



# VERMONT CHRONIC CARE INITIATIVE

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## ANNUAL REPORT

STATE FISCAL YEAR 2014  
Issued May 29, 2015



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## Executive Summary

The Vermont Chronic Care Initiative (VCCI) has been an evolving effort by the state of Vermont to help Vermonters with Medicaid better manage their chronic conditions. In SFY 2012 the program sharpened its focus on members with the highest risk/highest cost conditions. These members are typically 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. In addition, these members have complex psycho-social needs – food, housing, transportation, heating, financial security, etc. Although VCCI assists members with these issues the results of those efforts are not captured in this report.

During SFY 2014, VCCI continued to focus on non-dually-eligible Medicaid members with the highest utilization - in the top 5 percent for high risk/high cost (Top 5%) as they account for 39% of Medicaid expenditures - with the exception of persons with existing CMS covered case management services. For this past year the total number of individuals identified in the Top 5% by their risk scores included over 9,800 members.

In this same time period, VCCI engaged 1,740 Medicaid members via face-to-face and/or telephonic case management, despite significant staff attrition and duration of vacancies resulting from an anticipated contract end date of June 30, 2014. Services provided were comprised of assessments of general medical and psycho-social health, as well as disease specific assessments to support a holistic approach. From SFY 2013 to SFY 2014, reductions in utilization rates remained significant – inpatient 30%, readmissions 31% and emergency department visits 15%.

VCCI is an integrated model of case management supports and services provided by a staff of nurses, licensed and unlicensed social workers and substance abuse professionals with clinical, mental health, and substance abuse 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. This is accomplished with a combination of member self-management support through health coaching and education, and engagement/collaboration with providers. Motivational Interviewing techniques are used to help the member along the behavioral change continuum. Members are provided self-management information relevant to their chronic condition and needs. Clinicians in primary care provider (PCP) offices and in hospital settings are provided information about their patients, including gaps in evidence-based treatment. At time of discharge from VCCI, the member has the Action Plan they have been working on to continue progress with the involvement of their PCP or with further assistance from less intensive local services, such as Medicaid funded Community Health Team members (CHTs). In SFY 2014, the VCCI focused efforts on members with underlying depression and to support stabilization that impacts management of other co-morbid conditions.

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 the member and their providers. A careful review of the clinical, financial and utilization outcomes of this effort shows success for the VCCI interventions in SFY 2014. The expected Per Member Per Month (PMPM) rate of increase in the cost of care for the top 5% cohort was 20.7% over the previous three years, or from \$2,995 PMPM in the baseline year (SFY 2011) to \$3,616 PMPM in SFY 2014. The outcome data indicates the actual PMPM for the high risk/high cost population was

\$3,290 PMPM. Thus, overall care expenses were \$35,497,274 lower than projected, an average of \$326.16 PMPM for SFY 2014. After subtracting total administrative program costs, **the total net savings were \$30,289,353**, an average of \$278.31 PMPM for SFY 2014. 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's 7<sup>th</sup> Year of Service – Progress Continues***

VCCI achieved positive outcomes during Year 7 of its operation (July 1, 2013 through June 30, 2014) as the program continued to focus on members with any health condition who are in the Top 5% for service utilization. This VCCI Top 5% population accounts for 38% of the Medicaid spend. The goals of VCCI remained similar as in past years:

- To improve adherence to evidence-based treatment
- To engage members to participate in their own disease self-management
- To reduce emergency and inpatient hospital utilization by accessing appropriate levels of services - with focus on transitions in care and care management

Program focus on the Top 5% increases enrollment of those members with higher clinical complexity and psychosocial needs. These high risk/high cost members have historically had increased numbers of hospital inpatient admissions, readmissions and use of emergency room care. For example, the Top 5% produced 89% of the readmission costs in SFY 2014.

Outcomes for SFY 2014 are as follows:

- **3,435 unduplicated members** were contacted by VCCI - 1,740 accepted services and actively engaged with intensive and telephonic case management services.
- Members receiving case management services, including care coordination for at least 60 days, showed significantly better **prescription claims evidence** for depression medications for members with major depression and beta blockers for members with coronary artery disease. Challenges remain in increasing other prescription fulfillment rates, such as the use of both an Angiotensin Converting Enzyme Inhibitor or Angiotensin Receptor Blocker (ACEI/ARB) and a preferred beta blocker for members with systolic heart failure. A PDSA (Plan, Do, Study, Act) was done to investigate barriers to medication adherence and identify and test strategies for improvement. (See details at page 22.)
- **Inpatient hospital** utilization among the Top 5% was reduced from SFY 2013 to SFY 2014 by 30%, declining from 610 visits per 1,000 members in SFY 2013 to 425 visits per 1,000 members in 2014.
- **Readmission rates** for members in the Top 5% dropped from SFY 2013 to SFY 2014 by 31%, from 111 readmissions per 1,000 members in SFY 2013 to 77 per 1,000 members in SFY 2014.
- **Emergency Department** utilization was 15% lower among the Top 5% from SFY 2013 to SFY 2014, decreasing from 1,529 visits per 1,000 members in SFY 2013 to 1,299 visits per 1,000 members in 2014. This decrease is promising in light of the PCP access challenges that impact Medicaid.

In SFY 2014, Patient Health Registries (PHRs) and Patient Health Briefs (PHBs) continued to be shared with providers in an effort to identify gaps in evidence-based care. The PHR and PHB tools plus the APS Healthcare CareConnection® software system also provided VCCI staff with a dashboard view of accurate and current health status information enhancing their ability to prioritize needed services.

VCCI developed reporting on a variety of data including provider prescribing patterns, member home pharmacy attribution, 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 staff remained embedded in multiple high volume Medicaid provider practices and several hospital locations. Additionally, staff functioned as Hospital Liaisons statewide in a further effort to reduce ambulatory care, ED utilization and readmission rates. This enabled VCCI staff to facilitate referrals and warm transfers and to build relationships with providers.

## II. Background

Vermont began developing policies and programs for health improvement earlier than most other states and is now illustrating that prevention, early intervention, case management and integrated health care can bring positive changes. APS Healthcare began working with the State of Vermont in 2007 to establish specific strategies to address Medicaid members with chronic health conditions via the creation of the current VCCI. Over the past seven years this effort has been integrated with overall state health reform efforts. The state enacted health care reform legislation in 2006 (Act 191, Section 1903a) and has continued to do so in subsequent years including the present effort to focus on Accountable Care Organizations and cost containment. The initial legislation authorized the creation of VCCI to support Medicaid<sup>1</sup> members with chronic health conditions. As collaborators with the DVHA Blueprint for Health<sup>2</sup> and local partners, the VCCI integrates with Blueprint activities specific to the Medicaid High Risk/high cost population to assure transitions between levels of acuity and referral back to the medical home. The VCCI is also actively engaged with the Medicaid ACO's to assure collaboration on processes and services to deliver clinical and financial results.

As VCCI converted to a focus on the highest risk/highest cost members (top 5%), it concurrently expanded its focus to include more than 30 different health conditions among all member age groups. However, the conditions considered most prevalent and/or costly and therefore, a focus of the program in SFY 2014, include diabetes, asthma, depression, substance use/abuse disorders, heart failure and coronary artery disease. These are similarly aligned with AHS/DVHA goals including substance use/abuse and mental health management, as well as ACO and hospital measures and Blueprint/NCQA measures for advance practice medical homes.

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<sup>1</sup>For the purposes of this report "Medicaid members" includes Medicaid, VHAP, and Dr. Dynasaur members, but excludes individuals dually eligible for Medicare, individuals enrolled in Choices for Care, and individuals who are receiving long-term inpatient mental health services. 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. It includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives.

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.



