that is transmitted to the ICO. In receiving notice of a new enrollment, the ICO has immediate access to the member's preliminary dominant need and Medicaid program participation. This is the first operation of the Care Bridge.

The ICO immediately assigns a Preliminary Lead Coordinator (PLC) to the member[2]. The PLC reviews the enrollment data and gathers information on the person's utilization of services from the state data warehouse. If the member is receiving or has recently received MI Choice services, nursing home care, or behavioral health/I/DD services through a PIHP including through the Habilitation Supports Waiver, the PLC contacts the appropriate organizations. Those organizations direct the PLC to a person familiar with the member's care, which will likely most be a supports coordinator or case manager. Together, they discuss the member's current issues list and services and supports, agree on the person's dominant needs, and select the most appropriate individual to reach out to the member to begin the integrated

[1] At enrollment, substance abuse diagnosis and treatment are excluded, as a separate member consent is required.
[2] ICOs will stratify the immediate needs of new members, and those with high need will engage in face-to-face development of an Individual Integrated Care and Supports Plan within a specified period of time. This document and the associated vignettes focus exclusively on members with high needs.

person-centered planning process. Person-centered planning will be a face-to-face meeting with the member and his or her allies unless the member chooses to forgo this process. This is the second operation of the Care Bridge.

Individual Care Bridge Record

The ICO is responsible for opening an Individual Care Bridge Record (ICBR) for each member. The ICBR resides on the secure Care Bridge web-based portal[3]. The ICO assigns and manages access to selected portions of the ICBR to the member, his or her allies, coordinators, and providers.

The ICBR contains documents such as assessment and lab results, the person-centered IICSP, integrated issues list, medication list, referrals, specialty provider reports, etc. It also includes a notes and correspondence tool that allows care coordinators and providers to post key member updates and to selectively "push" them to members of the integrated care and supports team. This enables near-real-time communication and assures that all team members share key information.

A "live" Individual Care Bridge Record enables and supports all subsequent member and integrated team interactions and functions as the hub of the Care Bridge.

Individual Integrated Care and Supports Plan

The ICO's Preliminary Lead Coordinator facilitates scheduling a face-to-face person-centered planning meeting with the member, his/her chosen allies, key providers, and service coordinators[4]. Until this occurs, all of the person's current supports and services continue. The service and support planning process incorporates the member's existing assessments, person-centered plans, and other relevant documents provided by various team participants and the member. In the planning process, the member identifies health and life goals, and the team (including the member) identifies strengths, gaps, need for further assessments, and service and support needs.

During the planning meeting, the member selects a Lead Coordinator (LC) who will take over as the primary contact for the member and all providers and coordinators.

The planning process identifies who does what and when, the services (including the amount, scope and duration of each), supports, and the service provider(s). It also identifies the interval at which the ICO must monitor the member's health status[5]. The result of the planning process is a person-centered Individual Integrated Care and Supports Plan (IICSP). Immediately following the meeting, the Lead Coordinator uploads the IICSP to the ICBR, where it can be viewed by all parties who have been assigned secure access.

[3] Michigan has not yet determined whether the state will develop the Internet-based platform and allocate access to the ICOs, or if the ICOs will be charged with developing separate web portals.
[4] Members have the option of excluding providers and coordinators from this process.
[5] Depending on the member's acuity as identified in the Individual Integrate Care and Support Plan, the ICO must monitor member status at intervals ranging from monthly to annually.

The IICSP is a key element of the Care Bridge and changes over time as the member's needs and person-centered plan evolve.

Care Coordination

Care Coordination is a key process of the Care Bridge. The ICO is responsible for assuring that a single person is charged as Lead Coordinator with specific care coordination responsibilities at all times. The member and his or her delegated ally selects the Lead Coordinator, and the member is offered the option to change Lead Coordinators as his or her condition changes and as desired.

In some instances, the Lead Coordinator is not an employee of the ICO. When this occurs, the ICO must contract with the Lead Coordinator's organization for integrated coordination services using a uniform description of services, duties, and payment arrangements[6]. The ICO is obligated to train the Lead Coordinator and his and her organization in their duties, roles, and obligations. The Lead Coordinator's organization is obligated to monitor compliance with contractual requirements including appropriate billing for employing the services that the Lead Coordinator is obligated to provide.

