



# VERMONT CHRONIC CARE INITIATIVE

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## ANNUAL REPORT

STATE FISCAL YEAR 2013  
ISSUED APRIL 2014

APS Healthcare  VERMONT  
**VERMONT  
CHRONIC CARE  
INITIATIVE**  
*Healthy Together*

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## Executive Summary

The Vermont Chronic Care Initiative (VCCI) has been an evolving effort by the state of Vermont to help Vermonters with Medicaid better manage their chronic conditions. In SFY 2012 the program sharpened its focus on members with the highest risk/highest cost conditions. These members are typically persons with multiple disease conditions, two or more medical providers, and six or more prescriptions for daily use. Some members are well above these averages, and some below, but in nearly all cases there are complex co-morbid conditions that require not only consistent care by a Primary Care Provider (PCP), but also specialty care.

During SFY 2013, VCCI continued to focus on non-dually-eligible Medicaid members with the highest utilization - in the top 5 percent for high risk/high cost (Top 5%) - with the exception of persons with existing case management services. For this past year the total number of individuals identified in the Top 5% by their risk scores included over 8,500 members

In this same time period, VCCI engaged over 2,000 Medicaid members via face-to-face and/or telephonic case management. Services were comprised of assessments of medical and psychosocial health, with additional disease specific assessments completed when clinically indicated. These assessments (developed with input from members and providers) helped to generate an individualized Plan of Care (POC) to focus a particular episode of VCCI case management support. The duration of case management services is impacted by case complexity and member progression toward POC goals. On average, the episodes of care were 89 days long.

VCCI is an integrated model of case management supports provided by a staff of nurses, licensed and unlicensed social workers or substance abuse professionals with clinical, mental health, and substance abuse experience and education. A major objective of the case managers is to help a member stabilize – e.g., a member with diabetes begins to improve HbA1c readings toward a goal of below 7.0. This is accomplished with a combination of member self-management and provider engagement. Motivational Interviewing techniques are used to help member along the behavioral change continuum. Members are provided self-management information relevant to their chronic condition and needs. Clinicians in primary care physician (PCP) offices and in hospital settings are provided information about their patients, including gaps in evidence-based treatment. At time of discharge from VCCI, the member has an Action Plan to continue progress with the involvement of their PCP or with further assistance from less intensive local services.

The primary foundation of the VCCI effort has been to use health analytics to identify the high risk/high cost members, then to identify gaps in care that a VCCI case manager could address with the member and their providers. A careful review of the outcomes of this effort shows success for the VCCI interventions in SFY 2013. The expected Per Member Per Month (PMPM) rate of increase in the cost of care for this group was 13.38% over the previous two years, or from \$2,688.26 PMPM in the baseline year (SFY 2011) to \$3,047.68 PMPM in SFY 2013. The outcome data indicates the actual PMPM for the high risk/high cost population was \$2,767.20 PMPM. Thus, overall care expenses were \$27,633,227 lower than projected, an average of \$280.48 PMPM for SFY 2013. After subtracting total administrative program costs, the total net savings were \$23,475,731, an average of \$238.28 PMPM for SFY 2013. VCCI has been successful in its focus on the high risk/high cost members and as part of the larger health care reform strategy pursued by the state of Vermont to stabilize the cost of care for Medicaid members and all Vermonters.

## I. Year in Review

### ***Vermont Chronic Care Initiative's 6<sup>th</sup> Year of Service – Progress Continues***

VCCI achieved positive outcomes during Year 6 of its operation (July 1, 2012 through June 30, 2013) as the program continued to focus on members with any health condition who are in the Top 5% for service utilization. The goals of VCCI remained similar as in past years:

- To improve member treatment and clinical outcomes;
- To engage member to participate in their own disease self-management
- To reduce emergency and inpatient hospital utilization by accessing appropriate levels of services and with focus on transitions in care and care management

Focusing on the Top 5% increased participation by those with higher complexity - clinical and psychosocial needs. These high risk/high cost members have historically had greater hospital inpatient admissions, readmissions and use of emergency room care. For example, the Top 5% produced 83% of the readmission costs in SFY 2013.

Outcomes for SFY 2013 are as follows:

- **3,033 unduplicated members** were contacted by VCCI with 2,026 actively engaged with intensive case management and telephonic case management services.
- Members receiving telephonic case management and intensive case management services, including care coordination for at least 60 days experienced significantly better **prescription fulfillment** in 84 and 180 day prescription fulfillment rates for depression medications. Challenges remain in increasing other prescription fulfillment rates, such as the use of both an ACEI/ARB and preferred beta blocker for systolic heart failure, and the use of lipid lowering agents among members with coronary artery disease (CAD). A PDSA (Plan, Do, Study, Act) will be done to investigate barriers to medication adherence and identify strategies for improvement.
- **Inpatient hospital** utilization among the Top 5% was reduced from Program Year 5 (PY5) to Program Year 6 (PY6) by 37%, declining from 476 visits per 1,000 members in SFY 2012 to 301 visits per 1,000 members in 2013.
- **Readmission rates** for members in the Top 5% dropped from PY5 to PY6 by 34%, from 77 readmissions per 1,000 members in SFY 2012 to 51 per 1,000 members in SFY 2013.
- **Emergency room** utilization was 17% lower among the Top 5% from PY5 to PY6, decreasing from 1,461 visits per 1,000 members in SFY 2012 to 1,215 visits per 1,000 members in 2013.

In SFY 2013, Patient Health Registries (PHRs) and Patient Health Briefs (PHBs) continued to be shared with providers in an effort to identify gaps in evidence-based care. The PHR and PHB tools plus the APS Healthcare CareConnection® software system also provided VCCI staff with a dashboard view of accurate and current health status information enhancing their ability to prioritize needed services.

VCCI developed reporting on a variety of data including pharmacy, emergency department use, and specific health conditions that has enabled the program to become a valuable partner delivering multiple levels of direct care and data reporting on member health status. VCCI reported on substance abuse and members in treatment, with an emphasis on gaps in care for

members receiving medication assisted treatment. Additionally and significantly, VCCI staff remain embedded in several high volume provider practices and hospital locations. This enabled VCCI staff to facilitate referrals and warm transfers, and to build relationships with providers. The result of these efforts was improved access to primary care and supportive transitions in care between inpatient and outpatient settings for the vulnerable VCCI population.

## II. Background

Vermont began developing policies and programs for health improvement earlier than most other states and is now illustrating that prevention, early intervention, case management and integrated health care can bring positive changes. APS Healthcare began working with the State of Vermont in 2007 to establish specific efforts to address Medicaid members with chronic health conditions via the creation of the current VCCI. Over the past six years this effort has been integrated with overall state health reform efforts. The state enacted health care reform legislation in 2006 (Act 191, Section 1903a) and has continued to do so in subsequent years including the present effort to create a single payer health system. The initial legislation authorized the creation of VCCI to support Medicaid<sup>1</sup> members with chronic health conditions. As collaborators under the Blueprint for Health<sup>2</sup>, VCCI supports Blueprint activities specific to the Medicaid High Risk population.

As VCCI converted to a focus on the highest risk/highest cost members (top 5%), it concurrently expanded its focus to include more than 30 different health conditions among all member age groups. A representative sample of conditions is listed below and on the graphs which follow.

ADHD	Diabetes
Arthritis	Hyperlipidemia (high cholesterol levels)
Anxiety	Hypertension
Asthma	Kidney Disease (chronic renal failure)
Chronic Obstructive Pulmonary Disease	Low Back Pain
Heart Failure	Sleep Disorders
Coronary Artery Disease	Stroke
Depression	Substance Use Disorders

The overarching goals of the VCCI are two-fold: 1) improve the health and health outcomes for Medicaid beneficiaries with chronic conditions through improved self-management of their health and coordination of services, and 2) reduce costs that would have otherwise been paid by the Medicaid program and thereby the taxpayers of the State of Vermont.

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<sup>1</sup>For the purposes of this report “Medicaid members” includes Medicaid, VHAP, and Dr. Dynasaur members, but excludes individuals dually eligible for Medicare, individuals enrolled in Choices for Care, and individuals who are receiving long term inpatient mental health services. These exclusions are required by the enacting statute.

<sup>2</sup>Blueprint for Health is the state plan for chronic care infrastructure, prevention of chronic conditions, and chronic care management program, and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives.

### III. Treatment Adherence and Utilization Results

#### ***Pharmacological Treatment***

The Medicaid members that are the focus of VCCI efforts have complex health challenges. It is common for members to have three or more chronic conditions (with many having co-morbid mental health and substance abuse conditions, as well), two or more providers — e.g., a PCP and specialist involved in their care – and at least six medications prescribed for daily use, likely from different providers. The complexity of the medication needs for the Top 5% often poses a risk for over and under prescribing, concurrent use of contraindicated medications, misuse of medications, and confusion that can lead to adverse events. For this reason, VCCI added a full time pharmacist to the team in 2012. VCCI is dedicated to assisting members who are struggling with these challenges to improve their personal health status and to educating providers via Patient Health Registries in order to reduce gaps in evidence-based care.

The information that follows is based on Medicaid claim files provided by the Department of Vermont Health Access (DVHA) and analyzed by APS Healthcare. Data reporting prescription fulfillment is based on the claims reported by pharmacies filling prescriptions for members and claims paid by DVHA. Similarly the lab testing information required for prescribing certain medications is also based on claims data.

In each of the following graphs, the first columns define members who were actively engaged for at least 60 days in the VCCI program. The second columns indicate members who were not engaged but were identified as in the population of the top 5% that were eligible for VCCI services.