## **Success Story**

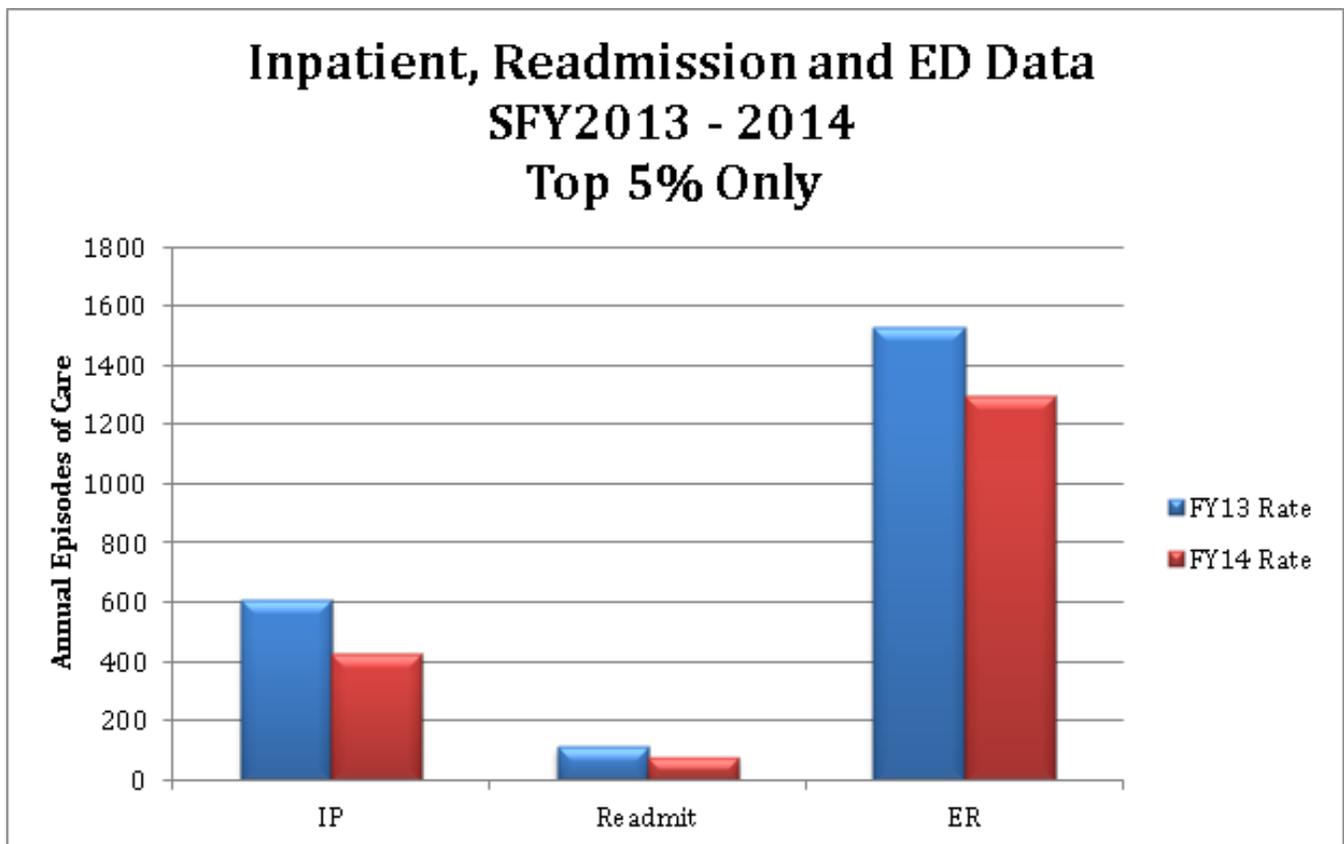
Member: A 54 year old female with medical claims for depression, anxiety, COPD and asthma was referred to VCCI by the Community Health Team because of her multiple co-morbid conditions. Barriers for this member included an inability to continue working due to her breathing, a household with impending financial consequences related to her inability to work, and a general unhappiness with her provider office.

Interventions and Outcomes: The Member was referred to a pulmonologist who adjusted her medications to address her breathing issues. She received assistance with an SSI application which resulted in the Member receiving back pay since 2008. The member was also provided assistance in applying for a new provider office. This Member met the clinical goals of her Plan of Care and transitioned back to her CHT.

### III. Utilization Results and Treatment Adherence

#### Utilization Results

There are many areas of expense in health care. The major cost drivers of care for members with chronic conditions are prescriptions (though not captured here), inpatient admissions, readmissions, and emergency department visits. In SFY 2014 VCCI completed its third year of operation with the change in the population measured and outreached - Top 5% high risk/high cost. It is exciting to find that from Program Year 6 (SFY 2013) to Program Year 7 (SFY 2014), the reductions in utilization rates remained significant - inpatient 30%, readmissions 31% and emergency department visits 15%. The numbers are equally encouraging when looking at the roughly 40% of members that were in the Top 5% for each of the past three years. For those members, utilization decreased less dramatically but continues to show improvement year over year- inpatient 11%, readmissions 4% and emergency department visits 9%. Significant decreases also hold true when comparing the utilization for the engaged population from SFY 2013 to SFY 2014 - inpatient 10%, readmissions 24% and emergency department visits 7%. Because of the nature of the population being measured (Top 5% high risk/high cost), once the member improves enough, they drop out of the Top 5% only to be replaced by new sicker/higher utilization members. As such, VCCI does not generally expect to see declines in the overall utilization of the Top 5% year to year. Therefore, these decreases are very impressive.



	IP	Readmit	ER
<b>FY13 Rate</b>	610	111	1529
<b>FY14 Rate</b>	426	77	1299
<b>% Change FY13 to FY14</b>	-30%	-31%	-15%

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

- Had at least two months of Medicaid eligibility in the rolling 12 month window.
- Met VCCI eligibility criteria (people on Medicare, commercial insurance, or having other specialized forms of state aid were ineligible and therefore excluded).
- Was designated as part of the population of Top 5% high risk/high cost members reviewed in the Return on Investment measured in 2014.

The characteristics of the Top 5% include very high utilization of inpatient and emergency department services. VCCI is increasingly focused on the inpatient and emergency department census data from local hospitals as a key 'real time' indicator of need and as a referral source, trying to intervene with members close to the moment they use these resources and may be most open to assistance. Additionally, the embedded staffing model has helped facilitate these real time referral processes, further supporting VCCI's capacity to outreach to members in a timely fashion.

### **Pharmacological Treatment**

The Medicaid members that are the focus of VCCI efforts 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 PCP and specialist involved in their care – and at least six medications prescribed for daily use, likely from different providers. The complexity of the medication needs for the Top 5% often poses a risk for over and under prescribing, concurrent use of contraindicated medications, misuse of medications, and confusion that can lead to adverse events. For these reasons, VCCI added a full time pharmacist to the team in 2012. VCCI is dedicated to assisting members who are struggling with these challenges to improve their personal health status and to educating providers via Patient Health Registries in order to reduce gaps in evidence-based care.

The information that follows is based on Medicaid claim files provided by the Department of Vermont Health Access (DVHA) and analyzed by APS Healthcare. Data reporting prescription claims evidence is based on the claims reported by pharmacies filling prescriptions for members and claims paid by DVHA. Similarly the lab testing information required for prescribing certain medications is also based on claims data.

In each of the following graphs, the first column defines members who were actively engaged for at least 60 days in the VCCI program. The second column indicates members who were not engaged but were identified as in the top 5% that were eligible for VCCI services.



## Success Story

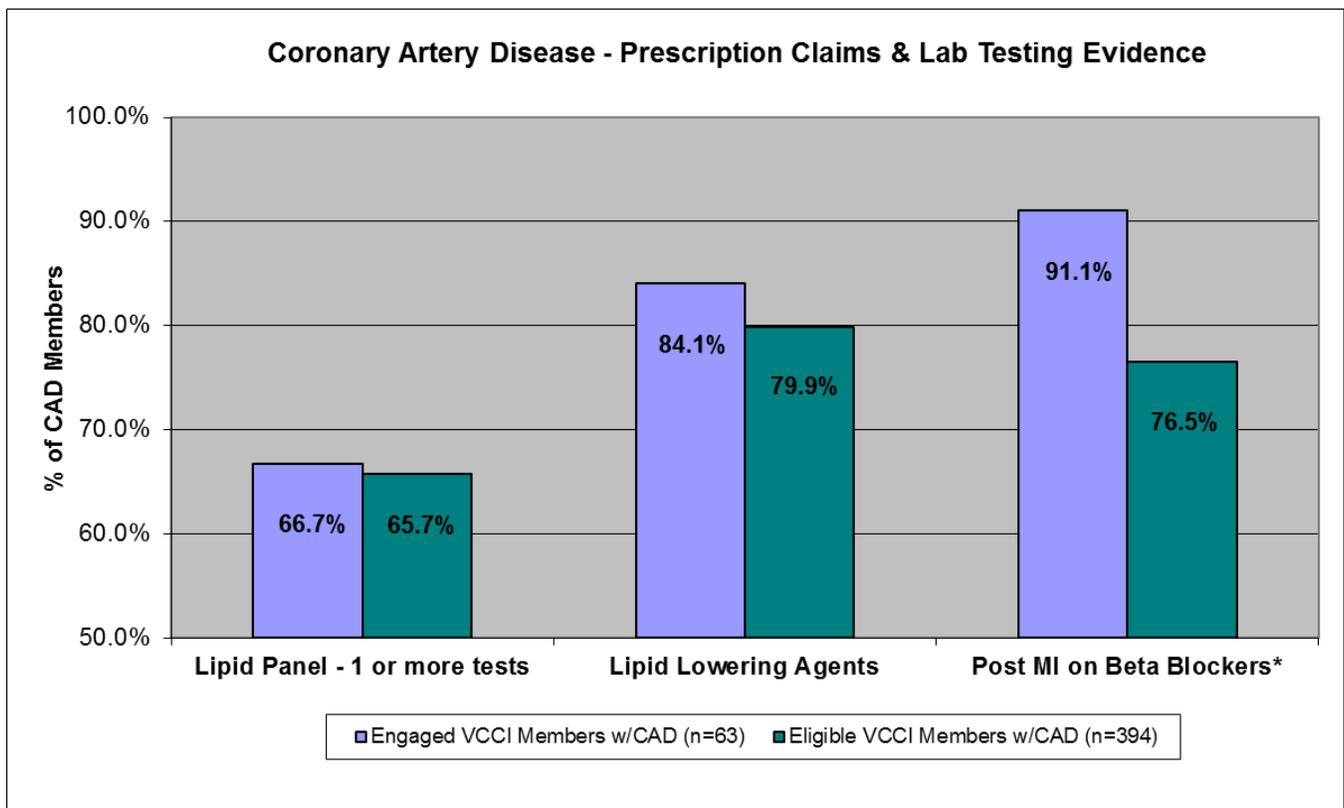
Member: A 3 year old boy born with a severe diaphragmatic hernia (which resulted in under developed lungs and developmental delays) and asthma was referred to VCCI by a Community Health Team case manager. The child was left in his grandmother's care with no custody arrangement, no medications and no services in place.

