



Vermont Program for Quality in Health Care, Inc.

Integrated Communities Care Management Learning Collaborative

Final Evaluation Report

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Introduction

Background on Integrated Care Management model

Persons with complex health conditions and psycho-social needs may benefit from a wide variety of medical and social services from many different providers. It is essential that the care provided to these persons is not “fragmented,” with different agencies providing care in multiple locations without communicating adequately with each other. Fragmentation of care can cause confusion and challenges following care plans; over-treatment and uncontrolled costs through unnecessary tests or duplication of services; or under-treatment and poor outcomes based on incomplete information or misidentification of the person’s primary health determinants.

In many communities throughout the country an Integrated Care Management (ICM) model has been implemented to make health care more person-directed, progressive, and non-episodic. The ICM model supports joint care planning with the person and his or her diverse providers across multiple organizations, with the goal of identifying and preventing the underlying reasons for poor health outcomes. These goals are detailed in a shared care plan, which is developed jointly with the participant and his/her diverse providers. Integral to the ICM is the recognition that, in the majority of cases, a person’s primary health determinants are related to social, environmental, and behavioral factors. In fact recent data suggest that only 20% of health outcomes are determined by clinical health care.

Once a person’s underlying reasons for poor health outcomes have been identified, a Lead Care Coordinator (LCC) guides joint care planning and helps the person define and work towards personal, social, emotional, and health-related goals. In addition to clinical support, the LCC helps coordinate essential community services based on identified needs, which may include housing, food insecurity, substance abuse, mental health, violence, economic issues, and/or transportation, among others.

The ICM model should produce these positive effects:

- Care is less fragmented
- Persons can access timely, appropriate, high-quality care
- Persons can engage more fully in their own care
- Communication between providers is better coordinated, improving continuity of care and lowering cost
- Systems and tools efficiently share and apply information about a person’s care among their providers

Implementing the ICM model in Vermont

In 2014, the Integrated Communities Care Management Learning Collaborative (ICMLC) began helping communities implement ICM in Vermont. The work was funded through a \$45 million State Innovation



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Models (SIM) Testing grant from the federal Center for Medicare and Medicaid Innovation and implemented through a collaborative effort of Vermont Program for Quality in Health Care, the Green Mountain Care Board, and the Department of Vermont Health Access including the Vermont Blueprint for Health. Since the inception of the ICCMLC, the program has increased from 3 initial volunteer communities to 11 communities across the state. Significant connections have been established among a broad group of stakeholders including, but not limited to, hospitals, primary care practices, ACOs, community health teams, social services, mental health services, home health services, housing agencies, peer and advocacy organizations, and agencies on aging, with the goal of better coordinating care for identified persons with complex health conditions.

VPQHC's Role in the ICCMLC

Between March 2015 and December 2016, the Vermont Program for Quality in Health Care, Inc. (VPQHC) supported the work of the ICCMLC through a contract with the State of Vermont, Department of Vermont Health Access.

A VPQHC staff member was one of two Quality Improvement (QI) facilitators who provided support to “integrated care teams” in three pilot communities (Burlington, Rutland and St. Johnsbury) as they began participation in the ICCMLC in January 2015. After June 15, 2015, the QI facilitators began to provide support to eight additional Round 2 pilot communities (Brattleboro, Central Vermont, Middlebury, Morrisville, Randolph, Springfield, St. Albans and Windsor). The QI facilitators worked with the integrated care teams in each community to build capacity for effective team-based care, to coordinate learning opportunities related to integration of services on behalf of people who need the services, to implement promising interventions to enhance integration, and to measure the results of those interventions. The QI facilitators focused on providing support in implementing quality improvement methods, team facilitation, group dynamics, understanding and using data, and project management. The VPQHC facilitator worked closely with the ICCMLC Planning Team and community leaders on developing tools for statewide use, including shared care plans, educational materials, and reporting templates. The VPQHC facilitator also specialized in providing support to all pilot communities for data collection, presentation and interpretation.

A VPQHC staff member also supported the ongoing and final evaluation of the ICCMLC, which included advising on the design of data collection tools and surveys, data analysis, and presentation of final results of the evaluation.

Purpose of this report

This report will describe the work VPQHC was a part of through 2015-2016, with an emphasis on key measures that can be used to evaluate the success of the ICCMLC and recommendations to support the ongoing success of this program.



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Community participation in the Vermont ICCMLC

Participating communities

Community name	Contact(s)	Contact email address
Burlington	Robyn Skiff	Robyn.Skiff@uvmhealth.org
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Windsor	Jill Lord	jill.m.lord@mahhc.org

Organizations participating in each community

The following lists provide a snapshot of the organizations and members participating in each community coalition¹. The number of organizations ranged from 7 to 20 across each community, highlighting the excellent community engagement present in each ICCMLC team.

Brattleboro

A total of 16 organizations participated in the Brattleboro ICCMLC.

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¹ Lists were most recently obtained in January 2016.

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Burlington

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Central Vermont

A total of 12 organizations participated in the Central Vermont ICCMLC.

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A total of 20 organizations participated in the Middlebury ICMLC.

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A total of 8 organizations participated in the Morrisville ICCMLC.

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A total of 10 organizations participated in the Randolph ICCMLC.

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A total of 13 organizations participated in the Rutland ICCMLC.

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St. Albans

A total of 14 organizations participated in the St. Albans ICCMLC.

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St. Johnsbury

A total of 10 organizations participated in the St. Johnsbury ICCMLC.

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Windsor

A total of 7 organizations participated in the Windsor ICCMLC.

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ICCMLC Learning Sessions

Throughout 2015 and 2016, the participating communities were supported with statewide In-Person Learning Sessions (LS), which were designed as opportunities to share best practices in care coordination and to encourage networking and shared learning among participants. Expert national faculty from leading organizations throughout the US that have helped to pioneer community-based care management presented content on key topics, tools and methods with proven records of effectiveness in implementing person-directed, interagency care and services. Eventually, as the number of communities expanded across the state, these learning sessions evolved to occur on two separate days in different locations across the state. The Round 1 learning sessions refer to those supporting the first “round” of communities (Burlington, Rutland, and St. Johnsbury), while the Round 2 learning sessions were initiated when the subsequent communities joined the ICCMLC.

