VERMONT
Agency of Human Services

Care Management in Vermont: Gaps and Duplication

Prepared for the Vermont Care Models & Care Management Work Group

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Key Recommendations:

- Increased process standardization, including increased use of common care management tools
- Creation of an organizational mechanism to coordinate the "family of care coordinators"
- Increased development and use of IT resources to coordinate care management activities
- Increased use of a shared data set to coordinate care and measure effectiveness
- Increased opportunities for care managers to build their skills through initiatives of share best practices and learn new skills

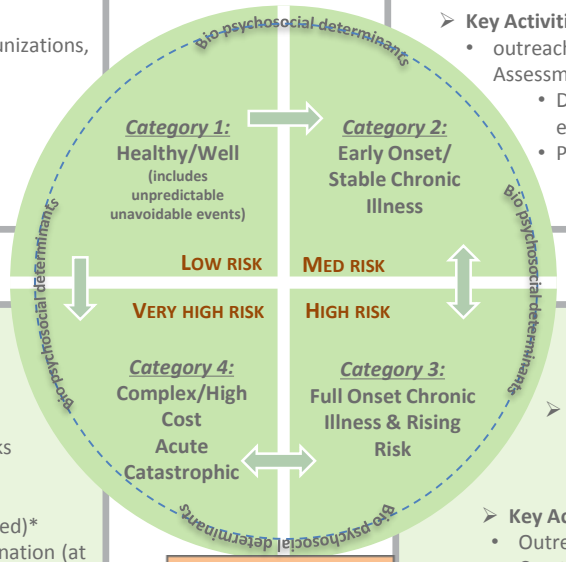
Complex Care Program can Aid in Achieving Quadruple Aim & APM Goals

- **Better Health for Patients**
  - Improved access to primary care (and other needed services)
  - Reduced prevalence and morbidity of chronic disease
  - Reduce deaths due to suicide and drug overdose
- **Better Patient Satisfaction**
  - Improved understanding and coordination of services and supports
- **Better Cost Control**
  - Savings to reinvest in population health programs
- **Better Workforce Satisfaction**
  - Retain employees; recruit new employees
  - Improve joy in work

Population Health Approach: A plan for every person

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)
  - RiseVT

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - outreach for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
  - Pregnancy education



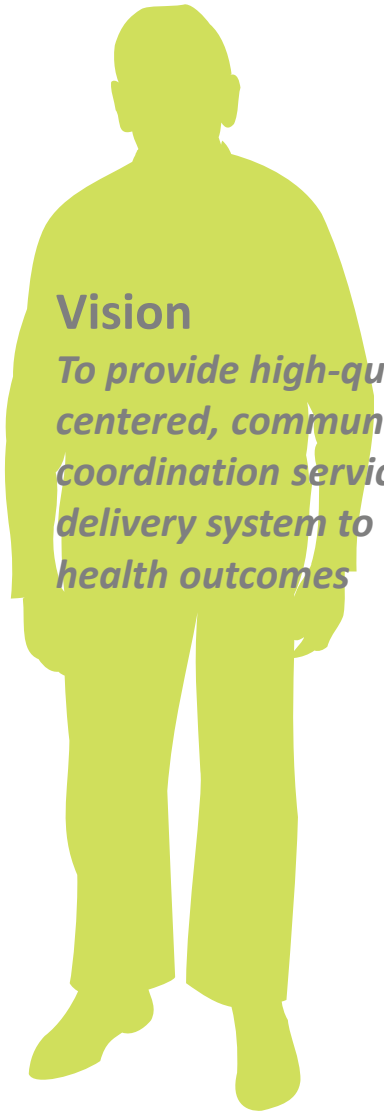
- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly)*
  - Coordinate among care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination Create & maintain shared care plan*
  - Coordinate among care team members*
  - Emphasize safe & timely transitions of care

