Vermont Chronic Care Initiative

House Committee on Health Care
April 6, 2017

Eileen Girling, MPH, RN, CAMS
Director, Vermont Chronic Care Initiative (VCCI)

VERMONT

Vermont Chronic Care Initiative (VCCI)

Mission

- Improve health outcomes of Medicaid members by addressing the increasing prevalence of chronic illnesses through comprehensive case management strategies.

Objectives

- Improve access to and utilization of primary care (medical homes)
- Increase adherence to evidence-based medical care (e.g. prescription drugs)
- Engage and empower members to participate in self-management of their health
- Reduce emergency and inpatient hospital utilization for ambulatory care sensitive conditions

Program Overview

Population

- Medicaid members at high risk/high cost (historically, top 5%)

Structure

- Licensed staff statewide provide in-person visits using a holistic approach (socio-economic indicators/clinical need)
- Staff are co-located in AHS district offices, primary care offices and hospital sites
- VCCI staff are members of local Community Health Teams (CHTs)

Services

- Provide short-term, intensive case management and care coordination, disease management, health coaching in collaboration with primary care providers (PCP) and specialty providers

Indicators for Medicaid Case Management

- Member's overall health status and related health care costs
- Fewer PCP visits among Medicaid members (higher ED)
- Poor member/PCP relationships:
  - High need adults less likely to report good patient : PCP relationships (42% vs 51% private)
  - Members with > 3 less satisfied (36% vs. 43%)
  - Members with ≥3 conditions & functional limitations least satisfied (34% vs. 35%)
- High mortality rates amenable to health care
- Hospital admission/readmission rates and utilization

Commonwealth Fund

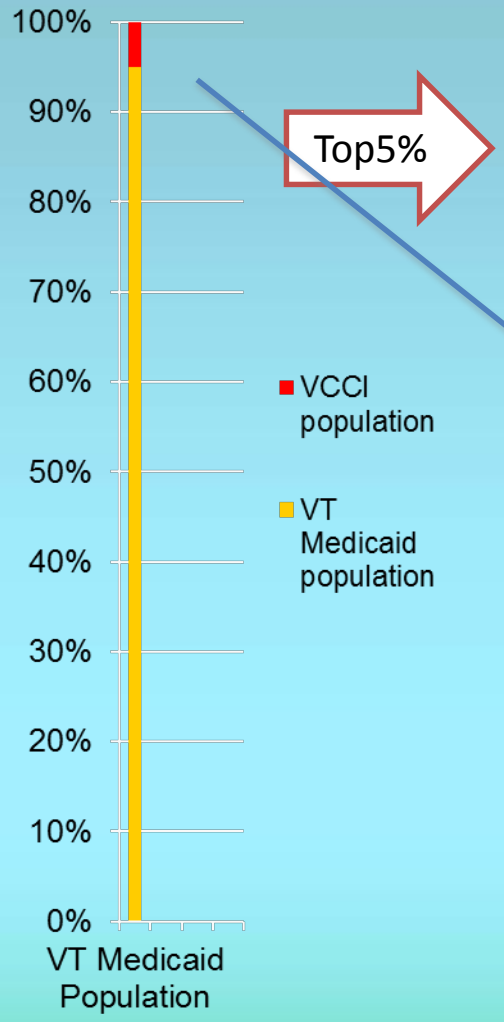
Eligibility Criteria for VCCI

- Medicaid is primary insurer (no dually insured)
- No other CMS-reimbursed case management
- No nursing home, assisted living resident, incarcerated; no other waiver programs (e.g., Choices for Care)
- Member profile:
  - High risk/cost including multiple chronic health conditions
  - Emergency department utilization
  - Frequent inpatient use
  - Poly-pharmacy
  - High predictability of future health care complications
- 'Impactable' medical condition