Date	Title / Agenda	Location	Participants
1/13/15	Round 1 – LS 1 Care Coordination: Benefits to the Family, the Practice	Randolph, VT	85

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Date	Title / Agenda	Location	Participants
	and the Provider Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management		
3/10/15	Round 1 – LS 2 Care Coordination Framework for People with Complex Needs: Identifying Lead Care Coordinators and Developing Shared Plans of Care	Northfield, VT	91
5/19/15	Round 1 – LS 3 Working Together as an Integrated Multi-Disciplinary Care Team: Ten Steps toward Implementation of Shared Plans of Care	Northfield, VT	82
9/29/15	Round 1 – LS 4 Change Management: Using an Easy Tool Process Mapping – Skill, Development and Support	Montpelier, VT	90
9/8/15	Round 2 – LS 1	Dartmouth, NH	75
9/9/15	Care Coordination: Benefits to Community Members and the Cross-Organizational Community Team Identifying and Engaging People in Cross-Organizational Care Management	Burlington, VT	96
11/16/15	Round 2 – LS 2	Lebanon, NH	59
11/17/15	Understanding the Population and Root Cause Analysis Identifying and Building a Cross Continuum Team	Burlington, VT	73
3/16/16	Round 2 – LS 3	Burlington, VT	64
3/17/16	Creating and Implementing Shared Plans of Care Conducting Effective Care Conferences	Lake Morey, VT	56
5/25/16	Round 2 – LS 4	Rutland, VT	57
5/26/16	Care Coordination for People with Complex Needs: Sustaining the Intervention Event Notification: An Overview of PatientPing	Waterbury, VT	60
9/6/16	Round 2 – LS 5	Rutland, VT	37
9/7/16	Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations	Waterbury, VT	52

(LS = learning session)

ICCMC Webinars

Webinars were also offered to participating ICCMLC communities to support additional learning on best practices for implementing the ICM model in Vermont. Expert national faculty from leading

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organizations throughout the US that have helped to pioneer community-based care management presented on key topics, tools and methods. The following provides the list of webinars, dates, and corresponding attendance.

Date	Title	Participants
2/18/15	Round 1 Introductory webinar	61
4/15/15	Round 1 Introductory webinar	52
6/24/15	Round 1 Introductory webinar	42
7/8/15	Round 2 kickoff	42
7/22/15	Round 2 kickoff	110
8/26/15	How to Embed Shared Care Plans in Emergency Departments and Other Acute Care Settings	53
10/14/15	Round 2 Eco-mapping	127
12/9/15	Practicing Root Cause Analysis – Lauran Hardin	90
1/6/16	Using, Sharing, and Updating Shared Care Plans – Lauran Hardin	33
1/26/16	Conducting Records reviews – Lauran Hardin	108
2/17/16	Informing Clients, Documenting Consent, and Resolving Disagreements when Sharing Confidential Client Information as a Team – Gabe Epstein	97
11/4/16	Community Progress with Care Navigator	83

Core Competency Trainings

As greater numbers of new agency partners began participating in the project, the ICCMLC Planning Team identified a need to provide statewide training in care coordination skills and competencies. After a competitive bidding process, the Primary Care Development Corporation and the Vermont Developmental Disabilities Council were selected to deliver trainings starting in March, 2016. The Core Competency trainings featured content on care coordination skills and disability awareness, and included a train the trainer program.

Date	Title / Agenda	Location	Participants
3/29/16	<i>Care coordination and care management, patient</i>	Burlington, VT	69
3/30/16	<i>engagement and health literacy, helping patients cope</i>	Waterbury, VT	65
3/31/16	<i>with chronic disease, care coordination is a team based</i>	Brattleboro, VT	65
8/17/16	<i>sport</i>	Burlington, VT*	44
4/22/16	<i>Introduction to disability awareness, disability and</i>	Brattleboro, VT	52
4/25/16	<i>wellness, person and family centered care, planning and</i>	Montpelier, VT	57

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Date	Title / Agenda	Location	Participants
4/26/16	<i>thinking</i>	Burlington, VT	65
4/27/16		Burlington, VT*	61
6/16/16		Burlington, VT*	42
5/17/16	<i>Person-centered care, person-centered assessment and</i>	Montpelier, VT	51
5/18/16	<i>care-planning, SMART goals, stages of change theory,</i>	Burlington, VT	70
5/19/16	<i>motivational interviewing, health coaching</i>	Brattleboro, VT	43
8/18/16		Burlington, VT*	42
6/14/16	Care Management Across Organizations	WEBINAR	69
6/17/16	<i>Universal design and accommodations, cultural</i>	Burlington, VT	63
6/22/16	<i>competency and communication</i>	Waterbury, VT	56
6/23/16		Brattleboro, VT	41
7/19/16	<i>Culture of poverty/working with people in poverty,</i>	Burlington, VT	68
7/20/16	<i>supported decision making, transitions of care,</i>	Montpelier, VT	61
7/21/16	<i>professional boundaries and self-care</i>	Brattleboro, VT	41
8/19/16		Burlington, VT*	37
7/19/16	Domestic & Sexual Violence	WEBINAR	50
8/12/16	Sexuality and Reproductive Health of Individuals with Disabilities	WEBINAR	27
8/30/16	Radical Accompaniment: Tools and Framework for Working with Complex Clients	WEBINAR	58
9/14/16	<i>Transition from pediatric care to adult care, adverse</i>	Montpelier, VT	52
9/16/16	<i>childhood events, a strength-based approach.</i>	Burlington, VT**	33
9/27/16		Burlington, VT	17
9/28/15		Brattleboro, VT	24
9/20/16	<i>Advanced Training (following participation in up to six CCT modules)</i>	Montpelier, VT	32
10/5/16	Facilitating Trainings That Are Inclusive for People with Disabilities	WEBINAR	16
10/18/16	<i>Core Competency Training for Care Coordination Managers and Supervisor's</i>	Waterbury, VT	31
11/16/16- 11/17/16	<i>Core Competency Training for Care Coordinators: Train the Trainer</i>	Waterbury, VT	24
11/18/16	Delivering Culturally Competent Care to LGBTQ Individuals	WEBINAR	39
12/5/16	<i>Tools for Effective Care Coordination</i>	Williston, VT	47

* Section 2; **Sections 1 and 2

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ICCMC Trainings Offered Locally by Participating Communities to Engage and Educate Community Partners

In order to sustain, share, and scale the work of the ICCMLC throughout the state, the ongoing engagement and training of new agency partners was identified as an important need. Participating communities were encouraged to develop and present local training sessions. The Rutland community assumed a leadership role in this process, developing training methods and materials that they shared statewide. Other communities developed trainings independently or with the help of the QI facilitators.

Rutland

Rutland offered a quarterly Care Coordination Tools training to all community partners. Some of the tools they used included:

- How to risk stratify patients
- How to do a 10 year look back
- How to do Root Cause Analysis
- How to conduct Eco Mapping
- Using Camden Cards
- How to conduct a Care Conference
- How to do Shared Care

The sessions were offered in two part sections:

Dates	Attending Communities	Participants
1/20/16 and 2/3/16	SASH, CHT, RRM, HUB, CHCRR, Homeless Prevention Center, SPOKES, Southwest Council on Aging	12
5/24/16 and 6/7/16	SPOKES, CHCRR, Southwest Council on Aging, SASH	12
8/24/16 and 9/7/16	SASH, Rutland County Parent Child Center, RRM, Court Diversion	14
		38 total

Springfield

Springfield offered three trainings:

1. Introduction to Essential Concepts and Tools on April 5, 2016. Topics included:

- Overall understanding of program
- Invitation to participate
- Obtaining CHT Consent
- Administering the Person Experience Survey
- Letter to Inform Provider of Participation in ICM
- How to do Eco Mapping
- How to use Domain Cards
- How to be a Lead Care Coordinator

There were 13 participants, representing 5 community partners.

2. Introduction to Root Cause Analysis on June 7, 2016. Topics included:

- How to do a Root Cause Analysis
- How to do a Chart Review

There were 9 participants, representing 5 community partners.

3. Care Planning, Care Conferencing and Care Team Facilitation on July 12, 2016. Topics included:

- Care Conference Meeting Facilitation
- What is a Shared Care Plan
- Barrier/Action Planning and Barrier Identification

There were 6 participants, representing 4 community partners.

