VHCIP Care Management Survey

October 16, 2014

Georgia J. Maheras, Esq., Project Director

Erin Flynn, MPA, Senior Policy Advisor

VHCIP Care Models and Care Management Work Group

- One of seven VHCIP/SIM Work Groups
- Key Tasks:
  - Map current landscape of care management activities in Vermont
  - Identify redundancies, gaps, and opportunities for innovation and coordination in order to address unmet needs, minimize duplication and improve alignment
- Tasks accomplished through:
  - Presentations by those performing care management activities
  - Releasing a survey

Key CM Functions

Center for Medicare and Medicaid Innovation

- Individual Identification and Outreach
- Needs Assessment
- Develops, Modifies, Monitors Care/Support Plan
- Referrals to Specialty Care
- Planning and Managing Transitions of Care
- Medication Management
- Individual Education
- Connections to Community/Social Service Organizations
- Team-based Care

Populations Most Likely to Receive Higher than Average Allocation of CM Services

- **People with Multiple Co-morbidities**
  - High Risk Management
  - Disease Management
  - Short-Term Case Management
  - Prevention/Wellness Engagement
- **People with Mental Health & Substance Abuse Needs**
  - High Risk Management
  - Special Services Management
  - Episodic Pathways
  - Life Resource Management
- **People with Multiple ED Visits**
  - Utilization Management
- **People at risk due to Social Determinants of Health**
  - Short Term Case Management
- **People discharged from IP services**
  - Post-Discharge Follow-up