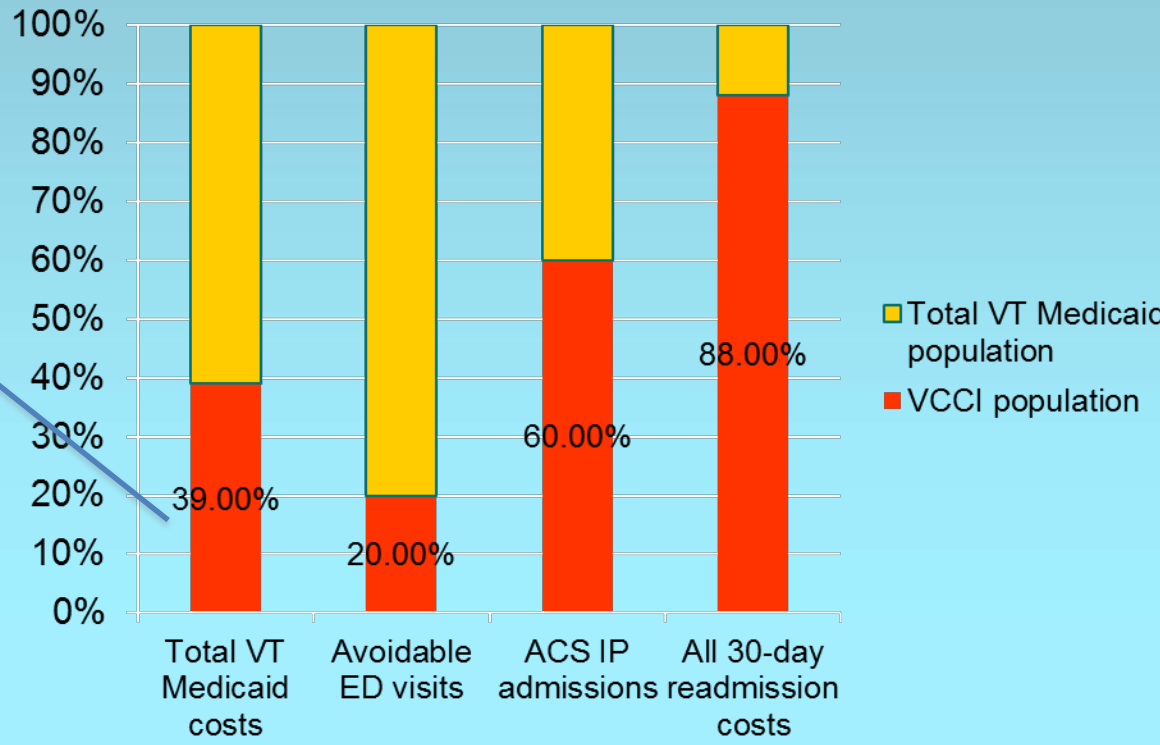
VCCI-Eligible Population: A Snapshot

- Historically, the top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs and a disproportionate number of hospital admissions and readmissions.

VCCI-Eligible Population: A Snapshot



Top5%



VERMONT

VCCI Population Identification

How are eligible Medicaid members identified?

- Members and diagnosis driving utilization/cost: SA, MH, CAD, CHF, diabetes, asthma & related risk factors (BMI)
- Analytical tools for population selection & stratification using claims data for predictive risk
- Hospital 'warm data' on ED/IP admissions via FTPs from 7 HSA's to reduce 30-day readmission rates
- VCCI liaison role with hospital partners/discharge planners
- VCCI access to hospital/PCP EMRs: Clinical & follow up

VCCI Services

Care Management & Care Coordination

- Referral via predictive analytics/eligibility rules; internal AHS partners & DVHA clinical units; hospitals, providers, CHT staff, community partners
- Facilitate 'Medical Home' access & adherence to treatment plan to improve quality of care and quality of life
- Evidence-based assessment tools, interventions; holistic, plan of care based on member needs/goals
- Collaborative approach with shared POC, 'action plans' and self-management goals/achievements with extended care team
- Strength based approach: MI, education/coaching for self-efficacy and sustainable results