The Lead Coordinator is the key point of contact for the member and all members of the care and supports team. The Lead Coordinator updates the Integrated Care Bridge Record to assure that all team members have access to near-real-time information. He or she communicates directly with the member on a regular basis (including in person as appropriate) and interacts on the member's behalf with other team members to assure timely access to supports and services, to identify and remediate barriers, and to improve the quality of the member's experience.

Care coordination services are documented using uniform procedure codes provided by the state.

Linkages

Linkages are a key outcome of the Care Bridge. A key component of care coordination is assuring that critical linkages occur in planning, executing, and monitoring the member's supports and services. The Lead Coordinator actively facilitates such linkages in collaboration with the member. As needed, the Lead Coordinator facilitates or engages other team members to assist the member with:

- Scheduling and attending appointments;
- Communicating special needs to providers in advance of appointments/procedures
- Preparing the member for appointments and procedures
- Navigating the healthcare and supports neighborhood
- Arranging formal and informal community supports

The Lead Coordinator assures that the member has been linked to services by communicating frequently with the member and by reviewing utilization data and the ICBR. The Lead Coordinator also posts or assures that other team members post updates on the outcomes of services on the ICBR (lab results, specialty provider appointments, ER visits) and "pushes" notification to team members as appropriate.

[6] Care coordination duties across the integrated team are additive to coordination duties associated with waiver, LTC or PIHP services, and are reimbursed separately by the ICO.

Monitoring

Monitoring is a key process of the Care Bridge. Responsibility for monitoring of the member's IICSP is the joint duty of the ICO and the Lead Coordinator. At the member level, the Lead Coordinator assures that services and supports occur as planned. He or she receives alerts from the ICBR when unplanned events (such as emergency room visits, inpatient admissions or other crises) occur and makes sure that the relevant team members are alerted and that follow-up (such as discharge planning) occurs. He or she follows up with the member regarding satisfaction with services, supports, and life situation, and posts results and notes on the Integrated Care Bridge Record as appropriate. The Lead Coordinator also assures that the IICSP is updated on a pre-determined basis through the IICSP, as the member's condition changes, and/or as needed or requested by the member.

The ICO monitors each member's status at specified intervals determined by the member's acuity and specifications in the IICSP (at least annually). Formal monitoring includes assessing whether services and supports were provided as specified, if fidelity to the person-centered IICSP was maintained, if providers and coordinators submitted all required data, if the member was satisfied with supports and services, and how provider and coordinator input was incorporated into care coordination efforts.

In addition, the ICO intervenes to address interim access or quality problems as identified by any party associated with the member at any time.

Advocacy

Advocacy is a key process of the Care Bridge. Where barriers to timely, high quality supports and services are identified, the Lead Coordinator advocates on the member's behalf and intervenes as desired by the member. This includes investigation, problem solving, communication, service authorization, and other activities to remediate problems and improve the member's experience. Where the Lead Coordinator and member are not able to achieve desired results, the Lead Coordinator escalates the matter to the ICO.

Integrated Care Vignette # 1 (Ben)

Adult with SMI and Untreated Chronic Conditions

Ben is a 54-year-old man who lives with his adult daughter. He has a long history of bipolar disorder with both manic and depressive episodes requiring acute psychiatric hospitalization; his condition has been fairly stable for the past five years. He sees a case manager through the Prepaid Inpatient Health Plan (PIHP) once a month, participates in a peer support group a few times a month, and sees a psychiatrist at the local community mental health services program (CMHSP) every three months for medication management. His treatment includes a mood stabilizer and the use of anti-anxiety and sleep medication as needed.

Ben also is 60 lbs. overweight (BMI 30>) and smokes a pack of cigarettes a day. He does not have a regular Primary Care Provider and typically relies on urgent care for episodes of illness like bronchitis. He recently sprained his ankle and was told in the emergency room that his blood sugar was 300 mg/dl and his blood pressure was 170/98. He was advised to seek primary care but has not acted on this recommendation because he did not know how to find someone who would treat him.

Ben is eligible for Medicare by virtue of his work history and disabling mental health condition. His prescriptions, with the exception of his anti-anxiety medication, are paid by Medicare Part D. Ben is enrolled in Medicaid, which covers his PIHP/CMHSP services and his anti-anxiety medication. His other health care services are covered by Medicare Fee for Service. Ben enrolls in the integrated care program, and his daughter assists him in selecting an Integrated Care Organization (ICO).