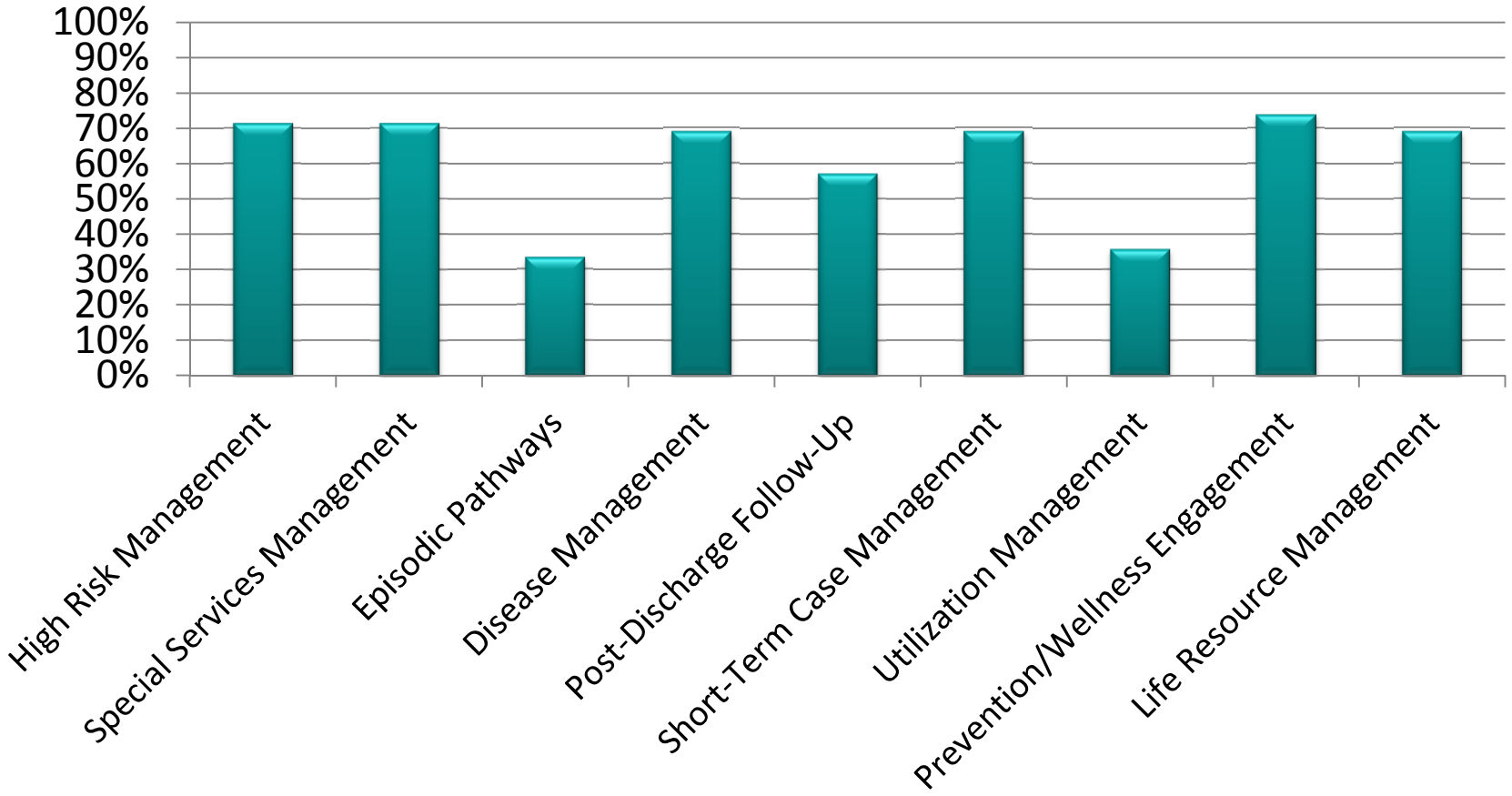
Survey

- Fielded from May 23rd – July 23rd 2014
- 42 organizations responded in the following categories:
  - ACO
  - Blueprint Community Health Team
  - Health Plan
  - State Agency
  - Community Service Provider
  - Health Care Provider
- 481 FTEs identified working on care management

Responding Organizations by Geographic Area

County	# of Organizations	% of Responses
Statewide	13	31%
Addison County	6	14%
Bennington County	4	10%
Caledonia County	2	5%
Chittenden County	4	10%
Essex County	2	5%
Franklin County	4	10%
Grand Isle County	2	5%
Lamoille County	2	5%
Orange County	7	17%
Orleans County	1	2%
Rutland County	4	10%
Washington County	6	14%
Windham County	5	12%
Windsor County	6	14%

