

# **Vermont Chronic Care Initiative: overview and results**

**Medicaid Advisory and Exchange Board  
9-9-13**

Eileen Girling, RN, MPH, CAMS

Director, VCCI

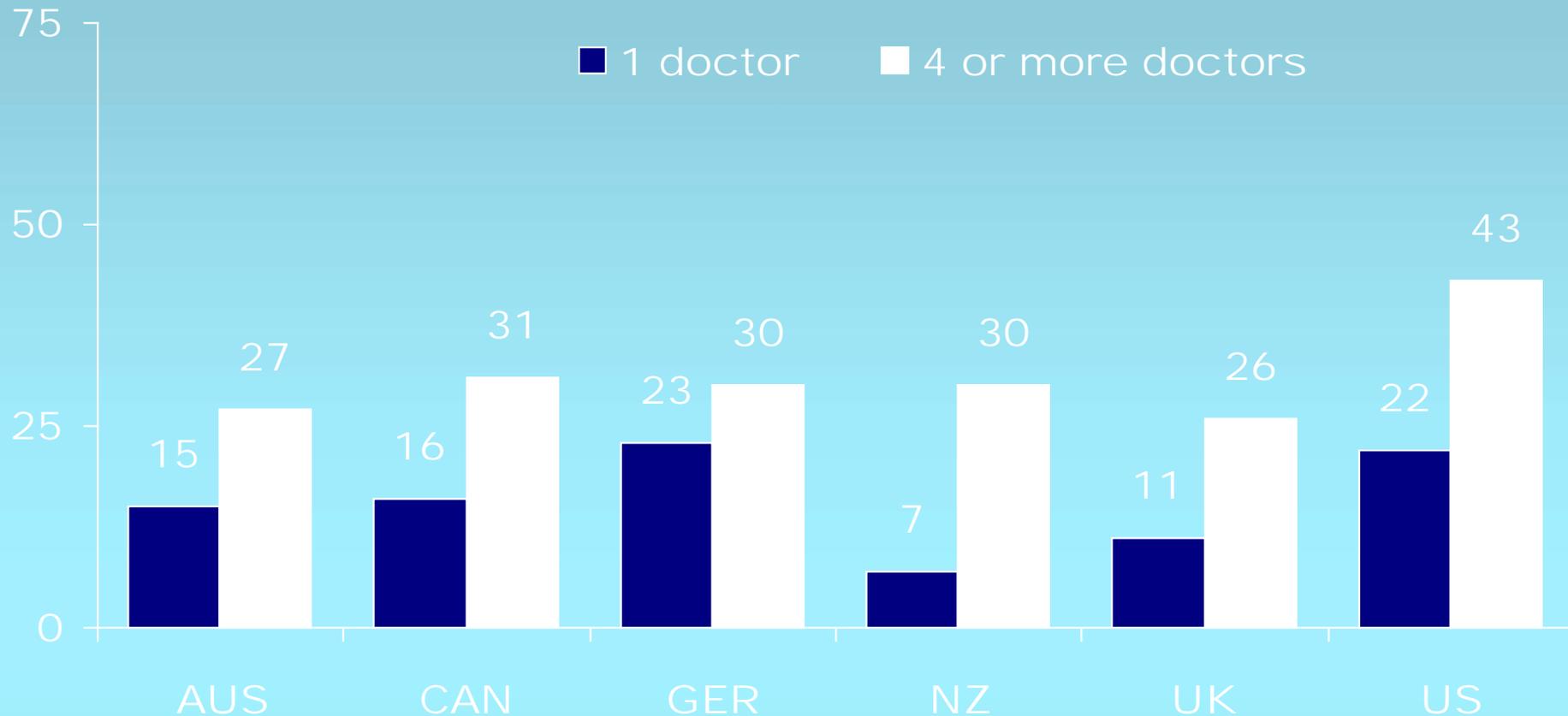
# Context for VCCI

*‘Studies have shown that nearly 30% of health care spending - up to \$300 billion each year – is for treatment that may not improve health status, may be redundant, or may be inappropriate for the patient's condition...’*

(Wennberg et al., 2002, Wennberg et al., 2004; Fisher et al., 2003, Fisher et al., 2003)

