



# VERMONT CHRONIC CARE INITIATIVE

ANNUAL REPORT

STATE FINANCIAL YEAR 2012

ISSUED APRIL 1, 2013



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## Executive Summary

The Vermont Chronic Care Initiative (VCCI) has been an evolving effort by the state of Vermont to provide the most effective and supportive response to chronic disease conditions experienced by members of the Medicaid population. In SFY 2012 the program sharpened this focus upon the members with the highest risk/highest cost conditions. These members typically are persons with multiple disease conditions, two or more medical providers, and six or more prescriptions for daily use. Some members are well above these averages, and some below, but in nearly all cases there are complex co-morbid conditions that require not only consistent care by a Primary Care Provider (PCP), but also specialty care for medical and behavioral health conditions.

The population of focus during SFY 2012 has been those in the top 5 percent high risk/high cost of the Medicaid population, with the exception of persons with existing case management services via another state funded program, usually within the Agency of Human Services, or persons with Medicaid but Medicare is the primary health insurance provider. For this past year the population of persons considered high risk/high cost has included over 11,000 members.

During SFY 2012, the VCCI engaged 3,015 Medicaid members via face-to-face and/or telephonic case management. Services were comprised of assessments of medical and psycho-social health, with specialty assessments done for persons for whom it was clinically indicated. These assessments generated a Plan of Care (POC) with member input regarding the focus of a particular episode of VCCI care, and care coordination/case management support as indicated by the assessment and POC. The duration of case management services is impacted by case complexity and member progression toward POC goals. On average, the episodes of care were 77 days long.

The VCCI is an integrated model of medical and behavioral health case management supports provided by a staff of nurses, social workers and substance abuse counselors with medical, mental health, and substance abuse oriented experience and education. A major objective of the case managers is to help a member stabilize — e.g., a member with diabetes begins to improve HbA1c readings toward a goal of below 7.0 — by a combination of direct service with medical and self-management information and planning for member, and engagement with providers in Primary Care Provider (PCP) offices and in hospital care settings to provide information, including gaps in evidence-based treatment. At time of discharge from VCCI, the member has an Action Plan they can carry forward on their own with the involvement of their PCP, or with further assistance from less intensive services at the local level to maintain progress made while engaged with VCCI.

The primary foundation of the VCCI effort has been to use health analytics to identify the high risk/high cost members, then to identify gaps in care that a VCCI case manager could address with them and their providers. A carefully executed review of the outcomes of this effort indicate success for the VCCI interventions in SFY 2012. The expected Per Member Per Month (PMPM) rate of increase in cost of care for this group was a 6.48 % increase over the previous year, or from \$2,544.05 PMPM in the baseline year to \$2,708.79 PMPM in SFY 2012. The outcome data indicates the actual PMPM for the high risk/high cost population was \$2550.01 PMPM. Thus, overall care expenses were \$15,322,808 lower than projected, an average of \$158.78 PMPM. The VCCI has been successful in its focus on the high risk/high cost members and as part of the larger health care reform strategy pursued by the state of Vermont to stabilize the cost of care for Medicaid members and all Vermonters.



## I. Year in Review

### ***Vermont Chronic Care Initiative Begins 5<sup>th</sup> Year of Service with a New Focus and New Tools***

The Vermont Chronic Care Initiative (VCCI) achieved positive outcomes during Year 5 of its operation (July 1, 2011 through June 30, 2012) as the program transitioned from focusing on members with 11 chronic health conditions to members with any health condition who are in the top 5% for service utilization. Concurrently, VCCI staff also adopted a new software system, CareConnection® version 3 (C 3). The goals of VCCI remained similar as in past years: to improve member treatment and clinical outcomes and reduce emergency and inpatient hospital utilization through accessing appropriate levels of services and care coordination. Focusing on the top 5% members increased participation by those with higher complexity clinical and psychosocial needs and greater hospital inpatient admissions, readmissions and use of emergency room care. The high risk/high cost members are markedly represented in these utilization areas. For example, the top 5% of Medicaid members produced 91% of the readmissions in SFY 2010.

Outcomes for SFY 2012 are as follows:

- **3,015 unduplicated members** were actively engaged with VCCI intensive case management and care coordination services.
- Members receiving care coordination and intensive case management services for at least 60 days experienced significantly better **prescription fulfillment and evidence-based testing** in some categories; most notably in 84 and 180 day prescription fulfillment rates for depression medications, and for use of ACEI/ARB medications by members with systolic heart failure. Concurrently, challenges remain in increasing other prescription fulfillment rates, such as the use of both an ACEI/ARB and preferred Beta Blocker for systolic heart failure, and the use of lipid lowering agents among members with coronary artery disease (CAD). Ongoing analyses and interventions include determining whether policy and pricing changes for certain evidence-based medications might increase prescription fulfillment and decrease morbidity associated with gaps in treatment.
- **Inpatient hospital** utilization among the top 5% of high risk/high cost members was reduced by 8.1%, declining from 518 members per thousand in SFY 2011 to 476 per thousand members in 2012.
- **Readmission rates for members in the top 5% dropped** by 11%, from 87 readmissions per 1,000 members in SFY 2011 to 77 per 1,000 members in SFY 2012.
- **Emergency room** utilization was 3.9% lower among the top 5%, decreasing from 1521 visits per thousand members in SFY 2011 to 1461 visits per thousand members in 2012.

In SFY 12, several new tools were introduced for use with providers, including Patient Health Registries (PHRs) and Patient Health Briefs (PHBs). Efforts to increase the use of preferred medications for members with heart failure led to numerous engagements with PCPs and the outcome was an overall increase in the use of evidence-based medications. The PHR and PHB tools plus the new C 3 software system also created a dashboard view for VCCI nurses, social workers, and licensed behavioral health providers of accurate and current health status information that is useful for prioritizing needed services. Changes have been supported with joint training sessions for DVHA and APS Healthcare VCCI staff, including training on specific

disease conditions, best use of the C 3 system, and development of a process with local hospitals for more timely referrals of members with inpatient and emergency room utilization.

VCCI developed reporting on a variety of data concerning pharmacy, emergency department use, and specific health conditions that has enabled the program to become a valuable partner delivering multiple levels of direct care and data reporting on member health status. VCCI reported on substance abuse and members in treatment, with an emphasis on gaps in care for members receiving medication assisted treatment. Additionally and significantly, VCCI field staff became embedded in several high volume provider practices and hospital locations, which helped facilitate referrals, warm transfers, relationships and improved access to primary care, as well as support transitions in care between inpatient and outpatient settings for the vulnerable VCCI population.

## II. Background

Vermont began developing policies and programs for health improvement earlier than most other states and is now illustrating that prevention, early intervention, and integrated health care can bring positive changes. For the fourth year in a row Vermont has been ranked the healthiest state in the nation by the United Health Foundation, which uses 51 indicators to establish a ranking of states. (The report is at: <http://statehealthstats.americashealthrankings.org/#/country/US/2012/Overall-State-Ranking>.) APS Healthcare began working with the State of Vermont in 2007 to establish specific efforts to address Medicaid members with chronic health conditions via the creation of the current Vermont Chronic Care Initiative (VCCI). In the past five years this effort has been joined with overall state efforts for health reform. The state enacted health care reform legislation in 2006 (Act 191, Section 1903a) and has continued to do so in following years including the present effort for the creation of a single payer health system. The initial legislation authorized the creation of VCCI to support Medicaid<sup>1</sup> beneficiaries with chronic health conditions. As collaborators under the Blueprint for Health<sup>2</sup>, the VCCI supports Blueprint activities specific to the Medicaid population.

At the outset of SFY 2012, the Vermont Chronic Care Initiative grew to encompass three times the number of disease conditions previously addressed in the first years of the program. Among these are:

|                                       |  |
|---------------------------------------|--|
| ADHD                                  | Diabetes                                 |
| Arthritis                             | Hyperlipidemia (high cholesterol levels) |
| Anxiety                               | Hypertension                             |
| Asthma                                | Kidney Disease (chronic renal failure)   |
| Chronic Obstructive Pulmonary Disease | Low Back Pain                            |
| Heart Failure                         | Sleep Disorders                          |
| Coronary Artery Disease               | Stroke                                   |
| Depression                            | Substance Use Disorders                  |

The overarching goals of the VCCI are two-fold: 1) improve the health and health outcomes for Medicaid beneficiaries with chronic conditions through improved self-management of their health and coordination of services, and 2) reduce costs that would have otherwise been paid by the Medicaid program and thereby the taxpayers of the State of Vermont.

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<sup>1</sup>For the purposes of this report “Medicaid beneficiaries” includes Medicaid, VHAP, and Dr. Dynasaur beneficiaries, but excludes individuals dually eligible for Medicare, individuals enrolled in Choices for Care, and individuals who are in an institute for mental disease. These exclusions are required by the enacting statute.

<sup>2</sup>Blueprint for Health is the state plan for chronic care infrastructure, prevention of chronic conditions, and chronic care management program, and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives.

### **III. Treatment Adherence and Utilization Results**

#### **Pharmacy Treatment Adherence**

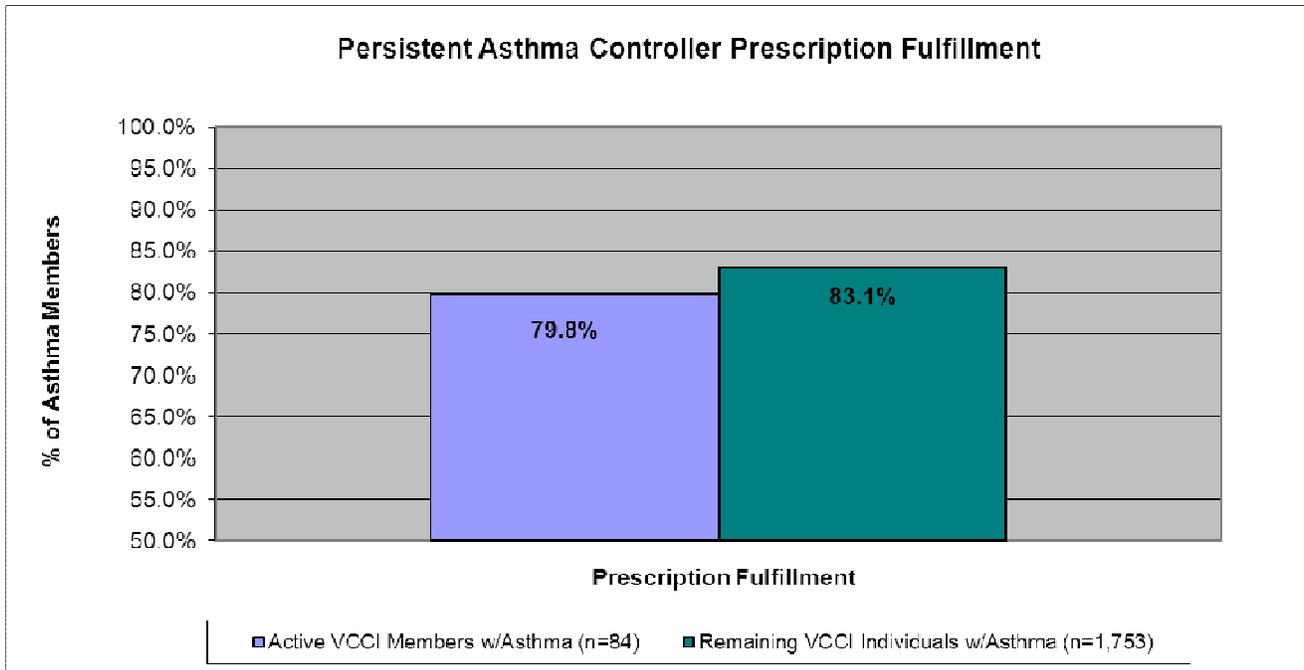
The Medicaid members that are the focus of VCCI efforts often have complex health challenges. It is common for members to have three or more chronic conditions (with many having co-morbid mental health and substance abuse conditions, as well), two or more providers – e.g., a Primary Care Provider (PCP) and specialist involved in their care – and at least six medications prescribed for daily use, including from different providers. The complexity of the pharmacy regime for the top 5% members often poses a risk for over prescribing, concurrent use of contraindicated medications and misuse of medications, and confusion that can lead to adverse events. For this reason, the VCCI added a full time pharmacist to the team in 2012. The VCCI is dedicated to assisting members who are struggling with these challenges to improve their personal health status, and to educating providers via early utilization of the new Patient Health Brief in order to reduce gaps in pharmacy treatment guidelines.