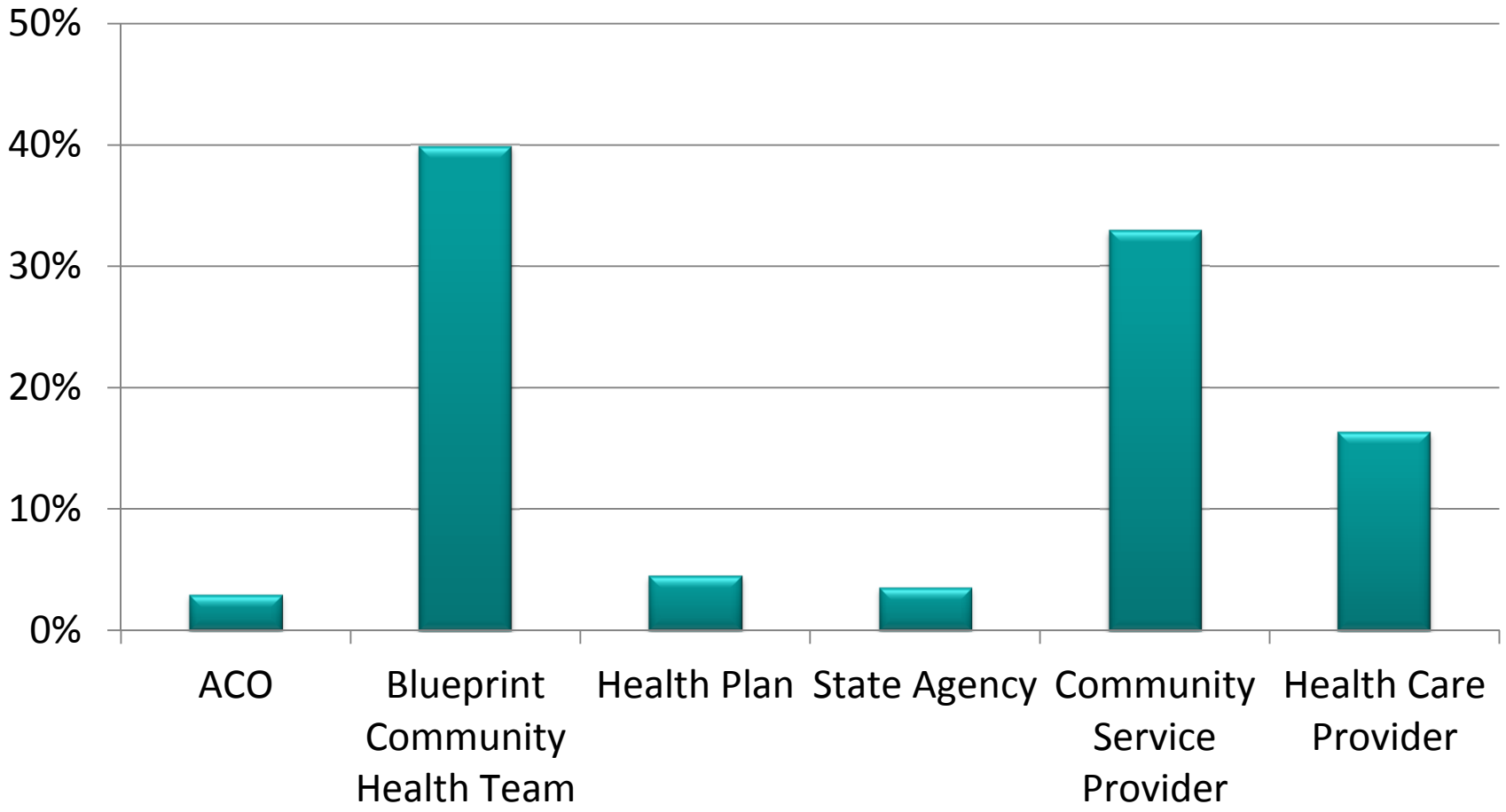
Percent of All Responding Organizations Providing CM Services By Type of Service