16% Lives
40% Spending
89% Multiple Chronic
67% MH Condition

* Activities coordinated via Care Navigator software platform

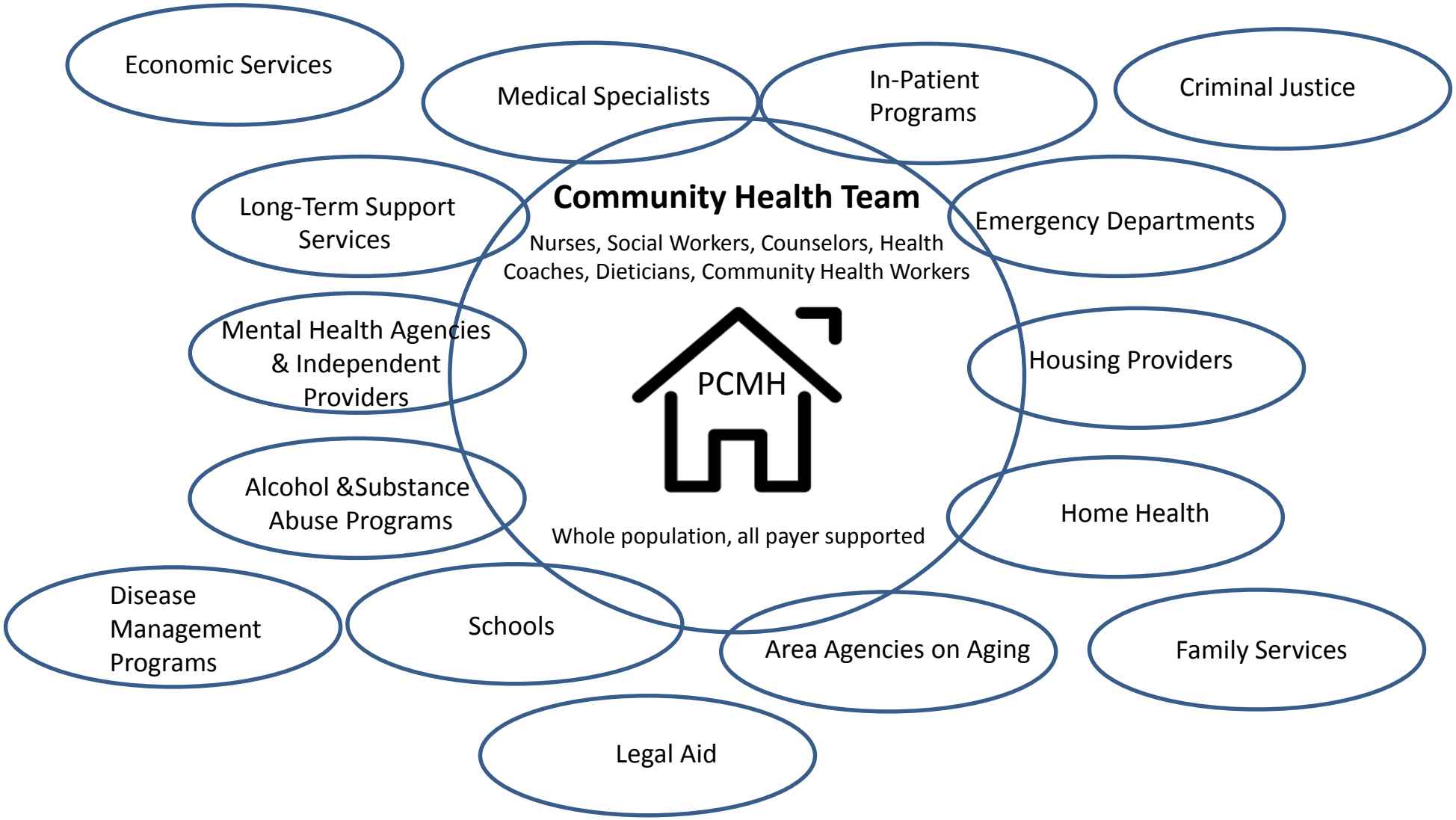
Central Components of the Care Coordination Model



Vision

To provide high-quality, person-centered, community-based care coordination services in an integrated delivery system to achieve optimal health outcomes

1. **Person-centered Shared Care Plan**
2. **Multi-disciplinary Care Teams**
3. **Risk Stratification**
4. **Tools & Training**
5. **Inclusive Payment Model**


Economic Services
Medical Specialists
In-Patient Programs
Criminal Justice
Long-Term Support Services
Community Health Team
Nurses, Social Workers, Counselors, Health Coaches, Dieticians, Community Health Workers
Emergency Departments
Mental Health Agencies & Independent Providers
PCMH
Housing Providers
Alcohol &Substance Abuse Programs
Whole population, all payer supported
Home Health
Disease Management Programs
Schools
Area Agencies on Aging
Family Services
Legal Aid