The information that follows is based on Medicaid claims files that DVHA has provided and that APS Healthcare has analyzed. Data reporting prescription fulfillment is made in reference to the claims reported by pharmacies filling prescriptions for members. The claims are based on prescriptions being filled by members and claims paid by DVHA. Similarly the lab testing information is also based on claims data.

In each of the following graphs, the blue column defines members who were engaged for at least 60 days in the VCCI program. The green columns indicate members who were not engaged but were identified as in the population of the top 5% of high risk/high cost Medicaid members that are eligible for VCCI services.

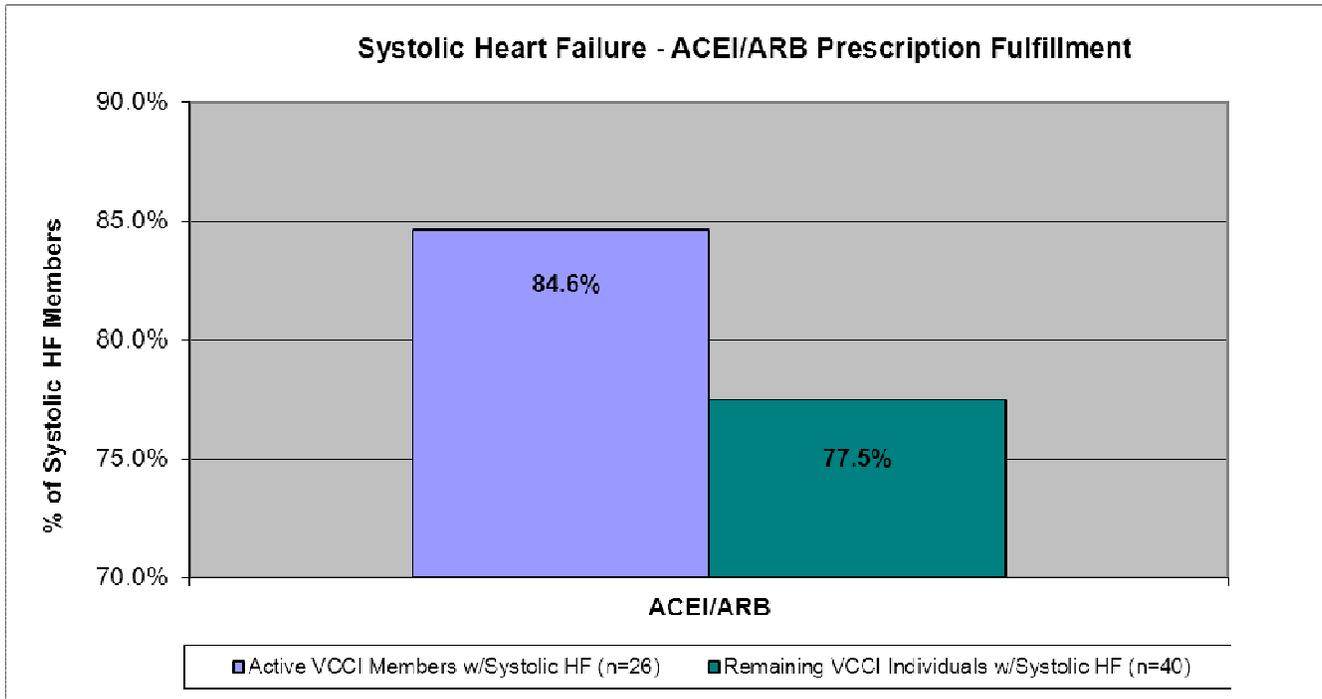
## Asthma:

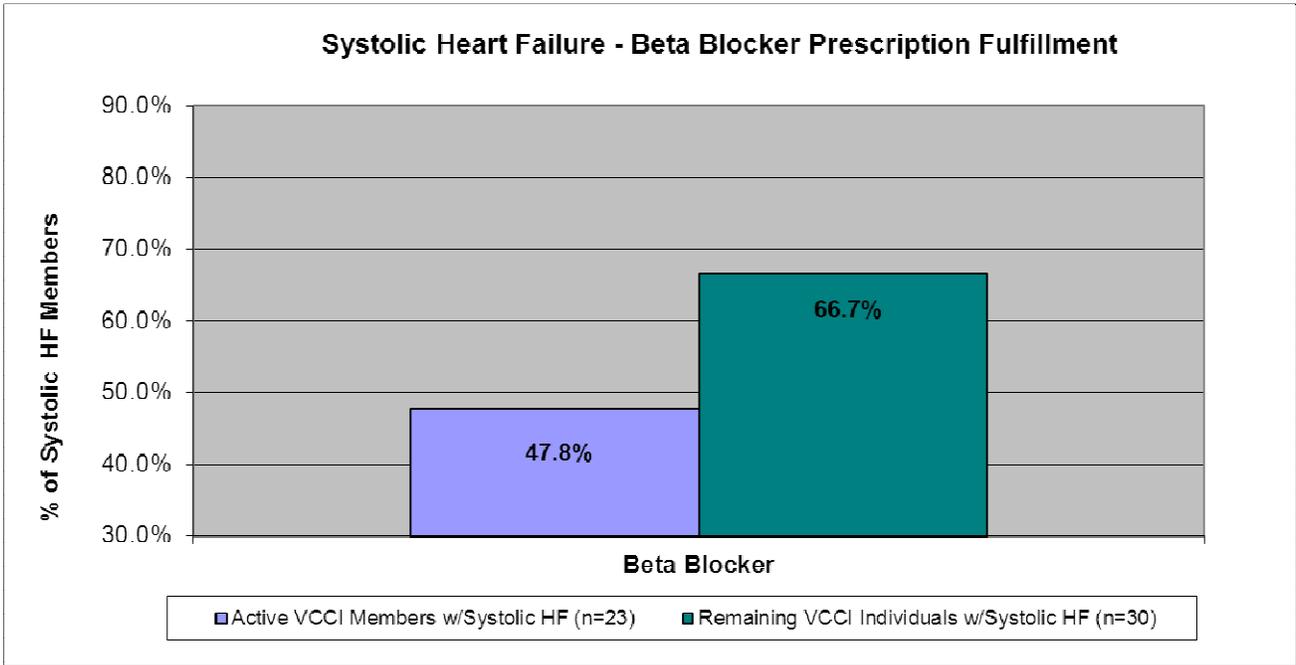
**Members active with VCCI show a prescription fulfillment rate for a controller medication of 79.8% compared to 83.1% for non-engaged members with persistent asthma.** Inhaled corticosteroids (ICS) are the recommended controller for members with persistent asthma to improve lung function. Asthma is a chronic inflammatory disorder of the airways; inflammation is associated with recurrent episodes of wheezing, breathlessness, cough, and tightness inside of the chest. Left untreated, chronic inflammation may result in structural changes or remodeling of the airways.



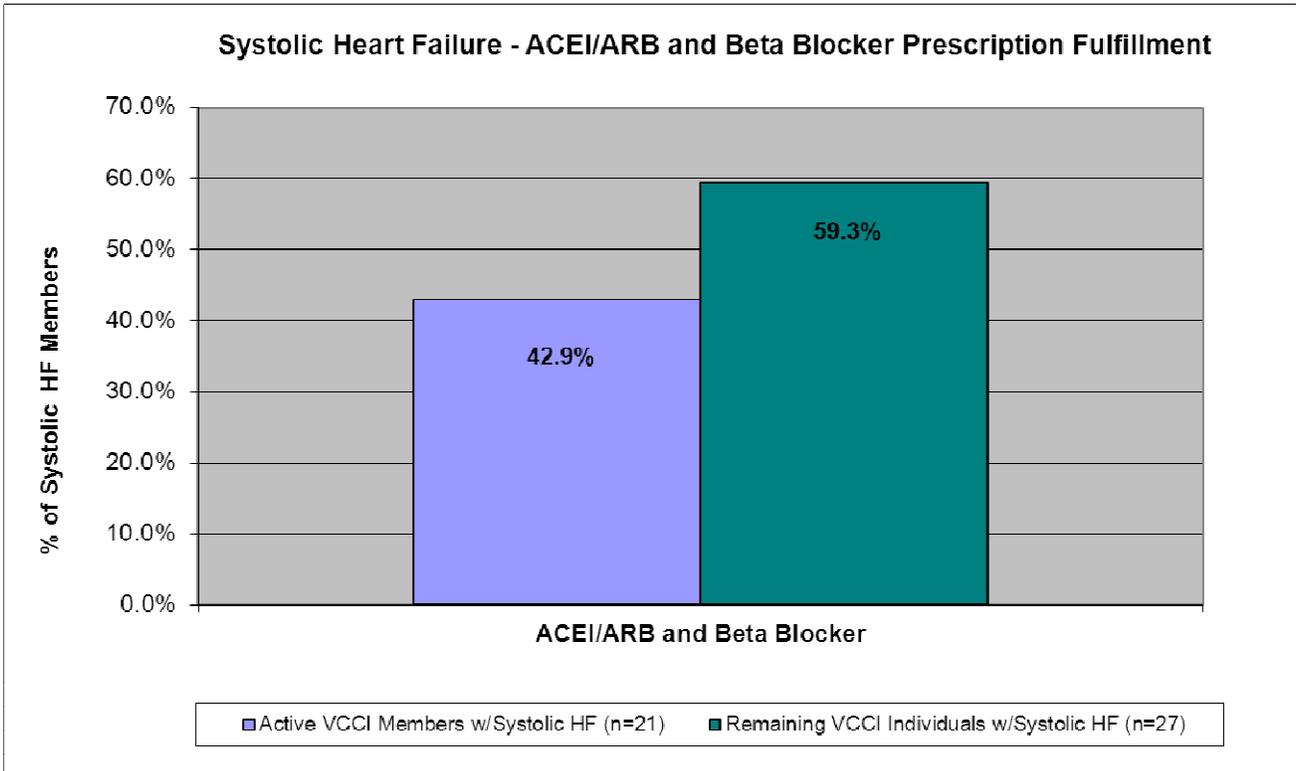
## Systolic Heart Failure:

Members active with VCCI are more likely to fill a prescription for an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin receptor blocker (ARB) for systolic heart failure compared to non-engaged members with systolic heart failure (84.6% versus 77.5%). ACE inhibitors increase survival and improve symptoms. Long-term prescription of beta blockers can lessen symptoms of heart failure, as well as improve clinical status and enhance quality of life. ACE inhibitors and beta blockers can reduce the risk of death or hospitalization.