The ICO enrollment broker receives Ben's enrollment information and determines whether he is served by a PIHP/CMHSP, the MI Choice Waiver or Habilitation Supports Waiver, or a nursing home. Ben's enrollment file is flagged to indicate that he is receiving Medicaid services that are managed by a PIHP.

The ICO receives Ben's enrollment file and assigns a preliminary lead coordinator (PLC). The PLC notes from the enrollment file that Ben has been receiving services through a PIHP. The PLC contacts the PIHP liaison, who connects her with Susan, Ben's Case Manager for the past three years. Together, they review Ben's current individual plan of services developed through the person-centered planning process and his medication prescribed by the CMHSP psychiatrist. Based on Ben's lack of a relationship with a Primary Care Provider and his current health status, they decide that Susan should initiate contact with Ben to discuss his ICO enrollment and begin the process to develop an Individual Integrated Care and Supports Plan (IICSP). In the meantime, the PLC establishes an electronic Individual Care Bridge Record (ICBR) on the ICO's web portal and grants Susan access to it.

Susan contacts Ben and arranges for a face-to-face meeting with him, the ICO PLC, herself, and Ben's chosen allies. With the participants, Ben identifies his life and health goals and develops an IICSP that addresses all of his objectives, including the continuation of his established relationship with the CMHSP psychiatrist who has been prescribing his medications. During the meeting, Ben also selects Susan as his Lead Coordinator, and she accepts. The intervals at which Ben and Susan will meet are also identified.

After the meeting, Susan documents Ben's Individual Integrated Care and Supports Plan and loads it on the ICBR. It includes the following goals:

- Evaluate and control his blood sugar and blood pressure
- Consider a smoking cessation program
- Enroll in a weight management program
- Avoid getting bronchitis this winter
- Manage bipolar disorder so that moods are stable and quality of sleep is high
- Try a moderate exercise program

Over the next few weeks, Susan helps Ben select a Primary Care Provider, schedule an appointment, and obtain orders for lab tests that can be completed before the appointment. Susan forwards Ben's IICSP to the Primary Care Provider the week before Ben's appointment and gives the office access to the ICBR. Susan also confirms with Ben's daughter that she will assist with transportation to the lab and his appointment.

Ben meets his Primary Care Provider and Nurse Care Manager and undergoes a complete history and physical, review of his lab results, and review of his current psychiatric issues and medications. The doctor advises Ben that he has Hypertension, Type II Diabetes, and early Chronic Obstructive Pulmonary Disease and explains that all of them are manageable chronic conditions. He prescribes medications to manage blood sugar and blood pressure to be started immediately and provides education on diabetes and dietary management. Ben is given written information on self-management of his conditions and the medications he will be taking. After the appointment, the office nurse posts Ben's lab results, prescriptions, and medical issues list on the ICBR.

At Ben's next meeting with Susan, they review the information from the Primary Care Provider, discuss how he is adjusting to the new medications and lifestyle changes, and address his mental health issues. Susan assists Ben in choosing a mental health therapist who will work with him using motivation interviewing and other behavioral health interventions to help him identify and act on his readiness to change his eating, smoking, and other behaviors and to effectively self-manage his conditions. She also forwards Ben's lab work and IICSP to his psychiatrist and encourages the psychiatrist to co-manage any changes in his psychotropic medication with the new Primary Care Provider.

All goes as planned for three months, at which time Ben suffers a broken pelvis in an auto accident. Doctors recommended that Ben undergo orthopedic surgery and extensive physical therapy. The hospital notifies the ICBR of Ben's admission, which pushes the message to Susan and Ben's Primary Care Provider. The team meets to determine who will be lead in working with the hospital discharge planner and decides that given Ben's injuries the ICO case manager will work with the hospital. Susan visits Ben periodically during his hospital stay to assess any changes in his behavioral health status and to keep abreast of his changing needs. The ICO case manager and Susan speak regularly. Susan asks Ben if he would prefer to select a different Lead Coordinator during this period of acute care needs, as required when a member's health status changes significantly. Ben elects to keep Susan.