Brattleboro

Brattleboro offered three trainings including:

1. Introduction to Root Cause Analysis on April 29, 2016. Topics included:

- How to do a Root Cause Analysis
- How to do a Chart Review

There were 8 participants, with 4 community partners represented including BMH, Brattleboro Housing Authority, Senior Solutions, OneCare, and Brattleboro Retreat.

2. Introduction to Essential Concepts and Tools on May 13, 2016. Topics included:

- Overall understanding of program
- Invitation to participate
- Obtaining CHT Consent
- Administering the Person Experience Survey
- Letter to Inform Provider of Participation in ICM
- How to do Eco Mapping
- How to use Domain Cards
- How to be a Lead Care Coordinator

There were 9 participants, with 6 community partners represented including: BMH, Brattleboro Retreat, Grace Cottage CHT, Health Care and Rehabilitation Services, and Brattleboro Area Prevention Coalition.

3. Care Planning, Care Conferencing and Care Team Facilitation on July 22, 2016. Topics included:

- Care Conference Meeting Facilitation
- What is a Shared Care Plan
- Barrier/Action Planning and Barrier Identification

There were 25 participants, with 17 community partners represented including: BMH, Brattleboro Area Prevention Coalition, Brattleboro Police Dept., Rescue Inc., Brattleboro Fire Dept., The Gathering Place, Windham Windsor Housing Trust, Senator Jeanette White, Brattleboro Area Hospice, OneCare, SASH, Senior Solutions, Brattleboro Retreat, private therapist, VCCI, Groundworks, Home Health Hospice & Community Services, and VDH.

Windsor

Windsor presented multiple sessions covering the following topics:

- Definition and Process of Care Coordination
- Analysis of Top 5% Risk Patients Utilizing Hierarchical Chronic Conditions and Costs/Healthcare Utilization
- Role of Lead Care Coordinator
- Use of Best Practice Tools Including Camden Cards and Eco Maps
- Use of Interagency Consent Form
- Creation of an Interagency Care Plan
- Presentation of Case Studies

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Participating organizations included: Visiting Nurse and Hospice, Bayada Health, VCCI, SASH, Vermont Healthcare Innovation Project, VITL, Senior Solutions, Spoke Staff, Patient Centered Medical Home Nursing Staff, Healthcare and Rehabilitative Services, Agency of Human Services District Leadership Staff in Springfield and Hartford, and District School Nurses.

Middlebury

Middlebury offered a training called: **Care Coordination Tools Training on September 21, 2016 and October 5, 2016**. Topics included:

- How to risk stratify patients
- How to do a 10 Year Look Back
- How to do Root Cause Analysis
- How to conduct Eco Mapping
- Using Camden Cards
- How to do a Care Conference
- How to do Shared Care

There were 9 participants, with 6 community partners represented including: Middlebury Probation Office, SASH – Local SASH Coordinators, Community Health Team Care Coordinators, Hospital Discharge Planners, Aging Well, and Parent Child Center.

Feedback from participating ICCMLC Communities

Several communities offered additional feedback on some of the challenges, successes, and lessons learned, as well as some thoughts on the sustainability of their work. Direct quotes from ICCMLC community leadership are included below:

Challenges:

- *Identified need for developing a communication mechanism between team members.*
- *Recognized the need for staff training for new and existing members with investment to collaborative care*
- *Concerned with ongoing struggles to complete tools, specifically care plans.*
- *Challenge of continuously updating Shared Care Plans by engaging and empowering community partners/ providers.*
- *Ongoing flux in state of wellness of participating complex patients.*
- *Staff time constraints related to FTE status and role responsibilities of community partners.*



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- *Maintaining and expanding community partner knowledge related to ICCMC Care Coordination process.*
- *Need to address questions about reimbursement structures to support full engagement of community partners*
- *Organizing care conferences with multiple partners*
- *Easily sharing interagency care plans in a safe and encrypted manner protecting PHI*
- *Spreading, standardizing and universalizing the process and tools in our network of providers*
- *Prioritizing this work among the overwhelming need while serving complex patients with economic restraints and minimal staff*
- *Having partner agencies step up to the plate as lead care coordinators*
- *Systematically capturing individual and collective outcomes*
- *Weaving self-management programs into the care plan when patients have limited time and transportation*
- *Systematizing a process to update care plans*
- *Teaching staff to look for and to find care plans in the EMR*
- *Ensuring accountability across organizations and within interagency teams.*
- *Even though communication among partner organizations and individuals improved in many aspects, due to legal and technological constraints, communication and information sharing continues to be a barrier.*
- *There is a lack of shared technology to support the work.*
- *The different cultures and perspectives of the social and medical health realms can make integrating these silos challenging.*
- *Achieving through-put of engagement and knowledge at multiple staff levels within large organizations.*
- *Senior leadership-level engagement and championing.*
- *Measuring the qualitative vs. quantitative successes with complex individuals.*
- *Addressing and coping with change fatigue.*
- *Insufficiently supported time for planning and doing the work.*

Successes:

- *Shared tips among members. Considered Patient Navigator system as an option for more effective communication.*
- *Consider the most efficient means – who needs it, who should provide it.*
- *Identified triaging as a hindrance to completion of collaborative tools.*
- *Moved two clients to “maintenance” status, determined a lack of data was a hindrance.*
- *Steadfast attention to continuing the process of breakdown of medical and social service silos*

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- *Standing ICCMC Agenda Item related to designation of LCC and status of updated Share Care Plans.*
- *RN Care Coordinator identified, assisted and mentored community partners who expressed interest in assuming care coordination leadership roles.*
- *Development of electronic Shared Care Plan with BMH Information Services Department*
- *Best practice tools, using Eco maps and Camden cards and care plans, have improved the quality of information, goal setting and care planning and communication with both patients and health and human service partners*
- *Formal involvement with partner agencies has increased trust with families*
- *Patients are viewed as experts and central decision-making, i.e. shifting focus to patient centered approach*
- *Improved transitions of care from inpatient to outpatient and visa/versa*
- *New funding sources and resources have been discovered for patients when working in partnership*
- *Patients are empowered and are able to accomplish realistic goals when they have an active role in the care plan*
- *Increased connectivity and communication across multiple organizations within the largest health service area (HSA) in the state.*
- *Created stronger, more trusting relationships among organizations.*
- *Development of a collaborative team of interagency partners persisting beyond the initial pilot phase who have formed an ongoing network poised to create true shared care.*
- *Increased understanding of the different systems that provide care and support across the HSA, and a clearer understanding of how to access those services.*
- *Development of a common language about care coordination now in use across HSA.*
- *Increased clarity in accountability and role definition within interagency care teams. It is now clear who is responsible for a person's care plan and the interventions associated with goals.*
- *Creation of a structured process to identify people at risk and who among the team has engaged with them so that we can bring them into shared-care.*
- *Engagement of ED social work and development of electronic "ED Flag" tool.*
- *Decreased isolation among direct service providers when supporting complex people and situations.*
- *Staff participating on shared care teams and in collaborative planning meetings note improved job satisfaction and decreased feeling of burnout.*
- *Creation of three quality training videos that demonstrate the tools and steps of shared care for use in training across teams.*