Interventions and Outcomes: VCCI coordinated the replacement of the child's medical equipment and medications. He was enrolled in daycare and obtained a subsidy so that his grandmother could continue to work. The child was included in his grandmother's state benefits case for food stamps and reach-up. Both the family and the daycare provider were educated regarding asthma - an Asthma Action Plan was put into place. The Member was re-enrolled to receive respite services to meet an identified family need and a referral was made to Children with Special Health Needs. The child's grandmother was referred to legal aid, and they were able to transfer the child's SSI check to her to assist with the cost of his care. There is also claims evidence that the child's controller prescription is being filled.

The Member is now thriving under the care of his grandmother. His services are well aligned to meet this family's needs.

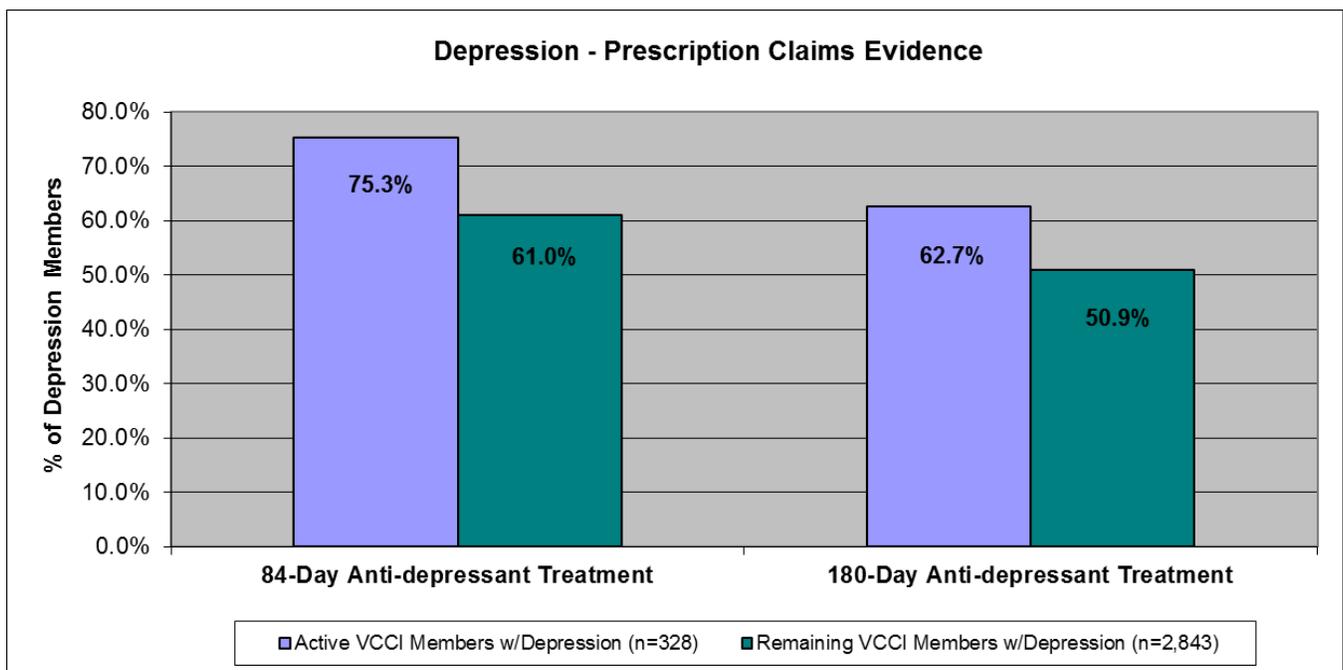
## Coronary Artery Disease:

*Members with coronary artery disease (CAD) who are active with VCCI have slightly better adherence to lipid testing than those not engaged with VCCI. However, it may be difficult to capture this testing if it is bundled with hospital services or if it is done as a Point of Care (POC) test as no separate claim is generated.* 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, can 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 91.1% of the time while non-engaged members post myocardial infarction filled beta blocker prescriptions 76.5% of the time in SFY 2014. In addition VCCI members filled prescriptions for lipid lowering agents 84.1% of the time while those not engaged filled lipid lowering agents 79.9% of the time. Completion of the Transition of Care Assessment by VCCI staff and performing medication reconciliations continue to improve prescription fulfillment by engaged members.



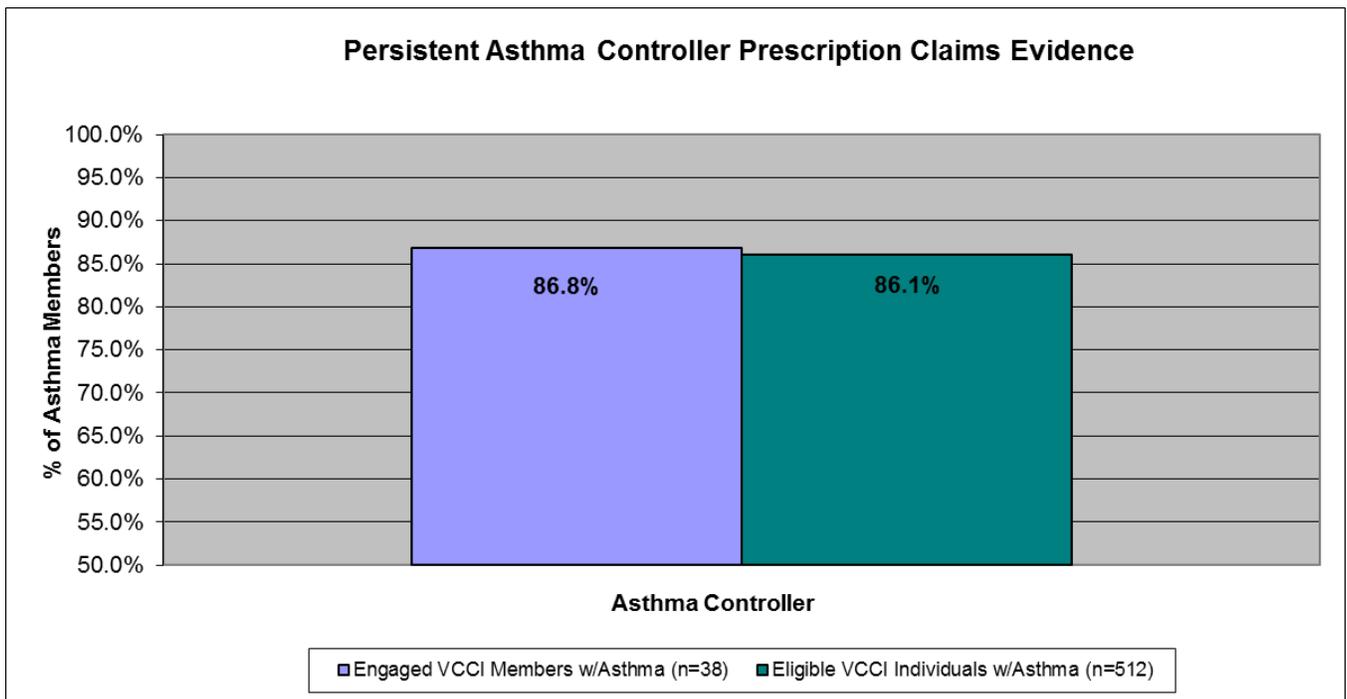
## Depression:

*In this HEDIS-like measure, members active with VCCI have higher rates of prescription claims evidence than members who do not receive VCCI case management and care coordination services: 75% versus 61% over 84 days, and 63% versus 51% over 180 days.* Depression rates among the population in the Top 5% are significant (25% of members have depression as a primary diagnosis) and VCCI has attempted to focus on stabilization of this underlying condition prior to working on other co-morbidities given the adverse impact of unmanaged depression and other mental health conditions on self-management skills. 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, including addictive disorders. 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.