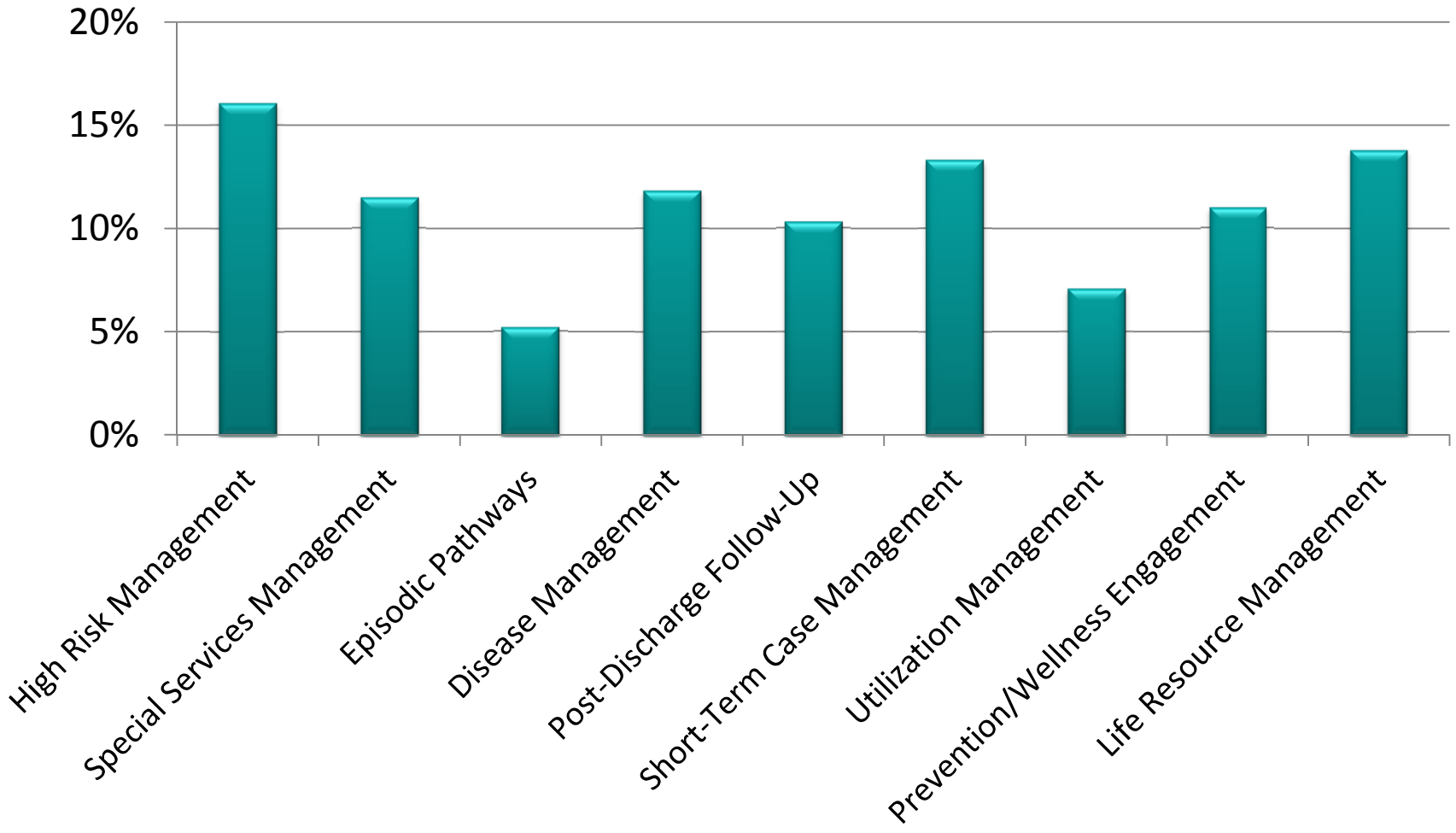
Number of Respondents: 42

Vermont Health Care Innovation Project

