Integration of Blueprint DVHA Care Coordination

DVHA VCCI

Blueprint CHT

Indicators for Referring to DVHA Care Coordination by BP CHT

1. Ages – up to age 64
2. Medicaid beneficiary with one or more chronic condition
3. PCP, hospital or AHS referral
4. Intensive case management, one on one intervention required (e.g. home visits)
5. Limited health literacy with respect to condition(s)
6. Medical, behavioral and psychosocial instability
7. Emerging needs identified that could destabilize future plans for health improvement

Criteria for DHVA Care Coordination

1. Medicaid beneficiary with one or more chronic condition
2. Ages – up to age 64
3. Dual eligible or other third party insurance are ineligible
4. Others with case management covered by CMS are ineligible
5. Predictive modeling score of moderate to very high risk
6. Work with CHT to determine best approach to complex health and psycho-social coordination among multiple service providers including substance abuse treatment (e.g. buprenorphine)

Shared Tools

1. Evidence-based guidelines
2. Patient Action Plans
   - Population Management Reports
   - Patient Care Plans
   - Clinical Data
3. Docsite Clinical Tracking Tool

Transitioning from DVHA Care Coordination to Blueprint CHT

1. General and at least one disease specific assessments performed
2. Care plan implemented and mutually agreed upon by beneficiary and provider
3. Initial teaching to evidence-based guidelines performed; action plan(s) initiated
4. Basic knowledge about condition(s) and motivated to change
5. Care plan goals and objectives related to the primary diagnosis met or partially met
6. Medical home established
7. Medical, behavioral and psychosocial stability established
8. No new needs surfacing that are serious enough to destabilize future plans
9. Home visits no longer required
10. PCP concurs with transition and discharge plans on file from the PCP

CHT Activities

1. Provides ongoing support for general patient population in Patient Centered Medical Homes (PCMHs) across a community
2. Work closely with PCPs to optimize adherence rates with age and gender appropriate health maintenance and prevention
3. Work closely with PCPs to optimize ongoing adherence with individual care plans
4. Work closely with PCPs to monitor and evaluate care plans with modifications as needed
5. Work closely with PCPs to support achievement of self-management goals with reevaluation and modification of self management goals and plans as necessary
6. Linkages to social support and economic services that contribute to health and well being
7. Work closely with PCPs to coordinate care across all domains of the healthcare system
8. Work closely with PCPs to assure that care support is suited by USPSTF recommendations and disease specific guidelines adapted by the Blueprint providers
9. Continuous evaluation of the need to transfer care back to DVHA and/or case closure