## Asthma:

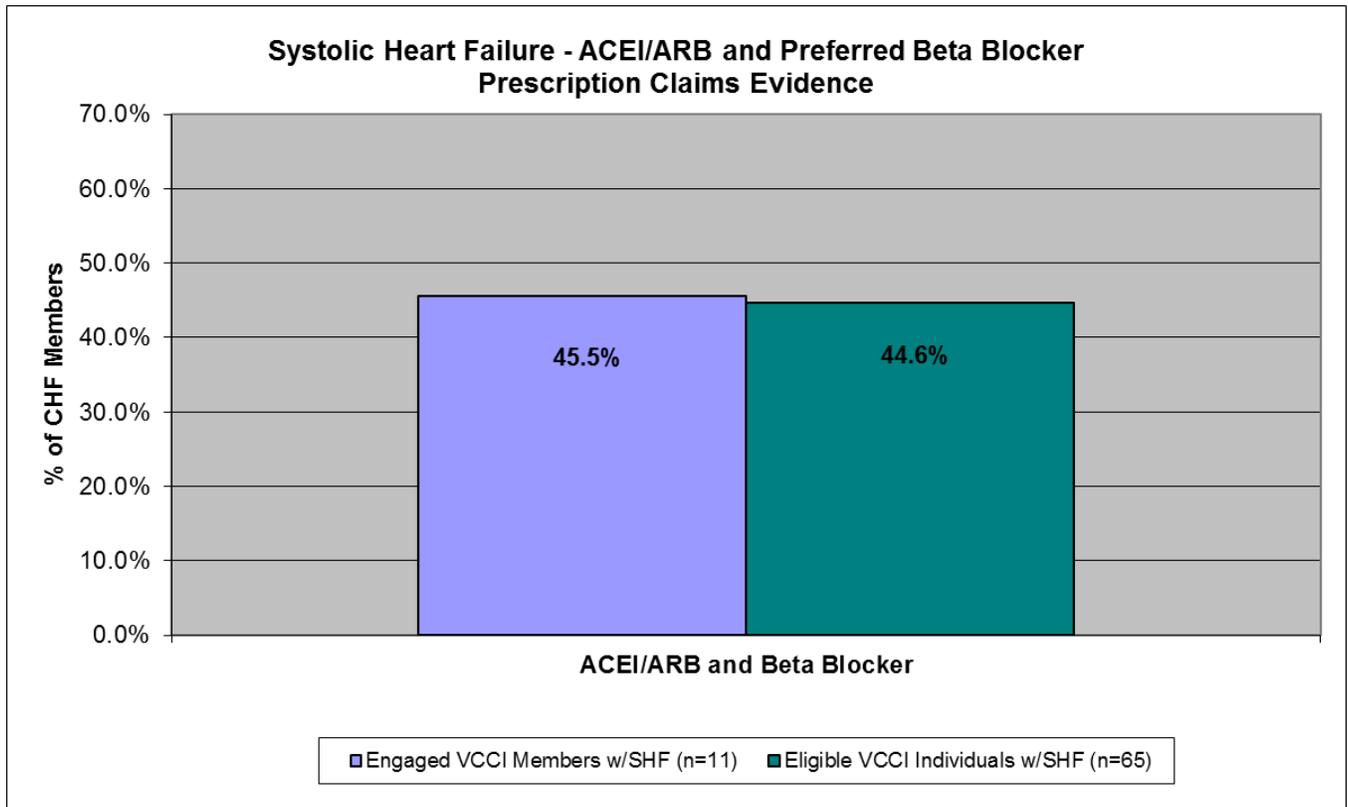
*Members engaged with VCCI show prescription claims evidence for a controller medication of 87% compared to 86% for non-engaged members with persistent asthma.* Inhaled corticosteroids (ICS) are one of the recommended controllers for members with persistent asthma to improve lung function. Asthma is 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:

*The claims evidence of both an ACEI/ARB and a preferred beta blocker for systolic heart failure was 46% for the VCCI engaged members vs. 45% for non-engaged members with systolic heart failure.*

Evidence shows ACE inhibitors and preferred beta blockers can reduce the risk of death or hospitalization. ACE inhibitors increase survival and improve symptoms. A long-term prescription of a preferred beta blocker can lessen symptoms of heart failure, as well as improve clinical status and enhance quality of life. In SFY 2014, VCCI focused staff educational efforts on the evidence-based combination of a preferred beta blocker and ACEI/ARB to reduce morbidity and mortality. A new heart failure assessment was developed which incorporates alerts about evidence-based guidelines and has a focus on these medications as well as on medication adherence. Managers received monthly reports of medication gaps of engaged members and worked with staff to resolve those gaps. In addition, a heart failure Patient Health Registry was distributed to providers in the fall listing their members that were not on these evidence based medications. Despite these educational efforts the claims evidence declined for both engaged and non-engaged members. Going forward continued efforts will be made to educate staff; specifically, the Drug Therapy Overview for Systolic Heart Failure will be updated and presented in an educational session. VCCI will also continue to present providers with a Systolic Heart Failure Registry of their patients who have a medication gap and offer support through case management of the patient.

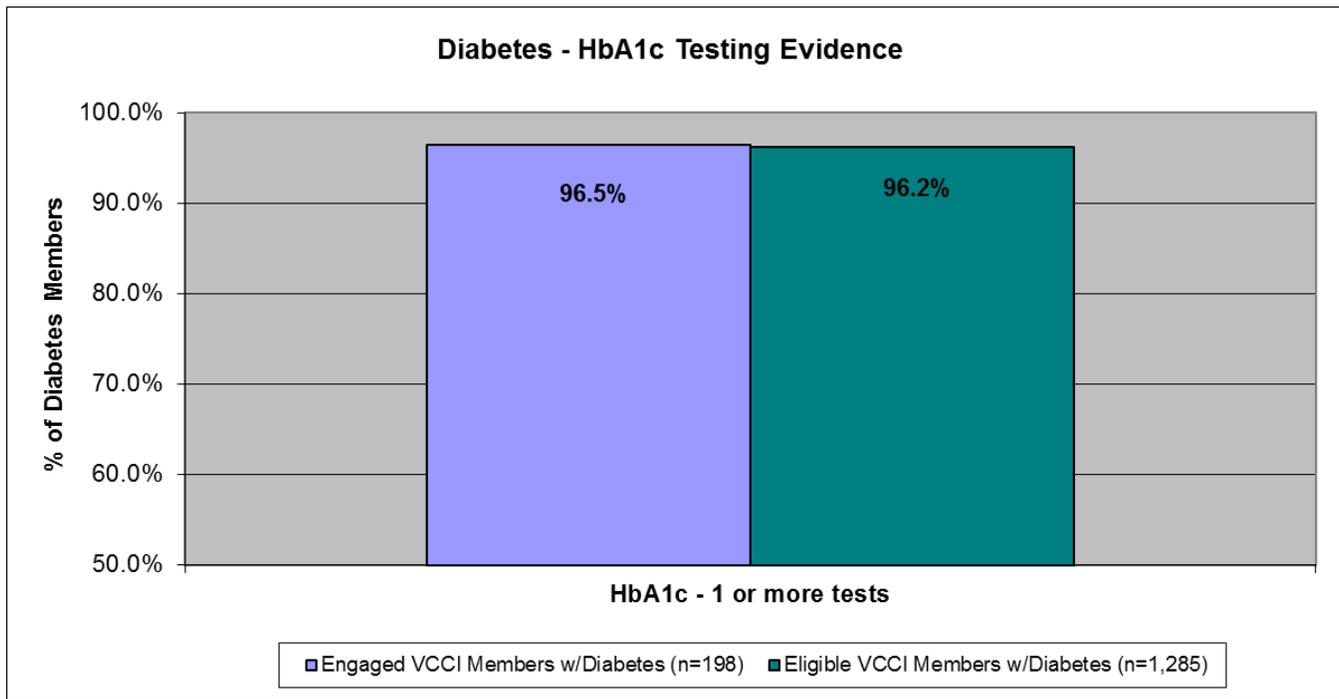


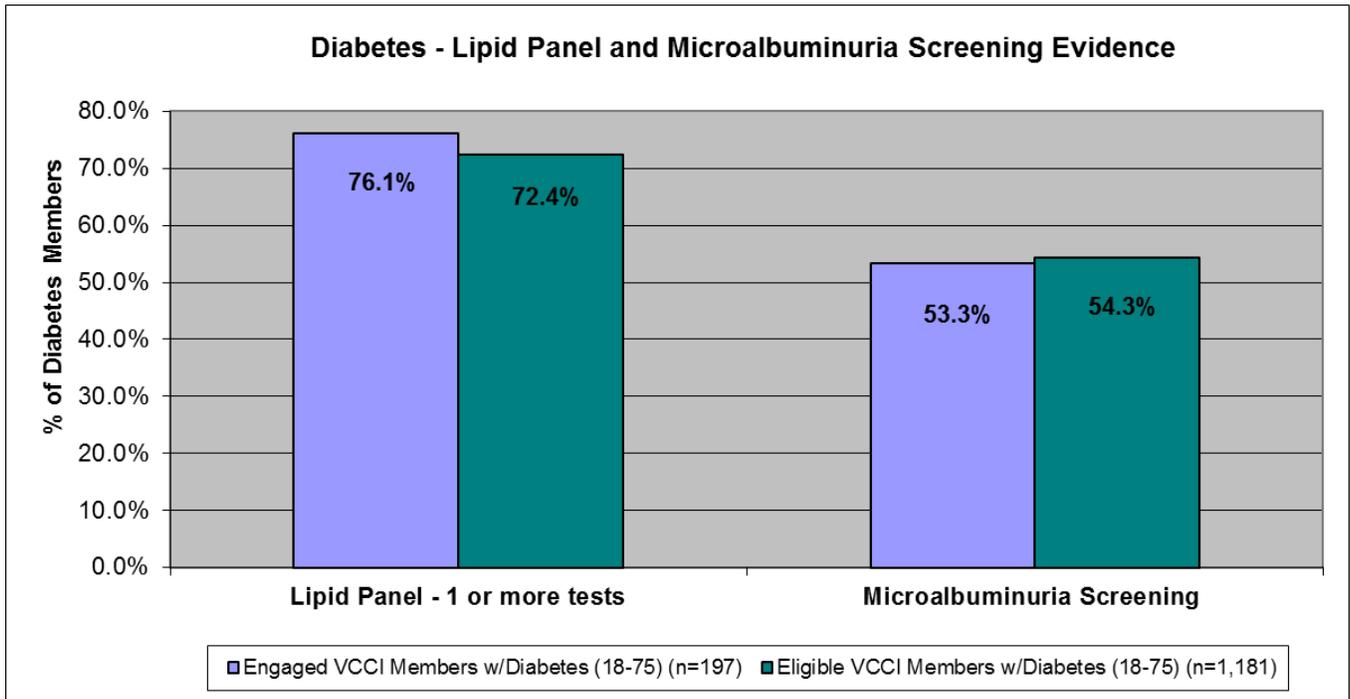
## Diabetes Mellitus

*Members engaged with VCCI obtained HbA1c testing at about the same rate – 96% as non-engaged members with diabetes mellitus. Members engaged with VCCI are more likely however to receive appropriate lipid level testing annually compared to non-engaged members with diabetes: 76.1% versus 72.4%. This is a significant factor in addressing the co-morbid risk for CAD. Microalbuminuria testing for kidney function was slightly lower, at 53.3% for VCCI engaged versus 54.3% for the non-engaged members and is an area for continued focus for VCCI.* In SFY 2014 a follow-up PHR was run to compare members previously identified with gaps in testing. Thirty one (31) members were noted to have already had their labs done.

