Vermont's Integrated Communities Care Management Learning Collaborative

Webinar #1

February 18, 2015

The webinar will begin shortly. Please note that all participants will be placed on mute during the webinar. If you have a question for the presenters, please either "raise your hand" so that we can take you off mute, or type your question into the text box.

Vermont Health Care Innovation Project

Overview of Today's Agenda:

Time Frame	Agenda Item	Speaker
12:00 – 12:10	Welcome, Introductions and Overview	Pat Jones Green Mountain Care Board
12:10 – 12:20	St. Johnsbury Progress Report Presentation	Laural Ruggles, MPH, MBA VP Marketing and Community Health Improvement Northeastern Vermont Regional Hospital
12:20 – 12:30	Burlington Progress Report Presentation	Robyn Skiff, MS Medical Home Self-Management Program Coordinator Community Health Improvement
12:30 – 12:40	Rutland Progress Report Presentation	Sarah Narkewicz, RN MS Director, Bowse Health Trust/Blueprint Manager Rutland Regional Medical Center
12:40-12:55	Overview of Proposed Measures	Jenney Samuelson and Mary Kate Mohlman VT Blueprint for Health
12:55 – 1:00	Preview of Learning Session #2, March 10th, 2015	Nancy Abernathey Quality Improvement Facilitator

Vermont Health Care Innovation Project

Learning Collaborative Overview:

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.
- A number of national models have potential to address these concerns.
- **Health and community service providers were invited to participate in the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models on behalf of at-risk people in 3 communities: Burlington, Rutland and St. Johnsbury.**

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Near-Term Goals:

- Increase knowledge of data sources; use data to identify at-risk people
- Learn about, implement, test and measure promising interventions to better integrate care management:
  - "Integrated Care Agreements" to improve communication between organizations
  - "Shared Care Plans" to improve coordination of care for at-risk people
  - Identification of "Lead Care Coordinator" to serve as a primary point of contact for at-risk people
- Develop training opportunities and tools for front-line care management staff
- Provide opportunities for teams to learn from expert faculty and each other, and receive support from skilled quality improvement facilitators

Longer-Term Goals:

- Longer-term goals mirror the Triple Aim and Vermont's Health Care Reform goals:
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of health care.

- While the Learning Collaborative will initially focus on at-risk populations, the ultimate focus will be on all Vermonters.

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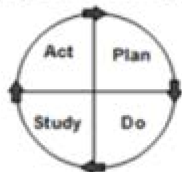
How we will do it – Learning Model:

Pre-Work
(November 22nd - January 12th)

The Learning Collaborative will use the Plan-Do-Study-Act (PDSA) quality improvement model.

Learning Session I
(Teams gather for a face-to-face meeting)
(January 13th)

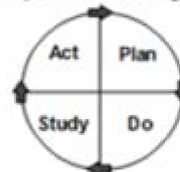
Action Period
community teams working together to implement change)



(January 14th - March 9th)

Learning Session II
(Teams gather for a face-to-face meeting)
(March 10th)

Action Period
community teams working together to implement change)



(March 11th - May 18th)

Learning Session III
(Teams gather for a face-to-face meeting)
(May 19th)

Spreading the Change

Objectives for Today's Webinar:

- Hear from each community about successes and barriers in identifying at-risk people and establishing Integrated Care Agreements among participating organizations
- Learn about the measures that will be used to assess Learning Collaborative progress
- Obtain a preview of the March 10th in-person Learning Session in Northfield, VT

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ST. JOHNSBURY PROGRESS REPORT

Presented by:

Integrated Communities Care Management Learning Collaborative

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Team Reports: Building Coalitions and Identifying and Engaging At-Risk People

A little bit about our Health Service Area…

- Just under 30,000 people in Caledonia and s. Essex counties. Health priorities include poverty, obesity/chronic disease, mental health/substance abuse.
- **Collaborative participants:**
  - AHS
  - Northeast Kingdom Human Services (mental health)
  - Northeastern VT Regional Hospital
  - Northeastern Vermont Area Agency on Aging
  - Northern Counties Health Care (FQHC & home health)
  - RuralEdge (housing and SASH)
  - VCCI

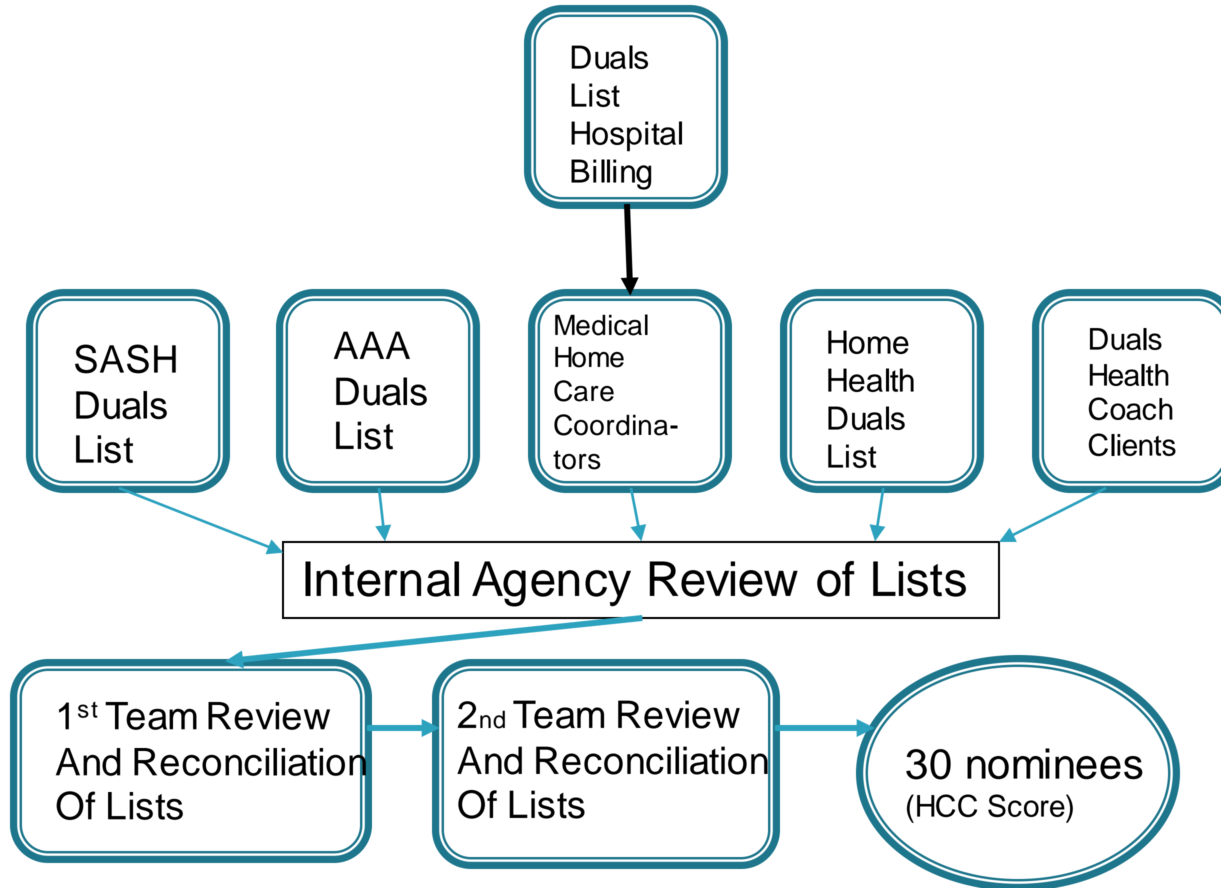
- **Unique**:
  - Existing working relationships and collaboration
  - Community Connections program
  - Additional financial resources from VHCIP grant including staff and flexible funding
  - Low number of dual eligible with current case management