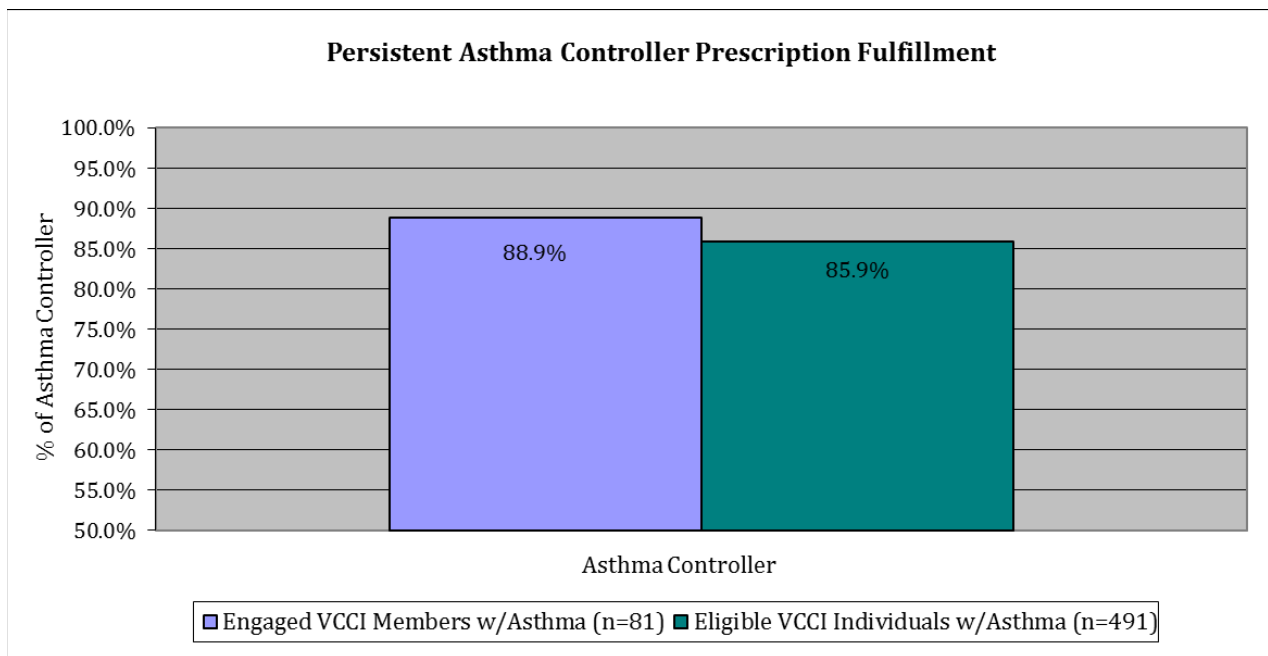
#### **Success Story**

Member: A 42 year old female with severe depression and alcohol abuse was identified as a VCCI candidate due to her high emergency room utilization for routine healthcare needs. She had no income or stable housing.

Interventions and Outcomes: The VCCI Case Manager connected the member to Vocation Rehabilitation enabling her to acquire and maintain part-time employment. In addition, the VCCI Case Manager helped the member apply for and secure SSDI, apply for stable housing and locate a primary care physician. The member is now using her medical home for her healthcare needs.

## Asthma:

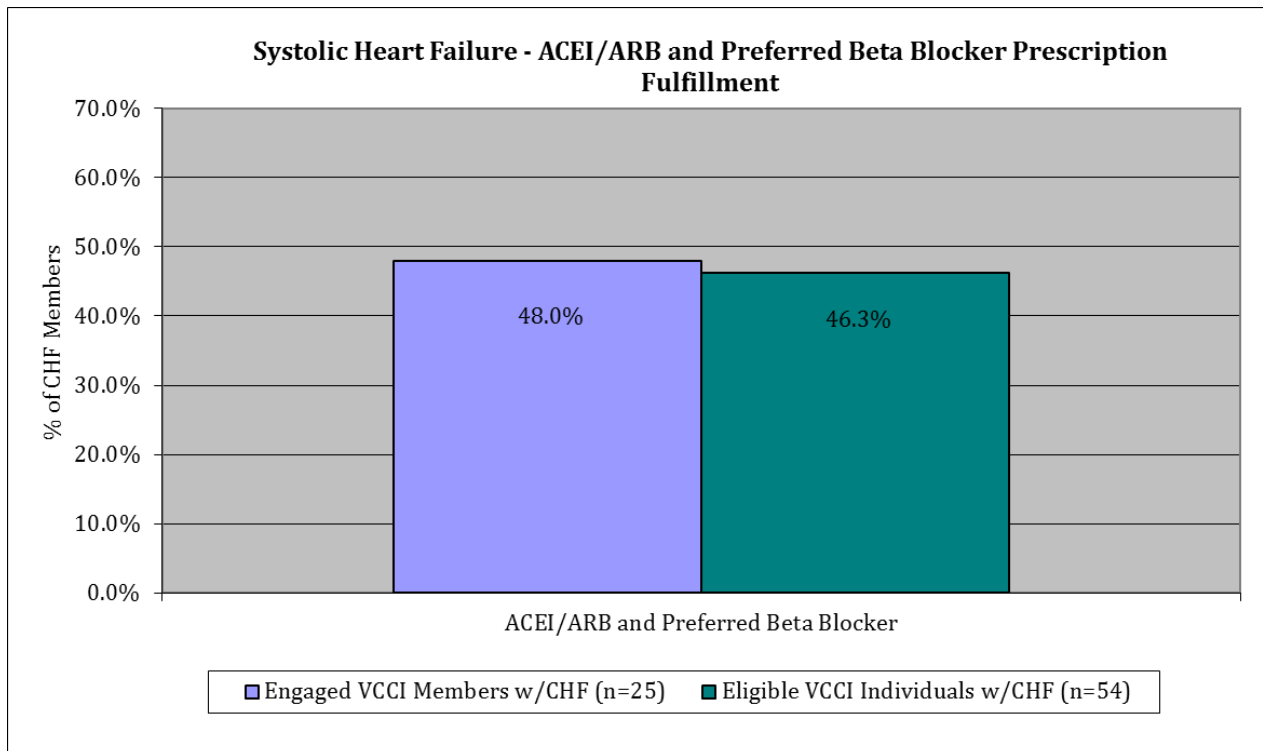
**Members engaged with VCCI show a prescription fulfillment rate for a controller medication of 89% compared to 86% for non-engaged members with persistent asthma or 3% higher.** Inhaled corticosteroids (ICS) are the recommended controller for members with persistent asthma to improve lung function. Asthma is a chronic inflammatory disorder of the airways; inflammation is associated with recurrent episodes of wheezing, breathlessness, cough, and tightness inside of the chest. Left untreated, chronic inflammation may result in structural changes or remodeling of the airways.



## Systolic Heart Failure:

*The fulfillment of both an ACEI/ARB and preferred beta blocker for systolic heart failure was 48.0% for the VCCI engaged members vs. 46.3% for non-engaged members with systolic heart failure.*

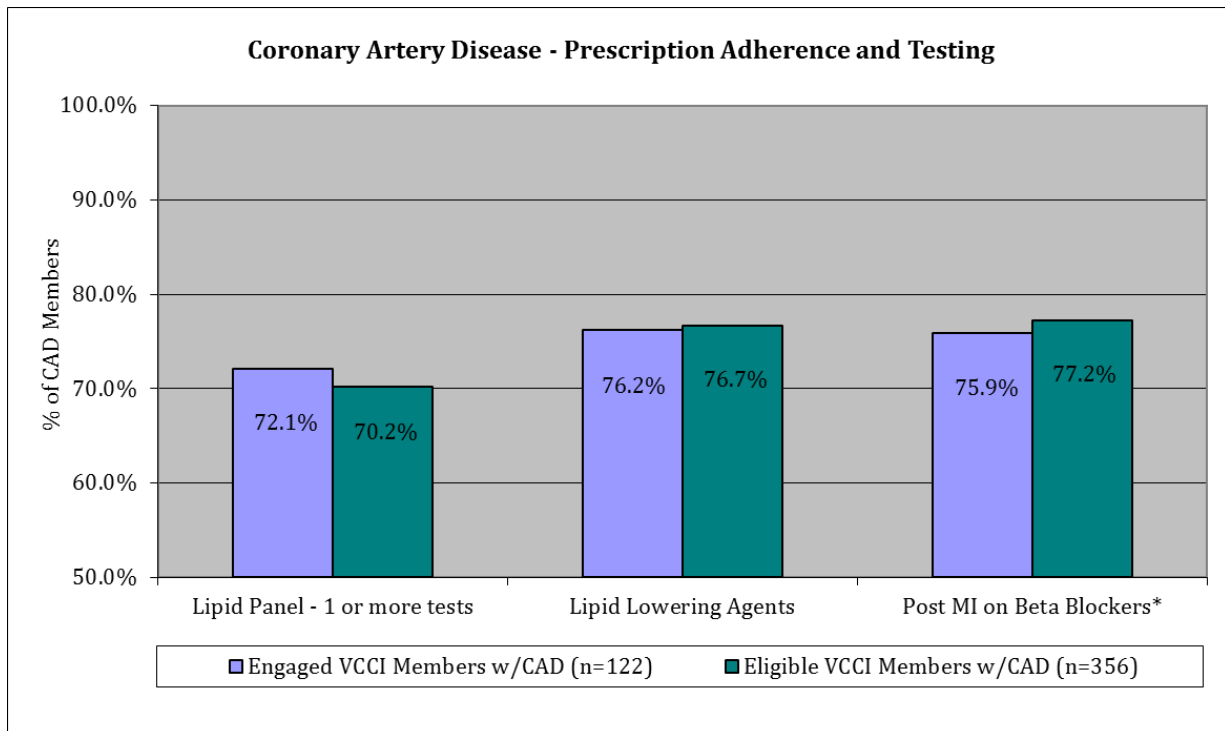
Evidence shows ACE inhibitors and preferred beta blockers can reduce the risk of death or hospitalization. ACE inhibitors increase survival and improve symptoms. A long-term prescription of a preferred beta blocker can lessen symptoms of heart failure, as well as improve clinical status and enhance quality of life. In SFY 2014, VCCI will refocus staff educational efforts on the evidence-based combination of preferred beta blockers and ACEI/ARB to reduce morbidity and mortality. This will be accomplished with the development of a new heart failure assessment which incorporates alerts about evidence based guidelines and has a focus on these medications as well as on medication adherence. Data will then be gathered on the use of the new assessment. Managers will receive monthly reports of medication gaps of engaged members and work with staff to resolve those gaps. In addition, a heart failure Patient Health Registry will be distributed to providers in the fall listing their members that are not on these evidence based medications. VCCI staff will follow-up with providers to assist with member education and adherence, if needed. Finally, a VCCI staff meeting with case presentations on members with systolic heart failure is planned for the fall to reinforce case management of these complex members.