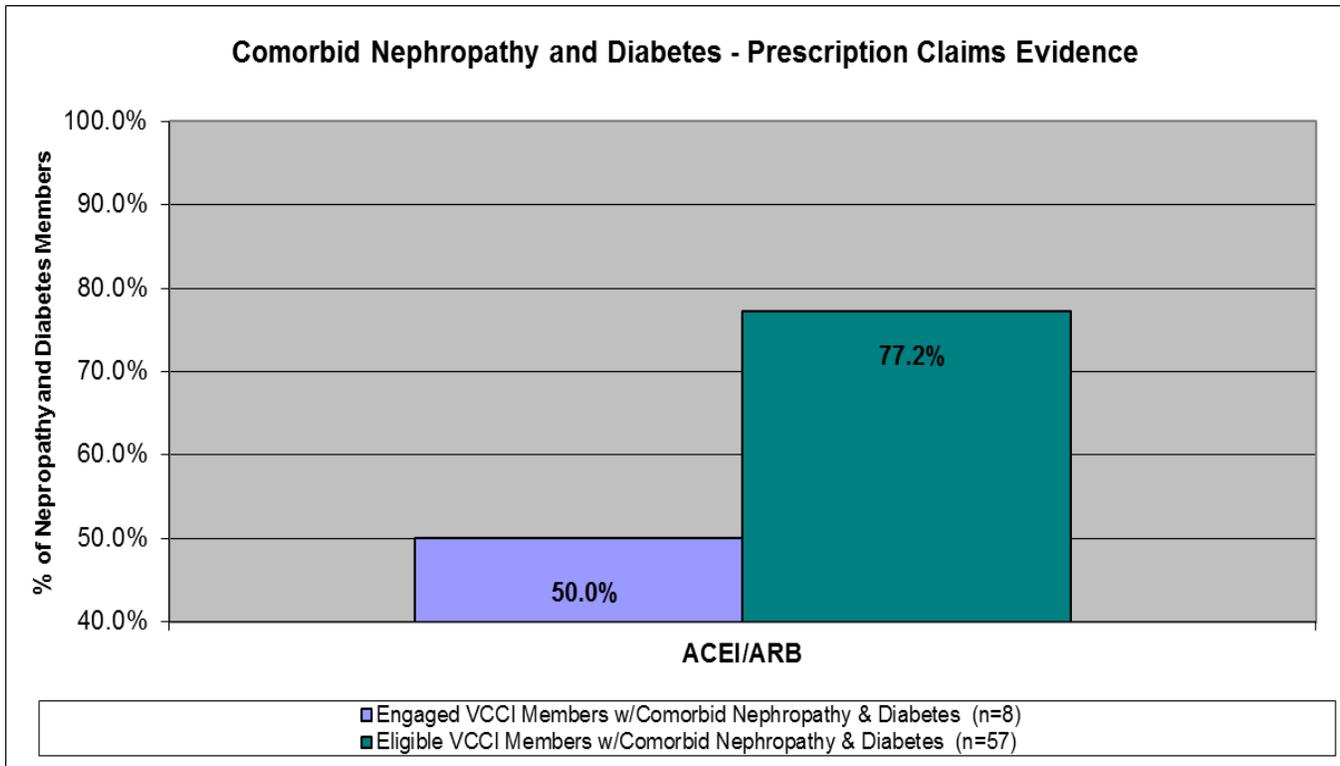
The Diabetes Action Plan was also updated to emphasize these gaps and assist the member in developing a personal action plan to work to close them. In addition, VCCI case managers received monthly reports on engaged VCCI members who have these gaps in care and worked with providers and members to close these gaps. VCCI further revised the current diabetes assessment tool to increase focus on these potential gaps in SFY 2014. The assessment addresses the importance of screening for kidney function in patients with diabetes because of their increased risk for kidney damage.

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.





**Members with diabetes and nephropathy engaged with VCCI had a prescription claims evidence rate of 50% for ACEI/ARB prescriptions versus non-engaged members who had a rate of 76.4%.** This may be a function of the several factors, including a small intervened sample size, significant socio-economic barriers, and staff selection for member outreach based on the highest acuity/complexity scores among the top 5%. It also may be a function of direct referral by PCPs and CHT partners of their most challenging non-adherent patients. VCCI updated the diabetes assessment for SFY 2014 to include these classes of medications and to focus awareness on adherence to evidence-based guidelines for diabetic members with nephropathy. The Diabetes PHR for panel management includes prescription fulfillment of ACEI/ARB for members with nephropathy as well as absence of lipid testing and HbA1c to improve adherence to these important aspects of diabetic care. Ideally, all patients with diabetes and kidney disease should be treated with an ACEI or an ARB if there is not a contraindication. Through the Diabetes PHR, members with kidney disease are identified as having a gap in care if they are not on an ACEI or ARB. VCCI staff work with providers and members to close that gap. In addition, in March 2014, a PHR was distributed and was compared to the previous registry to determine if efforts were working to close the gap. VCCI found some gaps had closed and conducted additional outreach in those instances where it did not. If a provider identified the member as non-adherent to treatment, the member was referred to VCCI or Community Health Team (CHT) staff for supportive care.



## IV. Operations Report

### Community Integration

In SFY 2014, VCCI continued to make progress as an integrated partner in the Vermont health community, including with NCQA certified medical homes through the DVHA Blueprint for Health and the associated locally deployed Community Health Teams (CHTs), funded in large part by Medicaid. VCCI staff remained embedded in multiple high volume primary care sites including high volume FQHC practice sites which support direct referral and management with PCP partners.

VCCI continued to expand collaboration with case managers at other local emergency departments and inpatient units regarding direct referral of cases for telephonic case management and intensive case management/care coordination with focus on the transition of care. Use of a secure FTP site continues to enable VCCI to receive inpatient and emergency department admissions data from six of Vermont’s hospitals, including Vermont’s only tertiary care center.

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 identification and outreach to high risk members, assisting medical homes to achieve or maintain their NCQA accreditations.

VCCI continued a population approach with primary care providers to supplement individual case management services, using the disease specific Patient Health Registries (PHRs) and supporting Patient Health Briefs (PHBs) to assure Medicaid beneficiaries with potential gaps in evidence-based

care can be proactively identified, outreached and managed. In SFY 2014, PHRs/PHBs were provided to practices related to Heart Failure, Depression, Asthma, and Diabetes. Evidence indicates that gaps in care impact quality of life and may lead to increased emergency department or inpatient hospitalization rates. By using PHRs, VCCI was able to communicate with providers to assure that gaps were not due to oversight and/or other member issues that create barriers to appropriate treatments, such as health literacy, financial or transportation barriers to securing medication and resultant adherence, etc.

## **Member Outreach**

VCCI continued to engage in direct outreach to members as a prime method for engagement. Outreach activities included:

- **Member Welcome Packet:** This introductory mailing is the first contact members receive after enrolling in the program. It introduces the program and describes what they may expect while engaged, along with member rights and responsibilities.
- **Follow-up Letter with Health Care Literature:** This letter is routinely sent to members and includes but is not limited to: Krames Fast Guides, Krames on Demand fact sheets, condition Action Plans and articles from the Healthwise Knowledgebase regarding targeted information to address members' individual health concerns.
- **No-Contact Letter:** VCCI sends this letter after one or more unsuccessful telephone contact attempts to enroll the member and to conduct the general assessments, such as the Social Needs Assessment and Behavioral Health Risk Assessment.
- **Member Brochure:** VCCI staff sends members a brochure that further explains the program, provides contact information and offers tips on working with healthcare providers.
- **Telephonic Engagement:** 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 work with members to complete a Plan of Care and engage them in care coordination, health coaching and case management services.
- **Consumer Web Site:** VCCI's consumer web site is located at [www.vtccmp.com](http://www.vtccmp.com) and features a program description, member rights and responsibilities, Action Plans, educational materials described above, and direct access to the Healthwise Knowledgebase. Everything on the web site is pre-approved by DVHA as well as APS Healthcare.
- **Face-to-Face Engagement:** For members with the most complex needs, VCCI clinical staff are available to meet 1:1 with the member and/or attend appointments with the member and their provider. This direct communication is creating a patient centered environment and is providing opportunities to assess member status with regard to their management of their health condition; assess barriers and priorities; help support the development of a member driven action plan and to narrow the information gap between the member and healthcare providers. During SFY 2014, VCCI staff participated in 4616 face-to-face interactions with 948 unique members.