Susan connects Ben's psychiatrist to the hospitalist[1], to effectively co-manage emerging anxiety and to stave off a manic episode. She also works with Ben to develop short-term goals and remain actively involved in planning his care. Ben is discharged home with medical equipment, short-term in-home physical therapy and nursing support, and a long list of new medications. During his first few weeks at home, Ben experiences numerous medication side effects, his anxiety worsens, and his blood pressure is elevated. Susan maintains daily phone contact with Ben and contacts the Primary Care office to arrange for in-home lab work. She arranges for a teleconference between the psychiatrist and Primary Care Provider to review the labs and to modify Ben's medications. Within another two weeks, Ben's mood has stabilized and his blood pressure and blood sugar levels are within normal limits. Susan phones Ben every few days for a brief check-in. Ben continues to gain functioning and eventually returns to his stable, pre-accident state.

INTEGRATED CARE HIGHLIGHTS

Member Experience

The dually eligible person is at the center of care planning and delivery. The process assures fidelity to the elements of Person Centered Planning. A single individual is always available and accountable to the member for coordination of all services and for maintaining a single integrated plan. The member is offered the option to alter care coordination responsibilities as his condition evolves. There is no disruption of the existing services provided by the CMHSP and managed by the PIHP, and the member's medical care is more closely integrated with his behavioral health services.

Elements of the ICO and PIHP contracts and the Care Bridge are transparent to the member but provide for timely, efficient, well-planned, and responsive supports and care from an integrated team that addresses the member as a whole person.

Relevant Elements of the Care Bridge

- Real-time access to current issues and medication list for all providers
- Care coordinators move in and out of the process as the member's condition evolves but are all responsible to communicate through the ICBR to assure coordination of care.
- Single Lead Coordinator who is
    - Selected by the member and responsible to the member at all times
    - Appropriately trained in person-centered planning and responsible for an explicit set of care coordination functions
- Timely communication between all providers, facilitated by the Lead Coordinator
- Timely and informed care transitions
- Coordination with specialty care providers to accommodate the member's unique needs.
- The ICO or PIHP provide cross-training to employees or contractors providing supports and services to the member.

[1] Most hospitals employ "hospitalists" who are physicians that manage the inpatient stay.

Integrated Care Vignette #2 (Ada)

Nursing Home Resident

Ada is an 87-year-old woman in very frail condition. She suffered a stroke four years ago that left her very weak on her left side and with speech limitations. She is a resident of Valley Nursing Home, where she receives extensive assistance with mobility and several other Activities of Daily Living (ADLs). At Valley, she participates in social activities, cares for a collection of houseplants, and interacts with her son and his family who visit weekly and occasionally take her on outings. She takes blood pressure medication and gastric acid medication prescribed by the house medical director, Dr. Prat.

Ada and her son periodically consider a transition back to the community, but Ada prefers to stay at Valley. Medicaid pays for Ada's nursing home care. Her prescription drugs and any off-site medical services are covered by Medicare fee for service.

Ada receives information to enroll in the duals program. Neither of the Integrated Care Organizations (ICOs) available to Ada show that they have a contract with Valley Nursing Home, but both guarantee that she will not have to move if she enrolls. Ada and her son are not sure how joining an ICO will alter her care, but they are interested in the supplemental dental benefit that some of the ICOs offer. They select an ICO together, and Ada enrolls.

The enrollment broker receives Ada's enrollment information and checks the file provided by the state to determine whether she is or has been served by a Prepaid Inpatient Health Plan (PIHP), MI Choice or Habilitation Support Waivers, or a nursing home. The broker flags the enrollment record accordingly. From this information, the enrollment broker makes a preliminary determination that Ada's dominant need is based in long-term care. Her enrollment file is flagged to indicate that she is a nursing home resident and that her preliminary dominant need is long term care.

The ICO receives Ada's enrollment information and assigns a preliminary lead coordinator (PLC) who gathers initial information from the data warehouse identifying the nursing home serving Ada and recent services and prescriptions she has used. The PLC notes that Valley Nursing Home is not contracted with the ICO.

The PLC contacts Kay, Ada's social worker at Valley, to discuss Ada's new membership in the ICO. Together, they review her current status, medications, and existing care plan. They decide that Kay should approach Ada and her son to set up a face-to-face meeting with the ICO. Kay will explain that the purpose of the meeting is to build communication and care coordination between Ada, Valley Nursing Home, and the ICO and to establish Ada's Individual Integrated Care and Supports Plan (IICSP). Ada can identify other allies to participate as well. In the meantime, the PLC establishes an electronic Individual Care Bridge Record (ICBR) on the ICO's web portal.