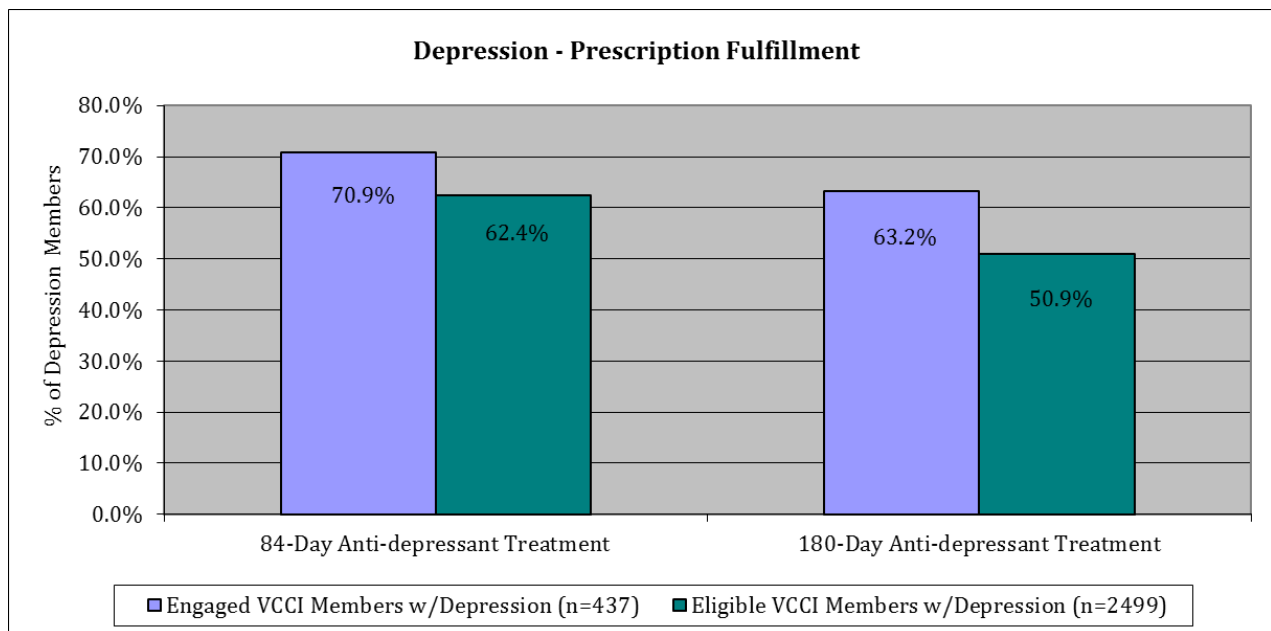
## Coronary Artery Disease:

*While members with coronary artery disease (CAD) who are active with VCCI have better adherence to lipid testing, they have slightly lower fulfillment of lipid lowering prescriptions than non-engaged members with CAD.* The measurement and monitoring of lipids is critical to the management and improvement of CAD. The use of lipid lowering agents, such as statin medications, can prevent further disease progression for members with CAD. Best clinical practice shows a reduction in heart attacks and death from heart attacks for members who are hospitalized for a myocardial infarction (heart attack) **and** who receive a beta blocker medication upon discharge. VCCI members filled prescriptions after discharge for beta blockers 75.9% of the time while non-engaged members post myocardial infarction filled beta blocker prescriptions 77.2% of the time for SFY 2013. Through the Transition of Care Assessment VCCI staff are doing medication reconciliation to improve prescription fulfillment.



## Depression:

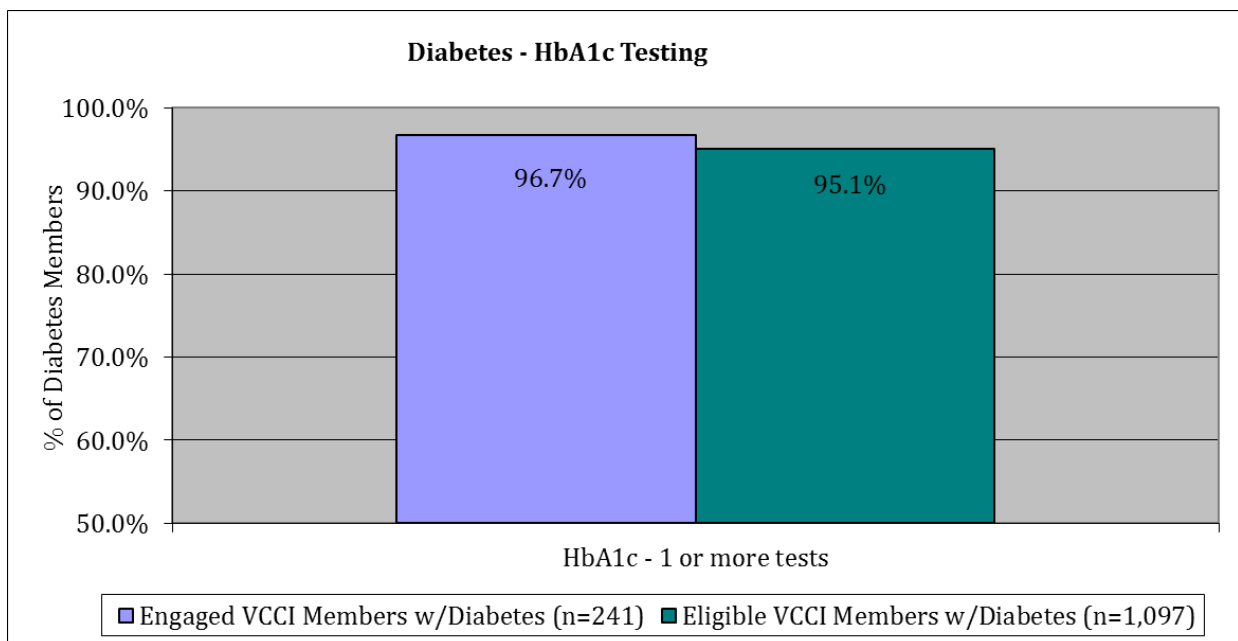
*In this HEDIS-like measure, members active with VCCI have higher rates of prescription fulfillment than members who do not receive VCCI case management and care coordination services: 70.9% versus 62.4% over 84 days, and 63.2% versus 50.9% over 180 days.* Depression rates among the population in the Top 5% are significant (25% of members have depression as a primary diagnosis) and VCCI has attempted to focus on stabilization of this underlying condition prior to focus on other co-morbidities, to enhance results. Members with depression often have a personal or family history of depression, have had a recent trauma or loss, or have co-morbid medical conditions. In the Top 5% population, 84% had at least one of the other 31 chronic conditions monitored by VCCI – 30% had at least one of the most common chronic conditions – Asthma, CAD, CHR, Diabetes, COPD, Hyperlipidemia and Hypertension. For people age 18 through 44 years, depression is the leading cause of disability and premature death. Treatment of depression requires close follow-up for up to one year. If an individual with depression improves after continuous treatment for 12 weeks (84 days), the individual is viewed as having entered remission.

