Integration of Blueprint and DVHA VCCI

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, behavioral 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. High Risk Pregnant women including MAT (pilot Franklin County)

DVHA/VCCI Activities

1. Outreach eligible/referred members and access clinical, behavioral and psycho-social need
2. Facilitate access to PCP/ Medical Home and/or behavioral 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
   - Patient Health Briefs
3. DocSite Clinical Tracking Tool
4. 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
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. Medical, behavioral and psychosocial stability 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