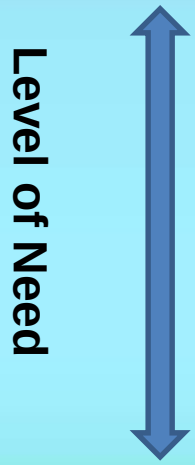
VCCI Specialty Case Management

MOMS: Medicaid Obstetrical and Maternal Supports

- In 2015, VCCI began to offer case management for at-risk pregnant women, with focus on those with a history of premature delivery, mental health diagnoses, or substance use during pregnancy.
- Substance abuse and mental health are factors impacting adverse pregnancy outcomes and related cost (including NICU stays)
- Medication Assisted Therapy (MAT) is critical to successful treatment during pregnancy
- Postpartum support indicated to assure MAT adherence & safety of infant; minimize DCF custody

VERMONT

Continuum of Care: Level of Service & Support



Advanced Primary Care Practice

- Health Maintenance
- Prevention
- Access
- Communication
- Self Management Support
- Guideline Based Care
- Coordinate Referrals
- Coordinate Assessments
- Panel Management

Community Health Teams

- Support Patients & Families
- Support Practices
- Coordinate Care
- Coordinate Services
- Referrals & Transitions
- **Case Management**
  - **Medicaid CMs**
  - SASH Teams
- Self Management Support
- Counseling
- Population Management

Specialized & Targeted Services

- Specialty Care
- Advanced Assessments
- Advanced Treatments
- Advanced Case Management
- Social Services
- Economic Services
- Community Programs
- Self Management Support
- Public Health Programs
- ***Medicaid/VCCI Case Mgn't***
  - **High Risk & Acuity (top 5%)**
  - **MOMS (Medicaid Obstetrical and Maternal Supports)**

Integration of VCCI & Blueprint

DVHA VCCI

Blueprint CHT

Eligibility Criteria for Referring to VCCI

1. Ages: individuals up to age 64, (assume SSI at 65),
2. Medicaid primary coverage (no dual insured); Population Stratification targeting high risk, high cost, medically complex cohort (multiple co-morbidities, providers, poly pharmacy, high IP/ED usage for ACSC)
3. Intensive case management required (complex medical and psycho-social need) and not receiving other CMS case management services
4. Limited health literacy with respect to medical condition(s)
5. Medical, mental and/or psychosocial instability adversely impacting health and generating high utilization patterns
6. Emerging needs identified that could destabilize future plans for health improvement (housing instability, pharmacy non-adherence)
7. Substance use/abuse history including medication assisted therapy (MAT) and post induction phase with stabilized SA tx (hub/spoke)
8. PCP, hospital or AHS referral for high risk factors impacting health
9. At Risk Pregnant women including MAT

DVHA/VCCI Activities

1. Outreach eligible/referred members and access clinical, mental and psycho-social need
2. Facilitate access to PCP/ Medical Home and/or mental health service
3. Develop a goal based POC working with member, PCP and other service providers to improve health status
4. Facilitate evidence based care management (gap analysis, medication adherence, coaching/health literacy support, etc…) using individual and population based tools
5. Facilitate socio-economic resources (food, shelter, etc.) and engagement with local partners for sustainability
6. Home, provider or other in-person and phone assessments, coaching and behavioral change support, using MI to foster progression in goal achievement
7. Continuous evaluation and strength based coaching to build skill and confidence in self-management
8. Assure communication and care coordination among primary and specialty care providers
9. Facilitate transition between levels of service (IP to OP; VCCI to CHT)

Shared Tools

1. Evidence-based guidelines
2. Patient Care Plans
   - Action Plans
   - Clinical Data
3. Population reports (NCQA): gaps in care