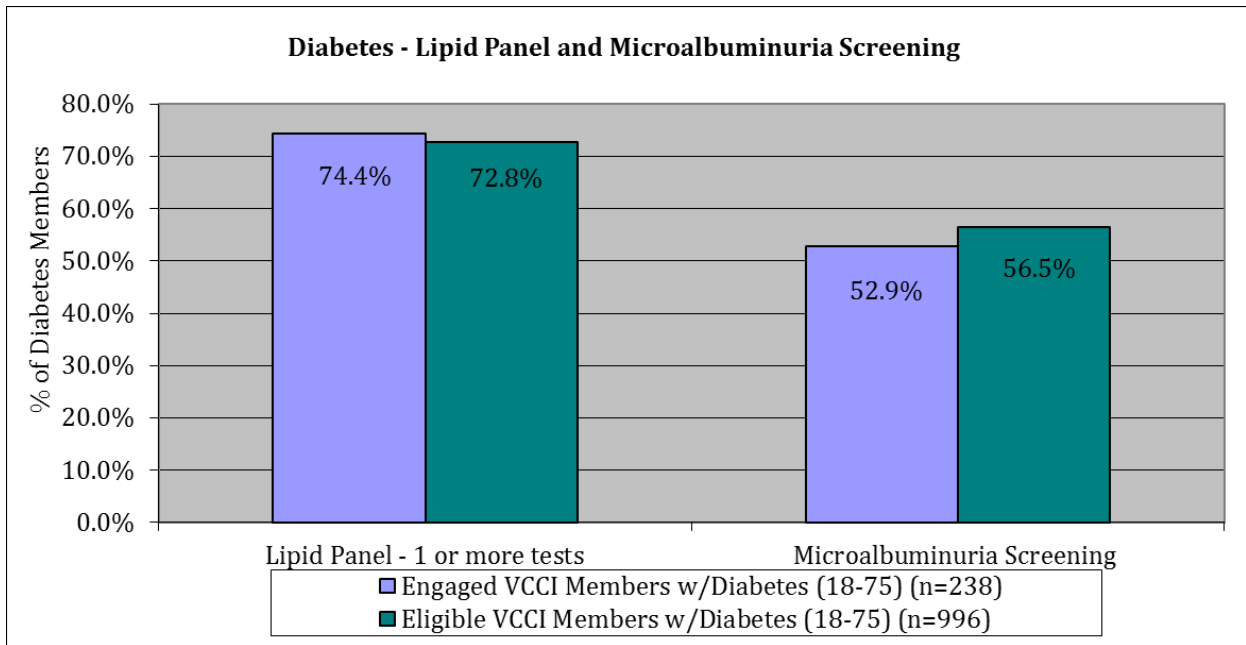


## Diabetes Mellitus

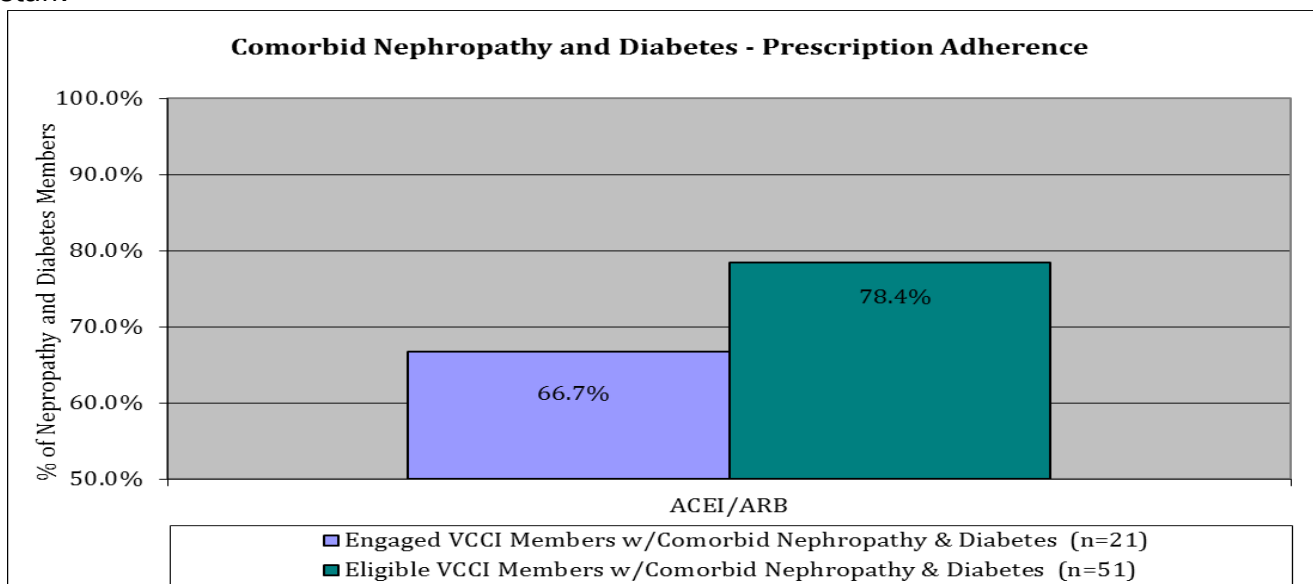
*Members engaged with VCCI obtained HbA1c testing slightly more frequently at 96.7% vs. 95.1% for non-engaged members with diabetes mellitus. For those members, the difference is comparable when looking only at members with 2 or more tests in the 12 month period - 80% for engaged members and 78% for non-engaged members. Members engaged with VCCI are more likely to receive appropriate lipid level testing annually compared to non-engaged members with diabetes: 74.4% versus 72.8%. Microalbuminuria testing for kidney function was lower, at 52.9% for VCCI engaged versus 56.5% for the non-engaged members and is an area for continued focus for VCCI.* In SFY 2014 a follow-up PHR will be run to compare members previously identified with gaps in testing. The Diabetes Action Plan will also be updated to emphasize these gaps and assist the member in developing a personal action plan to work to close the gap. In addition, VCCI managers receive monthly reports of engaged VCCI members who have these gaps and work with staff to close the gaps on their members. VCCI is revising the current diabetes assessment tool to increase focus on these potential gap areas in SFY 2014. VCCI's current diabetes assessment addresses the importance of screening for kidney damage in patients with diabetes because of their increased risk for kidney damage.

The Medicaid population has a very high rate of HbA1c testing among the high risk population. HbA1c testing reflects average blood sugar level over several months and provides a strong predictive value for diabetic complications. Cardiovascular disease is the major cause of death for members with diabetes and is the largest contributor to the direct and indirect costs of diabetes treatment; contributing to the high risk of heart disease is the increased prevalence of lipid abnormalities. Therefore, it is also important to monitor lipid levels of members with diabetes.



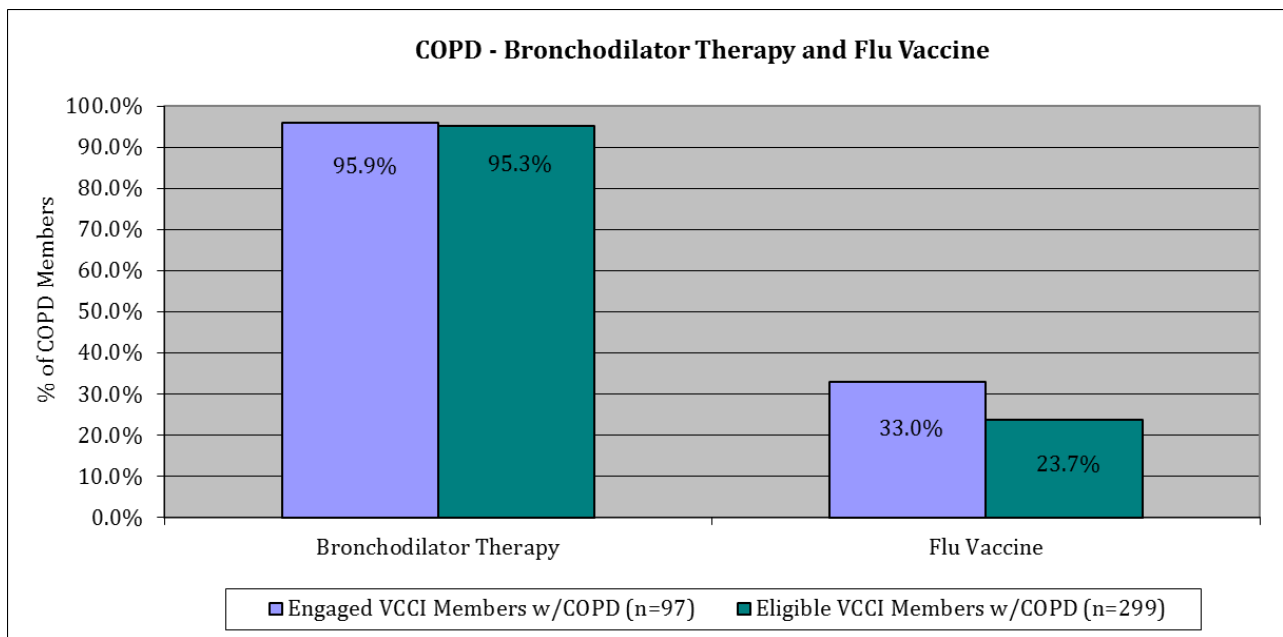


*Members with diabetes and nephropathy engaged with VCCI had a prescription fulfillment rate of 66.7% of prescriptions for ACEI/ARB versus non-engaged members who fulfilled prescriptions for an ACEI/ARB at a rate of 76.4%.* VCCI has updated the diabetes assessment for SFY 2014 to include these classes of medications and to focus awareness on adherence to evidence based guidelines for diabetic members with nephropathy. The Diabetes PHR for panel management includes prescription fulfillment of ACEI/ARB for members with nephropathy as well as absence of lipid testing and HbA1c to improve adherence to these important aspects of diabetic care. Ideally, all patients with diabetes and kidney disease should be treated with an ACEI or an ARB if there is not a contraindication. Through the Diabetes PHR, members with kidney disease are identified as having a gap in care if they are not on and ACEI or ARB. VCCI staff will work with providers and members to close that gap. In addition, in March 2014, a PHR was distributed and will be compared to the previous registry to determine if current efforts are working to close the gap. If a provider identifies the member as non-adherent to treatment, the member will be referred to VCCI or CHT staff.



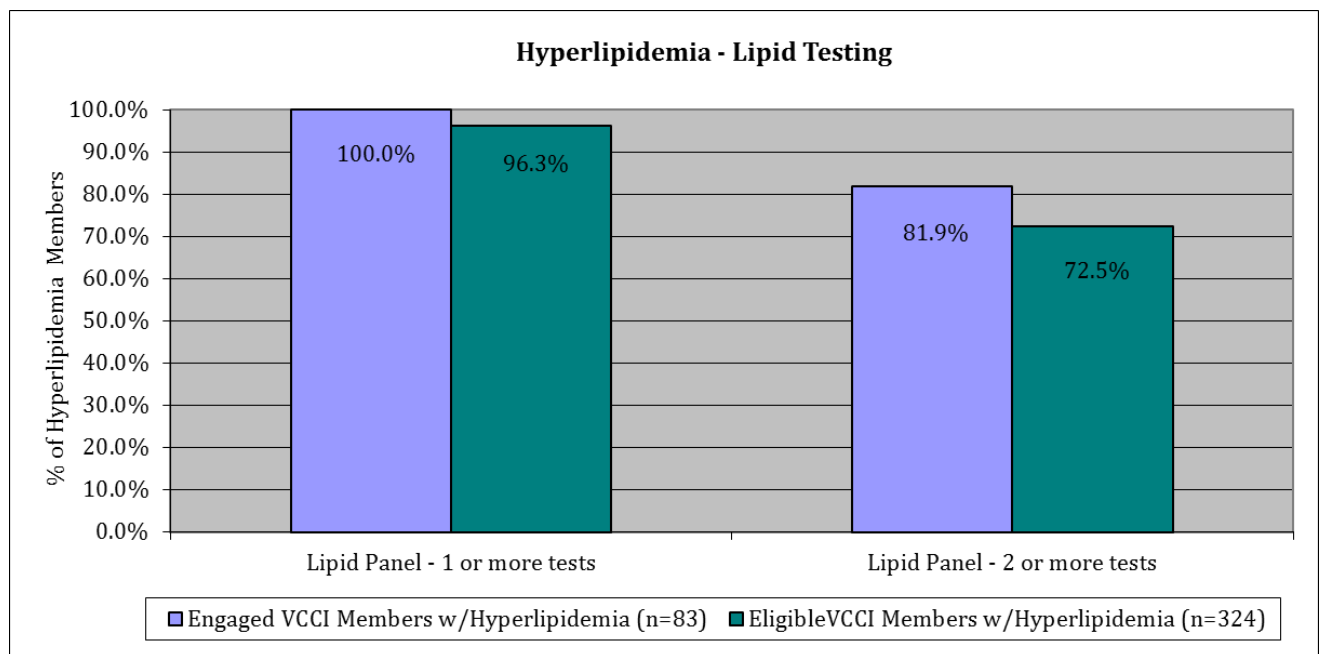
## Chronic Obstructive Pulmonary Disease (COPD):

*Individuals with COPD and engaged with VCCI have a similar fulfillment rate for bronchodilator therapy compared to members not engaged with VCCI and diagnosed with COPD – 95.9% vs. 95.3%.* Medication can improve lung function, relieve symptoms, prevent exacerbations, increase exercise tolerance, improve health status and enhance quality of life. Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend treatment with bronchodilators for all stages of COPD. COPD is the fourth-leading cause of death in the U.S. – despite being a preventable and treatable disease. Evidence indicates patients with mild to moderate airflow obstruction are especially at risk. During SFY 2013, VCCI placed a stronger emphasis on tracking members who received the flu vaccination during the year. This is difficult to capture as members may receive this vaccine but not have claims associated with it, such as when they receive it at public health clinics. Therefore, the percentage of members actually receiving the flu vaccine may be higher than reflected in the graph below.