# Coordination Problems by Number of Doctors, Sicker Adults, 2005

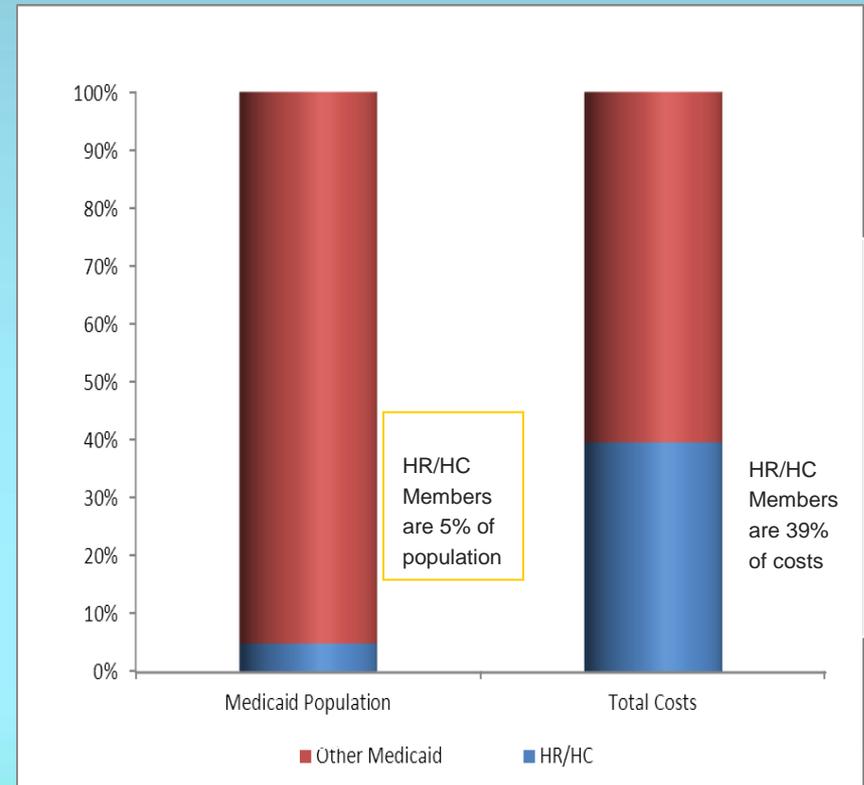
Percent



\* Either records/results did not reach doctors office in time for appointment OR doctors ordered a duplicate medical test

# VT: Small population (5%) account for 39% cost

- Uncoordinated/ fragmented care
- Non-emergent ER and IP Admissions for Ambulatory Care Sensitive Conditions
- High readmission rates
- Multiple providers
- Multiple medical, behavioral co-morbidities
- Poly-pharmacy