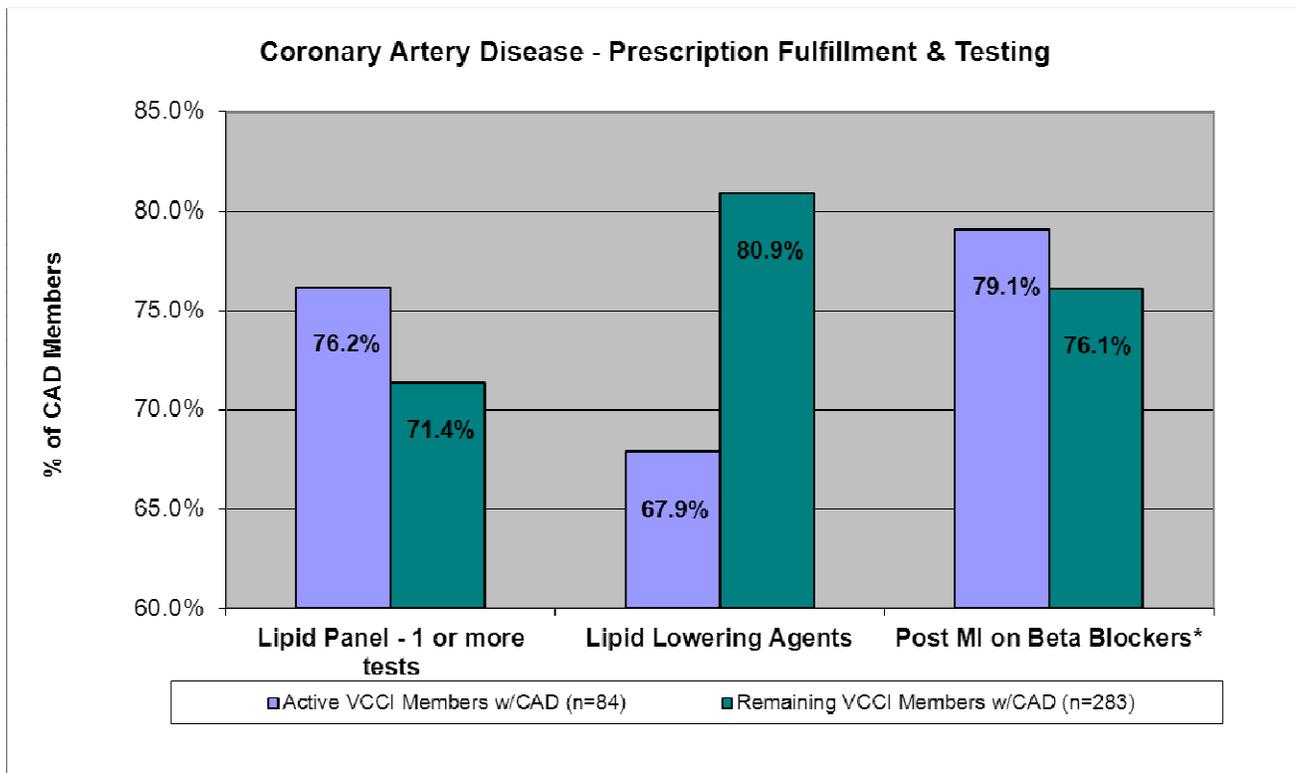


*The use of preferred beta blockers for VCCI engaged members was lower at 47.8% versus 66.7% and the fulfillment of both an ACEI/ARB and preferred beta blocker for systolic heart failure was 42.9% for the VCCI engaged members vs. 59.3% for non-engaged members with systolic heart failure. [It is important to note that the difference may reflect the overall effort by VCCI to work with all members with heart failure (not just those in the top 5%), related to the HF Performance Improvement Project.]*



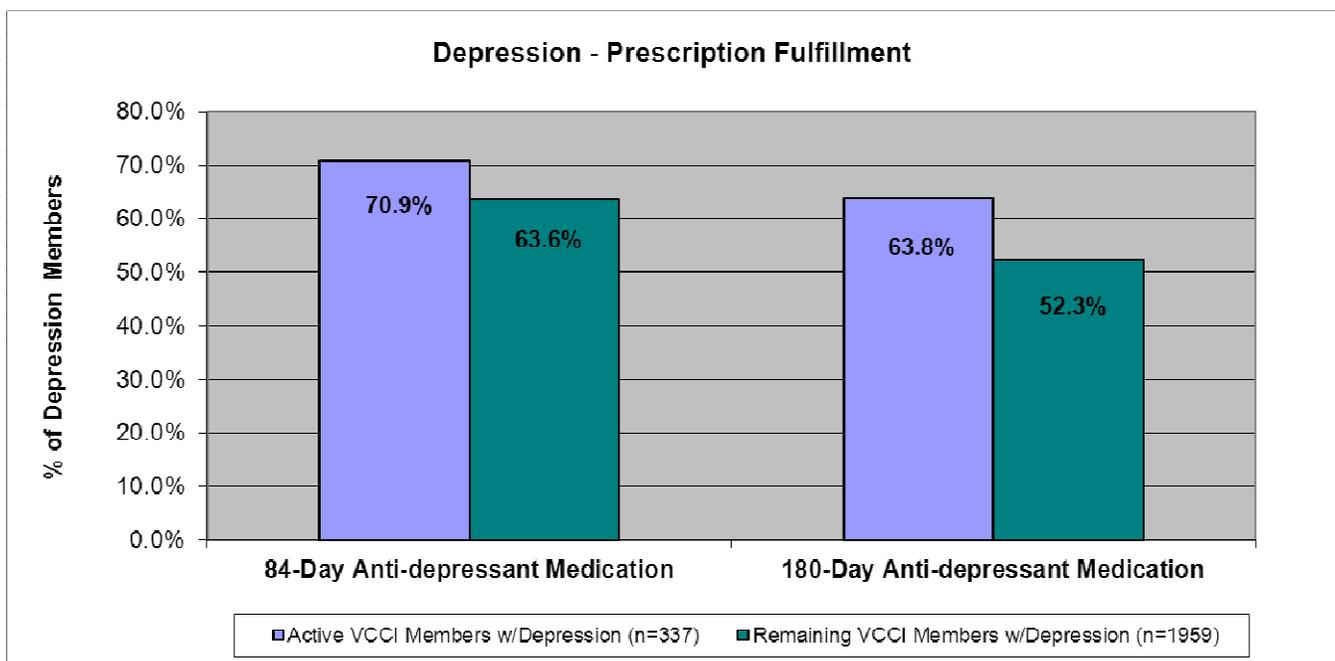
## Coronary Artery Disease:

*While members with coronary artery disease (CAD) who are active with VCCI have better adherence to lipid testing, they have lower fulfillment of lipid lowering prescriptions than non-engaged members with CAD.* The measurement and monitoring of lipids is critical to the management and improvement of CAD. The use of lipid lowering agents, such as statin medications, prevent further disease progression for members with CAD. Best clinical practice shows a reduction in heart attacks and death from heart attacks for members who are hospitalized for a myocardial infarction (heart attack) **and** who receive a beta blocker medication upon discharge. VCCI members filled prescriptions after discharge for beta blockers 79.1% of the time while non-engaged members post myocardial infarction filled beta blocker prescriptions 76.1% of the time for SFY 2012.



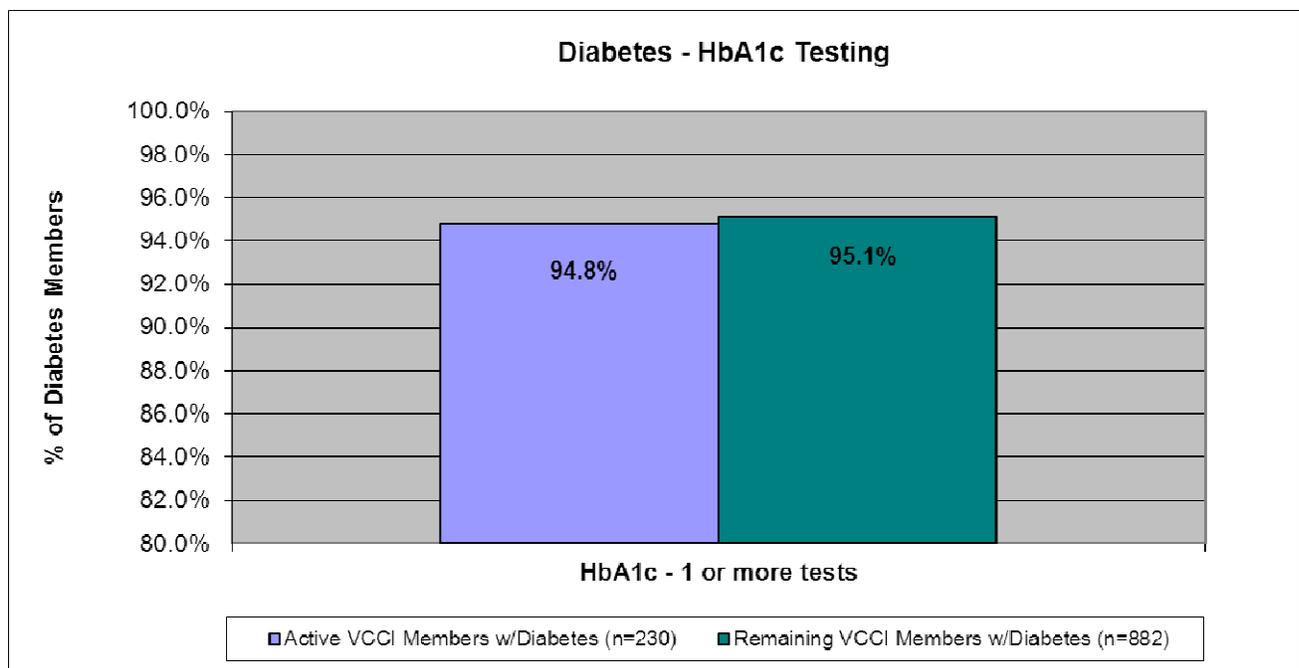
## Depression:

*In this HEDIS-like measure, members active with VCCI have higher rates of prescription fulfillment than members who do not receive VCCI health coaching or care coordination services: 70.9% versus 63.6% over 84 days, and 63.8% versus 52.3% over 180 days.* Depression rates among the population in the top 5% are significant (25% of members have depression as a primary diagnosis) and the VCCI has attempted to focus on stabilization of this underlying condition prior to focus on other co-morbidities, to enhance results. Members with depression often have a personal or family history of depression, have had a recent trauma or loss, or have co-morbid medical conditions. In people age 18 through 44 years, depression is the leading cause of disability and premature death. Treatment of depression requires close follow-up for up to one year. If an individual with depression improves after continuous treatment for 12 weeks (84 days), the individual is viewed as having entered remission.