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Lessons learned:

- *Training will be an ongoing process. Crucial to efficiently get new staff on board, trained, and committed for most effectiveness. This will take some time and experience - Continual guidance/support is needed.*
- *Communication, Communication, Communication. - We learn from each other.*
- *Often team changes are needed – Avoid ‘burn-outs’ and adapt to patient’s changing needs.*
- *Don’t underestimate the challenge of changing the culture of Complex Care Coordination!*
- *Remain Focused!*
- *Stay Strong!*
- *Best practice tools actually work*
- *Patients revealed, without hesitation the supports that they had which may not ever have been mentioned prior to using Eco maps*
- *Patients were able to easily sort out and recognize what they needed to work on for goal setting utilizing Camden cards*
- *Engaging complex individuals takes time and effort.*
- *People with complex needs often lack positive connection to a medical home.*
- *Urgent social determinants of health need to be addressed before health needs can be addressed.*
- *Being a lead care coordinator can be resource intensive.*
- *Complexity of data and information sharing across organizations will take time to fully address.*
- *The more we engage a person in their care the fewer hurdles we have in overcoming systems barriers to their care.*
- *Results take time. Changing a life-time of behaviors won’t happen overnight.*
- *Having multiple agencies involved gives us the ability to tap into many resources.*

Sustainability plans:

- *Attended initial Patient Navigation training. System rolled out. Future trainings scheduled.*
- *Created three levels of training in-house. Basic to advanced need.*
- *Continue to provide guidance to each other. Incorporate this topic in up-coming staff trainings.*
- *Reviewed list of high-utilizers, shared patients attributed to ACO, and chose 3 additional patients to invite into collaborative based on who would benefit the most from collaborative efforts.*
- *Publicize Future Plans for Care Navigator to enhance care coordination.*
- *Offer second Community ICCMC Education in fall/winter of 2016.*
- *Session to feature Care Coordination videos and follow up with group discussion.*
- *Develop and implement or “borrow” community education evaluation tool post session.*
- *Continue to invite and expand participation of community partners.*
- *Continue to engage acute care services to participate in ICCMC.*

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- *We will standardize quarterly assessment of high-risk patients and prioritize them for Interagency Care Management*
- *We will standardize the monthly Interagency Joint Care Planning and Care Management meeting among partners*
- *We will encourage ad hoc interagency care planning as needed*
- *We will track and report interagency care planning and care management to the Blueprint for Health*
- *We will celebrate successes*
- *Full use of Care Navigator to enhance communication and information sharing.*
- *Ensure a more comprehensive understanding of this initiative and the range of tools, (electronic and not), throughout the UVM Health Network. Identify physician champions to promote the collaboration.*
- *Foster engagement with smaller practices that may not have resources to be at the planning table/meetings.*
- *Accountability for practices engaged in the Blueprint to demonstrate engagement in this work.*
- *Assist practices of all sizes in demonstrating how complex care coordination work aligns with practice transformation and value based payment goals, with assistance of Vermont Care Organization.*
- *Develop standards for engagement and definition of ‘care coordination’.*
- *Designate point-people within not-yet-engaging organizations and practice groups to communicate with about this work.*
- *Development of outreach tools and a communication plan to increase HSA uptake.*
- *Create a brief ‘road show’ that can be used to convey the work to new audiences*
- *Enhance sharing of this work with RCPC/UCC.*

Many front line agency participants expressed enthusiasm for the power of the tools and methods in engaging persons with complex needs. Lead Care Coordinators were often surprised at the important personal information not contained in any clinical record, but shared by a person that they had already known for a period of time, once that person was encouraged within the program to share their ‘story,’ relationships, and most important priorities and goals. The prime benefit for many was the defining of manageable, time-limited accountabilities to work on goals that were determined to be important steps in achieving those priorities, and the continued engagement and participation of the person.

Lead Care Coordinator Self-Assessment Survey

A Lead Care Coordinator (LCC) Self-Assessment was made available online via SurveyMonkey from November 28 through December 12, 2016. The survey was intended to gauge the LCCs’ self-perception of competency and comfort with using the tools and methods of the ICCMLC, and to solicit comments on the need for training and other assistance as the project continues in 2017.

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Out of 96 people performing the LCC role statewide, 26 completed the survey. Results showed that:

- 64% were completely or very confident in their ability to use EcoMapping to improve care coordination for patients
- 69% were completely or very confident in their ability to use the Camden Cards to help patients identify and prioritize what's important to them
- 38% were completely or very confident in their ability to conduct a Root Cause Analysis
- 77% were completely or very comfortable explaining the purpose of care coordination to patients and families that could benefit from that approach
- 62% were completely or very confident in their ability to develop a shared care plan that describes patient goals, provides a strategy and timeline for meeting goals, and identifies a team member responsible for working with the patient to achieve each goal
- 50% were completely or very confident in their ability to plan and run a shared care conference
- 81% were completely or very confident explaining the informed consent process to patients and inter-agency partners

Results suggest the need for additional trainings on several of the key tools and processes of ICM, particularly root cause analysis, running a shared care conference, developing a shared care plan, and using EcoMapping. Some recommendations based on these results are provided in the Recommendations section below.

Participants in the ICCMLC

The sections below provide details on the number of persons who were provided care as part of the ICCMLC. Data are current as of November 2016.

Participant status

Participant status was defined in four ways following initial engagement. (Participant engagement includes signing consent, participation in at least one meeting with his/her LCC, and identification of personal priorities and relationships). Data are not provided for individuals who have not yet met the engagement criteria.

- **Current:** Participant and team are currently active in scheduled care conferences and recurring need-based updating of Shared Care Plan goals and tasks. Overarching goals, steps or tasks are not yet complete.
- **Maintenance:** Participant situation is currently stable, after having participated in Integrated Care Management with identified goals and tasks implemented or completed, and either no current need for regularly scheduled care conferences or updating of care plans; or less frequent need to do so, for example annually. Lead Care Coordinator remains aware of the



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participant’s ongoing situation and remains alert to changes in situation might necessitate re-engagement. Participant remains aware that he/she should contact Lead Care Coordinator regarding any concerns or changes in stability.

- Withdrew: After engagement, participant has either stated that he/she no longer wishes to participate in Integrated Care Management, including ownership of goals, team support with goals and tasks, or sharing of information among agency partners; or is no longer engaged with or available to LCC, such as has moved away, is not reachable, or has “fired” their LCC. To be considered withdrawn, they must first have been engaged (see above definition).
- Deceased: After engagement, participant passed away.