At the meeting, the PLC describes how payments for all of Ada's care will be managed by the ICO. She describes the ICO policy of holding Ada's bed at Valley should she need to be hospitalized, so that she

can return to her previous room and bed upon her discharge from the hospital. She describes the need for a single IICSP, which will be modified by Ada and her care and supports team should her condition change over time. Ada has a Nursing Facility care plan that she does not wish to modify at this time, except to add that she wishes to return to Valley if she should require a hospital stay.

The PLC describes the ICO's web based ICBR to the team. Finally, she describes how the ICO requires that Ada have a single Lead Coordinator of Ada's choice[1] that interacts with Ada and all her providers, performs a set of explicit functions, interacting with the ICO care manager assigned to Ada, and bills for all care coordination activities. Ada and her son want Kay to fill that role. Kay agrees. The PLC provides Kay with access to the ICBR. Finally, she connects the nursing home billing office with the ICO to establish reimbursement for Ada's care, which will include payment for care coordination services required by the ICO.

Following the meeting, Kay updates and transfers Ada's Nursing Facility care plan to the ICO's IICSP template and uploads it and Ada's medication list, current issues list, and allergies to the ICBR. She flags Ada's medical chart to indicate that all care must be coordinated with the ICO and its network.

A few weeks later, Ada develops abdominal pain unrelieved by dietary changes. Dr. Prat orders lab work, which indicates her hemoglobin is dropping. He prepares to refer Ada to a gastroenterologist. Kay ensures that the ICO is contacted for identification of a network provider and authorization of services. An appointment is authorized and scheduled.

At the gastroenterology appointment, the specialist orders an upper gastrointestinal examination to be done at the network hospital. Dr. Prat orders the preparation and Kay arranges for the appointment, transportation, and a staff member to accompany Ada. During the procedure, Ada is found to have a significant bleeding ulcer and is rushed into surgery with the consent of her son. He notifies Kay, who notifies the ICO. The ICO assigns a case manager and directs Kay to use her as the primary ICO contact for this episode of illness.

Ada's surgery is successful, and she revives after several blood transfusions but develops a serious wound infection at the surgical incision. The ICO case manager and hospital discharge planner facilitate discharge planning between the hospital and Valley. The plan is for Ada to return to Valley after an eight-day hospital stay. At Valley she will need twice daily wound care, IV antibiotics for five more days, and coordination with an infectious disease specialist until the wound is healed. The ICO case manager ensures that Ada's IV and other new post-operation medications and are ordered and delivered to Valley before discharge occurs. Kay updates Ada's IICSP on the ICBR.

Kay and the ICO case manager communicate daily for the first week Ada is back, and Dr. Prat confers with the Infectious Disease physician and writes all the orders for Ada's care. Three weeks after discharge, Ada has returned to her normal level of functioning.

[1] The Lead Coordinator must meet minimum standards established by the state and monitored by the ICO.

INTEGRATED CARE HIGHLIGHTS

Member Experience

The dually eligible person is at the center of care planning and delivery. As a nursing home resident, the member's nursing home remains her long term care provider even though the nursing home is not under contract to the ICO. The coordination and payment arrangements are transparent to the member, who experiences seamless transition from the nursing home to the hospital and back.

Integrated Care Vignette #3 (Suzie)

Adult with Intellectual/Developmental Disabilities

Suzie is a 45-year-old woman with an intellectual disability and cerebral palsy. She uses a power wheelchair with customized seating due to low muscle tone and difficulty sitting upright without support. Suzie lives in a group home with three other women. Her Medicaid supports and services are provided through the community mental health services program (CMHSP) and managed by the pre-paid inpatient health plan (PIHP). She likes to go out with her friends for social activities several times a week, and she has a part-time volunteer position at the local Humane Society.

The group home is staffed 24-hours a day by aides who have been trained to implement the ladies' plans of services and is supervised by Carol, the group home manager. They transport Suzie to her activities and stay with her because she needs assistance with toileting. Suzie also receives monthly visits from Kim, her Supports Coordinator from the CMHSP, to monitor her plan of service and to assure her needs are met. A nurse from the CMHSP makes quarterly home visits to monitor Suzie's health and receives calls from Carol when Suzie is ill. The CMHSP also provides an occupational therapy (OT) consultation annually for positioning in the wheelchair. Her Primary Care Provider sees her annually for routine physicals, and the group home staff or CMH nurse contacts the Primary Care Provider as needed for acute problems. The office can accommodate a wheelchair, but typically the provider examines Suzie in her chair, as the exam tables are immobile and office staff are not equipped or trained to transfer her.