In addition to these member specific outreach efforts, VCCI completed four targeted mailings to Medicaid beneficiaries on the following topics:

1. **Encourage Flu and Pneumococcal vaccine** – In November 2013, VCCI distributed a mailing to approximately 7,000 VCCI members with asthma (adult/child), COPD, diabetes (adult/child), or HF.

The mailing also included the Guide for Diabetes Care recommending tests and check-ups for diabetes. The purpose of the mailing was to help inform members on the recommendations for vaccinations thereby potentially reducing the risk of infection and subsequent ED or IP care.

**2. Health Benefits of Medication Adherence** - In February 2014, VCCI targeted approximately 4,200 VCCI members with one or more of 8 Chronic Health Conditions. The mailing included an “I Will Take My Meds Wallet Card” and tips on how to remember to take and refill your medications. This topic was chosen due to the top Medication Adherence Problems identified in VCCI Plans of Care - see PDSA below.

**3. Painkiller Safety** - In April 2014, VCCI targeted approximately 1800 VCCI eligible members (12 - 65 years old) who are residents of the Rutland, White River Junction or St Albans Health Service Areas. The mailing aligned with National Drug Take Back Day and included a refrigerator magnet with the message: Painkiller Safety - Don't Share, Secure and Properly Dispose. The purpose of this mailing was to heighten awareness about the importance of painkiller safety in three vulnerable geographic areas, to reduce the potential for abuse, misuse, and diversion of such medications into communities. In addition, information was provided to make members aware of a drug called Naloxone which can be used to save a life during an opioid overdose.

**4. Healthy Pregnancy** - In June 2014, VCCI distributed a mailing to 2,300 female VCCI members (18-50 years old) which included the “One Key Question” developed and trademarked by the Oregon Foundation for Reproductive Health. The question is: “Would you like to become pregnant in the next year?” Answers: “Yes, No, Maybe or I Don't Know”. Suggestions were provided for healthy behaviors for all potential answers. CY 2013 Health Service Area (HSA) Data showed complications of pregnancy to be the condition with the highest cost in most HSAs. It is believed many risks to the mother and baby (and therefore, costs) would be avoided if women engaged in healthy behaviors before and during pregnancy.

### **Provider and Community Outreach**

APS Healthcare 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 POC Letters:** As members completed the enrollment process, primary care providers were sent letters notifying them of their patients' enrollment in VCCI along with a copy of the Plan of Care. *A total of 344 unduplicated providers were sent 1,078 letters in SFY 2014.*
- **Health Service Area (HSA) Data:** Local HSA data was compiled to show each of the 13 HSAs highest cost conditions for Inpatient and Emergency Department use by Vermont Medicaid members in their area. The data was sorted to reflect the costs associated with the 32 most common chronic conditions managed by VCCI and the conditions associated with the remaining costs. The total statewide costs were also provided so that the HSAs could compare their area with the rest of the state. In addition to sharing with providers, this valuable data informed VCCI on the distribution/targeting of mailings and PHRs.

- **Hospital, Community Service Organizations, Community Health Teams:** VCCI staff have been embedded in several hospital locations and communicate with hospital partners regarding member discharge and related transition needs, as appropriate, for the eligible population and to prevent 30 day readmissions. In addition, VCCI staff continued to work with community service organizations and Community Health Teams for a coordinated approach to collaboration with mutual members. In SFY 2014, outreach visits were made to such organizations, as well as regular attendance at Community Health Team regional meetings.
- **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 providers were visited by case managers accompanying members in co-visits, and as part of the Patient Health Registry distribution process. VCCI met with 133 providers in these outreach efforts in SFY 2014. The engagement with providers also helps to increase the referral of members for VCCI services. *Local practices—including care managers and health center panel managers directly referred over 21% of VCCI members for services during SFY 2014 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 2014 the VCCI Medical Director continued to provide clinical consultation and support to VCCI staff including education and training on care standards. During a limited transition period, the VCCI Medical Director also acted as a DVHA Medical Director. This dual role fostered greater collaboration on prior authorization (PA) requests for Suboxone, resulting in the removal of its “forever” grandfathering and the requirement of urine drug tests before granting PA.

**Clinical Resources** – VCCI staff received an array of training and education in SFY 2104:

- APS Healthcare and DVHA continued to conduct joint training sessions geared toward improving clinical outcomes. Staff were trained on the CareConnection™ system throughout the year to assist in optimal use of the system. Topics included correct data entry to assure data integrity, utilization of PHRs/PHBs and processing of community referrals.
- Five disease specific assessments were revised to be up to date with the most recent Evidence Based Guidelines – Heart Failure, Diabetes, Asthma, COPD and CAD. Asthma and Diabetes were further refined to provide separate assessments of adults and children.
- Ten Action Plans were updated to include the most recent evidence-based practices and an individual plan to assist members in establishing and monitoring their goals. The plans were also modified to a fillable format facilitating ease of use of the form by community providers and workers. The specific conditions addressed in the Action Plans are Arthritis, CAD, COPD, Diabetes, Heart Failure, High Blood Pressure, High Cholesterol, Kidney Disease, Low Back Pain and Mental Health.

- Dr. Rowland Hazard of the Dartmouth Hitchcock Medical Center (DHMC) presented on chronic pain at a VCCI staff meeting. Specifically, he addressed low back pain and the Functional Restoration Program at the DHMC Pain Clinic. He reviewed pain management strategies, opiate use – medication choices and management, physical therapy/training and “functional” testing. The presentation provided valuable guidance on evidence-based practices and encouraged referrals to the program if geographically appropriate.
- Additional educational resources are available on the 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 Reference Binder, created in 2009, continued to be revised with oversight by the VCCI Medical Director, and VCCI staff were trained on its use. This resource contains clinical materials including: assessments, medication overviews, therapies, call guides, action plans, patient education materials and medical director summarized clinical guidelines.

Both the VCCI Medical Director and Pharmacist provided staff instruction at various monthly DVHA staff meetings as well as ad hoc individual sessions for staff with questions about how to proceed with their challenging member or how to understand the medical plan or complex medication treatment.

## **Quality Initiatives**

VCCI expanded upon our quality initiatives during SFY 2014. These initiatives were primarily focused on increasing the information available to PCPs regarding possible gaps in care. The initiatives included approximately 120,000 Medicaid members who may be eligible for VCCI services during a given year based on individual health conditions as well as VCCI eligibility criteria. Of that group approximately 47,500 members have a chronic health condition and thus were included in VCCI population health reports as described below.

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

In SFY 2014, VCCI continued to use PHRs and PHBs to support practices working with Medicaid members. The PHR is a condition specific document developed by analytical review of their chronic condition(s), procedure and pharmacy claims of members with specific criteria applied that will indicate if a gap in evidence based care of the member is present. For example, a member with diabetes who has not had a lab claim for an HbA1c blood analysis within the recommended time frame would show as having a gap in care on a Diabetes PHR. 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 with diabetes who are on the PCP’s patient panel. This report is then provided by VCCI to the PCP and/or practice clinical lead, with follow-up contact to review the provider’s feedback as well as potential cases for VCCI referral and supportive case management. In SFY 2014, PHRs were completed for provider practices showing gaps in care for patients with conditions including systolic heart failure, depression, asthma and diabetes. Practices with ten (10) or more members with gaps in evidence based care were selected for dissemination of the PHR.

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

- In August of 2013, thirty eight (38) PHRs for systolic heart failure were delivered to Vermont providers for forty five (45) members with gaps in evidence based care. Eighteen (18) PHRs were returned providing information on twenty one (21) members. Two members were referred to VCCI.
- In November of 2013, Forty eight (48) PHRs were distributed to one hundred thirty one (131) providers for three hundred thirty two (332) members with asthma who had a gap in evidence-based care. Eighty three 83 (or 68%) of the PHRs were returned that provided information on two hundred two (202) members. For these members, providers indicated that the recommendation had already been implemented or would be implemented for 36% of those two hundred two (202) members.
- In January of 2014, a PHR was distributed to one hundred twenty four (124) providers for three hundred six (306) members with gaps in care related to their depression treatment. The distribution of this PHR was limited to five (5) counties – Chittenden, Rutland, Washington, Windham and Windsor. The locations were identified by prevalence of the condition, costs according to local data sets and VCCI capacity.
- In March of 2014, a PHR on members with diabetes was distributed to sixty nine (69) providers for one hundred ninety eight (198) members identified with gaps in evidence-based care. Forty six (46) PHRs were returned with information on one hundred thirty four (134) members. 47% of the 134 members were either stable on their current regimen or the provider had already implemented the recommendation. Providers were planning to implement the recommendation on another 34% of the members.

### ***Patient Health Briefs***

The Patient Health Brief (PHB) is a member specific document of 1-6 pages that VCCI staff can share with providers and individual members to review their medical procedures and pharmacy fills over the past 6 months and to support health improvement. The PHB also indicates any chronic conditions in a member's record and associated gaps in care; utilization of other providers, hospital services and or supplemental prescriptions/pharmaceuticals ordered by other than the primary care provider. PHBs are included with all of the PHR distributions listed above. Many primary care providers have given positive reviews of this document as it informs them of additional care their patient may have received that could be better aligned with the care they are providing. This document can also help identify treatment gaps and when they occur. Lack of pharmacy claims even though a provider has prescribed a certain medication is one example of a gap in care that could be identified and explored for improved adherence.

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 and supplemental support services could be most helpful for the member to achieve improved adherence and health outcomes.