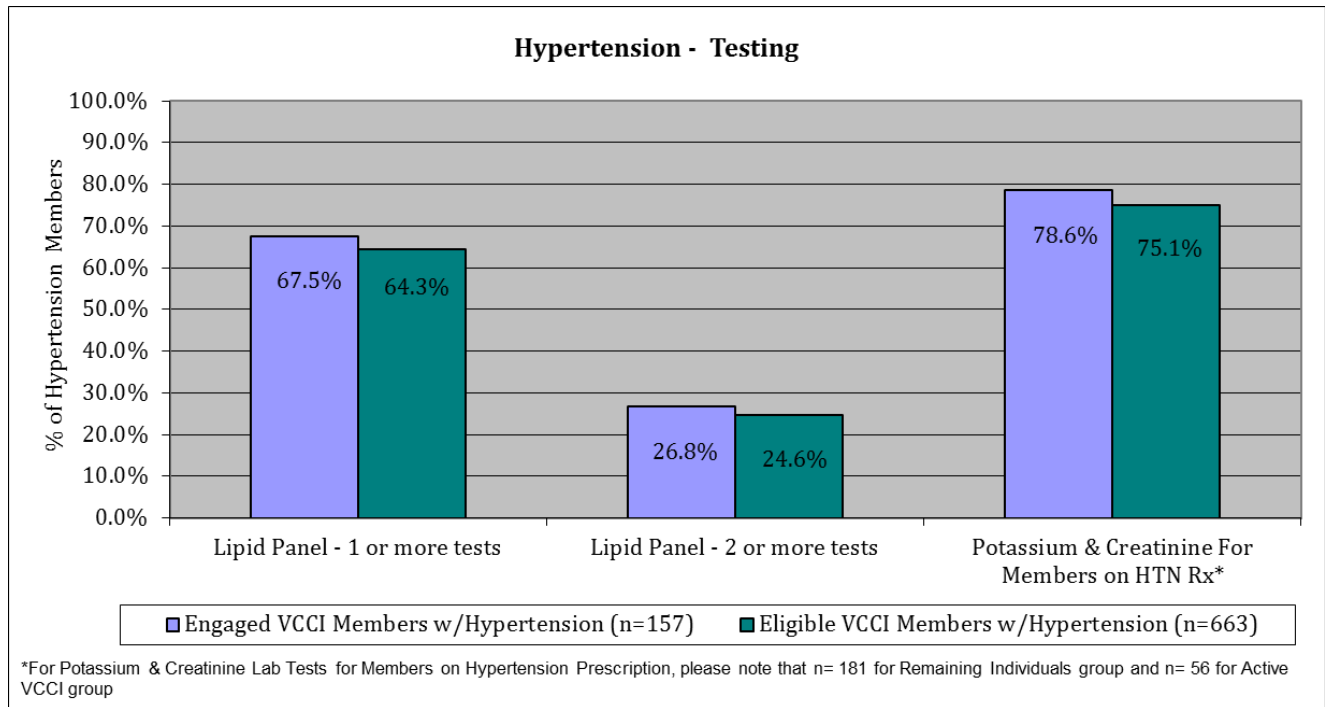
## Hyperlipidemia:

*Members with hyperlipidemia and engaged with VCCI completed single lipid testing 100% of the time compared to 96.3% for members not engaged with VCCI with hyperlipidemia (high cholesterol levels).* In addition, 81.9% of members engaged with VCCI obtained two or more lipid panels versus 72.5% of members not engaged with VCCI who have hyperlipidemia. Individuals with hyperlipidemia are at risk for coronary artery disease. In individuals with extremely elevated LDL-cholesterol and those at high cardiovascular risk, drug therapy may accompany diet and exercise as an initial therapeutic approach. It is recommended that lipids be monitored every six to twelve months for patients who adhere to lifestyle modifications and after lipid levels are at goal.



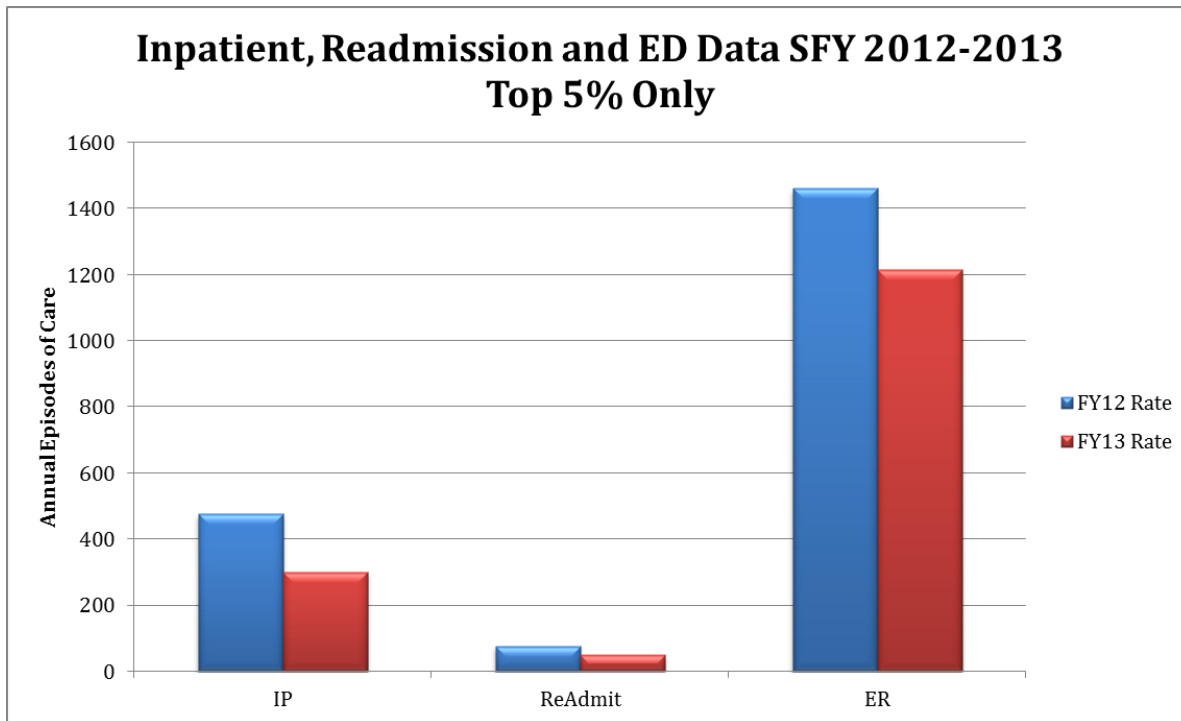
## Hypertension:

VCCI-engaged members with hypertension obtained higher levels of lipid testing as well as kidney function testing. VCCI engaged members obtained lipid panels at a rate of 67.5% compared to 64.3% for those not engaged with VCCI. Potassium levels and kidney function testing for members engaged with VCCI were obtained at a rate of 78.6% compared to 75.1% for those not engaged with VCCI. Treatment of hypertension reduces the risks of mortality and of cardiac, vascular, renal, or cerebrovascular complications. The risk of developing a stroke varies linearly with blood pressure, and blood pressure control reduces the risk of recurrent stroke. Individuals with hypertension are three times more likely to develop CHF (systolic or diastolic dysfunction) than individuals with normal blood pressure. Individuals with hypertension should have serum potassium and creatinine monitored at least annually.



## **Utilization Results**

There are many areas of expense in health care. The major cost drivers of care for members with chronic conditions are emergency room utilization, inpatient admissions and readmissions. In SFY 2013 VCCI completed its second year of operation with the change in the population measured and outreached - Top 5% high risk/high cost. Therefore, this is the first time VCCI is able to compare the Top 5% over a two year period. It is exciting to find that from Program Year 5 (SFY 2012) to Program Year 6 (SFY 2013), the reductions in utilization rates are significant - inpatient 37%, readmissions 34% and emergency room visits 17%. The numbers are equally encouraging when looking at the roughly 60% of members that were in the Top 5% for both years. For those members, utilization decreased significantly- inpatient 29%, readmissions 30% and emergency room visits 11%. These significant decreases also hold true when comparing the utilization for the engaged population from SFY 2012 to SFY 2013 - inpatient 28%, readmissions 40% and emergency room visits 28%. Because of the nature of the population we are capturing (Top 5% high risk/high cost), once the group improves enough they drop out of the Top 5% only to be replaced by new sicker/higher utilization members. As a result, VCCI does not expect to see declines in the overall utilization of the Top 5% year to year.



	IP	Readmit	ER
<b>FY12 Rate</b>	476	77	1461
<b>FY13 Rate</b>	301	51	1215
<b>% Change FY12 to FY13</b>	-37%	-34%	-17%



The hospital utilization and treatment adherence information within this report is based on claim files provided by DVHA and analyzed by APS Healthcare. Each individual in the analysis met the following criteria:

- Had at least two months of Medicaid eligibility in the rolling 12 month window.
- Was eligible for VCCI (people on Medicare, commercial insurance, or having other specialized forms of state aid were ineligible and therefore excluded).
- Were designated as part of the population of Top 5% high risk/high cost members reviewed in the Return on Investment measured in 2013.

The characteristics of the Top 5% include very high utilization of inpatient and emergency department services. VCCI is increasingly focused on the inpatient and emergency room census data from local hospitals as a key 'real time' indicator of need and as a referral source, trying to intervene with members close to the moment they use these resources and may be most open to assistance. Additionally, the embedded staffing model has helped facilitate these real time referral processes, further supporting VCCI's capacity to outreach to members in a timely fashion.