Transitioning from DVHA VCCI to Blueprint CHT

1. General and at least one disease specific assessments performed
2. Care plan implemented and mutually agreed upon by beneficiary and provider (readiness for change)
3. Initial coaching to evidence-based guidelines performed; action plan(s) initiated; self-management goals established
4. Basic knowledge about condition(s) and motivated to change
5. Care plan goals and objectives related to the primary diagnosis met or partially met/in process
6. Medical home established and utilizing
7. Medically, mentally and psychosocially stabilized

CHT Activities

1. Provides ongoing support for general patient population in Patient Centered Medical Homes (PCMHs) across a community
2. Work closely with PCPs to optimize adherence rates with age and gender appropriate health maintenance and prevention
3. Work closely with PCPs to optimize ongoing adherence with individual care plans
4. Work closely with PCPs to monitor and evaluate care plans with modifications as needed
5. Work closely with PCPs to support achievement of self-management goals with reevaluation and modification of self management goals and plans as necessary
6. Linkages to social support and economic services that contribute to health and well being
7. Work closely with PCPs to coordinate care across all domains of the healthcare system
8. Work closely with PCPs to assure that care support is suited by USPSTF recommendations and disease specific guidelines adapted by the Blueprint providers
9. Continuous evaluation of the need to transfer care back to DVHA and/or case closure

VERMONT

Member Story

Elementary school aged child with frequent use of ED for asthma exacerbations, referred by hospital to VCCI for treatment non-adherence and potential neglect

Medical

- Infrequent PCP visits, with evidence of prescribed inhalers
- High volume ED visits for acute asthma

Psycho/social

- Child lived with grandparents, pet in home, home schooled
- Grandmother dx cancer and in treatment

Nurse findings during home visit

- Black mold on kitchen walls, due to roof leak; no running water with walk to retrieve spring water nearby

Member Story

- Child not well socialized due to isolation and home schooling; ill health a factor in child's learning; grandparents stress related to cancer dx limiting care of child
- Grandparents concerned of loosing housing security
- Poor understanding of asthma triggers and management

<u>VCCI Interventions/collaboration:</u>

- Town health officer: assessment of housing code violations and risks to child and adults; assistance with expedited Section 8
- PCP: further assess child's asthma treatment and exposure – identification of triggers (mold, animals, other); as well as cognitive and social skills. Assess treatment plan - steroids