Baseline Data: Identifying People At-Risk

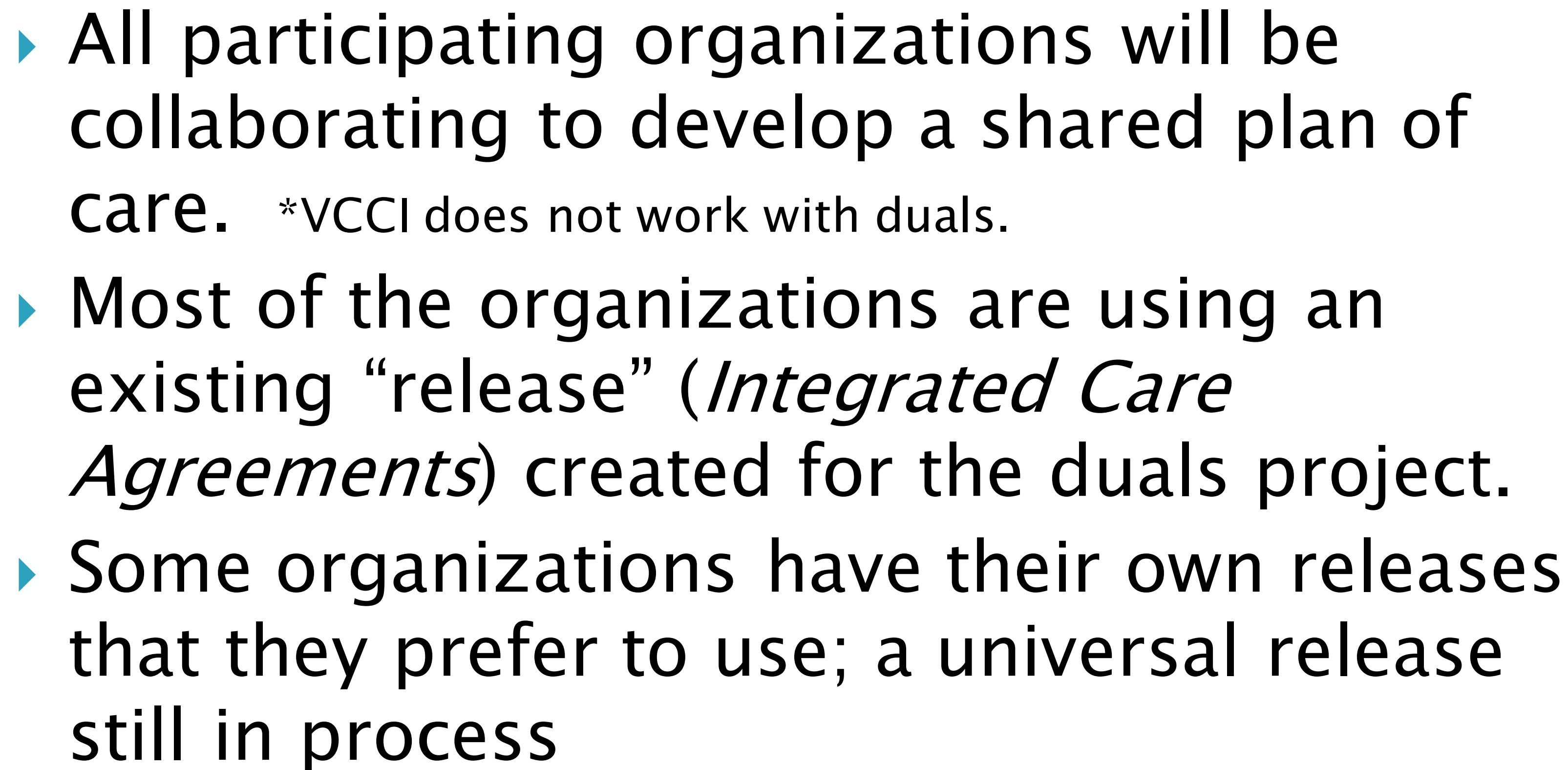
- Defining At Risk: People dually eligible for Medicare and Medicaid are often considered our most vulnerable citizens. Initial list from hospital billing system identified about 1000 people.

- Successes and challenges in defining at-risk people:
  - Still some discomfort in sharing patient names

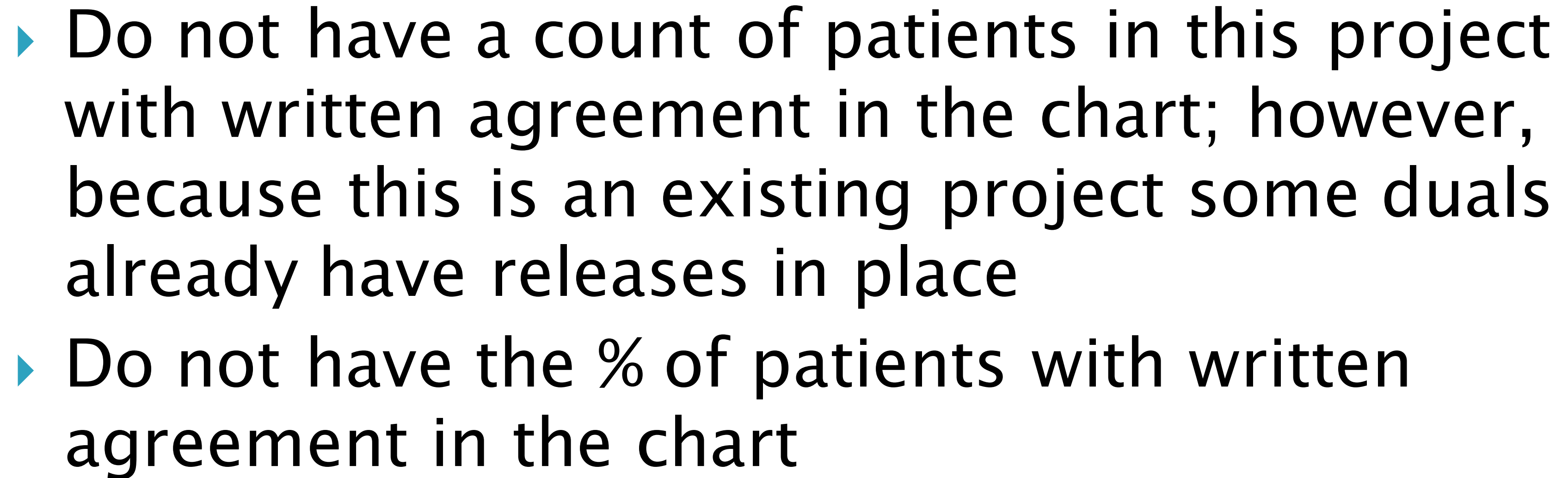
Baseline Data: Identifying People At-Risk



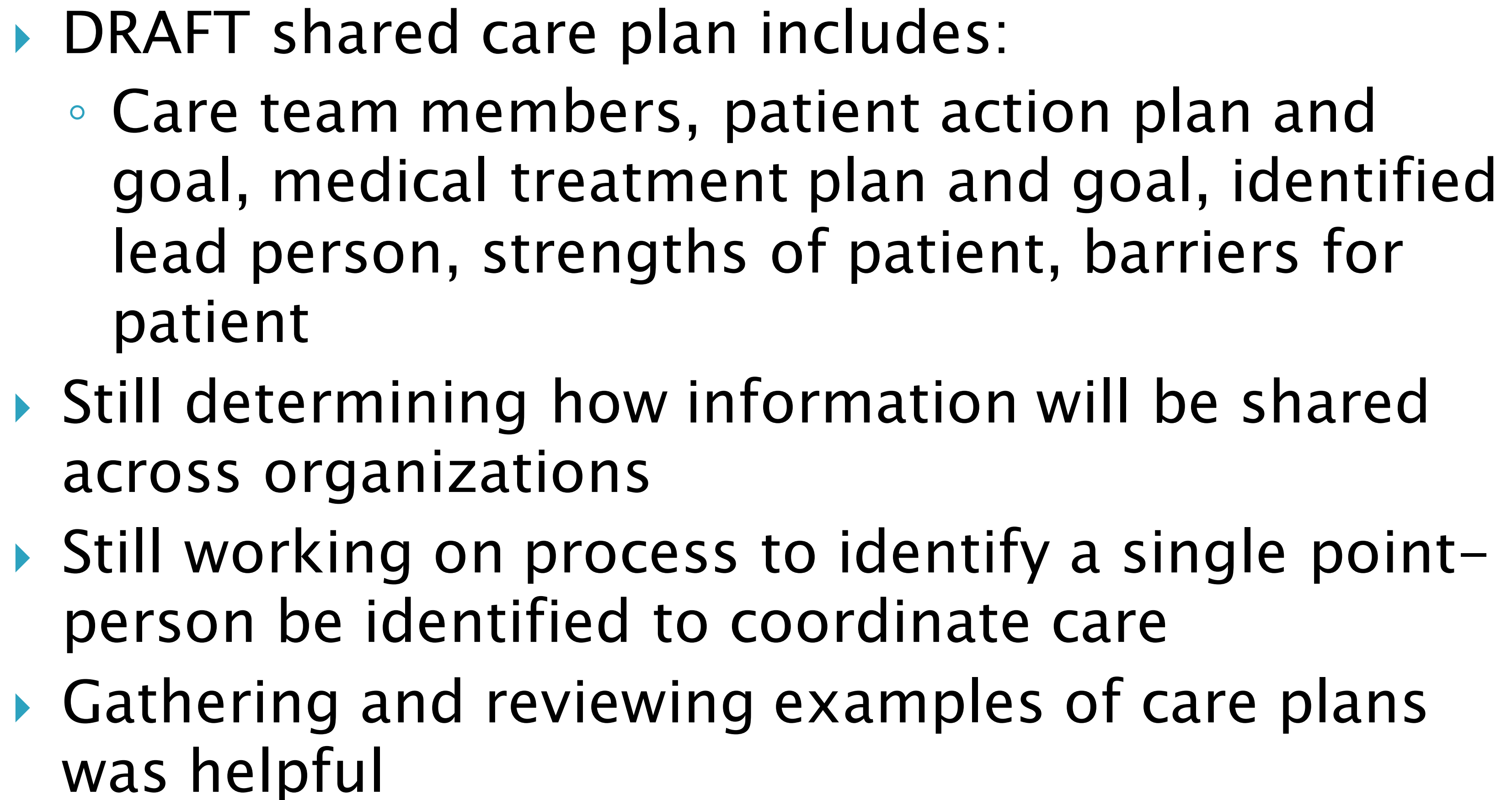
Baseline data: Building Health Care Coalitions (Information Sharing)