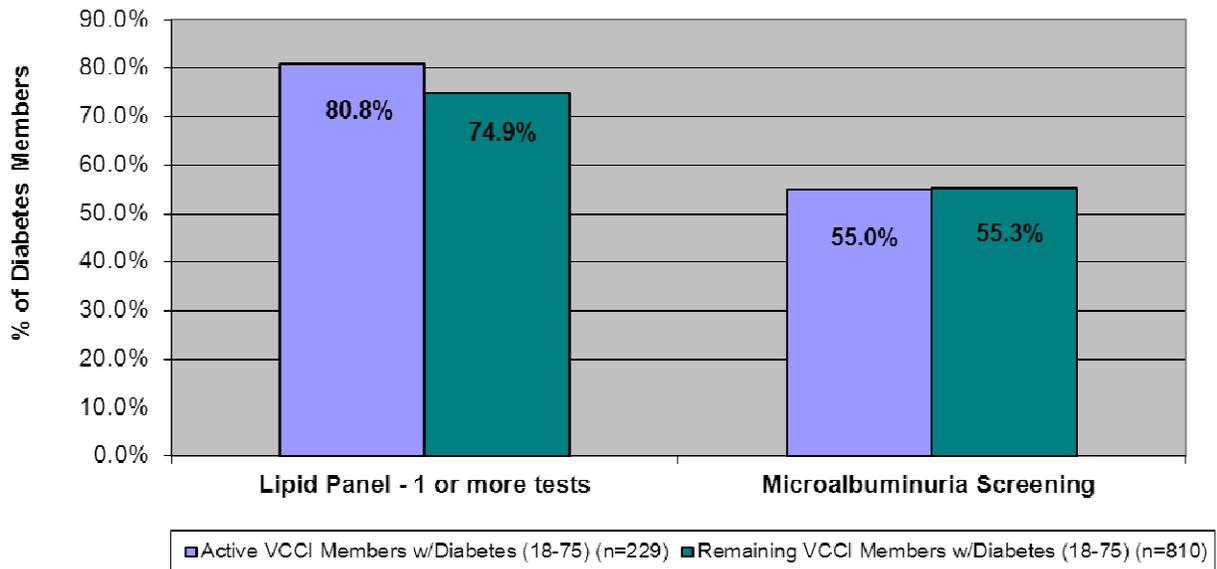


## Diabetes Mellitus

**While members engaged with VCCI obtained HbA1c testing slightly less frequently at 94.8% vs. 95.1% for non-engaged members with diabetes mellitus, this is still a high metric for A1c testing. Members active with VCCI are more likely to receive appropriate lipid level testing annually compared to non-engaged members with diabetes: 80.8% versus 74.9%. Microalbuminuria testing for kidney function for both groups was similar; 55.0% for VCCI engaged versus 55.3% for the non-engaged members and is an area for continued focus for VCCI.** The Medicaid population has a very high rate of HbA1c testing among the high risk population. HbA1c testing reflects average blood sugar level over several months and provides a strong predictive value for diabetic complications. Cardiovascular disease is the major cause of death for members with diabetes and is the largest contributor to the direct and indirect costs of diabetes treatment; contributing to the high risk of heart disease is the increased prevalence of lipid abnormalities. Therefore, it is also important to monitor lipid levels of members with diabetes.

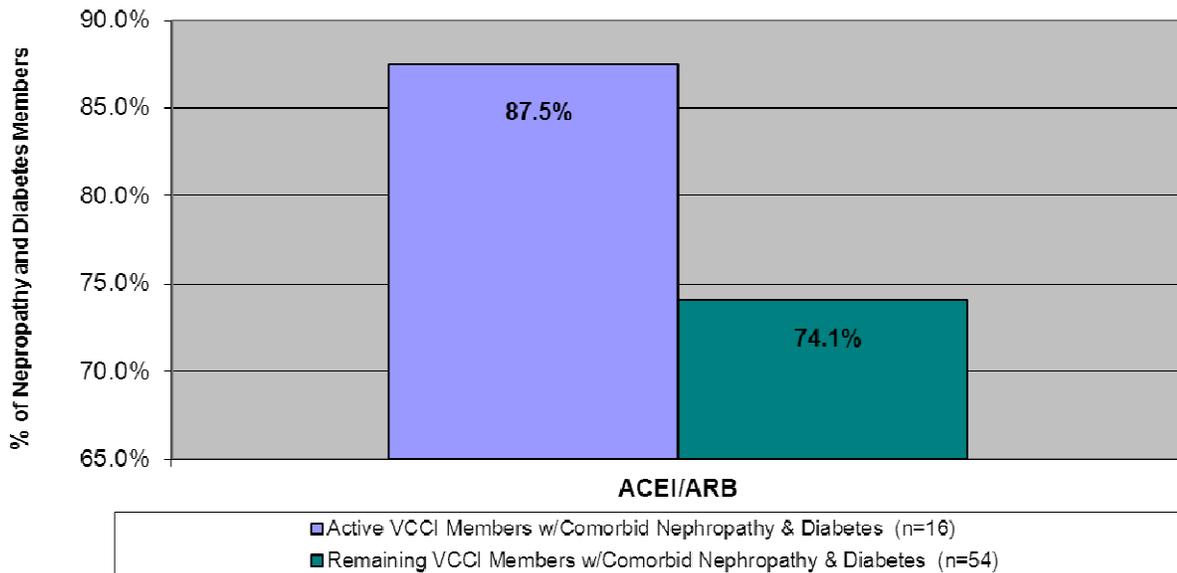


### Diabetes - Lipid Panel and Microalbuminuria Screening



Members with diabetes and nephropathy active with VCCI had a fulfillment rate of 87.5% of prescriptions for ACEI/ARB versus non-engaged members who fulfilled prescriptions for an ACEI/ARB at a rate of 74.1%.

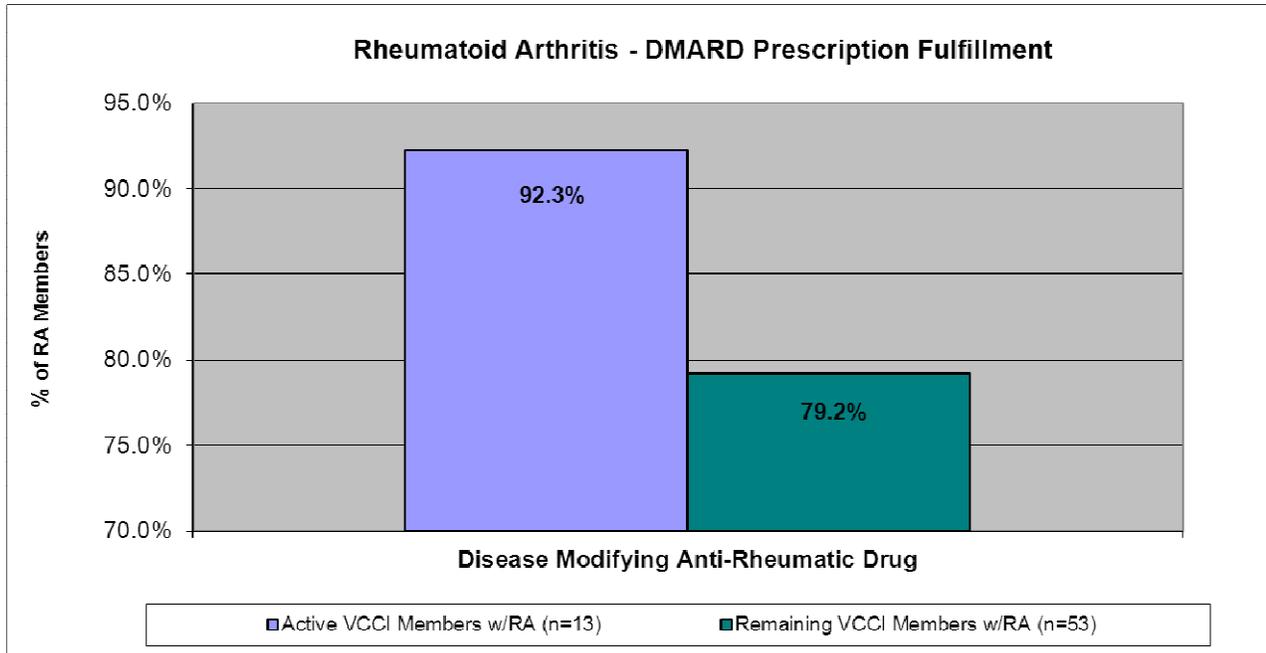
### Comorbid Nephropathy and Diabetes - Prescription Fulfillment



**Arthritis:**

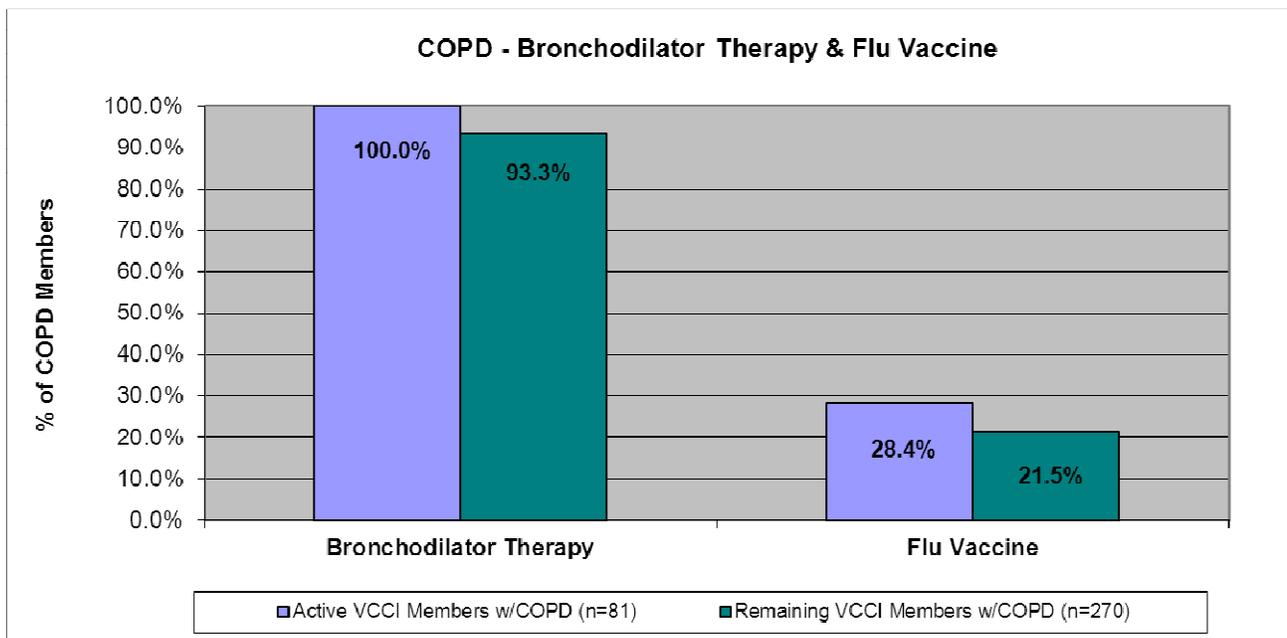
**Members engaged with VCCI have higher prescription fulfillment for a disease modifying antirheumatic drug at 92.3% vs 79.2% for those not engaged with VCCI.**

Individuals diagnosed with rheumatoid arthritis should receive a prescription for a disease-modifying anti-rheumatic drug (DMARD). Patients with rheumatoid arthritis who receive aggressive treatment from the outset have a good prognosis; however, a delay in or lack of treatment leaves many patients disabled within 10 years. Untreated rheumatoid arthritis is associated with an increase in premature mortality, most commonly from coronary artery disease.