## **Success Story**

Member: 51 year old female with Diabetes, CAD, Depression, Anxiety and Lumbar Stenosis for whom English is a second language. The member was facing eviction, had no heat, was in an abusive home environment, refused counseling and needed back surgery.

Interventions and Outcomes: The VCCI Case Manager (RN) and Social Worker dealt with medical issues and social needs. As a result, the member acquired Section 8 housing, fuel assistance, legal counseling and expedited SSI. In addition, the member is currently seeking counseling, taking antidepressants and able to cope with previously disabling panic attacks and anxiety. The member also had back surgery and was discharged with adequate pain control. The member is now able to focus on medical issues such as her Diabetes and Coronary Artery Disease and is engaging in her healthcare needs.

## **IV. Operations Report**

### **Internal Program Education**

In SFY 2013, APS Healthcare and DVHA continued to conduct joint training sessions geared toward improving clinical outcomes. Staff training included entering and using data in CareConnection®, correct use of various assessments relating to chronic conditions - substance abuse and updated general and behavioral assessments. The VCCI medical director facilitated telephonic group sessions with all VCCI staff and the VCCI pharmacist, utilizing staff discussion of various difficult complex cases as well as information relating to updated Evidence Based Guidelines and existing staff tools. These sessions focused on but were not limited to pediatric and adult asthma, depression and related mental illnesses, heart failure, pediatric and adult diabetes, and a broad range of other conditions. Training was also provided on the use of Patient Health Registries and Patient Health Briefs. A Patient Health Registry Workflow analysis was conducted in order to optimize electronic documentation in Care Connection® and improve distribution and feedback processes. Ongoing work in SFY 2014 will continue to increase electronic documentation of PHR gaps identified and outcomes. PHR workflow analysis also investigated various ways to increase provider engagement, which has been an ongoing challenge.

Both the VCCI medical director and pharmacist provided staff instruction at various monthly DVHA staff meetings as well as ad hoc individual sessions for staff with questions about how to proceed with their challenging member or how to understand the medical plan or complex medication treatment.

The APS Clinical Specialist Liaison also provided 1:1 assistance and training to DVHA staff on Care Connection®.

### **Community Integration**

In SFY 2013, VCCI continued to make progress as an integrated partner in the Vermont medical community, including with NCQA certified medical homes through the DVHA Blueprint for Health and the associated locally deployed Community Health Teams (CHTs). VCCI case managers are members of the local Blueprint teams. Coordination and collaboration continues to evolve, including referrals between levels of service, with VCCI servicing the Medicaid high utilizer population (super-utilizers).

VCCI also initiated efforts to facilitate referrals and establish an onsite presence at additional community health centers. VCCI embedded staff in multiple hospital and high volume primary care sites included the , Rutland Regional Medical Center, Central Vermont Medical Center, NOTCH FQHC, Cold Hollow Primary Care, St. Albans Primary Care, the Community Health Centers of the Rutland Region (2 locations) and the Health Center in Washington County.

VCCI continued to expand collaboration with case managers at other local emergency rooms and inpatient units regarding direct referral of cases for telephonic case management and intensive case management and care coordination. Use of a secure FTP continues to enable VCCI to receive inpatient and emergency department admissions from six of Vermont's hospitals.

The VCCI data reporting efforts have continued to grow, as well, with greater numbers of practice-specific reports generated for VCCI and other community teams to work with specific practices on identification and outreach to high risk members, assisting medical homes to achieve or maintain their NCQA accreditations. VCCI continued a population approach with primary care providers to supplement individual case management services, using the Patient Health Registries (PHRs) and supporting Patient Health Briefs (PHBs) to assure Medicaid beneficiaries with potential gaps in evidence-based care can be proactively identified, outreached and managed. In SFY 2013, PHRs/PHBs were provided to practices related to Heart Failure, Depression, Asthma, Diabetes, and Coronary Artery Disease. Evidence indicates that gaps in care impact quality of life and may lead to increased emergency department or inpatient hospitalization rates. By using PHRs, VCCI was able to communicate with providers to assure that gaps are not due to oversight and/or member issues creating barriers to appropriate treatments. VCCI continues to offer a small financial incentive to providers who collaborate with VCCI on specific members to improve their health outcomes.

### ***Member Outreach***

VCCI continued to utilize outreach to members as a prime method for engagement. Outreach activities included:

- **Member Welcome Packet:** This introductory mailing is the first contact members receive after enrolling in the program. It introduces the program and describes what they may expect while engaged, along with member rights and responsibilities.
- **Follow-up Letter with Health Care Literature:** This letter is routinely sent to members and includes but is not limited to: Krames Fast Guides, Krames on Demand fact sheets, condition action plans and articles from the Healthwise Knowledgebase regarding targeted information to address members' individual health concerns.
- **No-Contact Letter:** VCCI sends this letter after one or more unsuccessful telephone contact attempts to enroll the member and to conduct the general assessments, such as the Social Needs Assessment and Behavioral Health Risk Assessment.
- **Member Brochure:** VCCI staff sends members a brochure that further explains the program, provides contact information, and offers tips on working with healthcare providers.
- **Telephonic Outreach:** Following up on printed material with a personal phone call is a key activity for engaging members. Both non-clinical and clinical staff do outreach to attempt to reach members to complete an initial assessment of social and care needs. Clinical staff also work with members to complete a Plan of Care and engage them in care coordination, health coaching and case management services.
- **Consumer Web Site:** VCCI's consumer web site is located at [www.vtccmp.com](http://www.vtccmp.com) and features a program description, member rights and responsibilities, educational materials described above and direct access to the Healthwise Knowledgebase. Everything on the web site is pre-approved by DVHA as well as APS.
- **Face-to-Face Outreach:** For members with the most complex needs, VCCI clinical staff are available to meet directly with the member and/or attend appointments with the member and their provider. This direct communication is creating a patient centered environment and is providing opportunities to narrow the information gap between the member and healthcare providers. During SFY 2013, VCCI staff participated in 3,750 face-to-face interactions with 908 unique members. .

## **Provider and Community Outreach**

APS and DVHA use a variety of methods to outreach to providers and the community regarding providers' patients who are enrolled in the VCCI, and to provide general information about the VCCI program. Activities include:

- **Provider Letters:** As members complete the enrollment process, primary care providers are sent letters notifying them of their patients' enrollment in VCCI along with a copy of the Plan of Care. *A total of 347 unduplicated providers were sent 1,800 letters in SFY 2013.*
- **Hospital, Community Service Organizations, Community Health Teams:** VCCI staff have been embedded in several hospital locations and communicate with hospital partners regarding discharge, as appropriate, for the eligible population. In addition, VCCI staff work with community service organizations and Community Health Teams on behalf of members. In SFY 2013, outreach visits were made to such organizations, as well as regular attendance at Community Health Team regional meetings.
- **Practice Visits:** Connecting with primary care practices around the state is the key outreach activity that furthers the VCCI goal of helping members adhere to their providers' plan of care. In addition to many phone calls by VCCI case managers and outreach staff, many providers were visited by case managers accompanying members in co-visits, and as part of the Patient Health Registry distribution process. VCCI met with 163 providers in these outreach efforts in SFY 2013. The engagement with providers also helps to increase the referral of members for VCCI services. *Local practices—including care managers and health center panel managers directly referred over 350 members for VCCI services during SFY 2013 beyond the population of VCCI members identified in the Disease Management Identification (DMID) process of referral directly from CareConnection™.*

## **Clinical and Intervention Services**

**Clinical Oversight** – During SFY 2013 the VCCI medical director continued to provide clinical oversight to VCCI staff including education and training on care standards. The VCCI medical director initiated efforts that lead to the refinement of the buprenorphine prior authorization process for Vermont Medicaid beneficiaries.

**Clinical Resources** – VCCI staff members received **an array of training and education:**

- Staff were trained on the CareConnection™ system throughout the year to assist in optimal use of the system.
- During SFY 2013 the process to extensively review and revise disease specific assessments was initiated. Five assessments were identified for revision related to the most recent Evidence-Based Guidelines
- VCCI staff participated in telephonic clinical case conferences each month; these conferences focused on the use of action plans and disease-specific call guides with embedded clinical metrics for patient management. The teleconferences focused on members with medical co-morbidities along with mental health conditions, substance abuse conditions and chronic pain, addressing the challenges of case management with this population. The VCCI medical director

and pharmacist assisted with focus on patient medications as well as disease progression. All staff collaborated with each case presented for suggested next steps and other potential resources.

- Two training days in January and March 2013 were facilitated by an external expert in mental health and substance abuse. The training focused on methods and strategies for more successful engagement with members with co-occurring chronic medical conditions, mental health and substance use disorders.
- Additional educational resources are available on the VCCI website, including one-page focused health information for staff, members, and providers. Further, VCCI provided tri-fold educational brochures for staff to provide to members.
- VCCI staff received webinar training on tools, documentation standards, assessments and reassessments, use of action plans and call guides, and their relationship to quality improvement goals.
- Various staff attended national speaker webinars on Motivational Interviewing Techniques were emphasized during case presentation discussions.
- The VCCI Clinical Reference Binder, created in 2009, continued to be revised with oversight by the VCCI medical director, and VCCI staff were trained on its use. This resource contains clinical materials including: assessments, medication overviews, therapies, call guides, action plans, patient education materials and medical director summarized clinical guidelines. The diabetes and coronary artery disease call guides were updated and reviewed with staff.

In addition, the VCCI medical director presented at Department of Vermont Health Access (DVHA) VCCI staff meetings and participated in case reviews and reflective practice on challenging mental health and complicated medical cases. The VCCI pharmacist also presented occasionally at these meetings to further staff knowledge and address questions regarding the complex pharmaceutical needs of the VCCI population.

**Quality Initiatives** – VCCI undertook quality initiatives during SFY 2013. These initiatives were primarily focused on increasing the information available to PCPs regarding possible gaps in care. The efforts included the large group of approximately 105,000 Medicaid members who may be eligible for VCCI services during a given year. Of that group approximately 45,000 members have a chronic health condition. Gaps in care are identified and shared with providers on their panel of patients based on the specific disease of focus for the PHR.