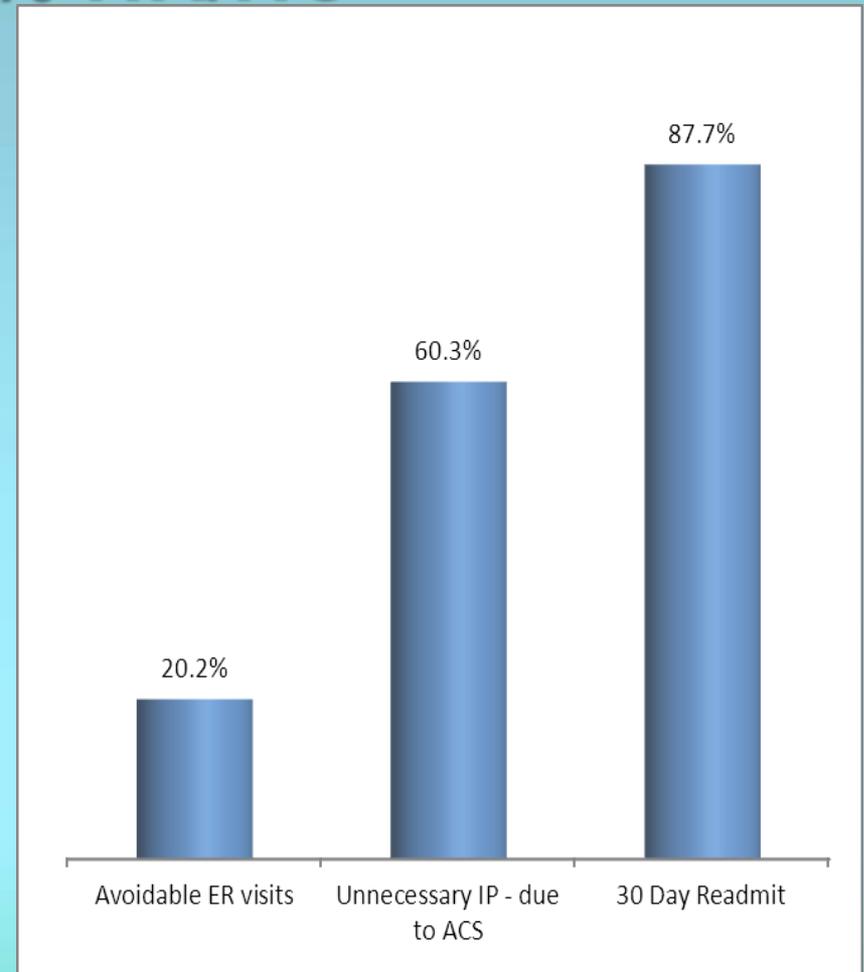
Data from CY 2012

# Disproportionate Utilization by Top 5% HR/HC

- 20.2% of avoidable ER costs
- 60.3% of Ambulatory Care Sensitive hospital admissions
- 87.7% of all 30-day hospital readmission costs
- Case Management & Care Coordination can improve utilization, quality and costs

## ***VCCI results FY 2012:***

- \$11.5 million (net) savings over anticipated for top 5%



Data from CY 2012

# VCCI Vision and Goals

**Improve access to care, reduce morbidity and improve quality of care & life for most medically complex Medicaid members; and generate savings**

- Increase access to primary care medical home and utilization of preventive health services
- Improve adherence to evidence based treatment by addressing barriers and gaps (knowledge, finance)
- Improve communication and care coordination among service providers for risk reduction
- Reduce ambulatory sensitive hospital admissions, readmissions and ED utilization
- Support self-management confidence and skills

# Strategic approach & partnerships

## Population ID and Staffing:

- Stratification of high risk population by contracted vendor
- Teams of nurses and social workers statewide; MD and Pharmacist
- Support with clinical and socio-economic barriers (housing, transportation)
- Individual and population approach to care management

## Providers Interface:

- Embedded staff in high volume medical homes
- Shared goals of PCP's and Medicaid creates synergy
- Co-visit with beneficiary at MD appointments &/or home visiting
- Goal setting and health coaching between PCP visits
- Provider reports on patient panel eligible and at risk; gaps in care (lab, Rx)
- Coordination/communication among multiple providers

## Hospitals:

- Hospitals liaisons for point of care intervention and support
- Post hospitalization follow-up (VCCI, MD) to support discharge plan

# Member Support

- Facilitate access to PCP for primary care
- Goal setting based on member needs & desires
- 'Action Plans' to support behavioral change
- Coaching, health education, referrals, care coordination among multiple providers to stabilize needs
- Strength based focus to self-management skill building
- Advocacy and support to reduce socio-economic barriers
- AHS Field Service - coordination and support among AHS partners and resources

# Program Results (FY 2012)

Reduction in all hospital ambulatory sensitive admissions:

- ED visits: decrease by 4%
- IP admissions: decrease by 8%
- IP readmissions: decrease by 11%
- Better adherence to evidence based care if VCCI engaged:
  - COPD: increase Rx for bronchodilator therapy
  - CAD: increase rate of Rx for ACE/ARB; lipid tests
  - Diabetics: increase labs testing (lipids, HbA1c)
  - Depression: higher rate of prescription adherence
- Net ROI of \$11.5million based on anticipated vs. actual

# National Recognition of Model

- CMS bulletin, July 2013 on ‘super-utilizer’ programs: recognized VCCI as a national model
- Speaker at CHCS and NGA *Summit* on ‘super-utilizers’
- NGA request for VCCI consultation: SIM grantee
- NCSL interest in Executive and Legislative support and how to ‘spread’ to other states

# VCCI - Specialty Populations

- Pediatric Palliative Care - October, 2012
  - Medicaid and under age 21
  - Life limiting condition
  - 30 children enrolled statewide
- High Risk Pregnancy - October 2013
  - initial pilot in Franklin
  - align with other programs and partners

# Questions ?

Eileen Girling – 879-5954

[eileen.girling@state.vt.us](mailto:eileen.girling@state.vt.us)