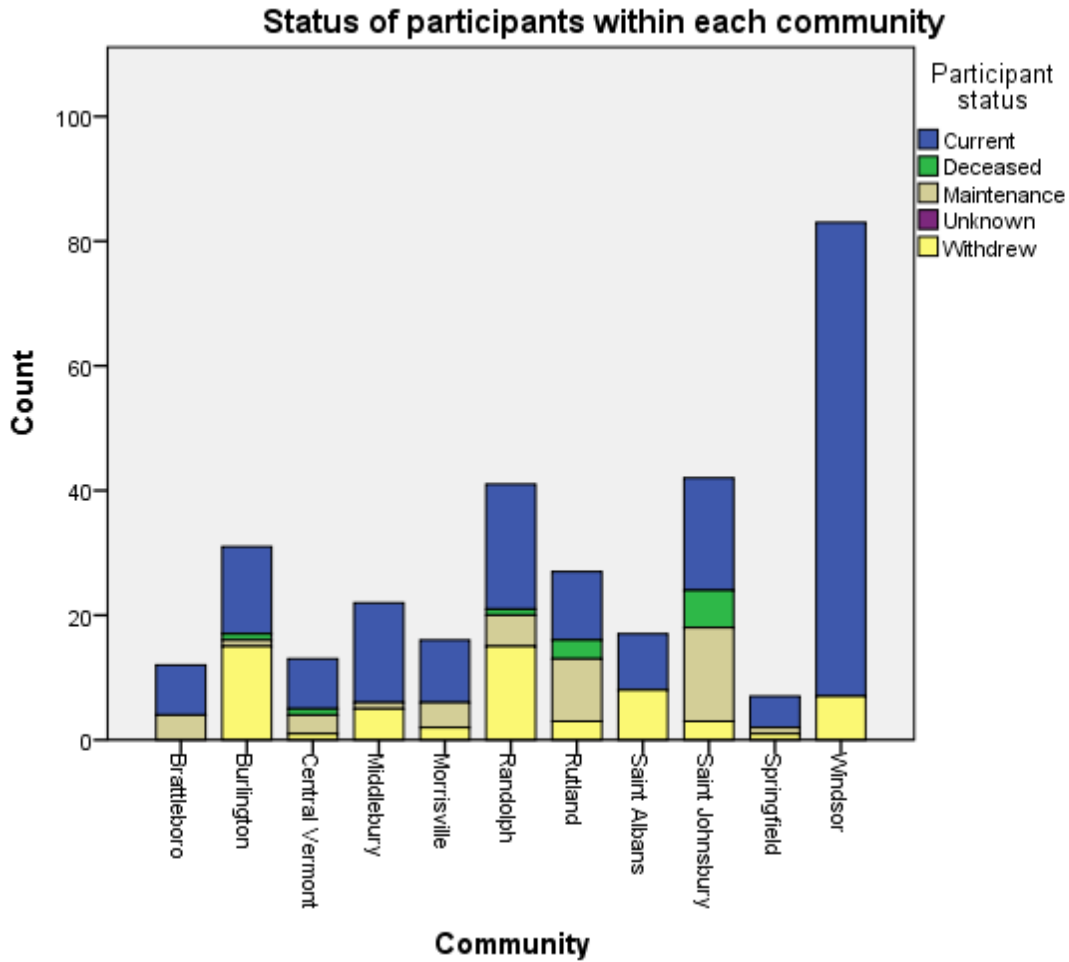
Based on data submitted bimonthly from participating ICCMLC communities, we have data on 311 participants, with 195 currently active and 44 considered in maintenance. Approximately 23% have been lost due to death or withdrawal (Table 1).

Table 1. Participant status in the Vermont ICCMLC, November 2016

	Frequency	Percent
Valid Current	195	62.7
Deceased	12	3.9
Maintenance	44	14.1
Withdrew	60	19.3
Total	311	100.0

Windsor had the highest number of participants followed by St. Johnsbury and Randolph (Figure 1). The number of participants is not correlated with the length of time the community has been participating in the ICCMLC.

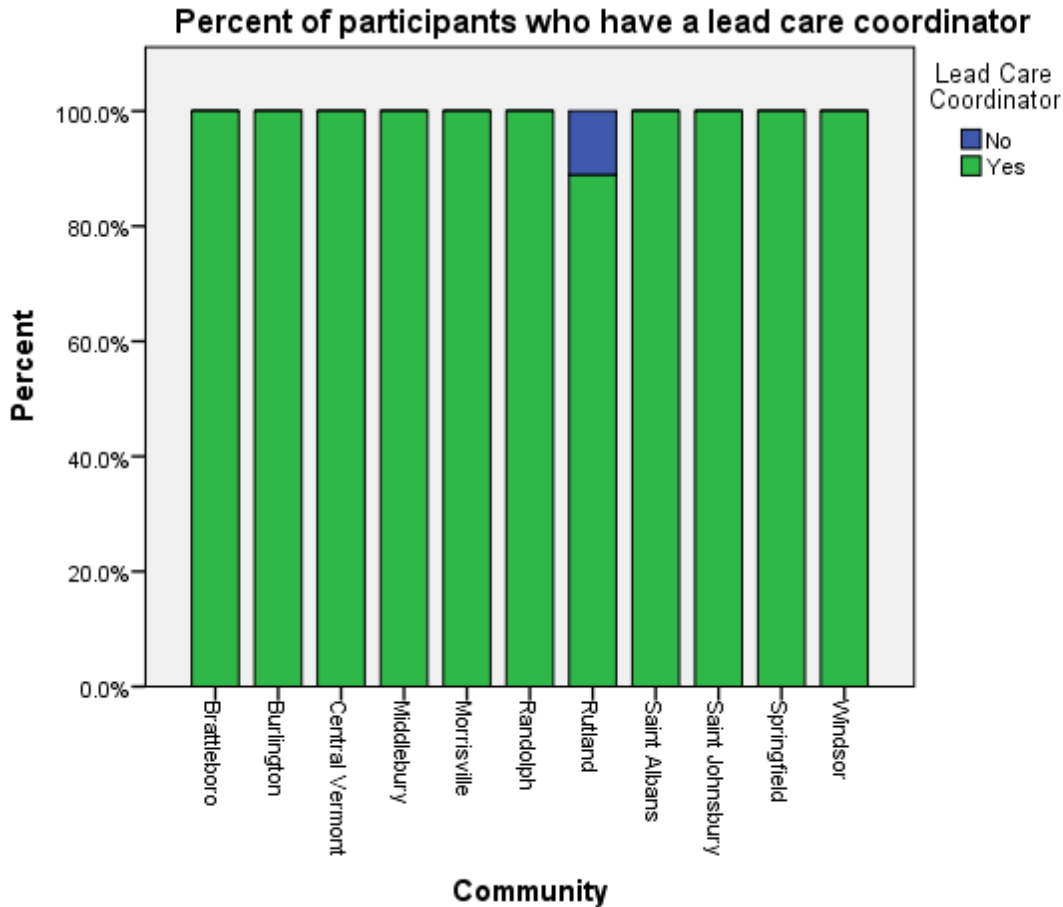
Figure 1. Participant status in the Vermont ICCMLC, by community – November 2016



Participants with a Lead Care Coordinator

One of the most important components of the ICM model is assignment of a lead care coordinator, and most current and maintenance participants have been assigned a lead care coordinator as shown in Figure 2.

Figure 2. Proportion of participants within each community with a lead care coordinator – Vermont ICCMLC, November 2016.