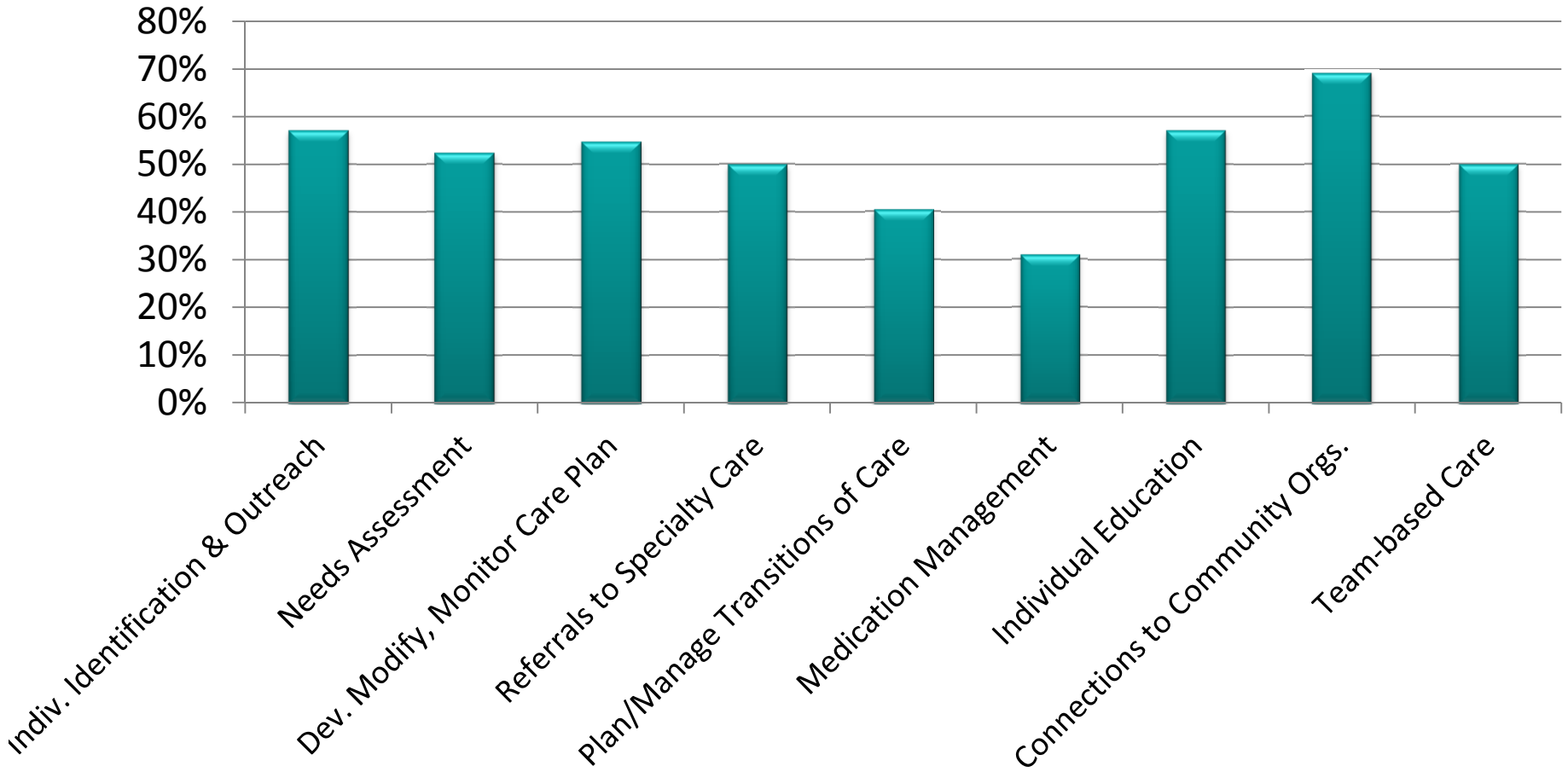
Estimated Percentage of People Receiving CM Services by Type of Organization