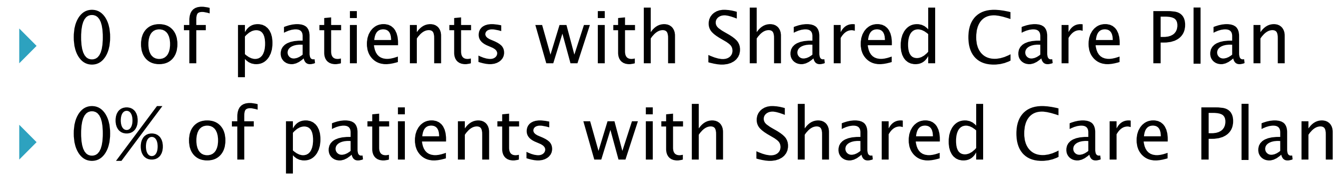
Integrated Care Agreements



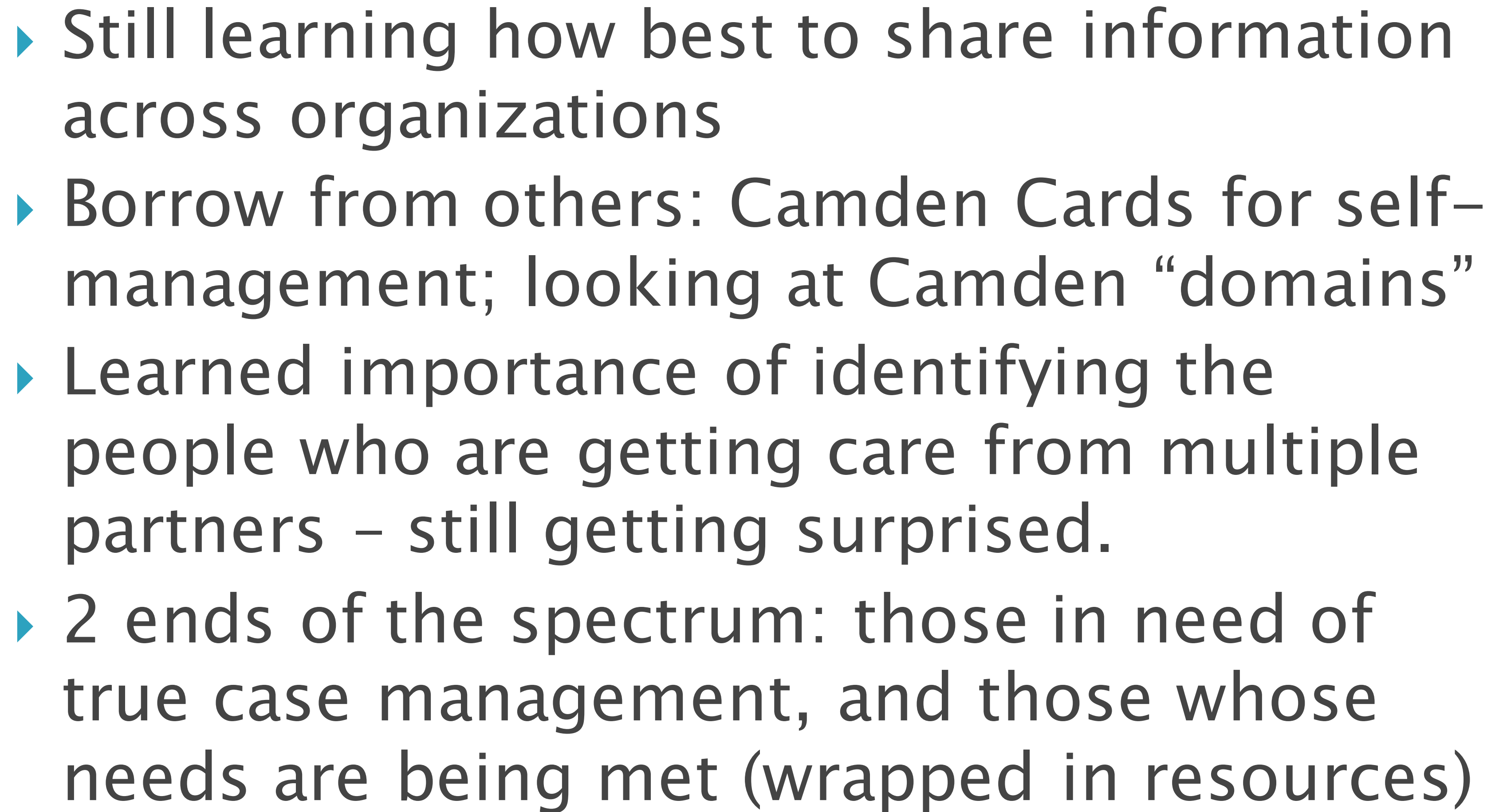
Baseline Data: Shared Care Plan



Shared Care Plan



What else our team has been working on: successes, challenges, lessons learned



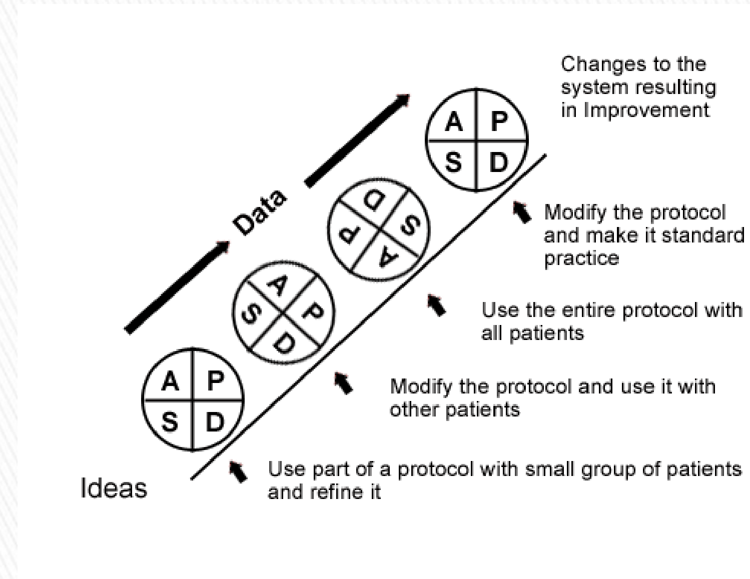
Implementing the Plan-Do-Study-Act Model

Aim: Identify and recruit participants

- First PDSA cycle – as outlined on Slide 4
- Second PDSA cycle– team will meet to identify who will take the lead to recruit the participants
- Third PDSA cycle – create a “script” to help recruit
- Fourth PDSA cycle – create a common release agreement
- Fifth PDSA cycle - obtain a signed release agreement

- Next Steps:
  - PDSA related to Shared Care Plans
  - PDSA related to Camden Cards

PDSA



BURLINGTON PROGRESS REPORT

Presented by:

Robyn Skiff, MS

Integrated Communities Care Management Learning Collaborative

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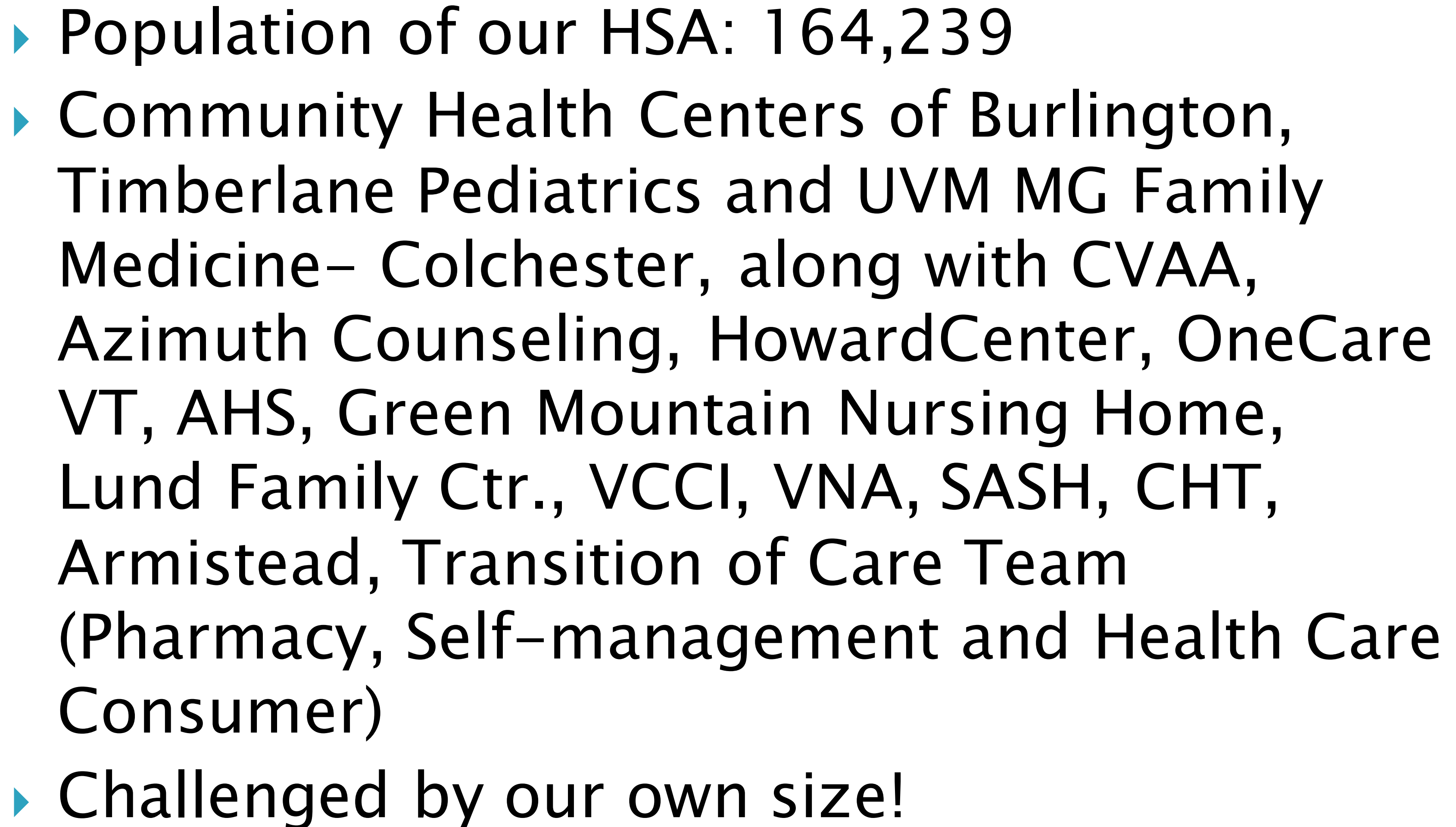
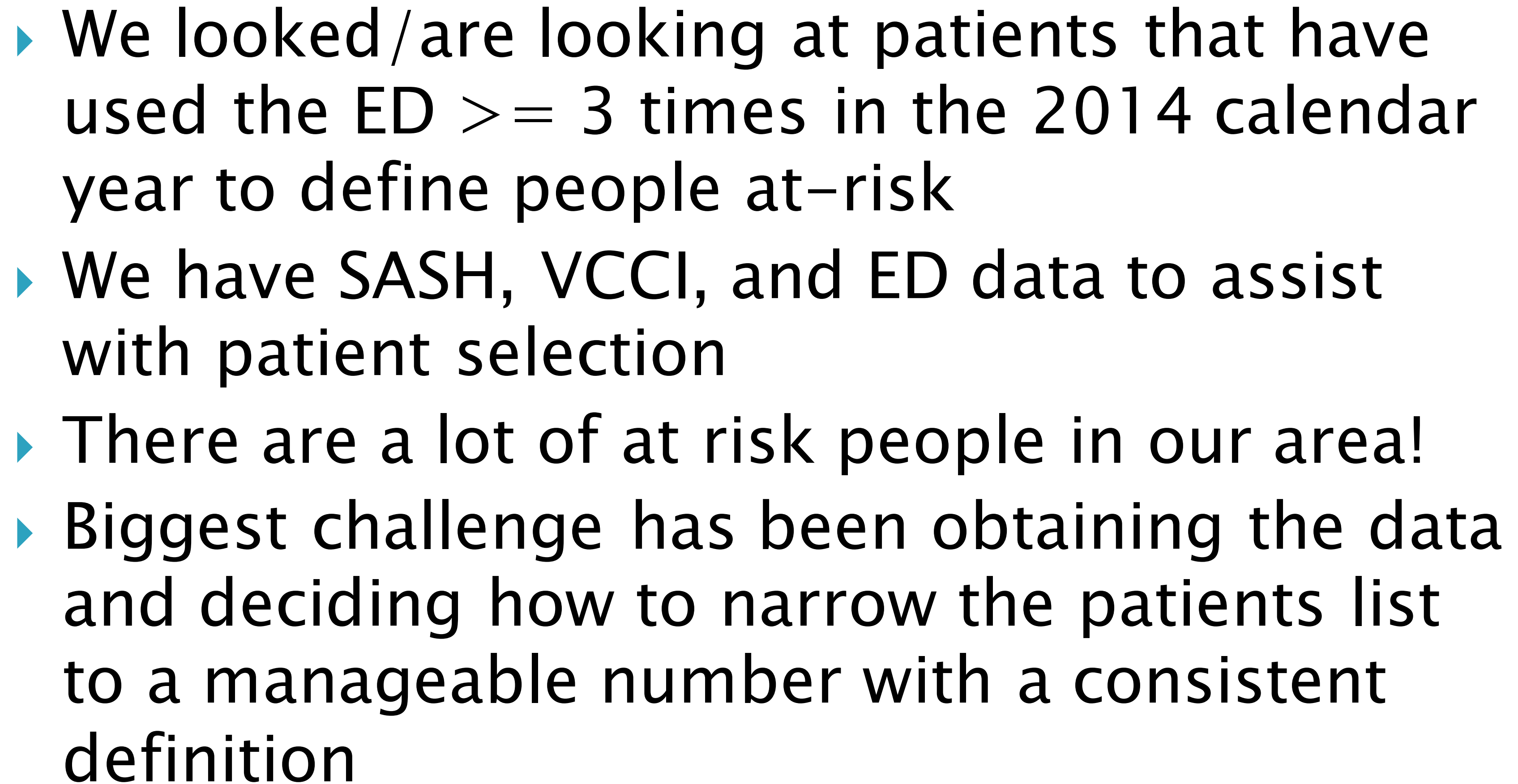
Team Reports: Building Coalitions and Identifying and Engaging At-Risk People

A little bit about our Health Service Area…

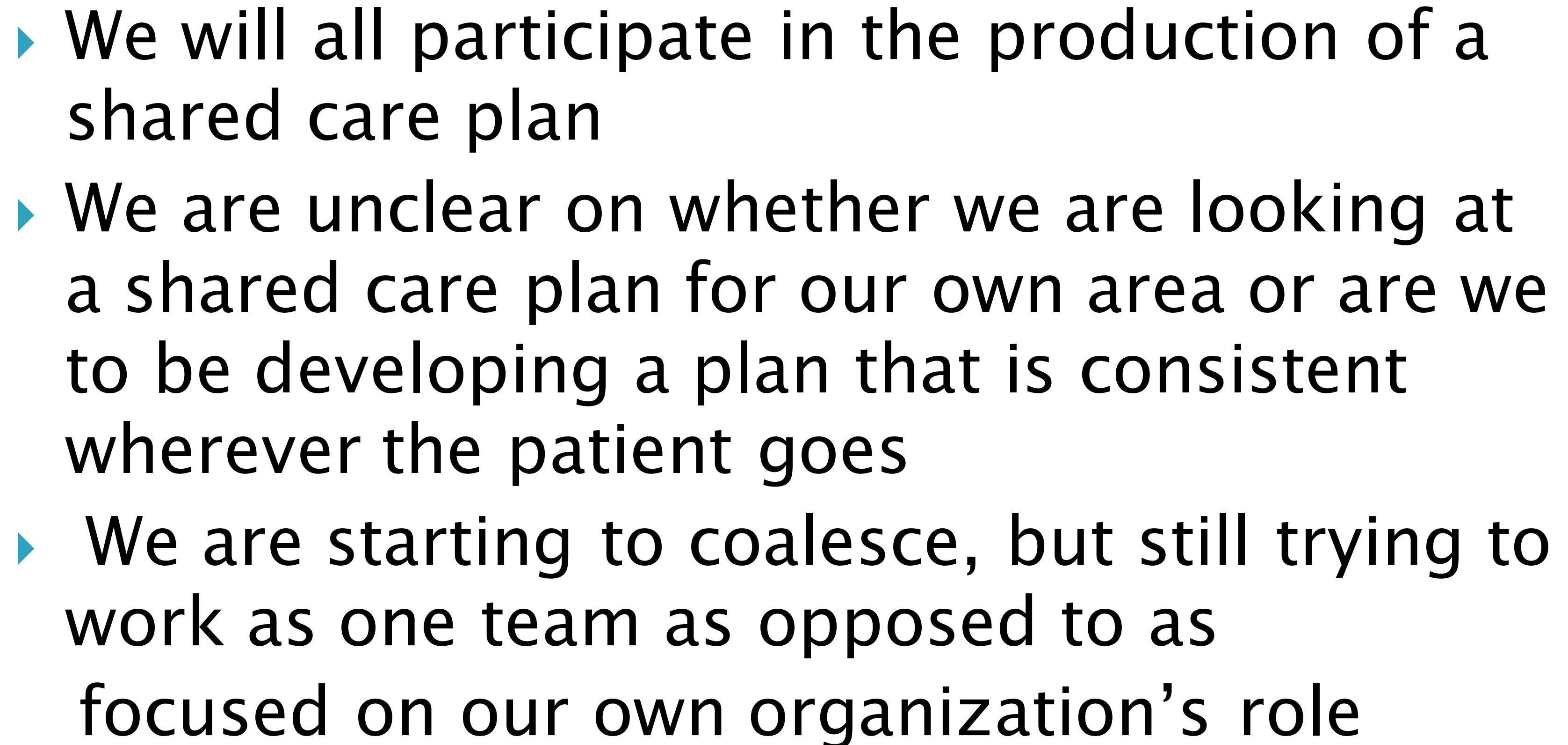


- Population of our HSA: 164,239
- Community Health Centers of Burlington, Timberlane Pediatrics and UVM MG Family Medicine- Colchester, along with CVAA, Azimuth Counseling, HowardCenter, OneCare VT, AHS, Green Mountain Nursing Home, Lund Family Ctr., VCCI, VNA, SASH, CHT, Armistead, Transition of Care Team (Pharmacy, Self-management and Health Care Consumer)
- Challenged by our own size!

