VCP Presentation: Regional Navigation/Care Coordination

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The legislative goal for regional navigation and resource centers is to foster improved access to efficient, medically necessary, and recovery-and resiliency-oriented patient care at levels of support that are least restrictive and most integrated for individuals with mental health conditions, substance use disorders, or co-occurring conditions. This goal certainly includes other coordination models that address the goal of an integrated delivery system.

The Designated and Specialized Service delivery system has been focusing on integrated care for years. The system strives toward a health delivery system that is integrated (inclusive of mental health, developmental disabilities, substance use, social determinants) and that is both person and family centered and directed. Every agency is at some level of the six levels of collaboration and integration as identified by SAMHSA and HRSA.

Past and current work includes participating and leading integrated care efforts through:

- The Blueprint for Health
- Unified Community Collaboratives
- Case by case coordination
- Psychiatric consultation, including tele-psych
- Collaborative "office rounds"
- DA clinicians in EDs
- Development of, and participation in, care teams
- Shared care plans and information sharing
- The provision of staff in primary care and pediatric practices
- Bi-directional models of care allowing for physical health services to be provided within designated agencies
- Staff in schools and child care
- Integrated Family Services
- Screening with community partners to provide postpartum depression and anxiety screenings and interventions
- Screenings that identify the social determinants of health needs and assistance with services to address those needs
- Increased services to house the homeless
- Embedded staff in police departments
- Education and training initiatives to address stigma, trauma, evidence based practices, YMHFA, work with law enforcement and integrated care delivery
- SASH and more.

Vermont Care Partners

Health care reform has incentivized regional collaboration in ways that have moved community based partners to work even more closely together expanding upon the work they have been doing.

Most recently, in the Medicaid Next Gen communities, OneCare has established an enhanced care coordination model in which four regions are participating. VCP and its network agencies agree with the care coordination model vision as it is similar to our own: high-quality, person-centered, community-based, integrated, and optimal health outcomes. The central component of the care coordination model is the use of care navigator – a care coordination tool that enables the sharing of information and shared care plans. VCP and the four agencies want to enhance care coordination statewide and are working with OneCare to address issues around compliance, payment, consent and information sharing. It is important for OneCare to understand that our agencies are designated by the State and as such, there are certain expectations agencies need to meet and rules they need to follow. The agencies have a 90+page master grant with the State that includes many expectations around clinical practices, assessment tools, and outcomes that while worded differently might meet the OneCare expectations. It will be important for the State and OneCare to work together to ensure that expectations are in alignment as they relate to: prioritization; data collection; payment; use of care coordination tools; and policies and procedures, and more.

Barriers to care coordination continue to play a factor. The most significant of which is information sharing and integrated data. The State of Vermont and their community based partners are limited in their ability to truly integrate data due to three primary issues:

- 42CFRPart2
- Electronic Medical Records
- Consent Management

If we are unable to resolve these issues, true care coordination that results in integrated care delivery to both reduce costs and to improve the health of individuals and the population at large cannot be realized. In addition, collaboration rather than competition should be incentivized and payment equity to level the playing field must be a top priority. There are many innovative models of care coordination and integration occurring around the state that could be further developed and replicated. For those to be successful, and in order focus to truly care for Vermonters, we must act as a system of, and for, all.

Thank you.

Simone Rueschemeyer