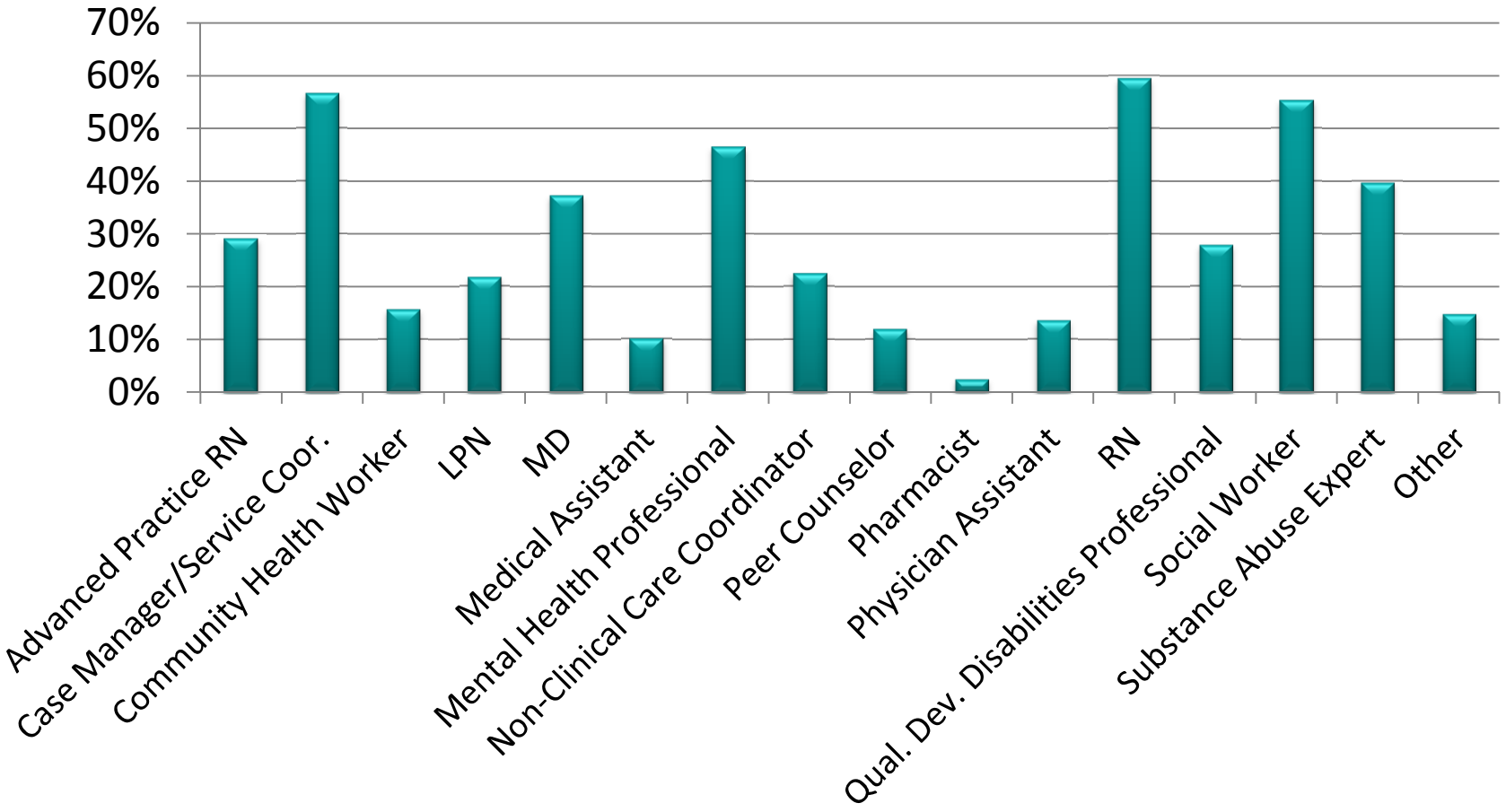
All Organization Types: Estimated Percent of People Receiving CM Services Provided by Service Types