### ***Pharmacy Improvements***

The VCCI pharmacist worked with VCCI clinical leadership, the DVHA Pharmacy and Substance Abuse Units, APS Health Intelligence, and with DVHA's Pharmacy Benefits Manager pharmacist to

develop informatics that can be helpful in optimizing member clinical outcomes and cost savings for DVHA. In SFY 2014, work focused on:

- An analytical assessment of the use of Suboxone® in the VCCI population. This is an ongoing process to help clarify understanding of prescribing patterns. A buprenorphine prescriber query was ultimately developed as a result. It indicated eligible population counts by buprenorphine prescriber and included data on concurrently prescribed drugs of interest, HSA of member and other factors. The DVHAs Chief Medical Officer and Medical Director received this data for additional assessment and possible outreach.
- Developing and refining specific indicators that can assist care coordination for members who are utilizing Suboxone® as part of their opioid use disorder recovery process. A new needs assessment for VCCI staff on inappropriate opioids was developed, implemented and trained on. Additionally, a query was initiated based on a trigger for assessment and potential member referral to appropriate DVHA unit.
- Opioid Use Disorder was identified as a disease that staff could benefit from additional education. A Drug Therapy Overview and Call Guide were created and VCCI staff received training on it. Additional staff education regarding the Buprenorphine triggers was also provided. These triggers “flag” staff when buprenorphine was prescribed and the member had another indicator (concurrent prescribed medication or other) that the DVHA was interested in targeting.
- Consultation with all VCCI staff concerning questions on the prescribed or over-the-counter medications of members.
- Reviewing internal processes and tools, along with other clinical leadership, to help ensure current evidence-based medications are being reflected appropriately in APS systems that involve medications.
- Attending DVHA Drug Utilization Review Board meetings to better understand how VCCI pharmacist efforts may be more synergistic with the efforts of this group in reducing costs and improving care in the VCCI specific population.
- A focus of the five revised Assessments reflected more guidance for the nurse user regarding prescribed medications. The corresponding desktop tools, Drug Therapy Overviews, were updated to reflect current evidence-based practice and to match the Assessment terminology. Staff training was provided on these tools.
- An analysis was initiated on Medication Adherence metrics reported monthly and this resulted in a Plan/Do/Study/Act (PDSA). The PDSA and resulting report provided a better understanding of the types of medication adherence problems that remain unresolved - “member forgets to take” and “has no refills”. As a result of this analysis, a targeted mailing was distributed to VCCI members who could benefit from this information and staff were educated about medication adherence problems and interventions, as well as timely documentation of problem resolution in the C3 data base to assure adherence is correctly monitored and data accurately reflects problem resolution.

These pharmacy related approaches are adding to the overall efforts by the VCCI to improve the effectiveness and reduce costs associated with substance abuse treatment and chronic medical conditions.



## Success Story

Member: A 50 year old male with uncontrolled Type II diabetes and hyperlipidemia was referred to VCCI by a local Certified Diabetes Educator (CDE) for in home assessment and support with his diabetes management. Barriers for this Member included a slight cognitive delay, a need to care for wife with medical and mental health issues, and a limited work capacity due to his inability to pass an employment physical due to his uncontrolled diabetes. In addition, he has not always felt comfortable checking his sugar or administering insulin when he was at work. The Member also needed general education on insulin management, including the proper handling of insulin (i.e., not leaving it in his vehicle in the heat and not using expired insulin).

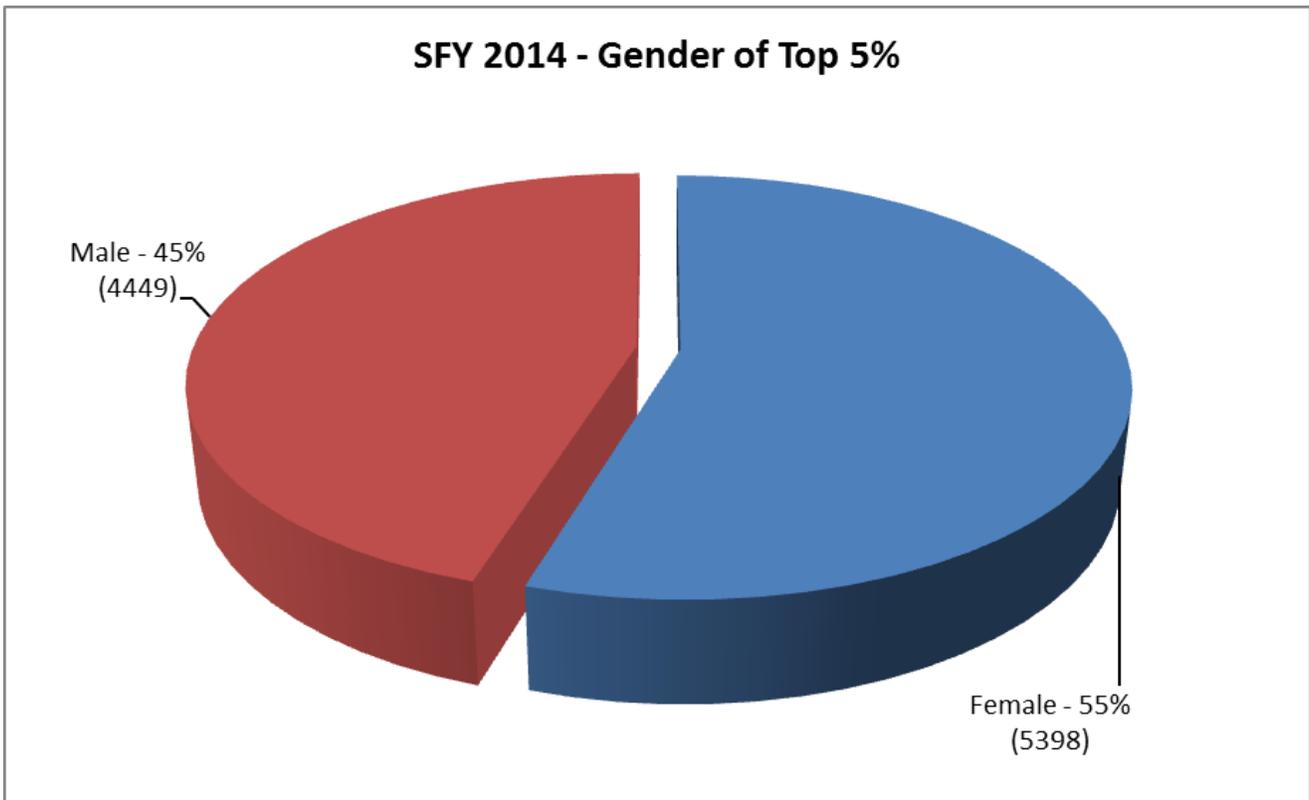
Interventions and Outcomes: VCCI staff made weekly home visits initially, focusing on the Member's insulin usage, education on expiration dates and how to handle insulin. Nutrition was also a focus, specifically his significant soda intake. As a result of these visits, the Member became interested in learning what other types of drinks he could have with him during the day to help manage his sugars. He finally attended two endocrinology appointments at DHMC, which he had not done up to that point. The Member's insulin is being adjusted weekly based on his blood sugar readings.

A1C on this Member was initially 12% but when recently checked at his endocrinology appointment was down to 9.3%. This is strong evidence of his successful collaboration with the CDE, his provider and the VCCI Case Manager.

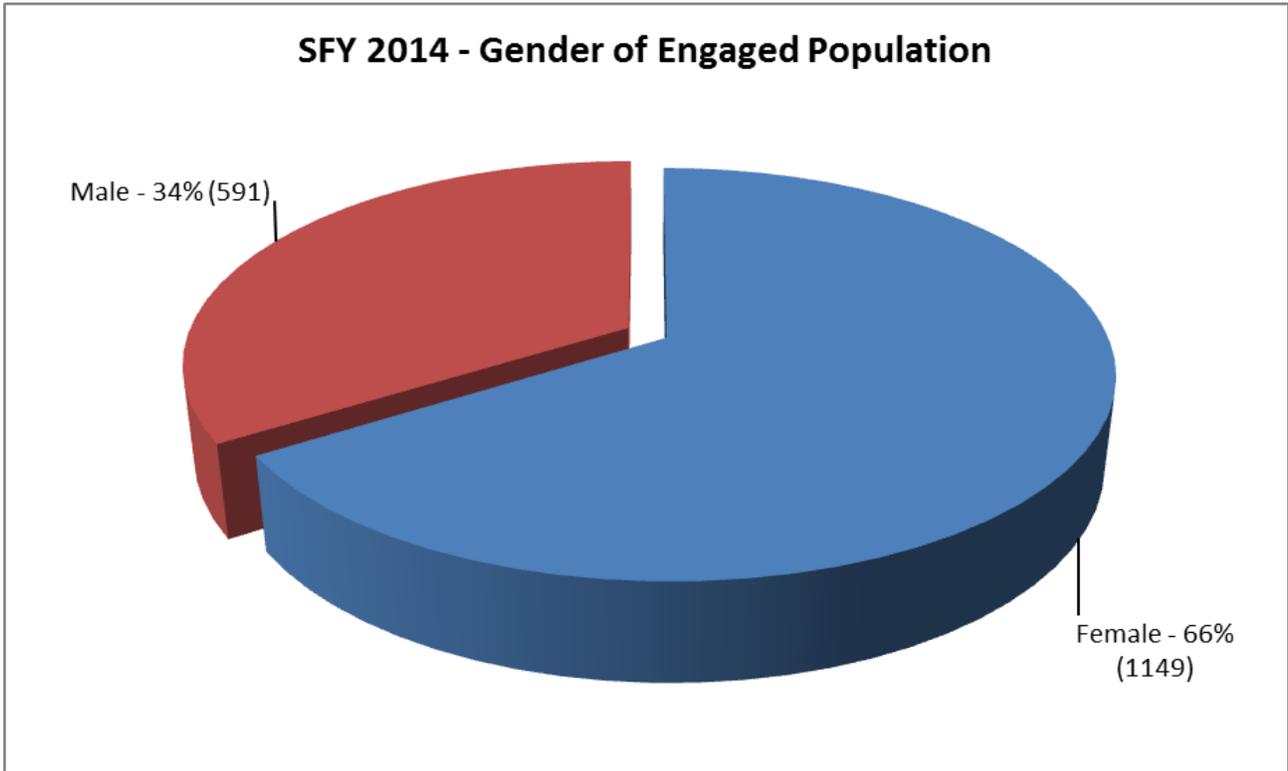
**Demographic and Operations Data**

The following pages outline demographic and operational data for the state fiscal year which ended June 30, 2014.