Excludes deceased and withdrawn participants

Participants with a Shared Care Plan

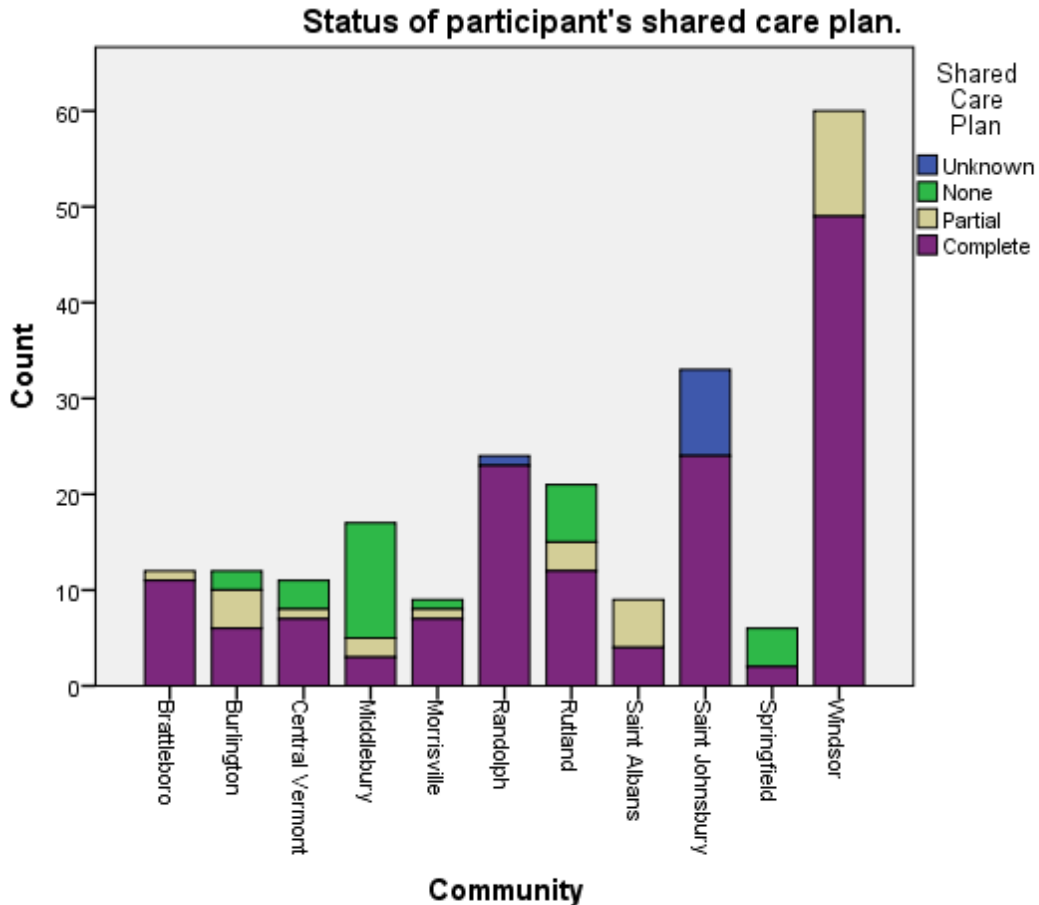
A shared care plan should be completed for each participant within two months of their enrollment into the ICCMLC. Table 2 only includes data on participants with a status listed as “current” or “maintenance”, and who have been enrolled for a minimum of 2 months. While the majority of participants have a completed shared care plan (69.2%), with another 13.1% having a “partially” completed shared care plan, ideally this number should be at 100%.

Table 2. Vermont ICCMLC participants with a shared care plan – November 2016.

		Frequency	Percent
Valid	Complete	148	69.2
	None	28	13.1
	Partial	28	13.1
	Unknown	10	4.7
	Total	214	100.0

Figure 3 describes the status of shared care plans across communities.

Figure 3. Status of Vermont ICCMLC participants' shared care plan, by community – November 2016.



Excludes deceased and withdrawn participants

Participants who had a Shared Care Conference

Every participant in the ICCMLC should have a shared care conference to ensure care is adequately coordinated among providers, ideally within the first two months of enrollment. Including those only considered current and enrolled for more than 2 months, 81 participants (47.6%) have not had a shared care conference. Additionally, of those with a complete or partial shared care plan, 41.4% (58/140) did not have a shared care conference. Although these numbers are lower than ideal, there is some concern regarding inconsistent documentation of these conferences in the bi-monthly reporting, therefore the true number could be higher.

Feedback from participants in the ICCMLC

With input from ICCMLC participating communities and ICCMLC leadership, and after a literature review of patient feedback surveys, VPQHC developed a Participant Survey for individuals obtaining care under the ICCMLC model. The original intent of the survey was that it would be provided to every participant at enrollment and then at subsequent 6 month intervals. However the survey was not available at participant enrollment within the initial three pilot communities, and logistical challenges along with survey fatigue in those and other communities inhibited the wide-spread use of the survey.

There were a total of 60 surveys received, including all communities except Middlebury and St. Albans. The following provides a summary of the pooled responses, noting whether the response is impacted by the length of time participating in the ICCMLC if relevant.

2a. 98.3% know who their care coordinator is

2b. 98.3% know how to contact their care coordinator

3a. 95.0% agree that their care coordinator/team explains things in a way that is easy to understand;
5.0% neither agree nor disagree

3b. 93.3% agree that if they asked for something, their care coordinator/team helped them get it; 6.7% neither agree nor disagree

3c. 90.0% agree that their Care Team helps them know what to do when they feel sick or need help; 10% neither agree nor disagree

3d. 96.7% agree their Care Coordinator/team know who else is helping with their care; 3.3% neither agree nor disagree

3e. 85.0% agree their Care Coordinator and team members communicate well with each other; 6.7% disagree; 8.3% neither agree nor disagree

- 3f. 91.7% agree their Care Coordinator/team does a good job coordinator their care; 1.7% disagree; 6.7% neither agree nor disagree
4. 72.4% responded that their Care Coordinator/team created a shared care plan for them; ** positively correlated with length of time participating in ICCMLC
5. 69.0% have a copy of their shared care plan; ** negatively correlated with length of time participating in ICCMLC, suggesting they appear to lose it
- 6a. 86.7% helped create their shared care plan; 2.2% disagree; 11.1% neither agree nor disagree
- 6b. 79.5% know what their shared care plan says; 6.8% disagree; 13.6% neither agree nor disagree; ** no correlation with length of time participating in ICCMLC
- 7a. 87.0% chose the goals for their shared care plan; 2.2% disagree; 10.9% neither agree nor disagree; ** no correlation with length of time participating in ICCMLC
- 7b. 89.1% agreed their Care Coordinator/team talked with them about progress on goals in shared care plan; 10.9% neither agree nor disagree
- 7c. 84.8% agree they can change a goal on their shared care plan; 2.2% disagree; 13.0% neither agree nor disagree; ** everyone who neither agreed nor disagreed had participated for over 12 months
- 8a. 82.1% agree their LCC asks them about things that make it hard for them to take care of their health; 5.4% disagree; 12.5% neither agree nor disagree; **no correlation with length of time participating in ICCMLC
- 8b. 91.1% agree their LCC talks with them about what they want for their future; 3.6% disagree; 5.4% neither agree nor disagree
- 8c. 89.3% agree their LCC respects their wishes if they don't want to share all of their information with certain members of their care team; 1.8% disagree; 8.9% neither agree nor disagree
- 8d. 92.9% agree their LCC asks them what is working well in their health care; 1.8% disagree; 5.4% neither agree nor disagree
- 8e. 86.0% agree their LCC knows their strengths in caring for them; 14.0% neither agree nor disagree
- 8f. 94.7% agree their LCC asks them about things that affect my well-being; 1.8% disagree; 3.5% neither agree nor disagree

Overall, participant feedback suggests that participants feel supported by their Care Team and Lead Care Coordinator, and have had overall positive experiences with the ICCMLC.