Percent of Responding Organizations Performing Key CM Functions



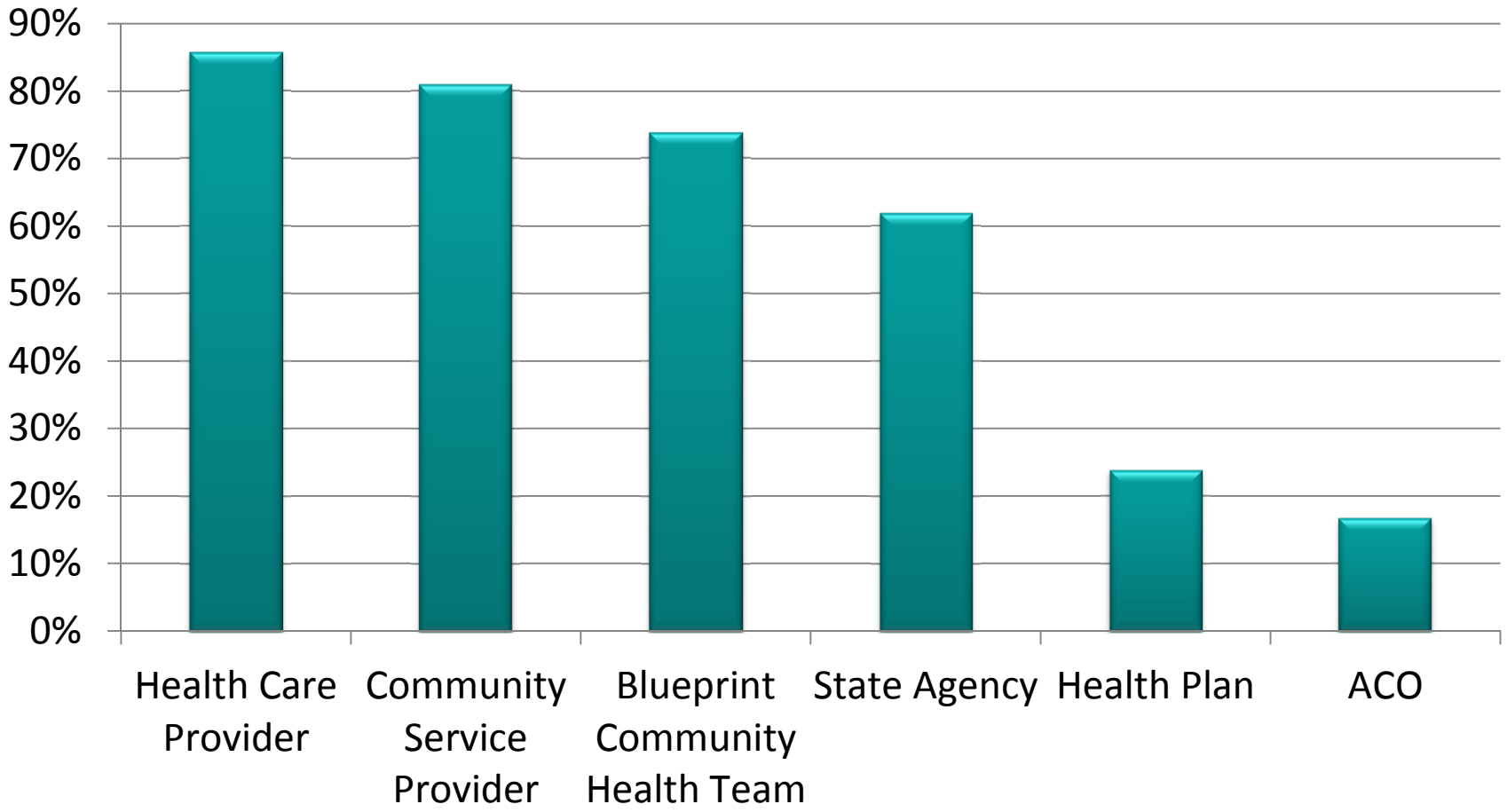
All Responding Organizations' Staffing by Type



Frequency of Interaction for All Responding Organizations by Type of Interaction

Organizations with which responding organizations Indicated interactions	Percent of all responding organizations indicating that they share information with this organization	Percent of all responding organizations indicating that they share resources with this organization	Percent of all responding organizations indicating that they make referrals to this organization	Percent of all responding organizations indicating that they receive referrals from this organization
ACO	62%	19%	17%	29%
Blueprint Community Health Team	83%	64%	74%	71%
Community Service Provider	88%	62%	81%	88%
Health Care Provider	90%	60%	86%	88%
Health Plan	55%	21%	24%	36%
State Agency	83%	40%	62%	67%
Count of Organizations Reporting	42			

Frequency With Which Responding Organizations Answered, "We make referrals to this organization," by Organization Type



Relatively High (H) and Low (L) Numbers of Relationships by Type of Relationship and Type of Organization