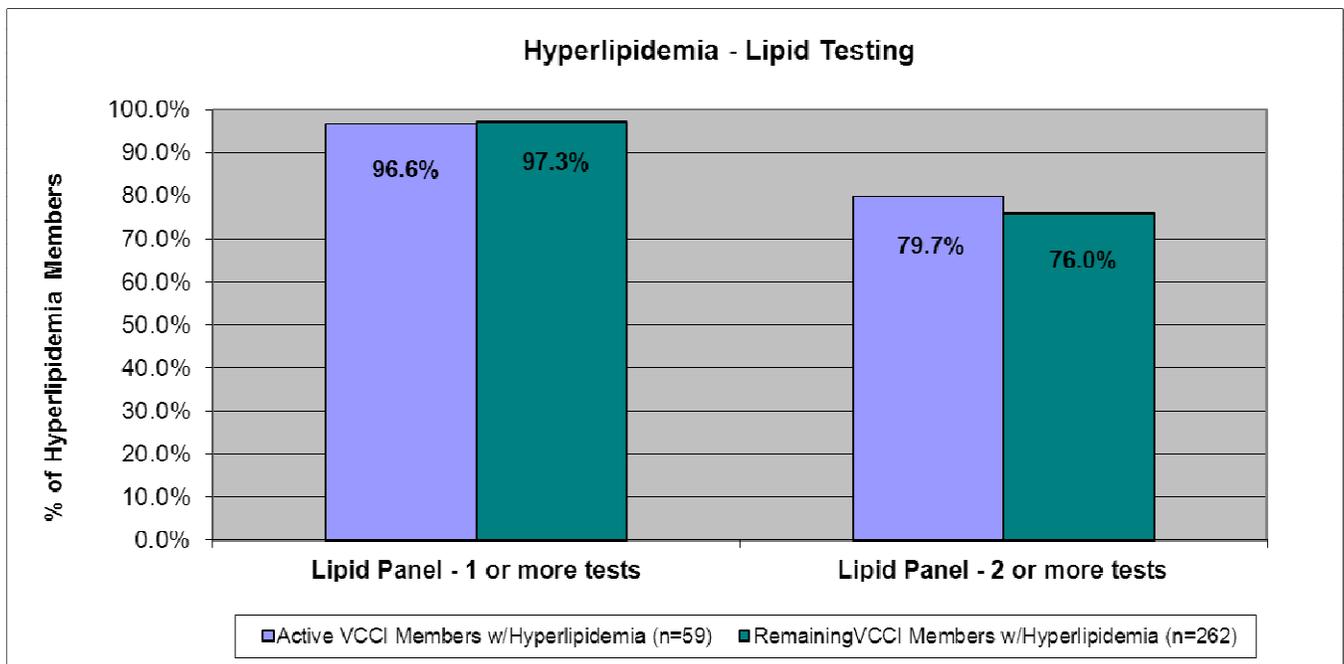
### Chronic Obstructive Pulmonary Disease(COPD):

*Individuals with COPD and active with VCCI have a 100% fulfillment rate for bronchodilator therapy compared to 93.3% of members not engaged with VCCI and diagnosed with COPD.* Medication can improve lung function, relieve symptoms, prevent exacerbations, increase exercise tolerance, as well as improve health status and enhance quality of life. Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend treatment with bronchodilators for all stages of COPD. COPD is the fourth-leading cause of death in the U.S. – despite being a preventable and treatable disease. Recent evidence indicates patients with mild to moderate airflow obstruction are especially at risk. During SFY 2012, VCCI placed a stronger emphasis on tracking members who received the flu vaccination during the year. This is difficult to capture as members may receive this vaccine but not have claims associated with it, such as when they receive it at public health clinics or pharmacies. Therefore, the percentage of members actually receiving the flu vaccine may be higher than reflected in the graph below.



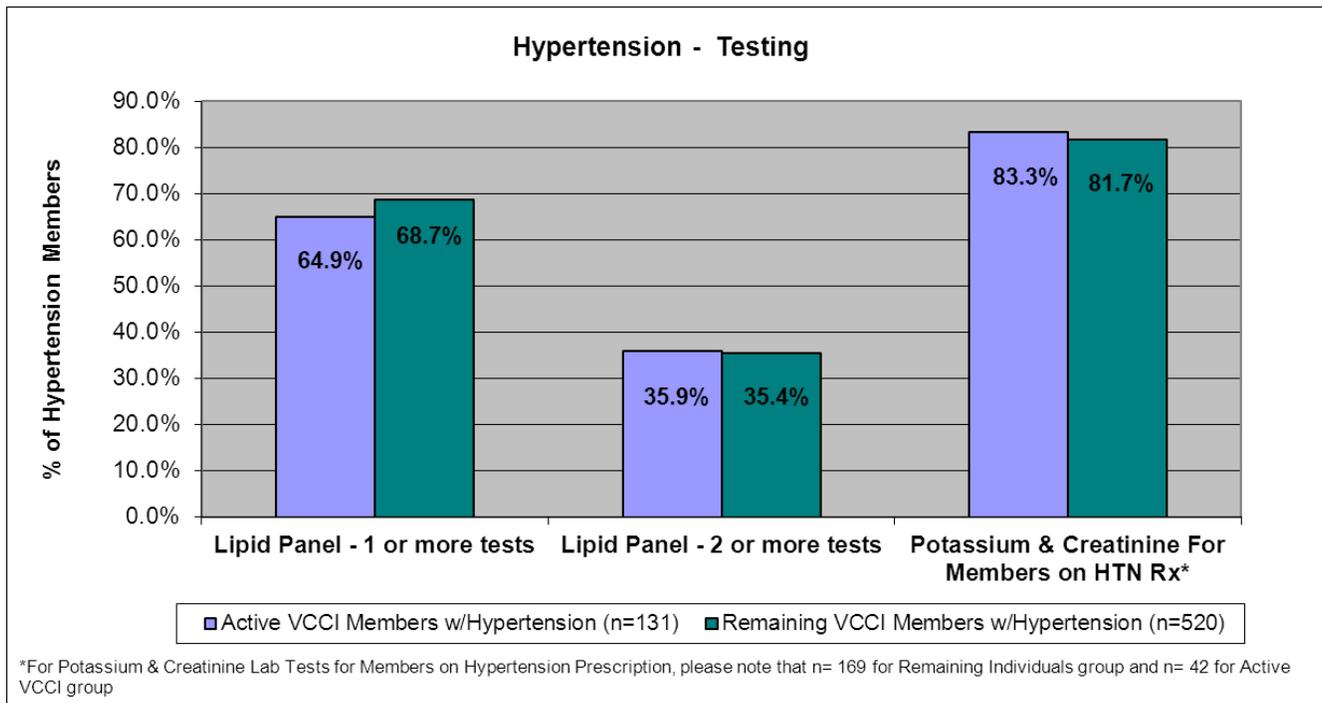
## Hyperlipidemia:

Members with hyperlipidemia and active with VCCI are slightly less likely to complete single lipid testing than members not engaged with VCCI with hyperlipidemia (high cholesterol levels). However, 79.7% of members engaged with VCCI will obtain two or more lipid panels, slightly higher than those members not engaged with VCCI who have hyperlipidemia. Individuals with hyperlipidemia are at risk for coronary artery disease. In individuals with extremely elevated LDL-cholesterol and those at high cardiovascular risk, drug therapy may accompany diet and exercise as an initial therapeutic approach. Lipid monitoring can take place every six to 12 months for patients who adhere to lifestyle modifications and after lipid levels have stabilized.



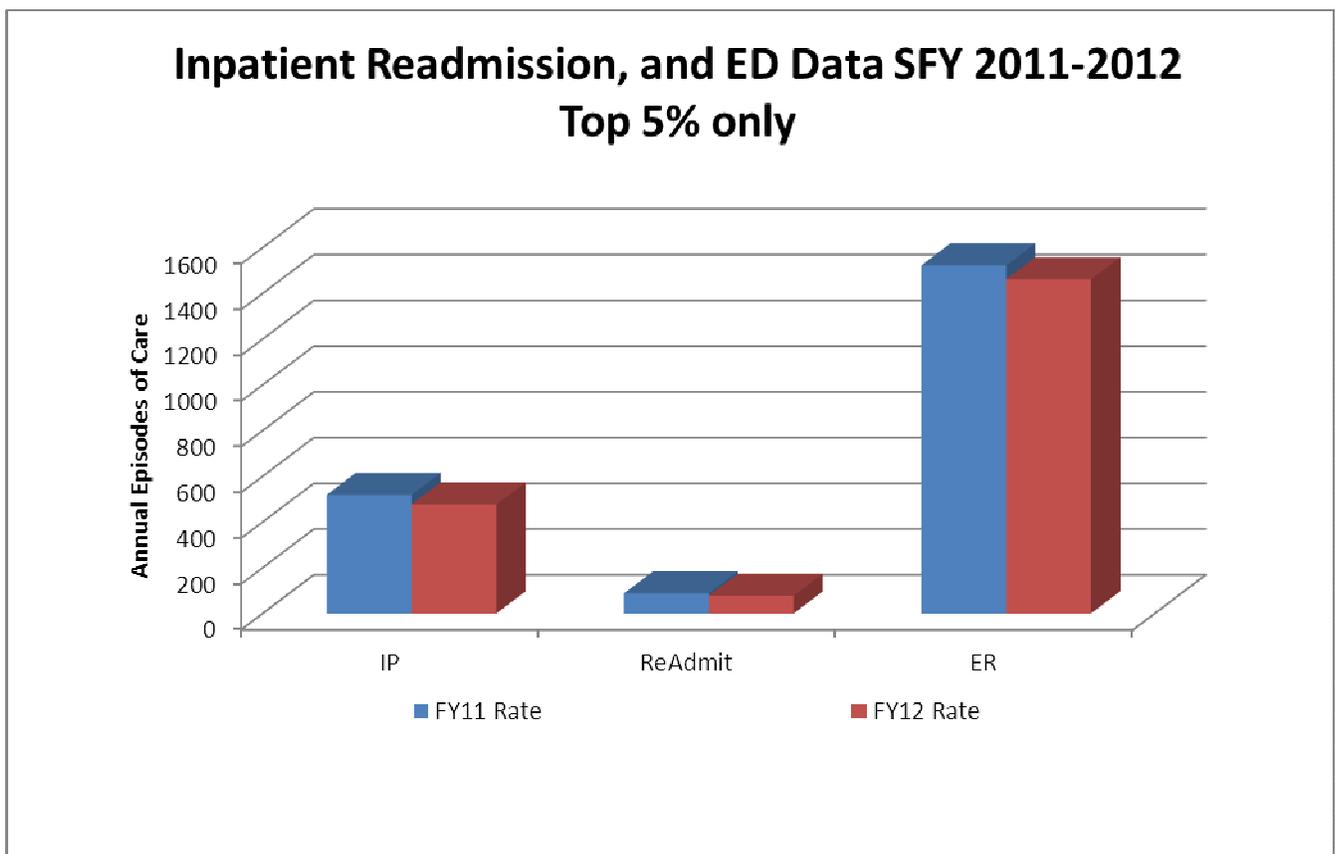
## Hypertension:

VCCI-engaged members with hypertension obtain potassium levels and kidney function testing at a rate of 83.3% compared to 81.7% for those not engaged with VCCI. Treatment of hypertension reduces the risks of mortality and of cardiac, vascular, renal, or cerebrovascular complications. The risk of developing a stroke varies linearly with blood pressure, and blood pressure control reduces the risk of recurrent stroke. Patients with hypertension are three times more likely to develop CHF (systolic or diastolic dysfunction) than patients with normal blood pressure. Individuals with hypertension should have serum potassium and creatinine monitored at least annually.



**Utilization Results**

There are many areas of expense in health care. Two major cost drivers of care for members with chronic conditions are emergency room utilization and inpatient admissions and readmissions. In these two areas the population of persons with chronic conditions showed consistent improvement annually since the inception of the program. For 2012, the data for these areas cannot be compared to previous years as there was a change in the population measured and outreached. The 2012 data now includes members in Rutland and Franklin Counties, which had been excluded in previous reporting due to funding attribution concerns. In addition, the focus on members in the top 5% high risk/high cost substantially changes which members VCCI outreached. Despite these differences, there continues to be a downward trend in use of hospital inpatient admissions and readmissions and in emergency department visits across the population of members with chronic conditions.



|           | IP       | ReAdmit  | ER       |
|-----------|----------|----------|----------|
| FY11 Rate | 517.7509 | 87.01695 | 1521.346 |
| FY12 Rate | 476.0152 | 77.41207 | 1460.918 |
| % Change  | -8.06%   | -11.04%  | -3.97%   |

**Table 1. Hospital Utilization Data<sup>3</sup>**

<sup>3</sup> These measures were gathered by recalculating SFY 2011 data with the inclusion of the previously excluded areas of Rutland and Franklin Counties. Thus, they do not match data reported in the SFY 2011 Annual Report.

The hospital utilization and treatment adherence information within this report is based on claims files that DVHA has provided and that APS has analyzed. Each individual in the analysis met the following criteria:

- Had at least two months of Medicaid eligibility in the rolling 12-month window.
- Was eligible for VCCI (people on Medicare, commercial insurance, or having other specialized forms of state aid were ineligible and therefore excluded).
- Were designated as part of the population of high cost/high risk members reviewed in the Return on Investment measured in 2012.

The characteristics of the top 5% do include very high utilization of inpatient and emergency department services. The VCCI is increasingly focused on the inpatient and emergency room census data from local hospitals as a key 'real time' indicator of need and as a referral source, trying to intervene with members at the moment they use these resources and may be most open to assistance. Additionally, the embedded staffing model launched by DVHA in Rutland and Franklin counties in 2011 and expanded in 2012 has helped facilitate these real time referral processes and also increase hospital data feeds to the VCCI, further supporting VCCI's capacity to outreach members in a timely fashion.

## **IV. Operations Report**

### **Internal Program Education**

In SFY 2012, APS Healthcare and DVHA continued to conduct joint training sessions geared toward improving clinical outcomes. These efforts included joint training on entering and using data in CareConnection®, assessments of various chronic conditions, substance abuse assessments, and many other areas of care. The VCCI medical director conducted telephonic consultation meetings with all VCCI staff, focusing on pediatric and adult asthma, depression and related mental illnesses, heart failure, diabetes, and a broad range of other conditions. Training was also provided on the use of Patient Health Registries and Patient Health Briefs and population reports, which began regular use in SFY 2012. In addition, a pharmacist was hired in recognition of the need for this provider service within the VCCI. This position has proved to be very useful in providing updates to clinicians concerning changes in pharmaceuticals in general as well as individual case consultation.

### **Community Integration**

In SFY 2012, VCCI continued to make progress as an integrated partner in the Vermont medical community, including with NCQA certified medical homes through the DVHA Blueprint for Health and the associated locally deployed Community Health Teams (CHTs). VCCI case managers are members of the local Blueprint teams. Coordination and collaboration continues to evolve, including referrals between levels of service, with VCCI servicing the Medicaid high utilizer population (super-utilizers).

The VCCI also initiated efforts to streamline referrals and establish an onsite presence at additional community health centers. VCCI had embedded staff in multiple hospital and high volume primary care sites including Northwest Medical Center, Fletcher Allen Health Care, Rutland Regional Medical Center and the NOTCH FQHC, Mousetrap Pediatrics, Cold Hollow Primary Care and St. Albans Primary Care in Franklin County, the Community Health Centers of the Rutland Region (2 locations) and The Health Center in Washington County.

VCCI continued to expand collaboration with care managers at other local emergency rooms and inpatient units regarding direct referral of cases for care coordination and intensive case management services. By the close of SFY 2012 a secure FTP site had been developed to receive inpatient and emergency department admissions and was online and operational at six of Vermont's hospitals.

The VCCI data reporting efforts have continued to grow, as well, with greater numbers of practice-specific reports generated for VCCI and other community teams to work with specific practices on identifying and reaching out to high risk members. VCCI adopted a population approach with primary care providers to supplement individual case management services, using the new Patient Health Registries (PHRs) and supporting Patient Health Briefs (PHBs) to assure Medicaid beneficiaries with gaps in evidence-based care can be proactively identified, outreached and managed; gaps in care impact quality of life and may lead to ED or inpatient care. This collaboration assures gaps are not due to oversights and/or financial burdens limiting prescription access by patients. VCCI continues to offer a small financial incentive to providers who collaborate with VCCI on specific members to improve their health outcomes.

At the close of SFY 2011, VCCI leadership had given presentations on the new program to hospitals, FQHCs, and clinics to encourage understanding of the broader condition criteria for SFY 2012. These included meetings at Fletcher Allen Health Care (FAH), Mt. Ascutney Hospital, Gifford Hospital, Dartmouth Hitchcock Medical Center (DHMC), Springfield Hospital and the NOTCH FQHC. During SFY 2012, these sessions continued with presentations for care managers at Rutland Regional Hospital, and Community Health Teams in Rutland, Burlington, Barre, and other Vermont communities.

### **Member Outreach**

Focusing on members who have the highest risk/cost ratio of all Medicaid beneficiaries, VCCI continued to utilize outreach to members as a prime method for engagement. Outreach activities include:

- **Introductory Mailing:** The introductory mailing is the first contact with a member upon their agreement to participate in the program. It introduces the program and describes what they may expect while engaged.
- **Follow-up Letter:** On occasion it is difficult to reach members directly. When this occurs, VCCI sends follow-up letters to targeted members who have not responded to the introductory mailing or who have not been successfully outreached by VCCI staff.
- **No-Contact Letter:** VCCI sends this letter after one or more unsuccessful telephone contact attempts to conduct a Skilled Nursing Assessment.
- **Member Brochure:** Upon completion of the enrollment assessment, VCCI staff sends members a brochure that further explains the program, provides contact information, and offers tips on working with healthcare providers.
- **Telephonic Outreach:** Following up on printed material with a personal phone call is a key activity for engaging members. Both non-clinical and clinical staff do outreach to attempt to reach members to complete an initial assessment of social and care needs. Clinical staff also works with members to complete a Plan of Care and engage them in care coordination, health coaching and case management services. (See “Operations Data” below for volume data.)

### **Provider and Community Outreach**

APS and DVHA use a variety of methods to outreach to providers and the community regarding providers’ patients who are enrolled in the VCCI, and to provide general information about the VCCI program. Activities include:

- **Provider Letters:** As members complete the enrollment process, primary care providers are sent letters notifying them of their patients’ enrollment in VCCI along with a copy of the Plan of Care. *A total of 213 unduplicated providers were sent letters.*
- **Hospital, Community Service Organizations, Community Health Teams:** VCCI staff is embedded in several hospital locations and communicate with hospital partners regarding discharge as appropriate for the eligible population, as well as with community service organizations and Community Health Teams on behalf of members. *In SFY 2012, outreach visits were made on 27 occasions to such organizations.*

- **Practice Visits:** Connecting with primary care practices around the state is the key outreach activity that furthers the VCCI goal of helping members adhere to their providers' plan of care. In addition to many phone calls by VCCI case managers and outreach staff, many practices were visited by case managers accompanying members in co-visits, and as part of the new Patient Health Registry distribution process. VCCI met with 75 practices in these outreach engagements in SFY 2012. The engagement with practices helps to increase the referral of members for VCCI services, as well. ***Local practices—including care managers and health center panel managers directly referred over 322 members for VCCI services during SFY 2012 beyond the population of VCCI members identified in the Disease Management Identification (DMID) process of referral directly from CareConnection™.***

## **Clinical and Intervention Services**

**Clinical Oversight** – During SFY 2012 the VCCI medical director continued to provide clinical oversight to VCCI staff including education and training on care standards. The VCCI medical director met regularly with the State of Vermont Medicaid medical director and VCCI director to collaborate on quality improvement initiatives and strategies, including development of a CMS Performance Improvement Project on systolic heart failure and medication adherence, a continuing focus on child and adult asthma, and substance abuse issues. The VCCI medical director also oversaw the establishment of the Patient Health Registry and Patient Health Brief for use in VCCI.

**Clinical Resources** – VCCI staff members received **an array of training and education:**

- Staff was trained on the new CareConnection™ system beginning in late SFY 2011 and into SFY 2012. The training was supplemented throughout the year to assist staff in optimal use of the system.
- The assessments used in CareConnection™ were extensively reviewed and revised by VCCI leadership at the outset of SFY 2012. This effort took many months, but resulted in a more intuitive format that was tailored to the VCCI user and Vermont Medicaid member. Staff was then given training on the use of these assessments.
- VCCI staff participated in telephonic clinical case conferences two times per month; these conferences focused on use of action plans and disease-specific call guides with embedded clinical metrics for patient management.
- Additional educational resources are available on the revised VCCI website, including one-page focused health information for staff, members, and providers. Further, VCCI provided tri-fold educational brochures for staff to provide to members.
- VCCI staff received webinar training on tools, documentation standards, assessments and reassessments, use of action plans and call guides, and their relationship to quality improvement goals.
- The VCCI Clinical Binder, created in 2011, continued to be revised with oversight by the VCCI medical director, and VCCI staff was trained on its use. This resource contains clinical materials, including: assessments, medication overviews, therapies, call guides, action plans, patient education materials, mini clinical guidelines, and disease stratification.

