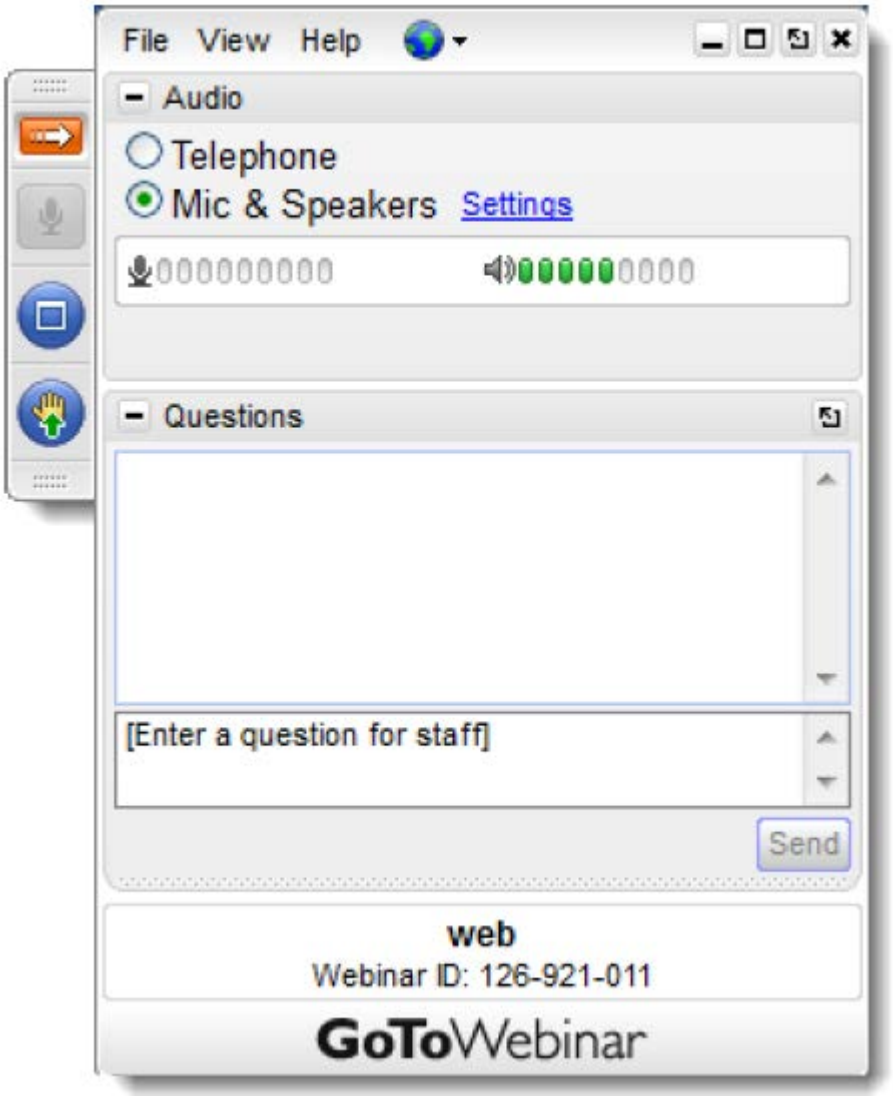
Vermont Health Care Innovation Project Core Competency Training Series

"Providing High Quality Care Management Across and Between Organizations: Challenges and Tips for Success"

June 14th, 2016

Vermont Health Care Innovation Project

Before we get started…



- By default, webinar audio is through your computer speakers.
- If you prefer to call-in via telephone, click "Telephone" in the Audio pane of your control panel for dial-in information.

Before we get started…

- **We've reserved time for Q&A at the end of this event.** Please submit questions via the Questions pane in webinar control panel.
- **This webinar is being recorded.** Slides and recording will be used for training purposes

Today's Learning Objectives

- **Improving Cross-Organization Care Coordination** is a focus nation-wide.
- Vermont has a strong infrastructure of both medical and community based services and supports working together to address health issues and the social determinants of health.
- The **Integrated Communities Care Management Learning Collaborative** that many of you are participating in is supporting this challenging work.
- New York is engaged in similar work. Today we will hear from a panel of providers from New York, and look forward to sharing our experiences and learning around common challenges and emerging best practices.