Suzie is prone to frequent upper respiratory infections (URIs). The URIs appear year round and are resolved after a course of antibiotics, but recur. Typically, the CMHSP nurse or the home manager reports the infection by phone to the Primary Care Provider's office, and the provider orders antibiotics without seeing Suzie.

Kim helps Suzie enroll in the integrated care program, and both are excited that Suzie can receive vision services, as her glasses are five years old. Suzie opts for the Integrated Care Organization (ICO) that includes several primary care offices with moveable exam tables, her current wheelchair provider, and a supplemental vision benefit. Suzie understands that she will change Primary Care Providers.

The ICO enrollment broker receives Suzie's enrollment information and determines whether she is served by a PIHP/CMHSP, the MI Choice Waiver or Habilitation Supports Wavier, or a nursing home. Suzie's enrollment file is flagged to indicate that she is receiving Medicaid services that are managed by a PIHP.

The ICO assigns a preliminary lead coordinator (PLC) who gathers initial information from the data warehouse identifying the PIHP serving Suzie and recent services and prescriptions she has used. The PLC contacts the PIHP liaison, who connects her with Suzie's Supports Coordinator, Kim. Together, they review Suzie's current issues list, supports and services, and medications. They decide that Kim should approach Suzie about scheduling a face-to-face meeting to begin developing an Individual Integrated Care and Supports Plan (IICSP). Kim will help Suzie identify the allies she would like to participate. In the

meantime, the PLC will establish an electronic Individual Care Bridge Record (ICBR) on the ICO's web portal, and grant Kim access to it.

Suzie, Kim, Carol, Suzie's sister (at Suzie's request), and the CMHSP nurse attend the meeting, along with the ICO PLC. During the session, the team reviews Suzie's current individual plan of services that was developed through the person-centered planning process. The PLC explains how Suzie will access health care services through the ICO and, in the short term, how to reach the ICO for after-hours physical health issues until she has been seen by her new Primary Care Provider. The CMHSP nurse reports that Suzie's frequent respiratory infections might be due to silent aspiration of food as a result of Suzie's low muscle tone and slouched posture when she sits in her wheelchair too long. The group home manager also reports that transferring, dressing and undressing, and positioning Suzie for exams takes a considerable amount of time and that Suzie has not had a gynecological (GYN) exam that anyone can recall.

Suzie and the participants agree that she should select and see a Primary Care Provider and that Carol or the CMH nurse should contact the ICO if Suzie develops an acute problem before that time. Suzie adds three items to her IICSP: get a GYN exam, have her frequent coughs evaluated, and get new glasses. Suzie decides that Kim should serve as the Lead Coordinator. Kim's first duties will be helping Suzie select a Primary care Provider, requesting that Suzie's primary care records be transferred to the new Primary Care Provider, and uploading Suzie's new IICSP into the ICBR.

Suzie and Kim schedule a physical exam with Suzie's new Primary Care Provider and request a longer appointment time than normal to accommodate her needs. At Suzie's first appointment with her new Primary Care Provider, a videofluroscopy test is ordered to evaluate her coughing. The referral process automatically notifies the ICO care manager, who identifies a radiology provider that has some experience with adults with intellectual/developmental disabilities. The ICO care manager contacts Kim and recommends that Kim discuss accommodations that Suzie may need to complete this difficult test with the radiology office. The radiology office agrees that Carol or an aide can be in voice contact with Suzie throughout the test and at her side where clinically appropriate.

The test is challenging but is completed, and it confirms small aspiration events when Suzie swallows thin liquids. The Primary Care Provider writes a prescription for OT and speech therapy assessments to recommend positioning and eating strategies, and Kim advises him that the CMHSP has contracts with therapists who are experienced in working with adults with intellectual/developmental disabilities. Kim updates Suzie's record on the ICBR to reflect these developments.