Nature of Interactions Between Organizations (Functional Care Mgmt Teams)	Legal Relationship (e.g., contract, MOU)	Financial Relationship (funding supports team interaction)	Regular, Structured Interaction (e.g., scheduled meetings)	Ad Hoc Interaction Using Established Communication Mechanisms
Average Rate for All Respondents	24%	19%	43%	54%
ACOs	H			L
Adult Day Providers	L	L	L	
Blueprint Community Health Teams	H	H	H	
Children with Special Health Needs Providers	L			
Community Action Agencies	L	L		
EPSDT Providers			L	L
Faith-Based Organizations	L	L	L	
Fitness Providers			L	L
Health Care Provider Offices	H		H	H
Health Insurers		H		
Home Health Agencies/VNAs			H	H
Hospitals	H	H	H	H
Housing Organizations				H
Medicaid VCCI		L		
Mental Health Providers (Designated Agencies)	H	H	H	
Schools				H
Transportation Providers				H

Top Four Challenges Experienced by CM Organizations (In Bold)

- **Difficulty identifying individuals**
- Insufficient funding
- **Challenges in recruiting qualified staff**
- Services not currently reimbursed by payer
- Lack of communication mechanisms with other organizations
- Challenges to developing relationships between organizations
- **Technical barriers to sharing information between organizations**
- Privacy barriers to sharing information between organizations
- Privacy concerns
- **Challenges in engaging individuals**
- Challenges in engaging providers

Care Management (CM) Services Definitions

- **High Risk Management** is the deliberate organization of care activities for high risk individuals, designed to improve their health status and reduce the need for expensive services. High risk people may include individuals experiencing serious illness, high utilization of health care services and/or transitions in care (e.g., changes in setting, service, practitioner, or level of care).
- **Special Services Management** is the deliberate organization of care activities for a specified population requiring ongoing management (other than high risk individuals and those receiving disease management services), for an undetermined time frame. Examples of specified populations include people with mental health or substance abuse needs, and children with special health needs.
- **Episodic Pathways** are standardized care processes used to promote organized and efficient care based on evidence-based practice for a specific group of individuals with a condition that is characterized by a predictable clinical course with a limited time frame (e.g. pregnancy, joint replacements). The interventions involved in the evidence-based practice are defined, optimized and sequenced; they are also known as clinical pathways, care pathways, critical pathways, integrated care pathways, or care maps.
- **Disease Management** is a system of coordinated interventions and communications for specific groups of people with chronic conditions for which self-care efforts can have significant impact. Disease management supports the practitioner/person relationship, development of a plan of care, and prevention of exacerbations and complications. It is characterized by evidence-based practice guidelines and strategies that empower people.

CM Services Definitions (Continued)

- **Post-Discharge Follow-Up** consists of a phone call or visit to discharged individuals within 48 to 72 hours of their departure from a care facility. The purpose is to ask about the individual's condition, adherence to and understanding of medication orders and other treatment orders, general understanding of his or her condition, and intent to attend follow-up appointments. Post-discharge follow-up is for individuals other than those served by High Risk Care Coordination, Special Services Care Coordination, Episodic Pathways, or Disease Management.
- **Short-Term Case Management Programs** are targeted and short term (30-60 days maximum) interventions with the goals of empowering individuals to better understand their illnesses and manage their own conditions, and coordinating care between individuals, providers and the community.
- **Utilization Management** is the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures to ensure appropriate access to and management of the quality and cost of health care services provided to health plan members or other populations.
- **Prevention/Wellness Engagement activities** are interventions designed to increase engagement and activation and promote positive behavior across populations, such as obtaining preventive care, exercising regularly, and modifying dietary habits. These activities may draw on the principles of positive psychology and the practices of motivational interviewing and goal setting (e.g., health coaching).
- **Life Resource Management** involves providing resources and counseling to help mitigate acute and chronic life stressors; and may include health care as well as social and/or community services.