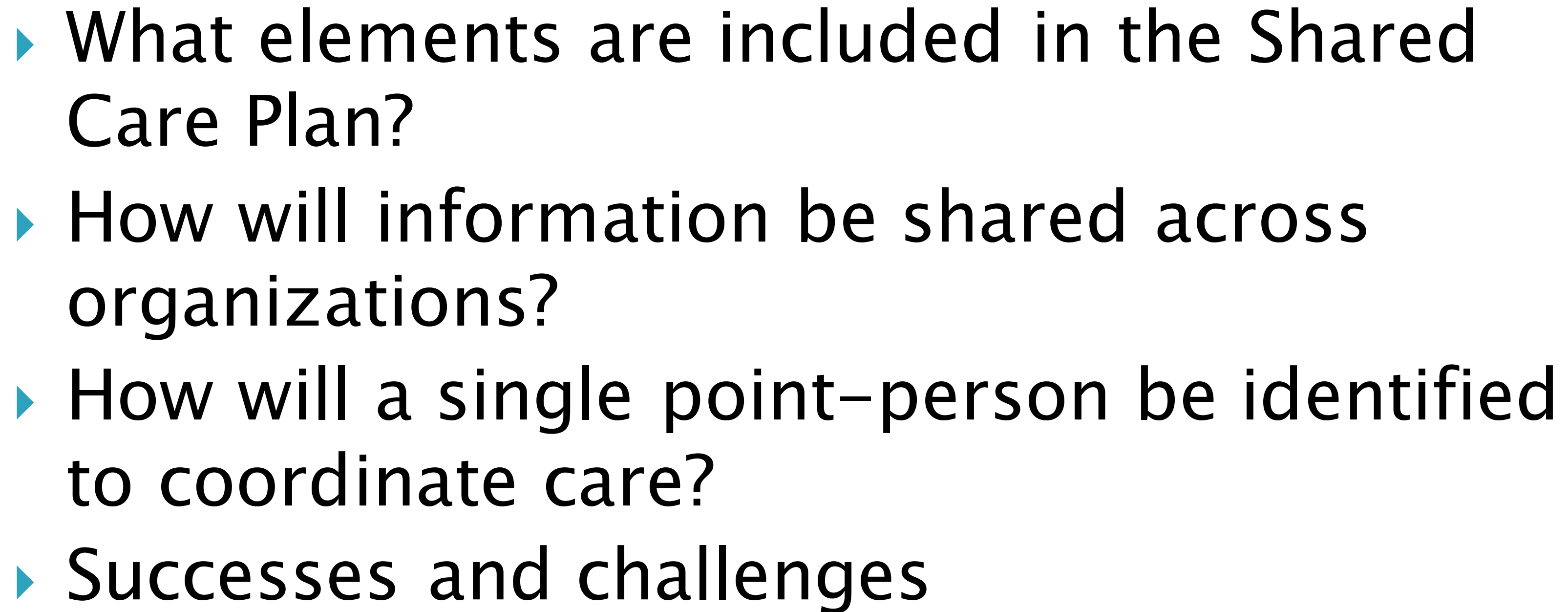
Baseline Data: Identifying People At-Risk



Baseline data: Building Health Care Coalitions (Information Sharing)

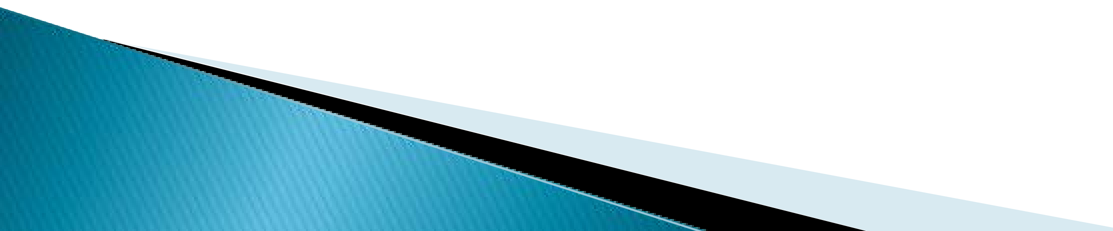


Baseline Data: Shared Care Plan

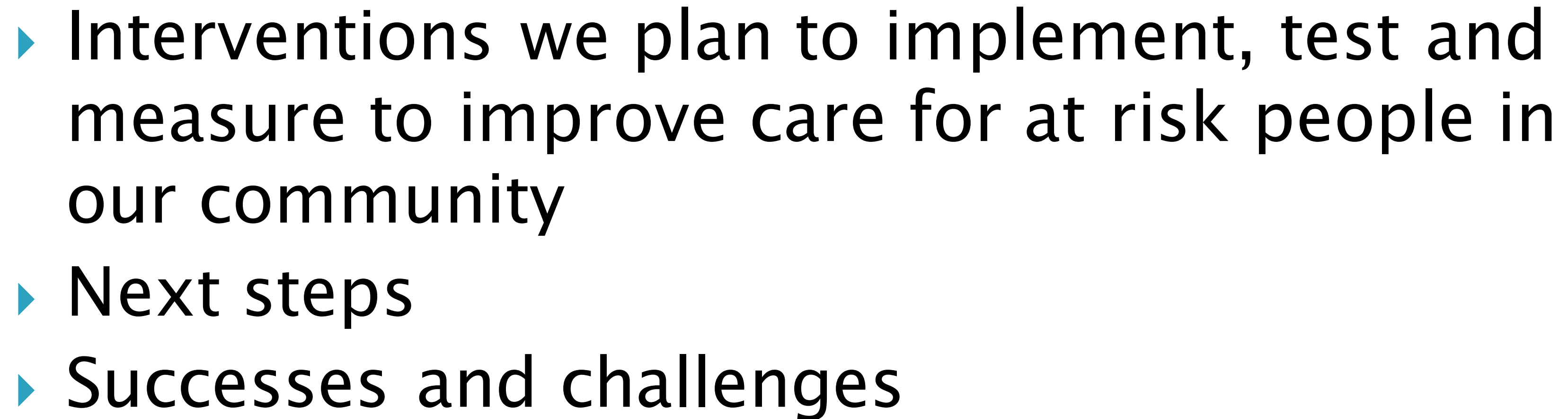


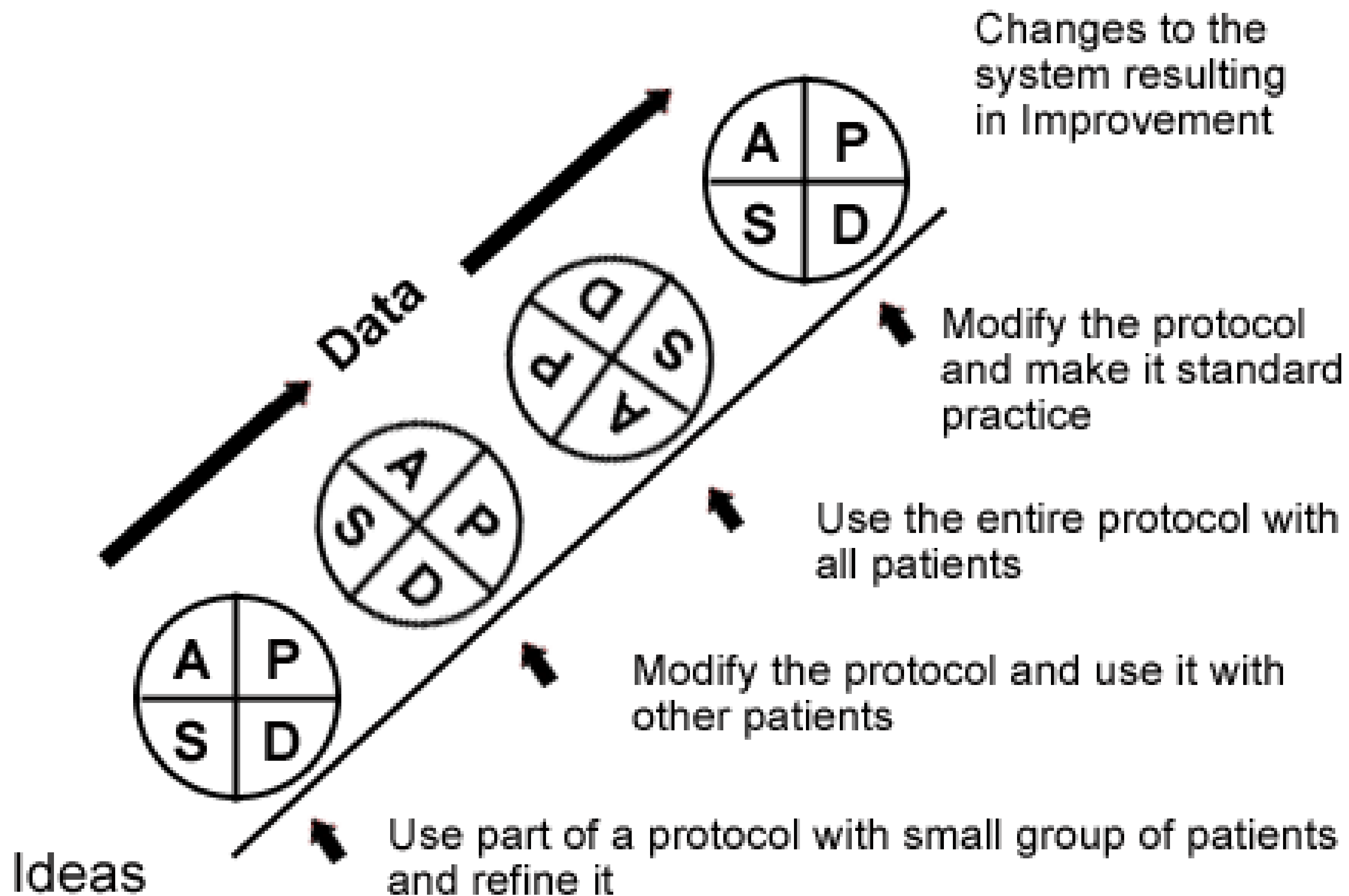
- What elements are included in the Shared Care Plan?
- How will information be shared across organizations?
- How will a single point-person be identified to coordinate care?
- Successes and challenges