Case Studies of Participants

Community leaders presented case study examples of their experience using ICM to colleagues and state agencies. Key elements of the ICM intervention are highlighted and the effectiveness of outcomes provides insight into the implementation of ICM in the five examples below:

Case Study 1

Description of participant: 66 yr. old female retired factory worker who lives alone in a mobile home in rural Vermont. Active health issues include Chronic Depression, Diabetes T2 poorly controlled, Morbid Obesity, PTSD, OB, Polycystic Ovarian Syndrome, and Arthritis right knee. Patient walks with 2 canes.

Patient priorities/goals:

- To participate in her own self care management
- Receive financial support assistance
- Address transportation challenges
- Help with prescription pick up, getting her groceries and light house cleaning

Services included:

- Care coordinator/CDE did home visits weekly for several weeks, training patient to participate in her own self care management.
- VNA, PT, HHA in home to oversee education on DM, self-management, wound care, and help with personal care.
- SASH was involved for financial support assistance, and wellness nurse for self-management support.
- Ottauquechee Health Foundation and Stagecoach provided grants to support her transportation challenges.
- Home Behavioral Health and Eldercare visits and psychiatric medication intervention
- Aging in Hartland assisted pt. with prescription pick up, getting her groceries and light house cleaning.

Case and/or Systems Challenges:

- Negative attitude and skepticism re: options of care for pain control and depression.
- Patient's weight - 380# and she does not fit into a regular sized car – refuses to wear a seat belt.
- She dismissed the importance of portion control and SMBG.

Outcomes:

- A1c dropped from 8.9% to 7% with no insulin changes from initial dosing and subtle diet modification. Checks fs 2x daily.



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- Wounds have healed. Patient reports less hopelessness, daily “crying jags,” and improved pain control.

Case Study 2

Description of participant: 54 year old man, paraplegic, living in subsidized housing at one of the SASH hub sites. Primary issue is wound care that is long standing and he is currently using a wound vac. Very upbeat positive person who is in need of a strong circle of support. Identified by Community Health Team as high utilizer of services, complex care needs, multiple agency assist.

Patient priorities/goals:

- Healing my wounds is most important to me so I do not have to stay in bed as much. Being in bed all the time is no way to live.”
- Cards chosen included Self-Care, Food and Nutrition, Identification, Medication and Supplies, Education, and Mental Health
 - o Self-care: “Consistency of HHA’s that I can count of and have confidence in.”
 - o Nutrition: “I do not have noon time help and often miss lunch.”
 - o Supplies: “Wound care staff and VNH staff need to communicate with the company that sends my supplies for my wound vac.”
 - o Identification: “I need a new non-drivers ID for Vermont.”
 - o Education and Mental Health: “I have trouble focusing and think that I have Attention Deficit Disorder. I can’t get organized.”

Services included:

- VNH- three times a week dressing change and wound monitoring
- VNH- Home health aide scheduled three times a week.
- VNH Choices for Care PCA every morning for two hours.
- Consumer directed Choices for Care services; two workers employed by him through ARIS.
- PT and OT were involved through VNH- not in at present.
- SASH Coordinator – almost daily check-in and support.
- Mental Health Counselor- home visit weekly
- SASH Coordinator identified as Lead Care Coordinator due to strong relationship and regular contact. SASH Coordinator did an Eco-Map with him to identify circles of support. LCC used Camden cards to identify areas of need and his priorities for coordination of care.

Outcomes:

- Secured funds for a small fridge and microwave for his room, PCA filled with ready-made meals weekly

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- Secured funds for a non-medical ride to DMV to get an ID, opened a local bank account, accessed health care and obtained meds at pharmacy
- Addressed concerns of ADD with mental health counselor and physician
- Obtained seat cushion for wheelchair that will help him to sit in electric wheelchair more comfortably
- Shared care plan with all medical and non-medical providers

Case Study 3

Description of participant: Patient has multiple advanced chronic issues such as heart failure, COPD, and diabetes with wounds and post amputation. He was in a nursing home for approximately a year, discharged and then shortly thereafter admitted to DHMC. Although he has his wife and 2 adult children in the home, he is alone most every day, all day. The family members are all working and out of the home each day. His wife works way up north near St. J.

Patient priorities/goals: He would like to be in an assisted living facility or nursing home where he would no longer be a “burden” to his family.

Team goal: Find a warm, comfortable, handicapped accessible place to live where there is adequate support for him to feel safe

Services included:

- VNA services thru VNH, skilled, for wound care to his R foot.
- Home health aide that comes in to assist with bathing
- The Current for transport to appointments
- Meals on wheels

Case and/or Systems Challenges:

He lives in a rented home that is not only not handicapped accessible, but it is handicapped unfriendly. The only bathroom and the bedrooms are upstairs. It is too difficult for him to “bump” up & down the stairs as he needs to in order to get to his weekly DHMC appointments for wound care. He is currently on an enclosed porch until it’s too cold, once that happens he will need to go back inside - either in the living room or upstairs again. It has been difficult to find placement for him. We have been, between DHMC, MAH, clinic care coordination and VNH, unable to find an assisted living facility or nursing facility for him. He has declined to live in a family care home.

Action Plan:

- Team will complete applications for handicapped subsidized housing in the Windsor area as well as up near St. Johnsbury – where his wife works. Target date: 1/2017
- VNH & staff will coordinate to contact area assisted living and nursing facilities

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- Contacted four facilities to date
- We will all need to think outside of the box to find a solution to his housing/care: Assist the family to find a handicapped accessible home to rent?

Outcomes:

Patient's goal of living in an assisted living facility or nursing home has not been met. He continues to live with his family and feels he is a burden to them. Patient's goals for quality of life have been improved in the following ways:

- He has been admitted to the care of the Visiting Nurses of New Hampshire and Vermont and has case management services.
- Patient's medication administration has been improved through the institution of bubble pack methodology.
- Patient now has access to supplies for incontinence care that were previously unavailable to him.
- Patient had a history of no-shows to appointment related to the fact that his wife who lives who works a distance away was required to take off time from work to transport him. He now has the knowledge and ability to arrange for Medicaid assisted transportation through a local transportation company and his no-shows to appointment has decreased.
- Patient now receives Meals on Wheels services for improved nutritional support.
- Patient is in the process of applying for subsidized housing.
- Patient has multiple advanced chronic issues such as heart failure, COPD, and diabetes with wounds and post amputation. He was in a nursing home for approximately a year, discharged and then shortly thereafter admitted to DHMC. It was at that time that the community health team began to work with this patient. Since inception of CHT care management over a period of three months, patient has had one ED admission and one inpatient admission.
- Wraparound supportive services have been initiated.
- Patient has newfound hope and a positive attitude. He reports feeling safe regarding his medication administration. He reports understanding and being able to reach out for support as needed. Patient expresses gratitude for services and support.
- Patient has been provided with the tools he needs for improved self-care management and quality of life.