#### ***Heart Failure Performance Improvement Project (HF PIP)***

The Systolic Heart Failure Performance Improvement Project reported final outcomes for the second year of re-measurement as part of CMS' quality improvement efforts of the Agency of Human Services. The goal was to increase the use of evidence-based medication for systolic heart failure. The final results indicate that the use of these medications increased from 21% in the 2010 baseline year to 26.6% in re-measurement year 2013.

In late 2010, VCCI began this 3 year heart failure performance improvement project following the Center for Medicaid and Medicare Services protocol, as required of DVHA as a managed care model under the Global Commitment for Health waiver. The project focused on the appropriate use of evidence-based medications, and improving the poor adherence rates (21%) to these medications among Medicaid members with a diagnosis of heart failure and one claim.

The use of ACEIs or ARBs and the preferred beta blockers have been proven to significantly reduce morbidity and mortality rates. Optimizing adherence to proven efficacious prescription medication therapies has the potential to improve quality of life and outcomes in patients with systolic heart failure, as well as reduce hospitalizations, lengths of hospital stays, and prevent readmissions.

VCCI SFY 2013 activities supporting the HF PIP included:

- A bulletin in the Provider Relations quarterly newsletter regarding the use of evidence-based medication for systolic heart failure
- Medicaid coverage of scales for heart failure members to improve self-management
- VCCI developed and distributed heart failure Patient Health Registries (PHR) to PCPs of members who were identified for the HF PIP. (See detail on PHRs in the following section.) This process included VCCI clinical staff visiting PCP offices, explaining the gaps in using ACEI/ARB medications and a preferred beta blocker for systolic heart failure.
- As a part of the PHR process, VCCI sent a mailing to PCPs focused on evidence-based medication guidelines to improve pharmacy adherence.
- VCCI clinical liaison reviewed the HF PIP and HF PHR results and assigned for case management all HF PIP members who were not prescribed the evidence-based medications and did not have a reason for exclusion from use of these medications.
- VCCI held educational telephonic conferences with staff, led by the VCCI medical director and VCCI pharmacist with staff focused on an overview of heart failure, defining heart failure, and recommended medications and self-care for members with heart failure.
- The VCCI medical director also engaged with PCPs at medical conferences to present information on heart failure to colleagues and discussed the improved outcomes for members on the evidence-based regime. Conferences attended include the following:
  - 9<sup>th</sup> Annual Tutorial in Cardiology (UVM) (9/7/12)
  - Vermont Academy of FP Annual Meeting (11/6/13)
  - Vermont Ethics Network (AHEC) (4/3/13)
  - Vermont Blueprint for Health (4/17/13)
  - 9<sup>th</sup> Annual Dartmouth Conference on Heart Failure (5/20/13)
  - 9<sup>th</sup> Annual Family Medicine Review Course (UVM) (6/11/13)

### ***Pharmacy Improvements***

The VCCI pharmacist worked with VCCI clinical leadership, the DVHA Pharmacy Unit, and with DVHA's Pharmacy Benefits Manager pharmacist to develop informatics that can be helpful in optimizing member clinical outcomes and cost savings for DVHA. In SFY 2013, work focused on:

- An analytical assessment of the use of Suboxone® in the VCCI population. This is an ongoing process to help clarify understanding of prescribing patterns and to look for stimulants prescribed over the FDA recommended maximum doses.
- Developing and refining specific indicators that can assist care coordination for members who are utilizing Suboxone® as part of their opioid addiction recovery process.
- Consultation with all VCCI staff concerning questions on the prescribed or over-the-counter medications of members.
- Reviewing internal processes and tools, along with other clinical leadership, to help ensure current evidence-based medications are being reflected appropriately.



- Attending DVHA Drug Utilization Review Board meetings to better understand how VCCI pharmacist efforts may be more synergistic with the efforts of this group in reducing costs and improving care in the VCCI specific population.

These efforts are adding to the overall efforts by the State of Vermont to improve the effectiveness and reduce costs associated with substance abuse treatment and chronic medical conditions.

### ***Patient Health Registries and Patient Health Briefs***

In SFY 2013, VCCI continued to use PHRs and PHBs to support practices working with Medicaid members. The PHR is a document developed by analytical review of the procedure and pharmacy claims of members with specific criteria applied that will indicate if a gap in the care of the member is present. An example would be a member with diabetes who has not had a lab claim for an HbA1c blood analysis within the recommended time frame. The claims data would indicate a lack of the claim and this information would be provided in a report that includes this member on a list with other members who are on the PCP's patient panel. This report is then provided by VCCI to the PCP, with follow-up contact to review the provider's feedback. In SFY 2013 PHRs were completed on heart failure, depression, asthma, diabetes, and coronary artery disease.

### ***The Patient Health Registry***

- In September of 2012, 28 heart failure PHRs were delivered to Vermont providers for 32 members with gaps in care. 25 PHRs were returned providing information on 29 members (or 90% of those delivered). Providers indicated they were planning to implement recommendations on 8 members. However, there were 6 members with a contraindication to the recommendation.
- In November of 2012, a PHR was distributed to 125 providers for 303 members with gaps in care related to their depression treatment. 90 or 78% of the PHRs (including 235 members) were returned with provider feedback and/or comment. Of the 71 members recognized as non-adherent, 12 members (17%) were noted as being in VCCI's top 5% and were assigned to VCCI staff for follow-up.
- In January of 2013, 227 PHRs were distributed to providers for 458 members with asthma who had gaps in their care. 181 (or 80%) of the PHRs were returned and provided information on 348 members. Of the 54 members recognized by providers as non-adherent to controller medication prescribed by them, 4 were in the VCCI top 5% and assigned to VCCI staff.
- In March of 2013, a PHR on members with diabetes was distributed to 138 providers for 383 members identified with gaps in evidence-based care. 95 PHRs were returned with information on 263 members. 57% of members were either stable on their current regimen or the provider had already implemented the recommendation. Of the 30 members recognized as non-adherent by the providers, 12 (40%) were in VCCI's top 5% and assigned to VCCI staff for follow-up.
- In June of 2013, there were 86 VCCI visits to providers to deliver PHRs for 205 members with coronary artery disease who had gaps in care. Providers returned PHRs with information on 101 members (49%). 13 members were identified as non-adherent and in the VCCI top 5% and assigned to VCCI staff. A follow-up PHR on coronary artery disease is planned for summer 2014 which will allow for additional analysis.
- Plans for collaborating with Community Health Teams are being developed, in order to increase follow up for the Medicaid members identified in the PHR's that are not in the top 5%

### ***Patient Health Briefs***

The Patient Health Brief (PHB) is a document of 1-6 pages that providers and individual members may use to review their medical procedures and pharmacy fills over the past 6 months. They also indicate any chronic conditions in a member's record. PHBs are included with all of the PHR distributions listed above. Many providers have given positive reviews of this document as it informs them of additional care the patient may have received that could be better aligned with the care they are providing. This document can also help identify treatment gaps and when they occur. Lack of pharmacy claims even though a provider has prescribed a certain medication is one example of a gap in care that could be identified.

The PHBs provide practitioners with a clear synopsis of the member's health care for the recent past and help to clarify where there may be gaps and conflicts that, if resolved, may help to increase the member's self-management of their conditions. They also may help to indicate which intervention services could be most helpful for the member to achieve improved health outcomes.





## **Success Story**

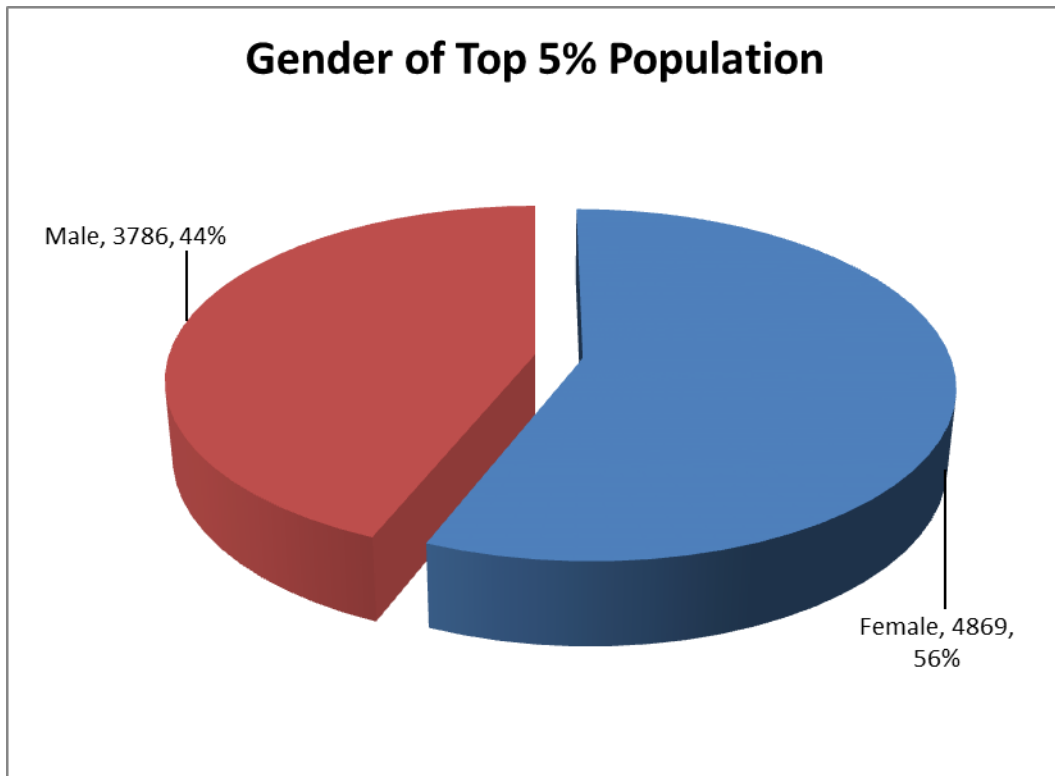
Member: The Fire Department identified a 59 yr. old male as wandering and getting lost frequently. The local hospital contacted VCCI. The member has dementia and encephalopathy causing confusion and loss of cognitive function, both conditions significantly impacted by the member's continuing alcohol use. At the time of the referral the member had no income, transportation, heat, electricity or phone, and an eviction was pending. The member had not seen a health care provider for 15 years.

