Medicaid Chronic Care Initiative: Strategies for High Utilizers

NGA and Center for Health Care Strategies

Summit: High Utilizers
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Department of Vermont Health Access (Medicaid)
Vermont Demographics

- **Population:** 630,000
- **Hospitals:** 14 (1 academic medical center, 8 critical access…)
- **PCPs:** 800 PCPs in 300 practices in 13 Hospital Service Areas
- **FQHC’s:** 8 organizations with multiple sites, serving 122,000
- **Mental Health:** 12 Agencies
- **Substance Abuse:** 4 specialty agencies
- **Health Insurance Carriers:** 3 major; plus Medicaid & Medicare
- **Most PCPs participate in all plans**
- **Strong history of working together**
# DVHA structure

**Commissioner:** Mark Larson

**Deputy Commissioners:**
- Medicaid Health Services and Managed Care (includes VCCI)
- Medicaid Policy, Fiscal and Support Services
- Health Benefits Exchange
- Health Care Reform

**Other Senior Leadership Team Members:**
- Blueprint for Health (infrastructure for PCPs includes CHTs/VCCI)
- Payment Reform and Reimbursement
- Chief Medical Officer
- Medicaid Medical Director
### Department of Vermont Health Access: Healthcare Reform Goals

- Quality Coverage for all Vermonters
- Improved Health of Vermonters
- Control Cost and Growth of Health Care
- Assure Financing is Fair and Equitable
Blueprint for Health: Overview

A Health Care Reform initiative focusing on primary care infrastructure, funded by insurance carriers:

- Supports PCPs becoming NCQA certified Patient Centered Medical Homes via grants to HSA’s to support improvement
- Enhanced pmpm payment based on NCQA score
- Funding of ‘core’ multidisciplinary Community Health Teams (CHT) with 5 FTE’s/20,000 patients in NCQA practices (VCCI supplements the CHTs)
- HIT support (registry) and resources to assist with adoption
- Evidence based self-management programs (Stanford Model)
- Multifaceted evaluation system
Team supports active caseload of 5,000 patients and oversees a total of 20,000 target population

Team composition varies by community (Formal Team)

Team coordinates with already existing community resources (Functional Team)

Team members move as individuals across practice sites

Are linked via an health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry

Designed to be flexible and scalable

Costs: $350,000 per 5-FTE team (equal shares by 5 payers)
Vermont Chronic Care Initiative

A *Healthcare Reform strategy for Medicaid population*

- **Internally aligned** with other Health Services/Managed Care units; the Blueprint for Health, Payment Reform, Policy unit, etc, etc…
- **Focus on Top 5% Medicaid** - highest risk, cost, utilization
- **Medicaid only** - all ages, all conditions; no other case management
- **State employed** licensed and non-licensed staff statewide
- **27 staff/20 locations** - State offices, hospitals/ED’s & PCP sites
- **Case identification** via predictive modeling; ED/inpatient data feeds; direct referrals from hospital, PCP, CHT’s; other Medicaid units (PI, SA, Pharmacy, Clinical…) and AHS colleagues
- **Members of the local Community Health Teams** - Blueprint for Health funded resource team for NCQA certified practices
# Highlights of VCCI Role

- Facilitate access to Medical Home and facilitates communication among treatment team providers, including MH and SA.
- Complete behavioral health, social needs and disease specific assessments to identify priority issue impacting health.
- Assess motivation, cognition, confidence, health literacy; coach and/or refer to support skill development for self-management.
- Develop a Plan of Care and Action Plan with patient and provider.
- Assess barriers to health and coordinate resources: housing, food/fuel security, transportation, financial support for medications and/or premium assistance as indicated by coverage type.
- Support transitions in care from ED/hospital; and post intensive case management, back to PCP and CHT colleagues.
- Share population based data with provider on gaps in care; acuity/risk levels and secure direct referrals for population in need.
VCCI Operational Model

**Staffing Model:**
- Field Staff: RN/SWs in state offices do field-based work (8 sites)
- Integrated RNs: High volume Medicaid practices, full & part-time based on practice size (8 current, 3 pending: FQHCs and private practices)
- Hospitals/EDs: RN/LADC in high volume hospitals secure referral, engage patients & coordinate transitions for high risk populations (2 hospital sites, 1 pending)

**Case Identification: Individual Approach**
- Predictive Modeling/Data Analytics: high acuity cases with vendor outreach or regional referral (push/pull) based on staff role
- Direct referrals: PCPs, ERs, state human service staff and Blueprint - CHT members/colleagues
- Daily ‘triggers’ for staff: prioritize cases based on POC, utilization & treatment gaps
- Hospital ‘liaison’: generate referrals to field & embedded staff to assure care transitions, medication reconciliation and PCP appointments to prevent readmissions
VCCI Operational Model, cont