What else our team has been working on: successes, challenges, lessons learned



Implementing the Plan-Do-Study-Act Model



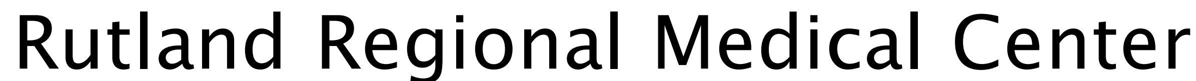

Changes to the system resulting in Improvement
A
P
S
D
Data
Modify the protocol and make it standard practice
Use the entire protocol with all patients
Modify the protocol and use it with other patients
Use part of a protocol with small group of patients and refine it
Ideas

RUTLAND PROGRESS REPORT

Presented by:

Sarah Narkewicz, RN MS,CDE

Director, Bowse Health Trust/Blueprint Manager



Rutland Regional Medical Center

Integrated Communities Care Management Learning Collaborative

Webinar #1
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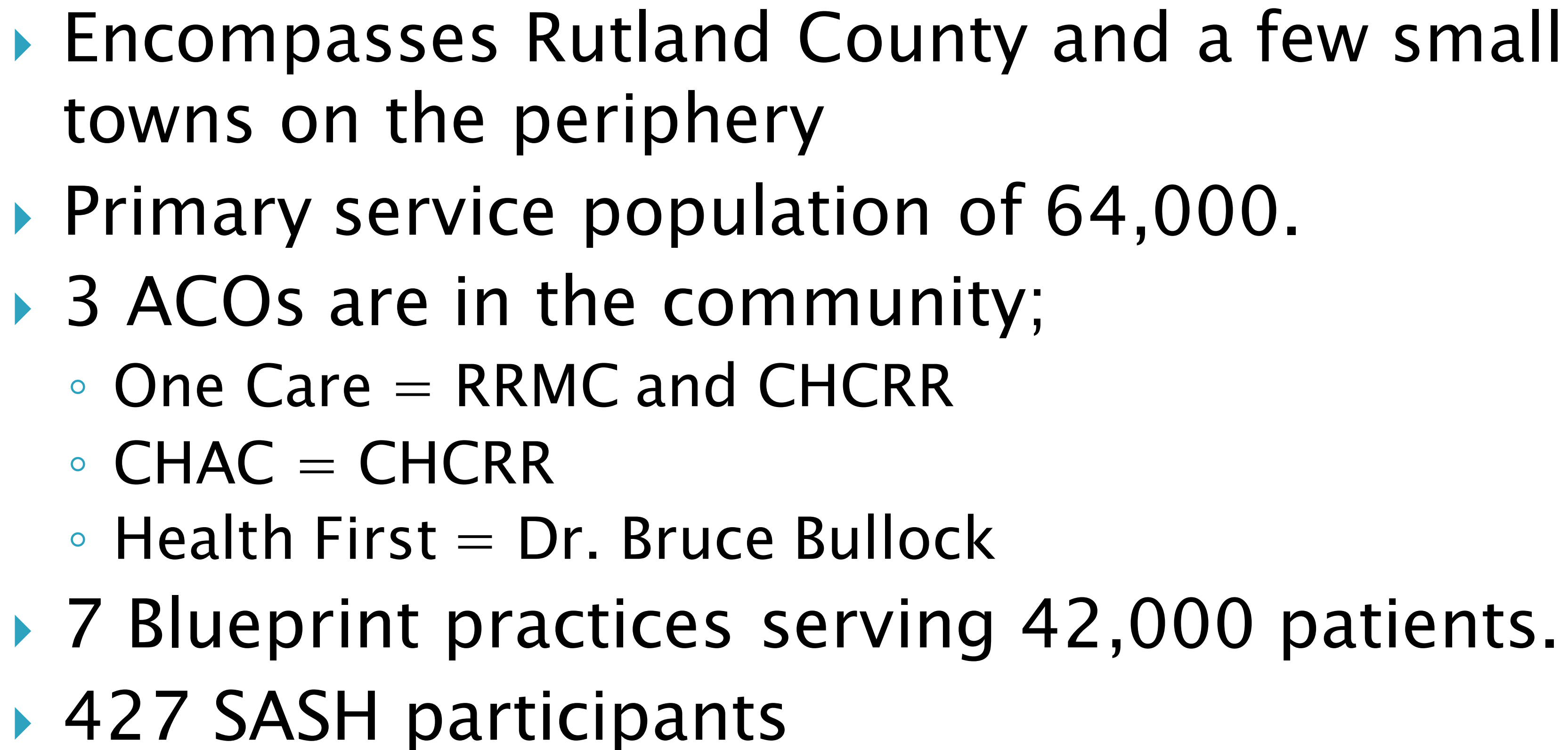
Rutland Report: Building Coalitions and Identifying and Engaging At-Risk People

A little bit about our Health Service Area…



Agencies participating in the collaborative

- 1. AHS and VDH
- 2. VCCI
- 3. RAVHAH
- 4. Bayada
- 5. SASH
- 6. SVCOA
- 7. Mountain View Genesis
- 8. The Pines
- 9. Rutland Mental Health
- 10. RRMC
    - CHT
    - Case management
    - Quality Improvement
    - Emergency Department

Unique characteristics, strengths or challenges within our HSA

Working Well:

- Willingness to work together
- Many resources available
- High Quality Caring providers
- Needs Assessment/ID High Risk
- Collaborative Efforts (COPD/CHF)
- Existing meetings

Needs:

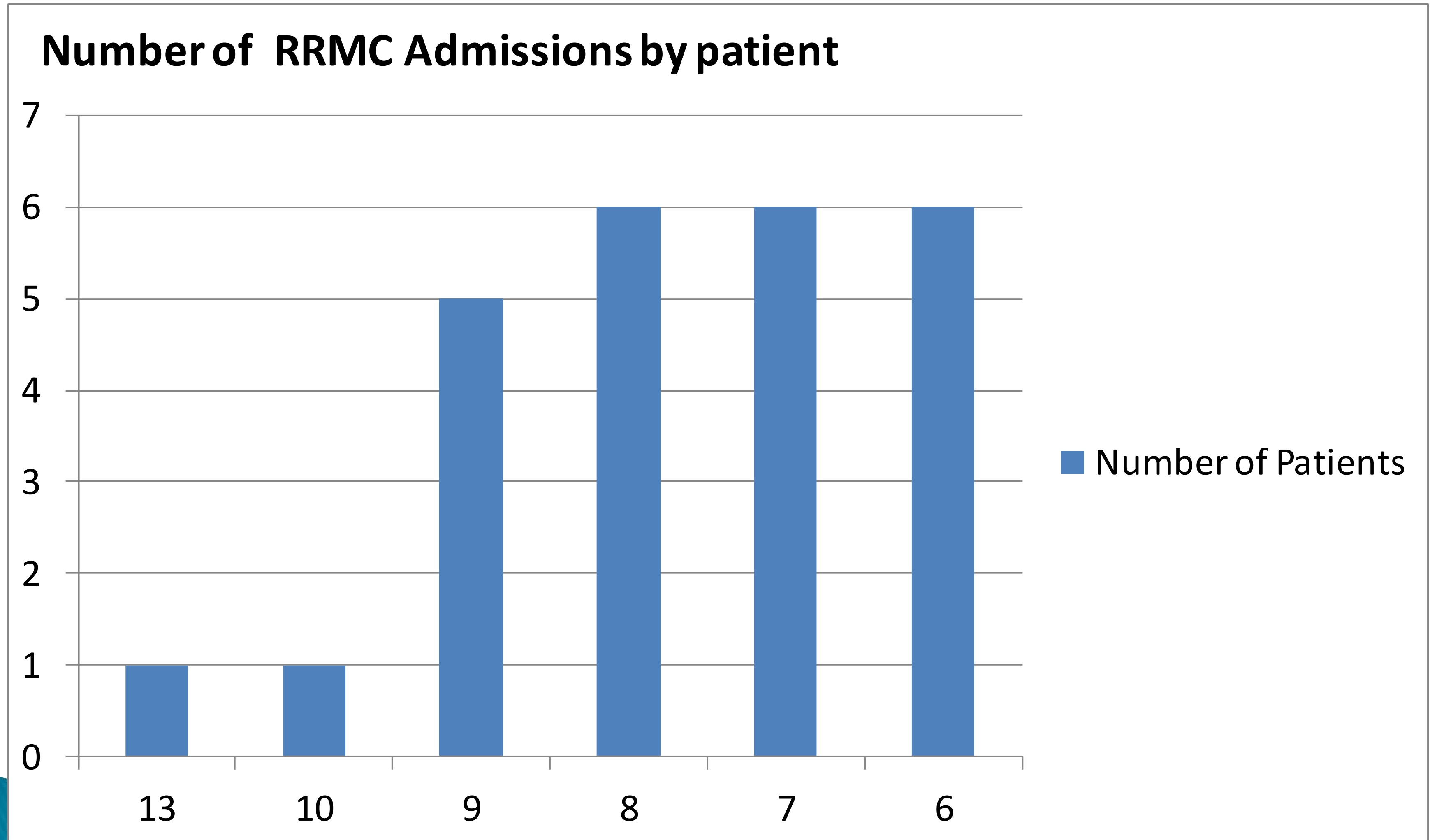
- Cooperation/Agreement
- Communication & access to information
- Handoffs & transitions
- Services
  - reduce duplication
  - smarter utilization
  - Identify gaps
- Increased knowledge of services
- Education of participants

