VERMONT
VERMONT CHRONIC CARE INITIATIVE
Healthy Together

Vermont Chronic Care Initiative: Case Management Services

Indicators for Referring to DVHA Vermont Chronic Case Management:

- Member has comorbidities (new or prior dx), including mental health/substance use disorder and a need for monitoring of treatment plan or medication adherence; needs coordination with community resources including housing, food.
- Member would benefit from community-based visits to support treatment plan, plan of care or redirection to patient centered medical home.
- High ED utilization, frequent hospitalization, poly pharmacy and/or high predictability of future health care complications.
- Medical, behavioral, and/or psychosocial instability, leading to gaps in care.
- Intensive case management, one on one intervention required (e.g. home visits).
- Member is new to Medicaid and needs orientation to the system of healthcare (i.e. PCP) and healthcare related resources (i.e. housing, food).

Eligibility Criteria:

- Be enrolled in a Medicaid program; may be dually insured.
- Not currently receiving other case management services (e.g. CMS covered case management such as CRT, Choices for Care and/or other waivers).
- Not currently residents of nursing homes, assisted living facilities or correctional facilities.
- Not currently attributed to the Medicaid ACO.

Case Management Role: Overall responsibilities include: Advocacy, Assessment, Planning, Implementation, Coordination, Monitoring, Evaluation and Outcome analysis. VCCI case managers are Registered Nurses, Licensed Clinical Social Workers or Licensed Alcohol and Drug Abuse Counselors with direct and relevant experience in clinical care delivery, as well as case management experience in the community setting. The case managers:

- Facilitate access to a medical home and communication/coordination among service providers.
- Develop a plan of care for clinical management based on the priority of both the provider and member, and social factors impacting health outcomes.
- Facilitate communication and coordination among member, PCP and specialty providers to support the treatment plan, 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).
- Orient members to the system of care to include navigation of services for health-related needs such as housing, food security, transportation, fuel assistance.
- Engage in the complex care model (eco mapping, care team member, shared care plan with member identified goals).
- Onboarding members ahead of their ACO attribution to include facilitation of access to primary care, and connection to community supports and resources.