The CMHSP OT and Speech Pathologists evaluate and develop interventions to improve posture during mealtimes and for thickened liquids, and they teach the group home staff. Kim monitors Suzie's status on a monthly basis, and the CMHSP nurse evaluates Suzie on a quarterly basis. Both enter their evaluations on the ICBR. The CMHSP OT and Speech Pathologist are available as needed for modifications to the plan.

In the interim, Kim works with the Primary Care office to schedule a GYN exam for Suzie and provides insight into how Suzie's fears can be allayed through allowing Carol to be present (though not in view of

the procedures) during the exam. Kim prepares Suzie for the exam with teaching and coaching. Suzie is moderately anxious during the exam, but it is completed without incident.

Suzie goes all winter without a URI, and enjoys her new glasses. Kim updates Suzie's IICSP on the ICBR when changes occur so that any provider seeing Suzie can immediately see her current status.

INTEGRATED CARE HIGHLIGHTS

Member Experience

The person with dual eligibility is at the center of care planning and delivery and experiences seamless and carefully integrated care and support. Regardless of the number of involved parties, the member experiences care provided by an integrated group of providers who understand her needs and work together to address them. The member always has a single individual who is available and accountable to her for coordination of all services and for maintaining a single integrated plan. The group of providers also have a single individual at all times who is available and accountable to them for coordination of all services and for communicating the member's unique needs. There is no disruption of the existing services provided by the CMHSP and managed by the PIHP, and the member's medical care is more closely integrated with her intellectual/developmental disability services.

Relevant Elements of the Care Bridge

- Access to integrated current problem and medication list for all providers.
- Single Lead Coordinator who is:
    - Selected by the member and responsible to the member at all times;
    - Appropriately trained and responsible for an explicit set of care coordination functions.
- Timely communication between all providers, facilitated by the Lead Coordinator.
- Coordination with specialty care providers to accommodate member's unique needs.
- The ICO or PIHP provide cross-training to employees or contractors providing supports and services to the member.

Integrated Care Vignette # 4 (Roscoe)

Transition from Nursing Home to Community

Roscoe is a 71-year-old man who has resided in a nursing home for the past five years. He has had nine hospital admissions during that time, primarily for heart failure and pneumonia. Roscoe has emphysema, insulin dependent diabetes, congestive heart failure, and intermittent depression. He is very obese and uses oxygen at all times. Roscoe is on 15 prescription medications, managed by his nursing home medical attending physician. He is alert and engaged with his family of four daughters, and one, Ellen, is his payee and takes care of his bills.

Ellen brings Roscoe the information received in the mail about the integrated care program. Roscoe seizes on the information about transitioning people from nursing homes to community, as he is adamantly determined to live independently once again. Roscoe decides to enroll, and Ellen submits his application. The enrollment broker receives Roscoe's enrollment information. Reviewing the file provided by the state, the broker confirms that Roscoe resides in a nursing home and flags the enrollment record accordingly to forward to the Integrated Care Organization (ICO). The enrollment broker makes a preliminary determination that Roscoe's preliminary dominant need is based in long-term care.

Before the ICO can take action, Ellen phones the new member line and asks for care coordination assistance, as described in the ICO's literature. Ellen describes Roscoe's passionate desire to leave the nursing home, and his family supports this desire, though none of his children can accommodate Roscoe in their homes. The ICO assigns a preliminary lead coordinator (PLC) who locates the enrollment file, gathers utilization data from the data warehouse, and contacts Roscoe's daughter.

The PLC arranges for the family, Roscoe, other allies he selects, and the nursing home social worker who works with Roscoe to meet at the nursing home in order to create an Individual Integrated Care and Supports Plan (IICSP) that addresses Roscoe's wishes. The PLC also recognizes that Roscoe will need significant coordination of his supports and services and engages Rick, a care manager from the ICO, who will be permanently assigned to Roscoe's case. Rick attends the care planning meeting in the place of the PLC, who will no longer be involved.

The care planning team reviews and discusses Roscoe's medical history, his current Nursing Facility care plan, and his wish to live in the community. The daughters describe what supports they can and cannot offer, and together they develop a list of services and supports Roscoe would need. These include assistance in locating accessible and affordable housing, personal care and homemaker services, meals, durable medical equipment, transportation, medication management and administration support, a personal emergency response system, incontinence supplies, ongoing monitoring, and primary care medical home. Rick suggests a mental health consultation, but Roscoe declines it for the time being.