In addition, the VCCI medical director presented at Department of Vermont Health Access (DVHA) VCCI staff meetings and participated in case reviews and reflective practice on challenging mental health and complicated medical cases. The VCCI pharmacist also presented occasionally at these

meetings to further staff knowledge and address questions regarding the complex pharmaceutical needs of the VCCI population.

**Quality Initiatives** – VCCI undertook quality initiatives during SFY 2012. These additional initiatives were primarily focused on increasing the information available to PCPs regarding possible gaps in care. Both of the efforts included the large group of approximately 105,000 Medicaid members who may be eligible for VCCI services during a given year. Of that group approximately 45,000 members have a chronic health condition. Gaps in care are identified and shared on the panel of patients based on the specific disease process of focus for the PHR.

### ***Heart Failure Performance Improvement Project (HF PIP)***

In late 2010, VCCI began a 3 year heart failure performance improvement project following the Center for Medicaid and Medicare Services protocol, as required of DVHA as a managed care model under the Global Commitment for Health waiver. The project focused upon an important component of outpatient management of systolic heart failure, which is the appropriate use of evidence-based pharmaceutical treatments, and improving the poor adherence rates (21%) to these medications among Medicaid members with one claim with a diagnosis of heart failure. In 2009, the following pharmaceutical recommendations for patients with a diagnosis of CHF and reduced left ventricular ejection fraction (LVEF) were published in the *Journal of the American College of Cardiology*:

1. Use of Angiotensin Converting Enzyme Inhibitors (ACEI) or Angiotensin Receptor Blockers (ARB) for all patients with current or prior symptoms of CHF and reduced LVEF, unless contraindicated, and;
2. Use of one (1) of three (3) preferred beta blockers proven to reduce mortality (bisoprolol, carvedilol, or sustained release metoprolol succinate) for all stable patients with current or prior symptoms of CHF and reduced LVEF, unless contraindicated.

The use of ACEIs or ARBs and the preferred beta blockers have been proven to significantly reduce morbidity and mortality rates. However, despite abundant evidence to support their efficacy and cost-effectiveness, these prescriptions are sub-optimally used in patients with CHF. Optimizing adherence to proven efficacious prescription medication therapies has the potential to improve quality of life and outcomes in patients with CHF and reduced LVEF, as well as reduce hospitalizations, lengths of hospital stays, and prevent readmissions.

The Heart Failure Performance Improvement Project (HF PIP) continued in SFY 2012 with a goal of increasing the rate of members using the evidence-based medications for non-diastolic heart failure. Utilizing the Patient Health Registry, the Patient Health Brief, the Heart Failure Call Guides, the VCCI Heart Failure Disease Specific Assessment and other clinical tools, the VCCI team conducted extraordinarily strong outreach to members. This effort was inclusive of any Medicaid member who met criteria for the PIP, including those not in the top 5%, to engage them and their providers in reviewing the current medication regime to determine whether or not the evidence-based medications could be prescribed.

At the close of SFY 2012, the HF PIP effort was on track to achieve the goal of increasing the use of the evidence-based medications by 1.5% in the first measurement year, which closed on 10/31/2011. The rate at baseline was 21.36% usage, and by the close of the measurement year was 22.87%, an increase above the target. While the project will continue into SFY 2013, the data

gathered on the impact of the effort to date does indicate that usage of the medication is continuing to increase.

VCCI activities supporting the HF PIP included:

- VCCI developed and distributed heart failure Patient Health Registries (PHR) to PCPs of members who were identified for the HF PIP. (See detail on PHRs in the following section.) This process included VCCI clinical staff visiting PCP offices, explaining the gaps in using both ACEI/ARB medications and a preferred beta blocker for systolic heart failure.
- As a part of the PHR process, VCCI sent a mailing to PCPs focused on evidence-based medication guidelines to improve pharmacy adherence.
- VCCI leadership clinical liaison reviewed the HF PIP and HF PHR results and assigned for care coordination all HF PIP members who were not prescribed the evidence-based medications and did not have a reason for exclusion from use of these medications.
- VCCI held educational telephonic conferences, led by the VCCI medical director, with staff focused on an overview of heart failure, defining heart failure, and recommended medications and self-care for members with heart failure.
- The VCCI medical director also engaged with PCPs at medical conferences to present information on heart failure to colleagues and discussed the improved outcomes for members on the evidence-based regime.

### ***Pharmacy Improvements***

The changes in the VCCI program for SFY 2012 included adding a pharmacist specifically for the program. This position was added to better improve member and staff understanding of the complex pharmacy that the majority of VCCI members have. The VCCI pharmacist has worked with the DVHA pharmacist and with the Pharmacy Benefits Manager vendor for DVHA to develop informatics that can be helpful in addressing optimal pharmaceutical use by members. In SFY 2012, work focused upon:

- An analytical assessment of the use of Suboxone® in the VCCI population. This is an ongoing process to help clarify understanding of prescribing patterns.
- Development of specific indicators that can assist care coordination for members who are utilizing Suboxone® as part of their opioid addiction recovery process.
- Consultation with all VCCI staff concerning questions on the prescribed medications of members.

These efforts are adding to the overall efforts by the State of Vermont to improve the effectiveness and accessibility of substance abuse treatment.

### ***Patient Health Registries and Patient Health Briefs***

In SFY 2012, VCCI began using Patient Health Registries (PHRs) and Patient Health Briefs (PHBs) to support practices working with Medicaid members. The PHR is a document developed by analytical review of the procedure and pharmacy claims of members with specific criteria applied that will indicate if a gap in the care of the member is present. An example would be a member with diabetes who has not had a lab claim for a HbA1c blood analysis within the recommended time frame. The claims data would indicate a lack of the claim and this information would be provided in a report that includes this member on a list with other members who are on the PCP's patient panel. This report is then provided by VCCI either in person or by fax to the PCP, with a follow up in 10 days to review the provider's feedback. In SFY 2011 two PHRs were completed, on asthma and heart failure. At the close of SFY 2012, the PHR process was moving toward a goal of monthly reporting.

### ***The Patient Health Registry***

- VCCI continued quality initiatives during SFY 2012. For members with diabetes, VCCI sent a mailing in the fall with information on recommended testing and screening for diabetes and included information on where members could receive flu vaccines.
- In July of 2011, a PHR on members with asthma who had gaps in care was distributed to 32 practices in Vermont
- In November of 2011, the next PHR was distributed to 95 providers for 186 members with gaps in care for their diabetic conditions.
- In January 2012, there were 36 VCCI visits to providers to deliver the PHR for members with heart failure who had gaps in their care.

### ***The Patient Health Brief***

The Patient Health Brief is a document of 1-6 pages that providers and individual members may use to review their medical procedures and pharmacy fills over the past 6 months. Many providers report positive reviews of this document as it informs them of additional care the patient may have received that could be better aligned with the care they are providing. This document also can help identify treatment gaps and when they occur, such as lack of pharmacy claims even though a provider has prescribed a certain medication.

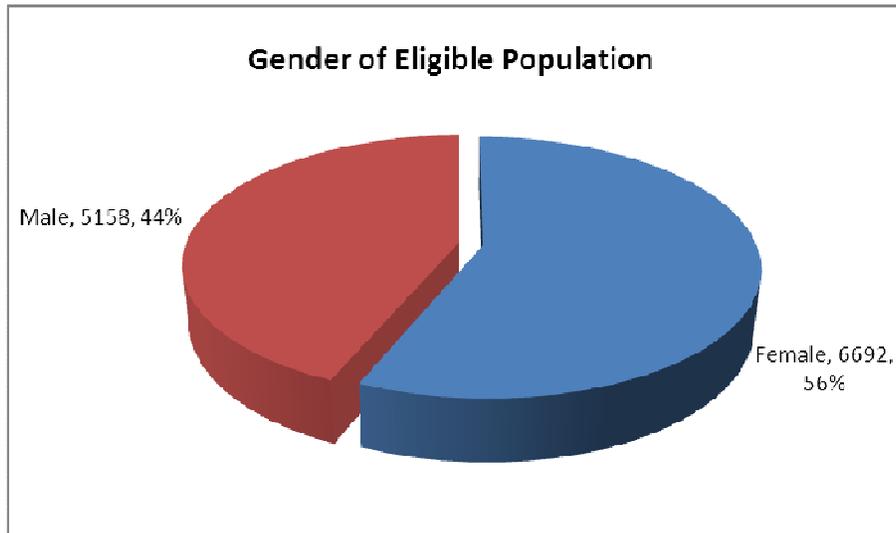
Included with all the distributions above were Patient Health Briefs (PHB) on individual patients and their health history via claims reports in the previous six months. PHBs indicate any chronic conditions a member's record indicates, as well as gaps in care for filling prescribed medications and for obtaining medical testing within proscribed time periods – e.g., HbA1c for persons with diabetes.

The PHBs provide practitioners with a clear synopsis of the member's health care for the recent past and help to clarify where there may be gaps and conflicts that, if resolved, may help to increase the member's self-management of their conditions. They also may help to indicate which intervention services could be most helpful for the member to achieve improved health outcomes.

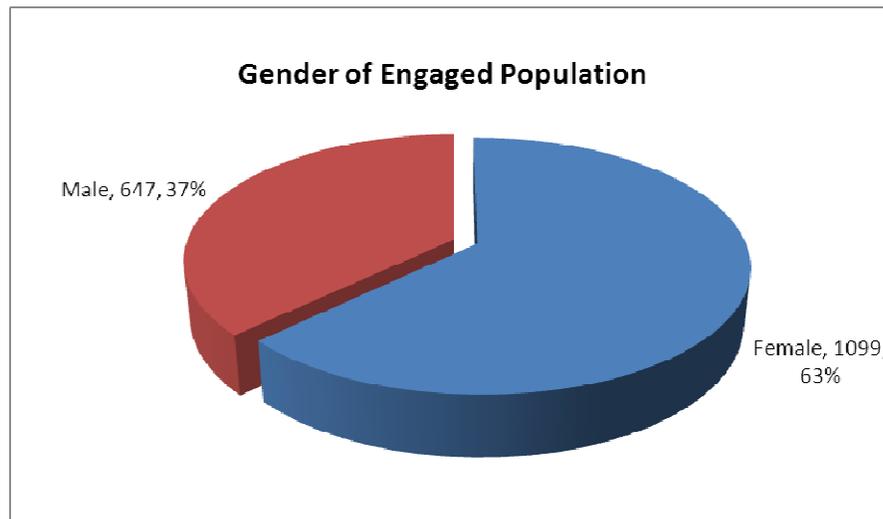
## **Demographic and Operations Data**

The following pages outline demographic and operational data for the state fiscal year ended June 30, 2012.