Member Story

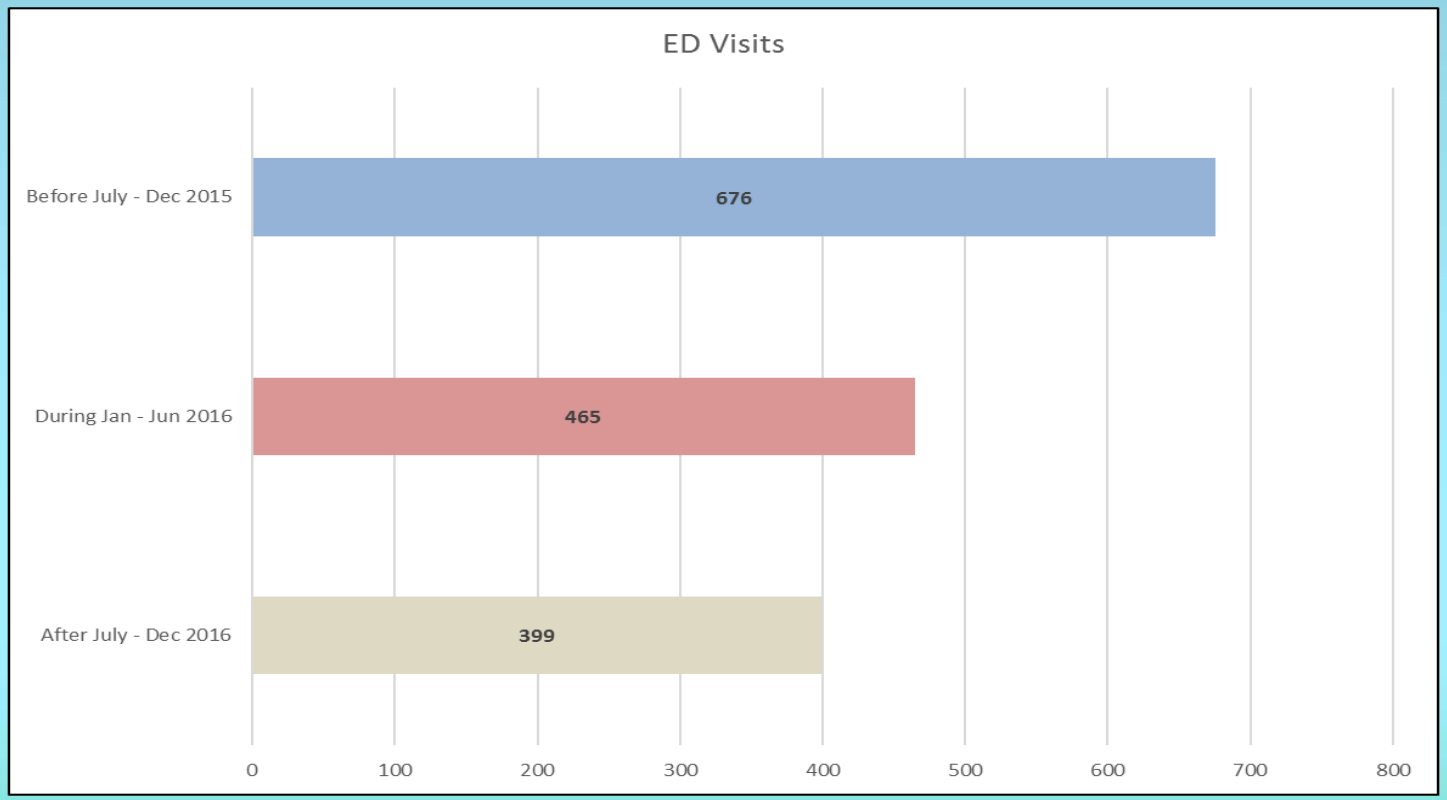
- Cancer support services: grandparents referred for support in managing diagnosis, treatment and stress reduction; planning

Results:

- Section 8 housing and family relocation away from asthma triggers and to less rural, walkable community
- PCP management of asthma, via control and rescue inhalers
- Public school system enrollment and school nurse collaboration for child's asthma management, including asthma action plan
- Education and coaching by VCCI RN on use of control and rescue inhalers; indications for PCP vs. ED use
- Humane Society for family pet dog
- Asthma improved with removal of triggers; ED decline

Outcomes

Emergency Department Visits – Comparisons 2015 to 2016



VERMONT

Appendix

VCCI History

VERMONT

DVHA/VCCI - History

2005 - 2010

- Rising rate & cost of chronic conditions in an acute care system
- PCP shortage/access, driving ACS hospital use
- VCCI enabled by legislation; statewide by 2008
- CMS Global Commitment (1115 waiver) - public MCO
- Initial focus 11 chronic health conditions, primarily adult
- Vendor contract for DM, analytics, data management tool

2011 -2015

- Shift focus to top 5% - all conditions, all populations
- Performance based vendor contract with 2:1 ROI

DVHA/VCCI - History

- Licensed SOV field staff in 12 AHS district offices & high volume provider settings, to facilitate referrals and care management
- Vendor professional staff provide telephonic management

2015 - 2017

- Case management for pregnant women added, focusing on mental health and substance use/abuse dx; preterm labor history
- Sunset legacy vendor & 15 licensed & ancillary staff, 12/2015
- Launch AHS Enterprise Care Management vendor (90-10 match)
- Focus on top 5% *and* predicted high future cost/utilization
- VCCI first to 'go live' in CM new system, 12/2015; subsequent deployments in 2016 and 2017 (functionality & programs)

Questions?

Eileen Girling, MPH, BSN, CAMS

VCCI Director

eileen.girling@Vermont.gov

802-881-2677

VERMONT