Rick explains that the ICO provides a continuum of Home and Community-Based Services (HCBS) that includes a Nursing Home Level of Care Assessment, which serves as the basis for identifying HCBS needs and coordination of HCBS services and supports[1].

At the end of the meeting, Roscoe decides that Rick should be his Lead Coordinator for the time being, who becomes responsible to all parties for coordinating services and on-going communication within and across the team. Rick establishes an electronic Individual Care Bridge Record (ICBR) on the ICO's web portal and grants the nursing home and Roscoe and his daughter Ellen access to it. He posts the IICSP, history, current issues list, allergies, and medication list on the ICBR.

Rick refers Roscoe's case to the ICO's HCBS contractor to assess Roscoe's ADLs and IADLs and to develop a proposed plan of HCB supports and services. The agency assigns Maggie as the Supports Coordinator. Maggie works closely with Roscoe, Ellen, and Rick to find and furnish housing for Roscoe. When housing is nearly finalized, the four of them and the nursing home social worker meet again to finalize Roscoe's community-based plan of services and supports. The agency has recommended the following services:

- One home delivered meal per day each weekday
- Two hours a day of personal care service each weekday
- Four hours of homemaker services a week
- Four hours a week of support for IADLs including banking and grocery shopping
- Portable oxygen, a walker, shower chair, toilet riser, and incontinence supplies
- An emergency response system
- Weekly nursing visit for one month, to set up oral medications and insulin and train Ellen to take over those functions.

The team discusses and agrees on the plan of services and supports. They discuss how the personal care and homemaker services will be managed.[2]

Rick obtains ICO authorization for the services, and Maggie initiates them. Roscoe's discharge date is set. Rick updates Roscoe's' IICSP on the ICBR. The nursing home physician writes prescriptions for 30 days of medications, which Ellen fills at the local pharmacy. Rick works with Roscoe to select a primary care physician and to schedule his first visit for one week after discharge. Rick arranges for non-emergency transportation to the office visit and assures Ellen that she can and should go with Roscoe. He forwards Roscoe's IICSP to the primary care office before the appointment and gives the office access to the ICBR.

Following a send-off party, Roscoe is discharged from the nursing home to his new apartment. The daughters decide to take turns sleeping on Roscoe's couch the first week he is in his new home and to gradually wean away until he is on his own. All his HCBS services begin as scheduled. After a complete exam by his new primary care provider and two fairly uneventful weeks at home, Rick arranges for a

[1] MDCH is considering ICO network requirements for HCBS; details are not finalized.
[2] MDCH is considering options for ICOs to assure access to Home Help services; details are not finalized.

face-to-face meeting to update Roscoe's IICSP. Maggie, Roscoe, Ellen, Rick, and the primary care nurse (by phone) participate. Roscoe identifies the following goals:

- Remain at home without accidents or unexpected illnesses
- Attend church on Sundays
- Keep his blood sugar under good control
- Get a cat

The team determines that his current services and supports are sufficient. Rick trains everyone on how to handle medical emergencies and changes in Roscoe's condition. Roscoe and the team decide that Roscoe does not need Rick's clinical involvement nearly as much as his success at home continues. They decide that Maggie should take over as his Lead Coordinator. The ICO provides Maggie with training in the duties and functions, pays for her services, and gives her access to the ICO ICBR. Maggie maintains monthly phone contact with Roscoe, coordinates services and supports as needed, and visits his home every six months to update his IICSP as necessary. She posts updates on any changes in Roscoe's condition and needs on the ICBR.

Roscoe lives in his apartment with his cat and achieves all of his health and life goals.

INTEGRATED CARE HIGHLIGHTS

Member Experience

The person who is dually eligible is at the center of care planning and delivery. His desire to move out of the nursing home is addressed by a competent multi-disciplinary team of community-based and clinical providers led by a HCBS contractor nursing facility transition worker, who work seamlessly to develop a challenging transition plan.

Relevant Elements of the Care Bridge

- Care coordinators and case managers move in and out of the process as the member's condition evolves but are all responsible to communicate with the integrated team.
- Single Lead Coordinator who is
    - Selected by the member and responsible to the member at all times
    - Appropriately trained and responsible for an explicit set of care coordination functions
- Timely communication between all providers, facilitated by the Lead Coordinator
- Timely and informed care transitions