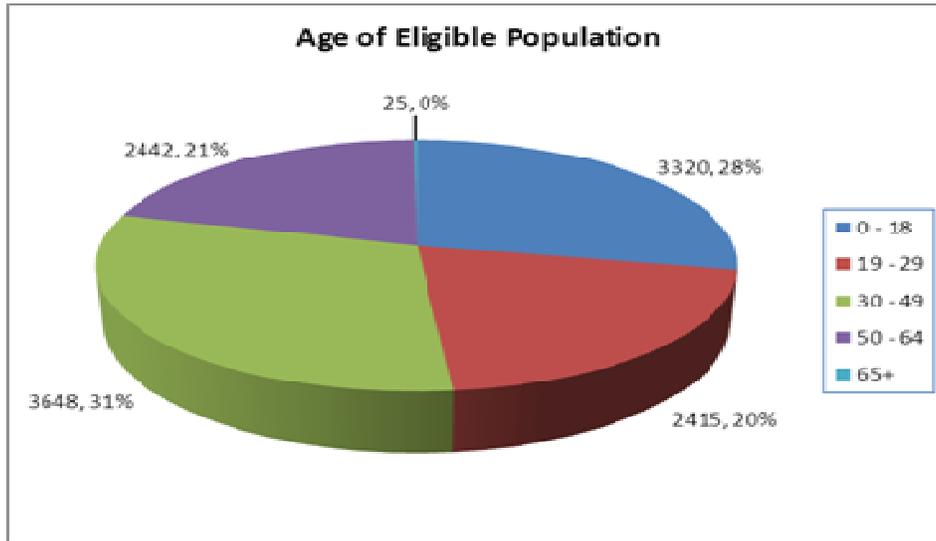
**Gender** – The number of VCCI eligible female beneficiaries continues to exceed the number of male beneficiaries.



Likewise, the number of female members actively engaged with VCCI exceeds the number of male members engaged with the program.



**Age** – The largest age group of eligible members is the 30 through 49 year age category (3,648 or 31%). The second largest group this year is the 50 through 64 year age category (2,442 or 21%).

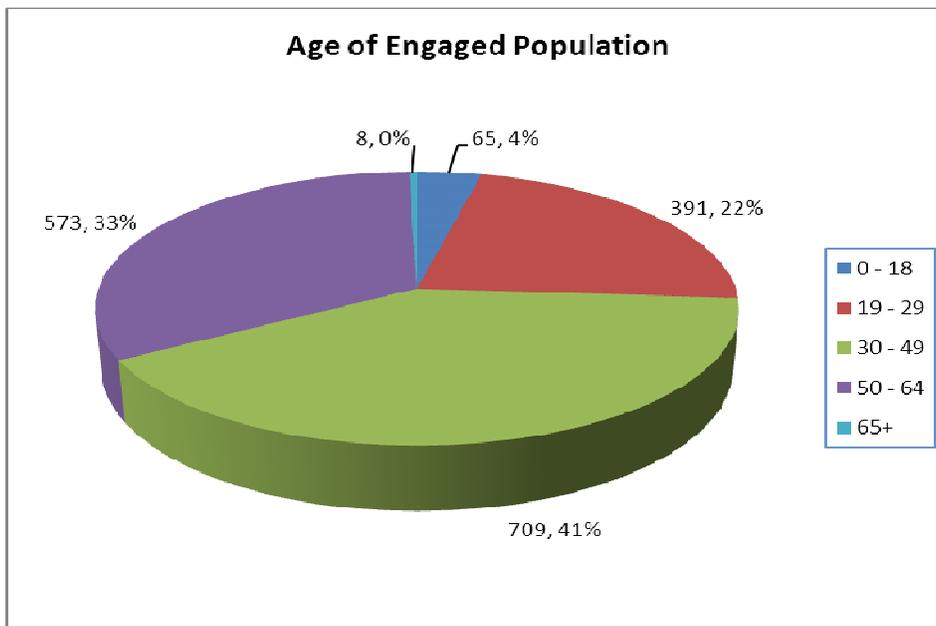


**Age of Population Eligible For VCCI**

| 0 - 18 | 19 - 29 | 30 - 49 | 50 - 64 | 65+ | TOTAL |
|--------|---------|---------|---------|-----|-------|
| 3320   | 2415    | 3648    | 2442    | 25  | 11850 |

**Age of Members Engaged with VCCI:**

The largest age group of members engaged with VCCI is the 50 through 64 year age category (902 or 41%). The 30 through 49 year age group closely follows (865 or 39%).



### Age of Engaged Population

| 0 - 18 | 19 - 29 | 30 - 49 | 50 - 64 | 65+ | TOTAL |
|--------|---------|---------|---------|-----|-------|
| 3320   | 2415    | 3648    | 2442    | 25  | 11850 |

**Member Services** – Care coordinators/case managers, social workers, and disease management coordinators systematically engage eligible Medicaid beneficiaries. The table below represents summary information regarding the level of activity during outreach and engagement.

Heather suggests we tie engagement POC work as a result of assessment

**Table 2. Member Services**

| Description                                | Total Number | VCCI Unduplicated Members |
|--|--------------|---------------------------|
| <b>Member Outreach</b>                     |              |                           |
| Introductory Letter                        | 1,144        |                           |
| Education Letter and Material              | 1,374        |                           |
| No Contact/Unable to Reach Letter          | 3,249        |                           |
| Telephonic Calls/Call Attempts             | 19,569       |                           |
| <b>Assessments</b>                         |              |                           |
| General Assessments - SNA, BR and TOC      | 2,712        | 1,677                     |
| Disease-Specific Assessments               | 1,410        | 936                       |
| <b>Plans of Care (POC)</b>                 |              |                           |
| New POC                                    | 1,768        | 1,705                     |
| New Problems (to new or existing POC)      | 8,245        | 1,777                     |
| New Goals (to new or existing POC)         | 7,458        | 1,749                     |
| New Interventions (to new or existing POC) | 8,865        | 1,715                     |
| <b>Successful Interventions</b>            | 32,697       | 3,015                     |

## Success Stories<sup>4</sup>



*By developing relationships, encouraging members to take charge of their health care, collaborating with medical providers and by following national standards for specific conditions VCCI can help members achieve significant success:*

A RN Clinical Practice Specialist was working with a VCCI member, Oscar, who is male and in his 30's and has Type 1 diabetes. Her initial call to the member occurred after he'd had an emergency room visit for fainting. She engaged the member as a result of the emergency room reporting process that had led to identifying him as a part of the high risk/high cost population of Medicaid. She was able to complete a Behavioral Health Risk Assessment and a Disease Specific Assessment for diabetes with the member. Though the member engaged with the VCCI staff, during the early calls the member often stated disagreement with the evidence based care guidelines being referred to. The nurse worked with the member and stated her recognition that he had some strong beliefs of his own about his condition. He did agree, however, to receiving a follow up call and to having a Diabetes Action Plan, and a Krames Guide, which provides additional detailed information on diabetes.

The nurse received labs from the member's primary care provider's office and they indicated that the last HbA1C was taken 60 days before and was 14.0 (A HbA1c of 14 is very high compared to the usual treatment goal of 7-8). The PCP office also indicated there were no cholesterol results, so she did request they do that at the member's next visit. The office offered that the member often rejected their advice regarding his diabetes care in the past, and was inclined to not follow through with recommendations.

In a follow up after the member made another office visit 45 days later, the PCP did do the fasting lipids test as well as the HbA1c. The outcome was that the member's blood sugars had decreased to 11.9--the lowest in the last 12 months--and that he also showed signs of high LDL. (This is important due to his increased risk of cardio-vascular disease due to his diabetes as high "bad" cholesterol will increase this risk.) He agreed to a prescription for Lisinopril (used to protect his kidney function) and had that filled. He also subsequently made appointments with a podiatrist and an ophthalmologist, both of which were overdue. He also mentioned he might consider going back to endocrinology.



<sup>4</sup> Names are pseudonyms.



***For many members who use VCCI services, housing, transportation, and finances are the most pressing needs they have and these often compete with their efforts to keep their medical conditions stable.***

*A VCCI social worker engaged with a member who was having great difficulty taking her diabetes and bladder medication regularly due to the challenge of affording the co-pays, which totaled over \$10 monthly. Another factor that was adding to this challenge was that she had lost her housing and had to move in with her parents in a very rural location. At this location there are very limited transportation options, thus she could not reliably travel to a more distant pharmacy. Thus she was relying on a friend to transport her to the pharmacy and this was costing extra money as well. It is most important with a medical condition like diabetes that medication is taken regularly to ensure that the most optimal impact is made to stabilize the member's health.*

*The social worker made a contact with the Fletcher Allen Health Care Health Assistance Program, and together a plan was conceived by which the member would have no co-pay for non-narcotic medications, and they had two pharmacy options that she could use for this. The member was very willing to work with the pharmacy, and the social worker helped to devise a transportation plan that could help her make it to the pharmacy location 1-2 times per month.*

*This outcome allowed for the member to have reliable and affordable access to her medication and to save some money to help reduce her economic stressors. In the following months she did stabilize her use of medications, and made appointments with other health providers to address a variety of issues she had not taken care of in the last year, including working with a mental health provider on her issues of depression. At the time of closure for services, just short of 90 days later, the member had a plan to carry her forward for many months.*





***Among the most challenging health issues is tobacco addiction. For persons with multiple chronic health conditions, coping with this addiction is a significant struggle.***

A VCCI nurse worked for many months with a female in her late 40's who had 4 serious chronic medical conditions and was a heavy smoker. She reconnected with VCCI after a series of health and family challenges arose for her. The member faced both minor and major medical issues, which were complicated by having had a stroke in the past and having to use an anti-coagulant (blood thinner) due to the risk of a second stroke.

Working with the VCCI nurse, the member developed a strategy for ending her use of tobacco. This proved to be a challenging time to take this step as over the next months there were many family crises and she also had to have same day surgery. During this time the VCCI nurse had weekly meetings with the member, reviewed her coping skills and adjusted her plan to remain smoke free.

Over the following months the member had an eye exam and then needed the assistance of the VCCI nurse and social worker to help her get new eyeglasses, which she could not afford and are not covered by her Medicaid benefits. Because the member kept her monthly outpatient appointments and received regular telephone calls from her VCCI nurse, she had only one visit to the Emergency Department, despite her complicated medical history. She had a major fall after surgery (she has permanent left-sided weakness from her previous stroke) and the fall was complicated with significant blood loss due to her regularly prescribed blood thinners, needed to help prevent another stroke.

The family continued to cope with emotional and legal issues which easily could have triggered a return to tobacco use, but the member kept her efforts up and by the close of the case she had been tobacco free for over 5 months. Her spouse also quit smoking.

The work of VCCI Care Coordinators, Clinical Practice Specialists and Social Workers provides a variety of medical and psycho-social support and assistance to members who often face constant and seemingly insurmountable challenges. The ability of the program staff to develop a strong helping relationship with members, and to work with them to establish realistic and meaningful goals, are shown above and in the previous examples. All of these members continue to cope with chronic disease conditions, but all have improved their health literacy and a clearer understanding of how they can direct their healthcare to help obtain the best healthcare outcomes possible.