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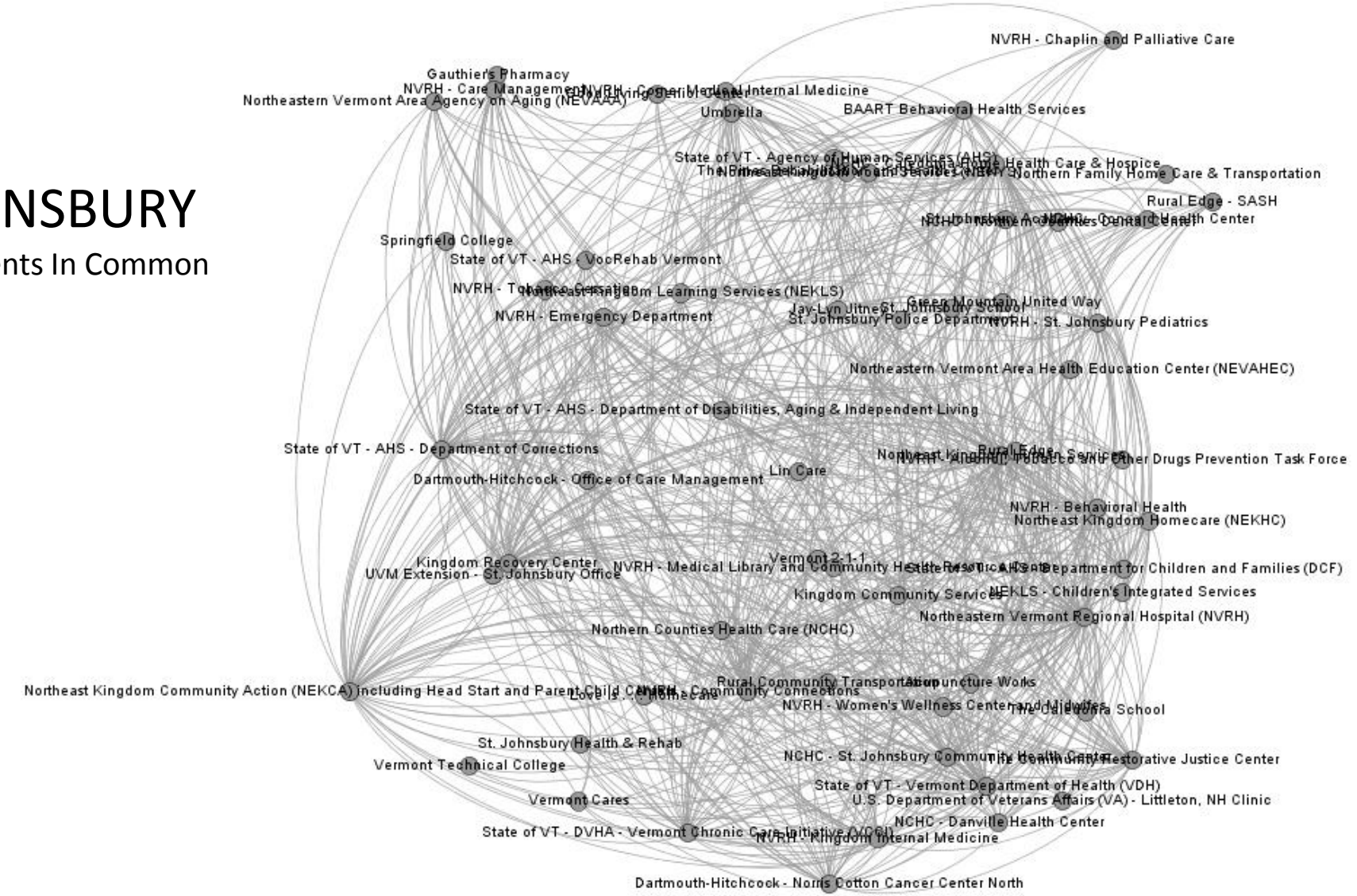
Patients/Clients In Common