Baseline Data: Identifying People At-Risk

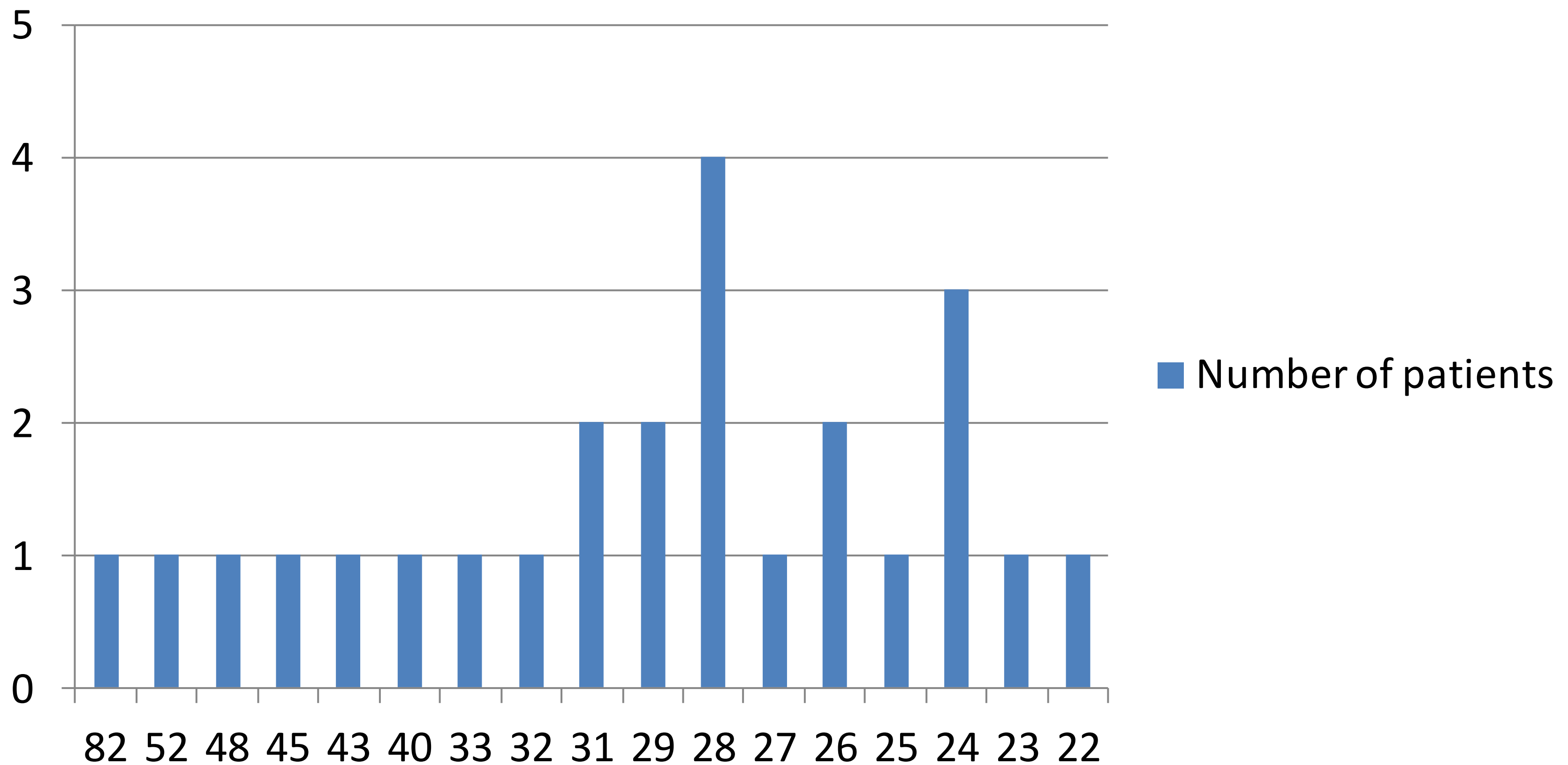
- 1st Collaborative: team voted to focus on the patients with the highest In Patient and ED utilization (omit: COPD, CHF, ESRD, Transplant, Catastrophic Ca, MS)

- Reviewed top 25 patients who had the most inpatient visits and ED visits 2014
  - Summary of top 25 presented to team
- Start by engaging 5 patients with high utilization that have been challenging to engage
  - Plan to engage 25 or more through out Collaborative

Top 25 Patients with In Patient Admissions for 1/1/14 to 12/13/14



Top 25 Patients with ED Visits for 1/1/14 to 12/13/14 828 ED visits(average of 33 visits/patient)



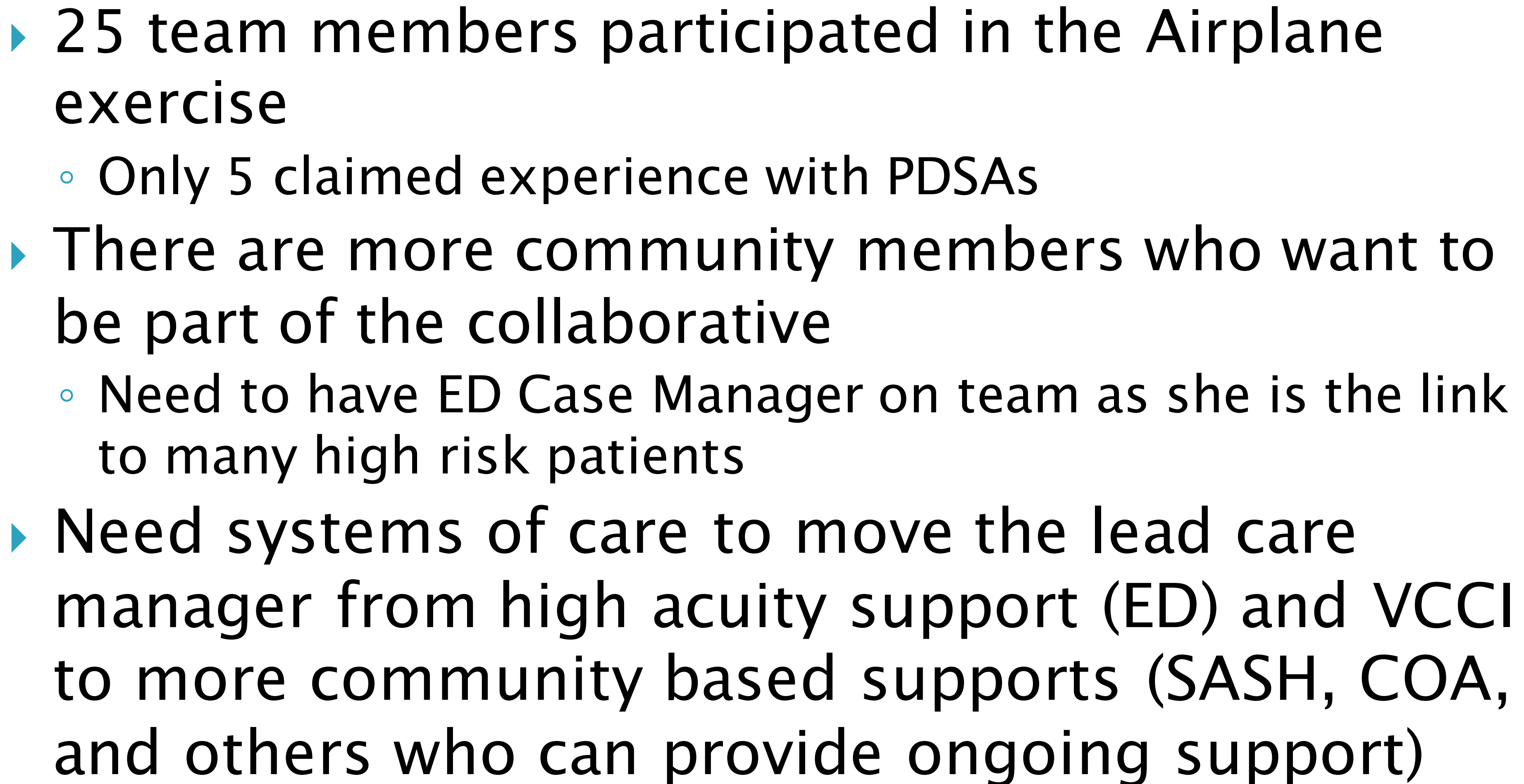
Baseline data: Building Health Care Coalitions (Information Sharing)

- Plan of care will be shared with all those involved in the patient's care
- Multiple consent forms exist to allow sharing of information
  - CHT Consent form
  - SASH Patient release
  - Rutland Area Facilitating Treatment patient release
  - LIT Team release
- Successes and challenges
  - With multiple forms there can be duplication of asking patients permission to share information; who owns that?
  - The community does not have a standardized form for a shared plan of care
  - Many EMRs will make a standard form a challenge
  - LIT team provides a great example about care conferencing