Interventions and Outcomes: The VCCI Case Manager assisted the member in applying for and securing SSI, obtaining a PCP and transportation for his medical appointments. The Case Manager also secured local funds for utilities, heat and cell phone, and found alternative housing with all utilities included and within walking distance to amenities. Because the member has cognitive dysfunction the Case Manager provided his family with education which helped to ensure the member's sobriety. The member is now able to maintain sobriety, slowing the progression of his dementia and encephalopathy, and is attending medical appointments.

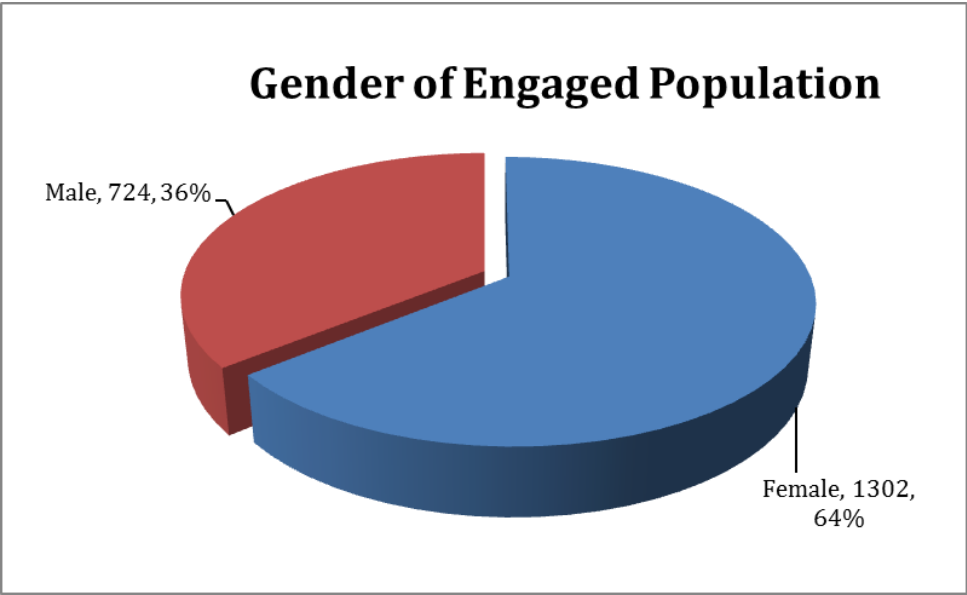
**Demographic and Operations Data**

The following pages outline demographic and operational data for the state fiscal year which ended June 30, 2013.

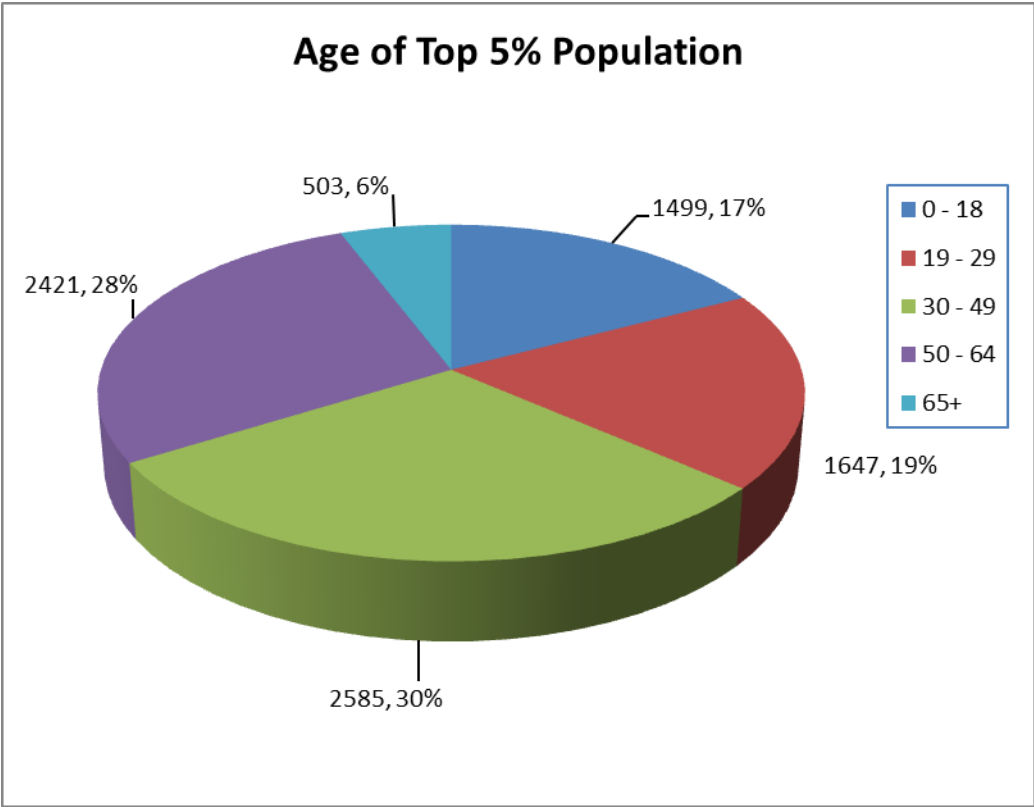
**Gender** – Over 8,500 Medicaid members were identified in SFY 2013 as eligible for VCCI services by their risk scores. The number of VCCI eligible female beneficiaries continues to exceed the number of male beneficiaries.



Likewise, the number of female members actively engaged with VCCI exceeds the number of male members engaged with the program.



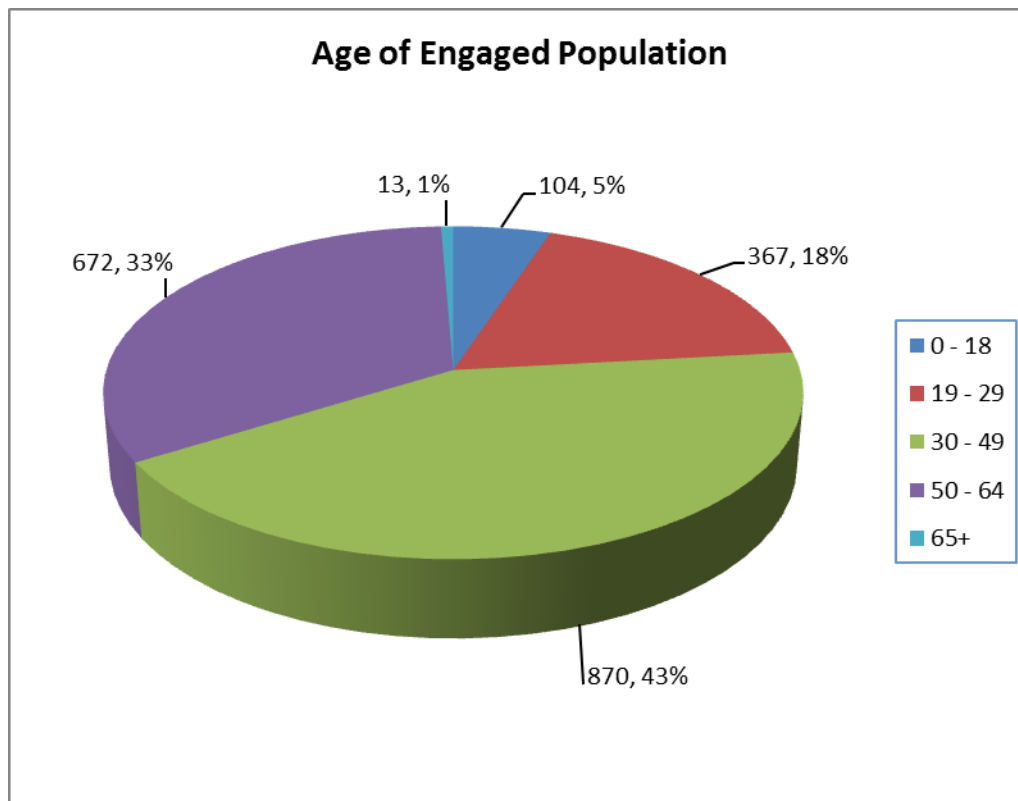
**Age** – The largest age group of eligible members is the 30 through 49 year age category (2,585 or 30%). The second largest group this year is the 50 through 64 year age category (2,421 or 28%).



**Age of Members Engaged with VCCI:**

The largest age group of members engaged with VCCI is the 30 through 49 year age category (870 or 43%). The 50 through 64 year age group is next (672 or 33%).

We engaged fewer children, ages 0-18, than we did adults. Many of the identified top 5% high risk/high cost children received multiple services through the Children with Special Health Needs/Children’s Integrative Services programs and were not enrolled in VCCI. In order to increase the number of enrolled children with diabetes and asthma in the coming fiscal year, we will have pediatric versions of our asthma and diabetes assessments finalized for use in the program in SFY 2014. Revisions to our asthma data base will also target Hospital Service Areas with pediatric asthma patients that do not appear to be appropriately using their asthma medications. As we operationalize the new pediatric assessments, we plan to train staff on these two prevalent pediatric conditions.



**Age of Engaged Population**

0 - 18	19 - 29	30 - 49	50 - 64	65+	TOTAL
104	367	870	672	13	2026

**Member Services SFY 2013** –Case managers and social workers systematically engage eligible Medicaid beneficiaries. The table below represents summary information regarding the level of activity during outreach and engagement.

<b>Description</b>	<b>Total Number</b>	<b>VCCI Unduplicated Members</b>
Member Outreach		
Introductory Letter	1,895	
Education Letter and Material	1,475	
No Contact/Unable to Reach Letter	4,457	
Telephonic Calls/Call Attempts	24,588	
<b>Assessments</b>		
General Assessments - SNA, BR and TOC	2,956	1,701
Disease-Specific Assessments	1,619	1,143
<b>Plans of Care (POC)</b>		
New POC	1,622	1,522
New Problems (to new or existing POC)	9,696	1,612
New Goals (to new or existing POC)	9,283	1,605
New Interventions (to new or existing POC)	11,824	1,579
<b>Interactions with Members</b>		
Face to Face Visits	49,757	3,033
	3,758	908

VCCI looks forward to continuing its efforts to improve the health and health outcomes for Medicaid beneficiaries with chronic conditions in SFY 2014 and beyond.