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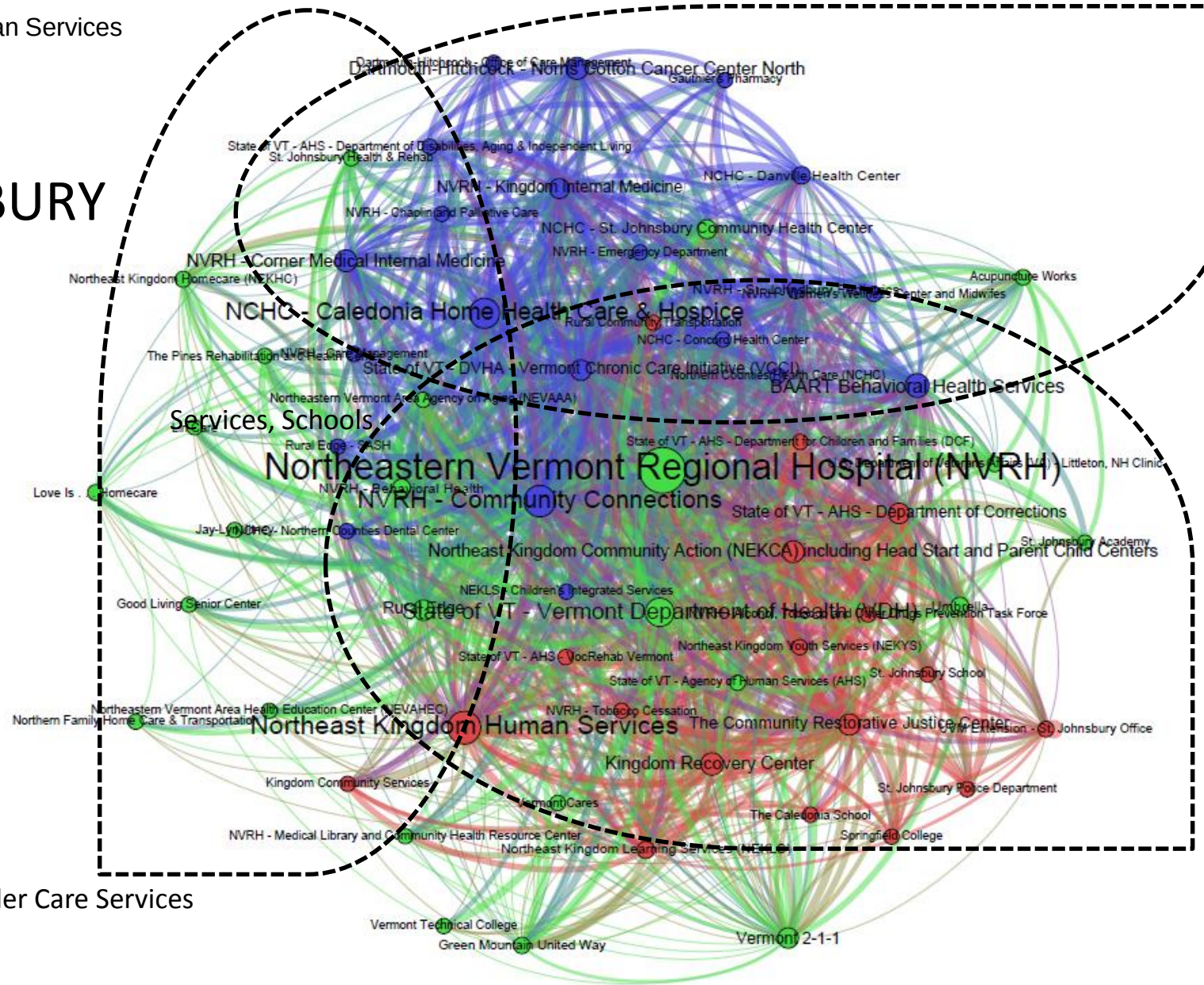
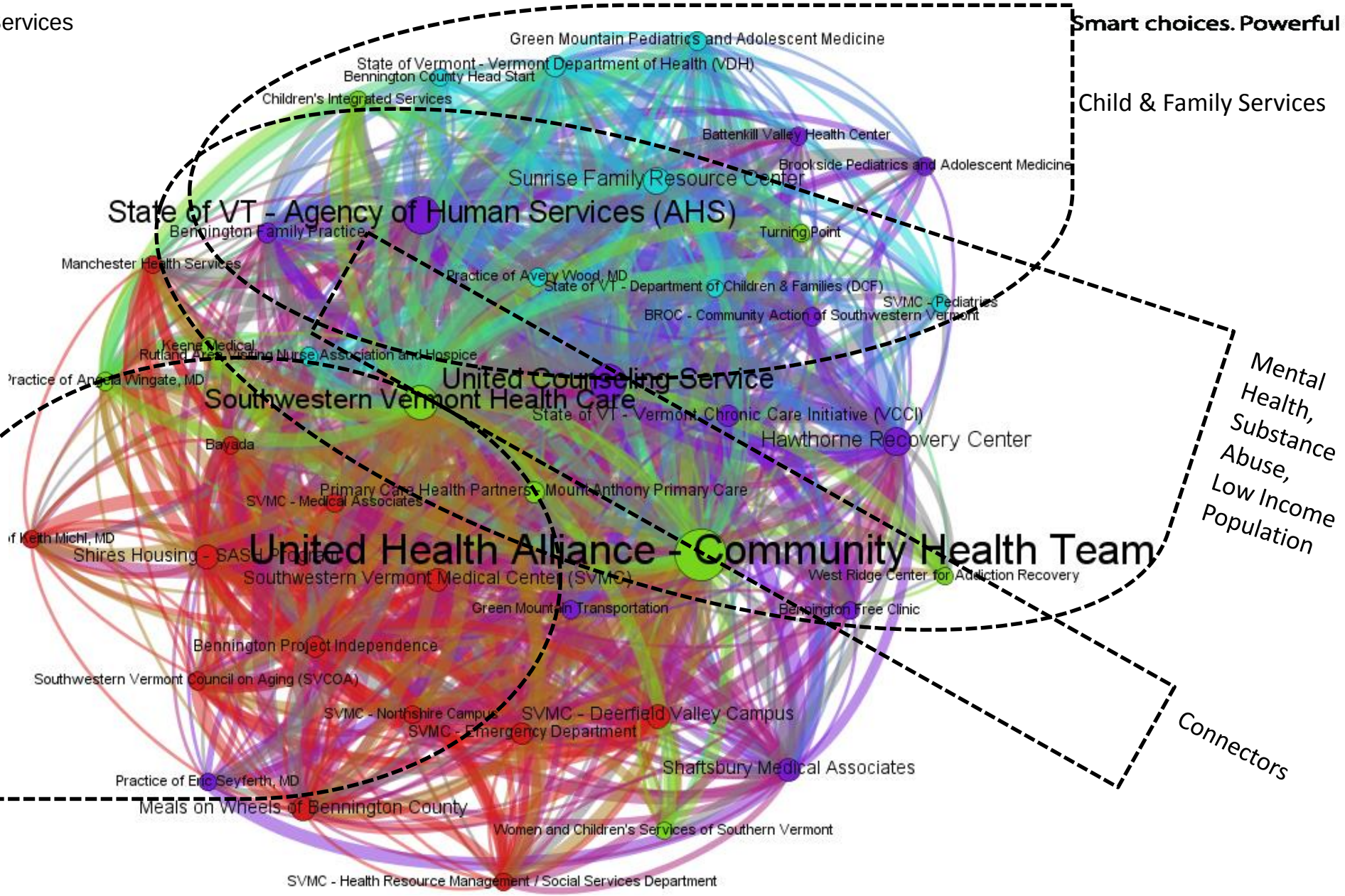
Full Network



BENNINGTON

Full Network



Looking to 2020 and Beyond… initial ideas

- Mature & Expand Adoption of the Care Model
  - Evolve OneCare's Complex Care Payment Model (capacity building → paying for value)
  - Explore expansion to additional payers and increase # Vermonters under an aligned care model (scale)
  - Tests: home health longitudinal care project, Chronic Kidney Disease care coordination intervention, etc…
  - Advance the approach to population segmentation for the pediatric population
- Ensure Sustainability of Community-based Model by Demonstrating:
  - Positive outcomes for patients
  - Financial Return On Investment (ROI)
- Explore Community Health Workers and other approaches to extended care teams
- Continue to evolve IT resources to support effective coordination of care and reduce administrative burdens
  - E.g. Care Navigator, Patient Ping, technology-enabled devices, telemedicine
- Coordinate data sharing across AHS and ACO (e.g. integrate social determinant of health data)

Looking to 2020 and Beyond…

What ideas do you have?