

## **Vermont Chronic Care Initiative: Case Management/Care Coordination Services**

### **Indicators for Referring to DVHA VCCI:**

- Intensive Case Management and Care Coordination (home visits, multiple diagnoses)
- Limited health literacy with respect to condition(s)
- Medical, behavioral, and/or psychosocial instability, leading to gaps in care
- Emerging needs identified that could destabilize future plans for health improvement (e.g. housing or financial insecurity impacting ability to manage health)

### **Eligibility Criteria:**

- Be enrolled in Medicaid program - no dually eligible populations
- Multiple complex health conditions. Individuals who have co-occurring conditions of substance abuse and/or mental health diagnoses may be especially good candidates
- High ER utilization, frequent hospitalizations, poly-pharmacy and/or high predictability of future health care complications
- Not currently receiving other case management services (e.g. CMS covered case management such as CRT, Choices for Care/PACE and/or other waivers)
- Not currently residents of nursing homes or assisted living facilities
- Not have Medicare or other primary insurance coverage; or be incarcerated.

**Case Manager/Care Coordinator Role: Overall responsibilities include: Advocacy, Assessment, Planning, Implementation, Care Coordination, Monitoring, Evaluation, and Outcome analysis. The Case Managers are Registered Nurses, Licensed Clinical Social Workers or Licensed Alcohol and Drug Abuse Counselors, and Medical Social Workers with direct and relevant experience with holistic care management and community support networks to facilitate sustainability. The case managers/care coordinators:**

- Facilitate access to a medical home, specialty care and communication among providers.
- Assess clinical and psychosocial need and develop a plan of care based on priority of the provider and beneficiary, and social factors impacting health outcomes.
- Facilitate communication and coordination among providers to support the treatment plan, minimize contraindicated or redundant treatments, including mental health and substance abuse providers.
- Support development of skill and confidence required for effective self-management of chronic condition via coaching, education, and/or referral to programs and/or services (certified diabetic educators, Healthier Living Workshops); and monitoring progress.
- Refer to appropriate resources to reduce the socioeconomic barriers to health and health care, including access to safe and affordable housing, employment, food stamps, fuel assistance and transportation to health care providers as appropriate.



## **VCCI Behavioral Health Service Supports : Rutland and Franklin**

The Vermont Chronic Care Initiative offers expanded services for eligible populations in Franklin/Grand Isle and Rutland county service areas to include short term support by licensed clinicians for individuals with mental health and substance abuse disorders. Specifically, LICSW/LADC staff can work with the PCP and/or designated mental health or substance abuse treating provider(s) including hub/spoke clinicians as appropriate to: facilitate access to care, complete a needs assessment and goal based plan of care, coordinate the approved plan among multiple service providers and provide short term direct support and case management pending access to the mental health/substance abuse treating clinician. These services are intended to benefit individuals experiencing delays in treatment access, high ED utilization, poor adherence to prescribed care, and/or situational support needed to facilitate improved self-management of their health conditions. Staff work in partnership with RN's for clinical support.

Services are free and target Medicaid beneficiaries who meet VCCI program eligibility criteria including high complexity, multiple co-morbidities, high utilization patterns and/or a persistent behavioral health challenges that adversely impact their quality of life and ability to access and/or self-manage care due to MH and/or SA related diagnoses.

### **Referral Criteria for Mental Health and/or Substance Abuse Services**

- Same baseline criteria as VCCI clients (see reverse)
- Medically and mentally stable (not actively psychotic, MH crisis; stabilized on buprenorphine or methadone, if part of hub/spoke)
- Documented or perceived mental health or substance related disorder evidenced by:
  - a pattern of high ED usage for ambulatory sensitive conditions, including anxiety, mental health and/or pain related conditions/complaints
  - participation in either Methadone or Buprenorphine Treatment Program
  - a positive urine drug screen for illicit substance(s) within past 60 days
  - absence of a treating provider including PCP, MH and/or substance abuse clinician

### **Objectives for Behavioral Health Referrals**

- Assure timely access to appropriate level of care
- Assure service coordination among treating providers for individuals with multiple providers including PCP, Mental Health and SA providers, and associated CHT colleagues
- Reduce gaps in care and/or services for vulnerable populations; improve adherence to MAT
- Provide screening, early intervention and/or coaching for members experiencing access delays and/or provide continued comprehensive care management as clinically indicated to support sustainable behavioral change
- Support medical and/or community health teams via addiction consultation as appropriate
- Coordinate referrals to determine and assure appropriate levels of care for beneficiaries
- Enhance coordination among AHS partners and beneficiaries to support medical home model and care access for vulnerable individuals including those in transition