Baseline Data: Shared Care Plan

- What elements are included in the Shared Care Plan?
  - Future work
- How will information be shared across organizations?
  - Future work
- How will a single point-person be identified to coordinate care?
  - Much discussion about this, needs to be determined by the patient, and need a process to hand off patients. ED Case Manager cannot be patients center of support.
- Successes and challenges

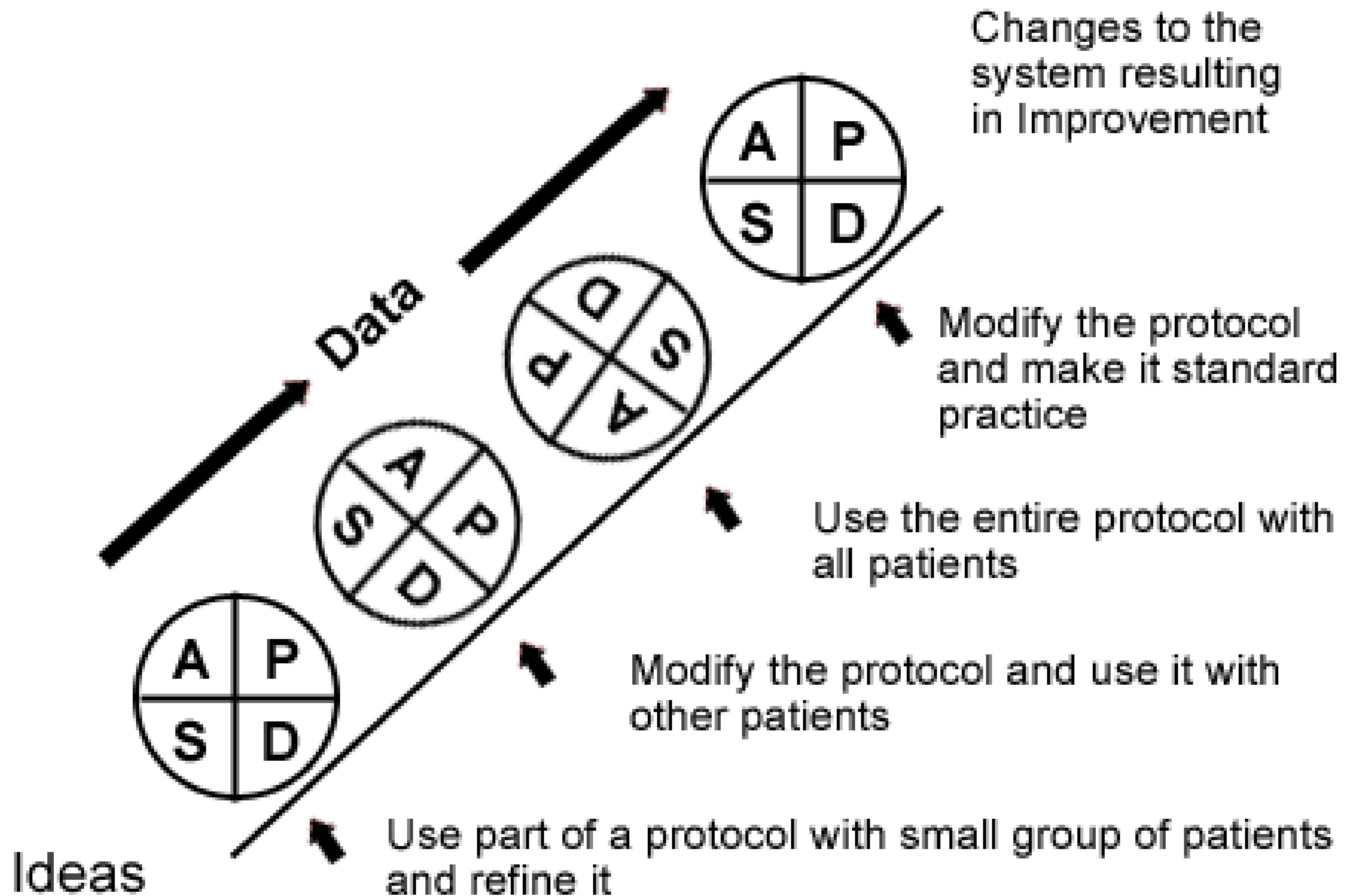
What else our team has been working on: successes, challenges, lessons learned



- 25 team members participated in the Airplane exercise
  - Only 5 claimed experience with PDSAs
- There are more community members who want to be part of the collaborative
  - Need to have ED Case Manager on team as she is the link to many high risk patients
- Need systems of care to move the lead care manager from high acuity support (ED) and VCCI to more community based supports (SASH, COA, and others who can provide ongoing support)

Implementing the PDSA Model

- First PDSA is to engage 5 patients
  - For 2 patients this means contacting the ‘team’ members that have routine contact with the patient to discuss how we can work together to engage the patient.
  - For 3 patients it means reaching out to the patient and begin the conversation about identifying the patient’s needs.
  - Include/engage new players for the team to develop new approaches.
- Next steps
  - Report out on progress at next meeting
  - Camden cards shared with team
    - to print and distribute at next meeting
- Successes and challenges
  - These are patients who are the most challenging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Ideas

Sample of Code Book for Data Collection Tool

Columns	Code Book for Care Coordination Learning Collaborative Data Collection Tool	
B-F	Lead Care Coordinator	
B	LCC Last Name	Last name of the Lead Care Coordinator
C	LCC First Name	First Name of the Lead Care Coordinator
D	LCC Organization	Organization that employs Lead Care Coordinator
E	Shared Care Plan	Is an up-to-date shared care plan included in the person's/patient's record maintained by the Lead Care Coordinator? 1. Shared Care Plan includes the following elements: • Date updated • Patient/family goal(s) • Clinical goal(s) • Action plan for achieving above goals • Overall current progress on reaching goals • Contact/communication information • Name of Lead Care Coordinator • List of members of care team and their organization 2. To be considered up-to-date the Shared Care Plan' 'Date Updated' should no older than the number of days identified in the 'Interval Between Care Conferences'. Response Key: • Enter "0"for No (N) if no Shared Care Plan has been developed for person/patient, or Lead Care Coordinator does not have copy, answer; • Enter "1" for Partial (P) if any element is missing or out-of-date; • Enter "2" for Complete (C) if all elements are present and up-to-date.
F	Date of Most Recent Care Conference	Date of the most recent Care Conference defined as a regularly scheduled evaluation of participant/patient's progress by participating care organizations
G	Interval Between Care Conferences (days)	Maximum number of days between Care Conferences
H-Y	Organizations (Please identify Other Organization in place holders in columns R-Y)	

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Sample of Data Collection Tool

Lead Care Coordinator - Data Collection Tool

	Lead Care Coordinator (LCC)‡						Designated Mental Health Agency (DA)		PCMH	
Patient	Last Name	First Name	Organization that employs LCC	Shared care plan (N/P/C)	Date of most recent care conference (MM/DD/YYYY)	Interval between care conferences (Days)	Particpating in care team (Y/N)	Updated progress report on file (N/P/C)	Particpating in care team (Y/N)	Updated progress report on file(N/P/C))
1	Doe	Jane	SASH	1	6/4/2014	180	0	0	1	1
2	Smith	Sarah	HHA	1	10/15/2014	90	1	1	1	2
3	Brown	Bob	DA	1	12/5/2014	360	1	0	1	2
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25	Miller	Mary	SASH	0	0	0	0	0	0	0

No (N) = 0
Partial (P) = 1
Complete(C) = 2

Vermont Health Care Innovation Project

Next Steps: Feb 20th-March 9th

- Quality improvement facilitators will review measures in more detail with project managers who will be available to assist community teams
- All sites will begin data collection using chart review tool
- Communities will continue PDSA cycles to test one change related to: Patient Engagement, Lead Care Coordinator, Shared Care Plan, or Integrated Care Agreements

Vermont Health Care Innovation Project

March 10th In-Person Learning Session

- Format is similar to January 13th Session:
  - All-day; 8:30 AM to 4:00 PM
  - Morning and afternoon presentations on components of Integrated Care Agreements, identification and role of Lead Care Coordinator, and communication strategies for care coordination across multiple organizations
  - Morning and afternoon breakout sessions for Community Teams
  - Closing report-out from each team

March 10th In-Person Learning Session (cont.)

- Location will be different, due to our size!
  - Norwich University in Northfield, VT – Cabot Building (students are on break – ample parking available!)
  - Auditorium for community-wide presentations; nearby classrooms for breakout sessions; lunch in nearby student center
  - If it works well, we will hold our May 19th Learning Session there as well
- Please bring with you:
  - binders from Learning Session 1
  - copies of PDSA tests of change
  - agreements, forms, patient engagement tools- anything you want to share with other groups

Vermont Health Care Innovation Project

Closing Remarks

- Thank you all for your participation in today's webinar. We will distribute slides from today's presentations via email as soon as possible.
- Should you have any further questions on material covered in today's webinar, please contact your community lead:

  -Burlington: Deb Andrews, Deborah.Andrews@uvmhealth.org

  -Rutland: Sarah Narkewicz, snarkewicz@rrmc.org

  -St. Johnsbury: Laural Ruggles, L.Ruggles@nvrh.org

Or contact Nancy Abernathey, Quality Improvement Facilitator, at n.abernathey@gmail.com

Vermont Health Care Innovation Project