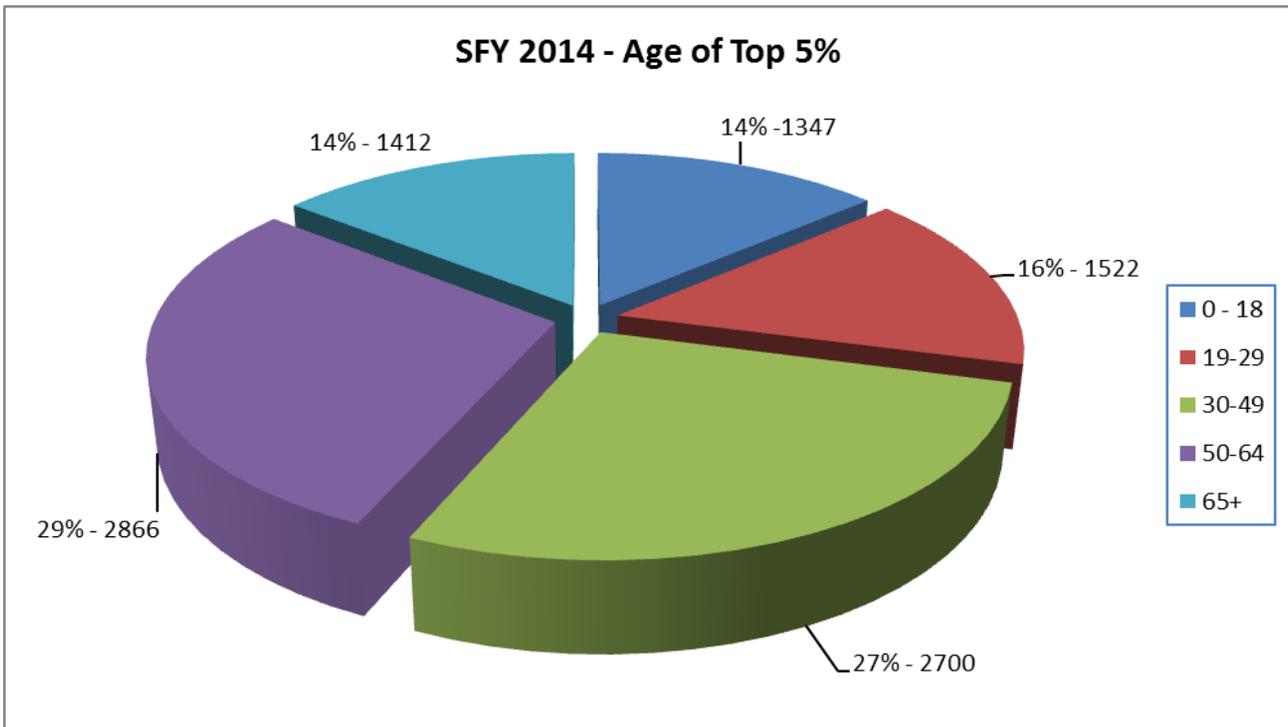
**Gender** – Over 9,800 Medicaid members were identified in SFY 2014 as eligible for VCCI services – high risk/high cost. The number of VCCI eligible female beneficiaries continues to exceed the number of male beneficiaries.



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



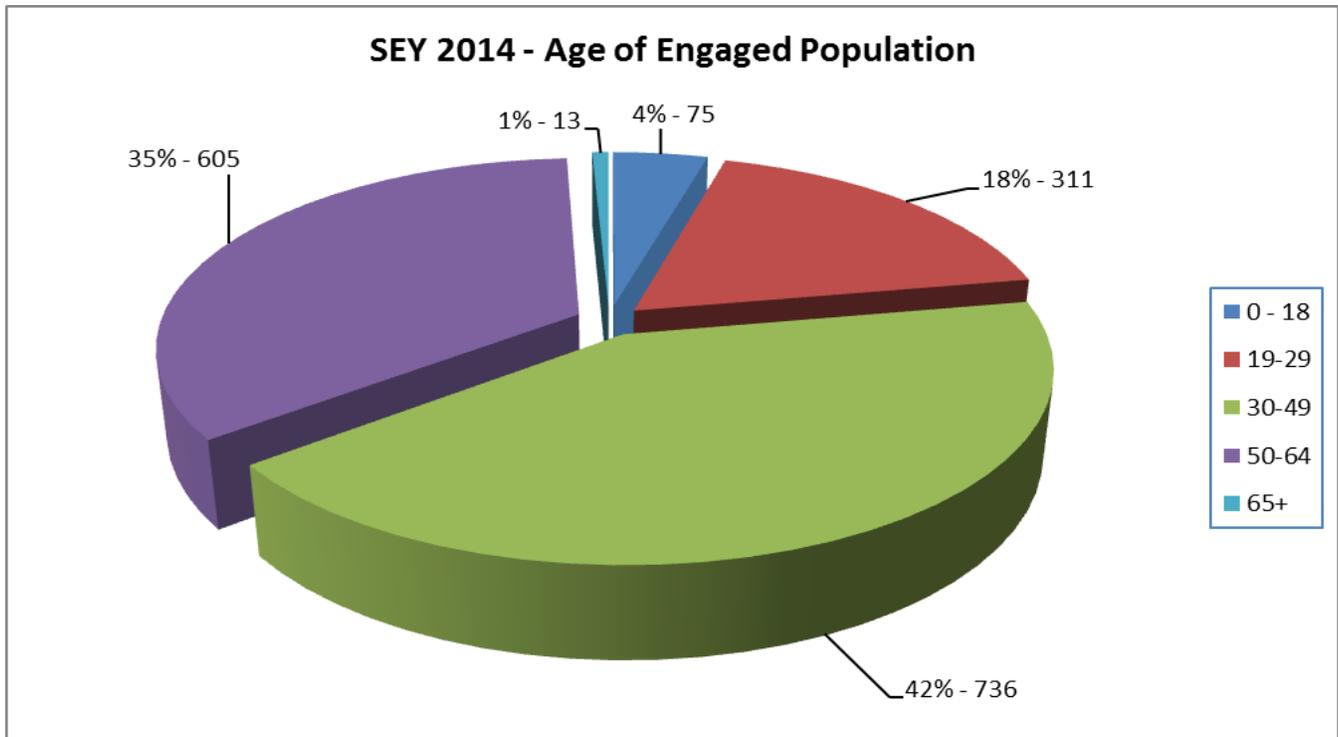
**Age** - The largest age group of eligible members is the 50 through 64 year age category (2,866 or 29%). The second largest group this year is the 30 through 49 year age category (2,700 or 27%).



**Age of Members Engaged with VCCI:**

The largest age group of members engaged with VCCI is the 30 through 49 year age category (736 or 42%). The 50 through 64 year age group is next (605 or 35%).

We engaged fewer children, ages 0-18, than we did adults. Many of the identified top 5% high risk/high cost children received multiple services through the Children with Special Health Needs/Children’s Integrative Services programs and were not enrolled in VCCI. VCCI will consider additional outreach approaches to parents, pediatricians and school nurses.



**SFY 2014 - Age of Engaged Population**

0 - 18	19 - 29	30 - 49	50 - 64	65+	TOTAL
75	311	736	605	13	1740

**Member Services SFY 2014** – Case managers and social workers systematically engage eligible Medicaid beneficiaries. The table below represents summary information regarding the level of activity during outreach and engagement.

<b>Description</b>	<b>Total Number</b>	<b>VCCI Unduplicated Members</b>
Member Outreach		
Introductory Letter	1,010	900
Education Letter and Material	1,223	472
No Contact/Unable to Reach Letter	2,306	2,025
Telephonic Calls/Call Attempts	25,498	
Assessments		
General Assessments - SNA, BR and TOC	2,570	1,408
Disease-Specific Assessments	1,331	947
Plans of Care (POC)		
New POC	1,282	1,216
New Problems (to new or existing POC)	8,334	1,336
New Goals (to new or existing POC)	8,114	1,338
New Interventions (to new or existing POC)	10,151	1,332
Interactions with Members	55,639	3,435
Face to Face Visits	4,616	948

VCCI looks forward to continuing its efforts to improve the health and health outcomes for Medicaid beneficiaries with chronic conditions in SFY 2015 and beyond.