Case Identification: Population approach
• Embedded RN at PCP site have practice level data to identify & outreach high risk patients (high acuity score, ED/inpatient visits)
• Hospital data feeds on ED and inpatients for timely outreach (FTP site, excel…)
• Disease specific PCP ‘registries’ to identify patients with gaps in evidence based care (labs, pharmacy); and support follow up; and NCQA/Blueprint goals

CHT/Blueprint interface
• VCCI staff are part of the local advance practice medical home CHT’s
• VCCI field staff perform home visiting and intensive services
• Transitions between VCCI & CHT based on level of service needed
• Piloting a ‘POC’ feedback tool for ED/CHTs on high volume users referred

Vendor contract for clinical & data analytic support (APS Healthcare)
• Predictive modeling and ‘percolator’ to identify highest need patients
• Ability to assign cases by both push and pull regionally and by staff role
• ‘Triggers’ for staff if gaps in care (pharmacy)
• Population based ‘registries’ and ‘patient health briefs’ for PCP’s
• Nurses, Social Workers, Pharmacist, Medical Director (.5 FTE) supports
## Key Success Factors

### Legislative/Policy:
- Visionary leadership: State administrative leaders and legislature support VCCI, Blueprint and other HealthCare Reform efforts as a priority and part of state law/rules
- CMS 1115 Waiver: VT Medicaid as MCE (flexibility)
- Strategic alignment within DVHA – all units working toward common goals

### Providers/partners:
- Financial Incentives for PCPs: Blueprint enhanced pmpm & CHT resources; VCCI supplemental payment for MD support
- Environment of Cooperation: state, hospitals, providers and carriers
- VCCI access to partner EMR/data systems (hospitals, PCP’s)
- VCCI vendor contract with 100% risk for performance
**Lessons Learned:**

*Complex System Change is Hard!*

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<tr>
<th>Population Engagement:</th>
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<tr>
<td>▪ Voluntary program: hard to engage via ‘cold calling’</td>
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<td>▪ Licensed staff not best for ‘outreaching’ eligible members</td>
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<td>▪ Population is difficult to locate &amp; keep engaged: change in phone, address</td>
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<td>▪ Incentives ‘up-front’ help enrollment, but not sustained engagement</td>
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<td>▪ Predictive model helps with population identification but, need ‘relationships’ with partners where patients ‘show up’ including hospital, PCP, MH/SA tx providers, human service offices, DOC/P&amp;P, PCP) to help ‘engage’</td>
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<td>▪ Direct referrals are the most likely to engage and remain engaged including PCP directed and post ‘event’ (ED, inpatient stay)</td>
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**Providers/Partners relationships:**

| ▪ Integrated model challenging for providers to fully embrace and commit to, including challenges with space, phones. MOU recommended |
| ▪ Financial incentives motivate partners to address their system weaknesses |
| ▪ Access to EMR/data systems supports staff integration as well as results |

**Staff skills/support:**

| ▪ Training and tools are imperative: Call Guides/Pharmacy Guides, Action Plans; substance use/abuse & MH skills; MI skills; team debrief time & passion for the work! |
| ▪ Data on performance is critical! |
VCCI Results - 2011

Medicaid Beneficiary Adherence to Evidence-based Clinical Guidelines by Diagnosis

- Asthma (medication adherence)
- COPD bronchodilator therapy
- Congestive Heart Failure (CHF) ACE/ARB
- Coronary Artery Disease (CAD) Lipid Test
- CHF Beta Blocker
- CHF Diuretic
- Lipid lowering med 84 days
- Depression med 84 days
- Diabetes HbA1c test
- Diabetes Lipid test
- Diuretic therapy
- Hyperlipidemia 1 or more lipid tests
- Hypertension 1 or more lipid tests
- Kidney Disease microalbuminuria screening
- Kidney Disease ACE/ARB

VCCI: Blue bars
Non-VCCI: Red bars
## VCCI Results 2011

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>ED visits</th>
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<tr>
<td><strong>Baseline:</strong> 188/1000</td>
<td><strong>Baseline:</strong> 1145/1000</td>
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<tr>
<td><strong>FY 2011:</strong> 161/1000</td>
<td><strong>FY 2011:</strong> 1030/1000</td>
</tr>
<tr>
<td>% change: -14%</td>
<td>% change: -10%</td>
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Blueprint progress

Blueprint Practices, Patients Served, and Community Health Team Staffing

*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.*
## Contact Information

Questions or additional information:

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