Today's Agenda

Time Frame	Agenda Item
12:00 – 12:05	Welcome and Introductions
12:05 – 12:45	Moderated Panel Discussion
12:45 – 12:55	Q&A
12:55 – 1:00	Wrap-Up and Next Steps

Speakers

- Host: Erin Flynn, MPA

  ACO and Practice Transformation Director,
  Department of Vermont Health Access

Moderator: Karla Silverman, MS, RN, CNM,
Interim Chief Program Officer,

Primary Care Development Corporation

Speakers

Panelist: Karlo Francis, LMSW

Deputy Director of Care Coordination

Community Healthcare Network, NYC, NY

Panelist: Jillian Gross, MSW

Operations Manager

Central New York Health Home Network

Herkimer, Oneida, Madison, and Cayuga Counties, NY

Panelist: Ari Rosner, LCSW

Co-Director of Health Homes Program

Mt. Sinai Medical Center,NYC, NY

New York Health Homes Program

- Care management program for patients with multiple chronic conditions or a mental health condition or HIV
- Care management providers receive a monthly fee for each patient enrolled in the program
- Provide care coordination including conducting an intial assessment, creating and updating care plans, coordinating care and linking patients to resources
- Goal: Reduce ER and in-patient admissions, improve outcomes and decrease costs

PCDC Integrated Care Planning Initiative

- Learning collaborative with five safety-net provider organizations in New York State
- Goal: Improved communication and collaboration between medical, behavioral health and care management providers
- Change teams worked at their pilot sites to identify challenges and develop and test strategies and solutions
- Solutions rolled out and spread to rest of the organization

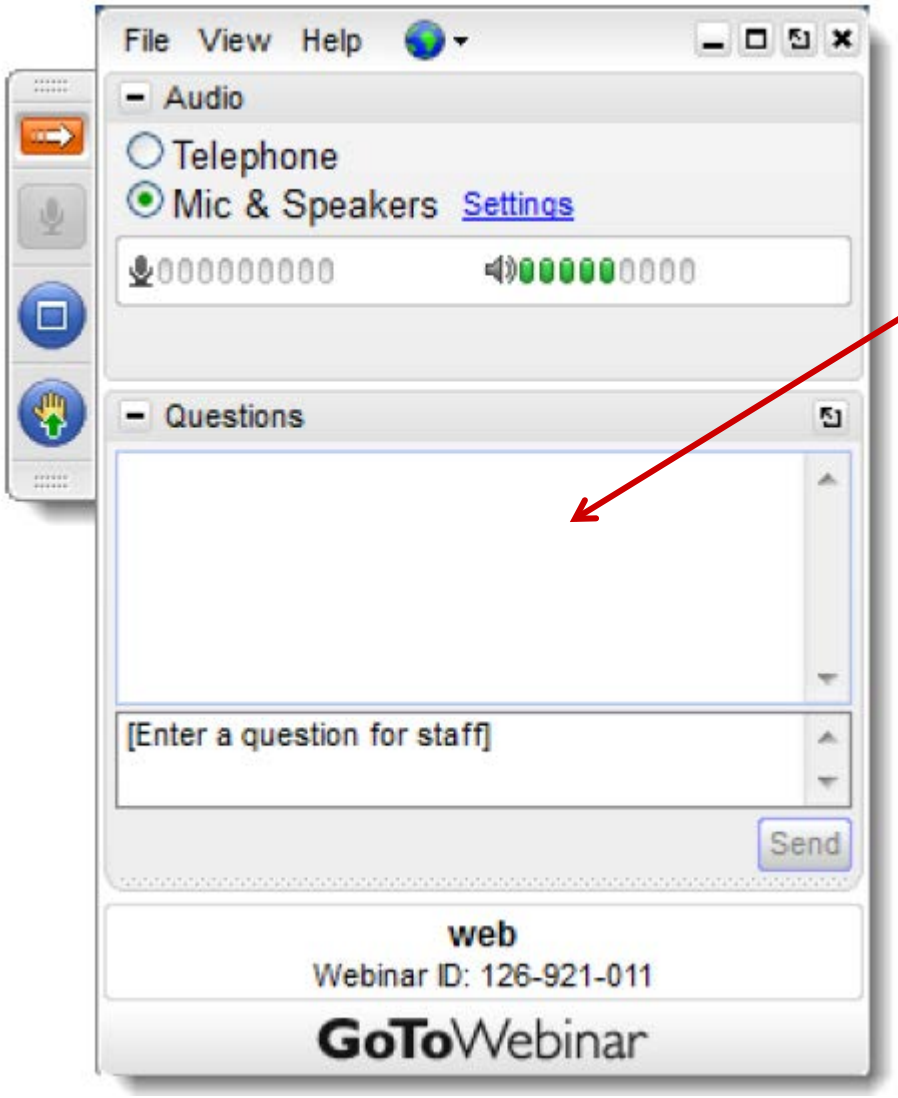
Specific Goals of the Integrated Care Planning Initiative

- Inter-disciplinary case conferences
- Integrated care planning processes
- Increasing referrals into the care management program
- Engaging doctors in care management
- Coordinated processes for follow-up with patients after critical events

Today's Topics

- The Inter-Agency and Internal Care Planning Process
- Coordinating Care Management Services with Other Organizations
- Engaging Doctors in Care Management
- Improving Communication and Addressing Systems Issues
- Improving the Delivery of Care Management for Patients

Questions?



- Enter questions in Questions pane of GoToWebinar control panel.

Stay tuned!

VHCIP Webinar Series July 2016 Event:

Domestic and Sexual Violence: *The affect of violence on people's lives & screening for violence*

Look for registration soon!

Thank you!