Case Study 4

Description of participant: 58 y/o female, Medicare/Medicaid, COPD, Hypertension, Hyperlipidemia, Hepatitis C, Multinodular Thyroid Disorder, Charcot Marie Tooth Disease, Allergic rhinitis, Tobacco use Disorder (currently vaping), Migraine, Chronic Pain, Polysubstance Abuse, Depression, Anxiety, Panic



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Disorder, Multiple Suicide Attempts, Self-reports of OCD and ADD, 12 ER visits, mostly for COPD exacerbation vs Anxiety, one for Over Dose and one for Abscess Tooth.

Patient priorities/goals:

- Reduce Anxiety (mental health collaboration)
- Increase food nutrition (wants to gain weight)

Root Cause(s) of utilization/risk: Anxiety

Participant Strengths: Successful recovery from heroin and tobacco use.

Services included:

- PCP
- Community Health Team
- Northeast Kingdom Human Services
- Local Hub and Spoke
- Chronic Care Coordination SJCHC
- BAART drug treatment services
- Specialist for COPD

Case and/or Systems Challenges:

- This patient is very difficult to reach. She only returns calls periodically and frequently no-shows her appointments. Transportation is frequently listed as a reason she cancels.
- Refuses to meet with team due to anxiety in being with a group

Outcomes:

- Obtained local Suboxone provider and counseling, weight gain from 144 to 155
- Since collaboration no ER visits
- No ER visits since May 2015
- Stable treatment with COPD specialist

Case Study 5

Description of participant: Diagnoses of Alcoholism, Depression & Anxiety (history Suicidal Ideation), HTN, Hyperlipidemia, Memory Loss/ Amnesia, Tourette’s, Cannabis Abuse, 13 ED visits prior to engagement

Services included:

- LCC (from medical home) identified
- Eco-map completed- support system identified
- Camden cards completed- domains of instability identified
- Pertinent team members contacted/ Treatment team formed

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- Care team meetings initiated to prioritize and address areas of instability
- Plan of Action (aka Shared Care Plan) created
- SASH services on site instrumental in helping support patient with care plan and with contacting medical home with any concerns (ie: when patient started to escalate).
- Care team meetings continued until patient was stabilized

Case and/or Systems Challenges:

- escalating depression and anxiety
- poor emotion regulation and decision making
- significant concern re: possible relapse
- SI (warranting repeated trips to the ER)
- financial insecurity/ inability to manage finances and pay bills/ large debt accruing
- family conflict (possibility of family members exploiting finances)
- housing instability/ eviction notice
- concerns with medication compliance
- concerns with connection to medical home and follow through with treatment plans
- Significant Neuro concerns but again, lack of follow through with treatment plans and specialists.
- Pattern of no-showing for medical appointments and appointments with specialists. The result was many offices were refusing to reschedule.

Outcomes:

- 0 ED visits for 17 months post engagement
- Transitioned from 'Self-Management' status to 'Re-Engaged' after a series of ED visits in April 2016
- Patient was present for every Care Team Meeting

Recommendations

Given our contract with the State of Vermont ends in December 2016, VPQHC provides the following recommendations for the ICCMLC moving forward.

State of Vermont Leadership

VPQHC recommends the leadership continue and expand statewide adoption of Integrated Care Management as a standard of care through ongoing state support and reinforcement of ICCMLC concepts, goals and methods.

Based on the currently available data, leadership may wish to consider emphasizing the importance of developing a shared care plan within 2 months of a participant's enrollment in the ICCMLC. While the

majority of participants have a completed shared care plan (69.2%), with another 13.1% having a “partially” completed shared care plan, ideally this number should be at 100%.²

Also regarding the shared care plan, leadership may also wish to consider suggesting the Lead Care Coordinator purposely review, update, and ensure the participant has a current copy at periodic intervals. Based on data from the Participant Survey, participants may lose track of their shared care plan the longer they stay in the ICCMLC. The shared care plan should ideally be a living/breathing document, that the participant feels ownership of, and can regularly access online. The Care Navigator plans available to some participants may fulfill that role, however will not be immediately universally available.

The number of participants who had a shared care conference to ensure care is adequately coordinated among providers appears to be inadequate. Almost 50% of participants who should have had a shared care conference have not had one (based on process data from the “Data Tool”). There also appear to be participants with complete or partial shared care plans, who have not had a shared care conference. We recommend leadership review the accuracy of these data with communities, and encourage either improved reporting or increased uptake in the shared care conferences.

Participants have found the wide variety of education opportunities extremely valuable in developing and implementing best practice for ICCMLC. We recommend leadership continue their support of shared learning sessions, and may wish to consider the following topics, highlighted based on participating community feedback from earlier learning sessions:

- A refinement of evidence based best practices for ICM based on organizations’ experience using its tools and methods
- Change management training to facilitate community wide adoption of ICM
- Strategies for leaders to move toward broad community ownership of ICM
- Integration of the LCC in the referral process
- Strategies for forming patient experience panels to contribute advice and insight to the work
- Strategies for including MD or ED staff in shared care planning
- Scaling ICM to new partners and patients
- Support for the implementation and use of care navigator, including the integration of EMRs

Data collection, reporting, and interpretation are essential toward evaluating the effectiveness of the ICCMLC. Please see our more detailed comments on the evolution of the data tool and participant survey that will support a strong evaluation moving forward.

² When the analysis did not exclude those enrolled within the past 2 months, the results did not differ significantly.

Without staffed QI Facilitators, it will also be essential to have an identified state point of contact for addressing any community needs, problems, etc. on an ad hoc basis.

Participating Communities

Without the same level of statewide support, it is essential that all participating communities draft Local Sustainability Plans. These Sustainability Plans should include:

- Agency partner recruitment and training sessions
- Continued process and outcome data collection and reporting
- Continued adoption of the Care Navigator electronic Shared Care Plan
- Mutual agreements for privacy and information sharing policy and practice among all agency partners

Participating communities should continue to attend any shared learning opportunities the statewide leadership presents, such as in-person learning sessions and webinars, to increase their knowledge of and insight into ICM principles and methods. Outside of organized shared learning activities, communities should also seek to maintain and expand collaborative communication and mutual support with other participating communities throughout the state.

The results from the LCC survey suggested some discomfort with the tools and processes used for ICM, such as Eco-mapping, Camden Cards, and Root Cause Analysis (RCA). VPQHC recommends communities retain a primary focus on the goal of each tool and method over any proscribed or regimented perspective on their use. For example, teaching LCCs that the goal of using RCA for ‘discovering what we may have been missing as a cause of a person’s frequent utilization’ may be more instructive and less intimidating than ‘review the record for the last 10 years and be sure to identify root causes from 4 domains.’ Consider emphasizing the ‘why’ of the method of analysis for the purpose of the goal of insight into the person’s situation over the specific terminology of the process and tools.

Data Tool

The “Data Tool” was developed to collect process data on ICCMLC participants from each participating community. It is currently sent bi-monthly as an excel file to the QI Facilitator (often after several reminders were sent out to communities), and often has large amounts of missing data. Our recommendation is to replace the Data Tool with a cloud-based database, that will allow for ongoing data entry by multiple users and a clear record of changes made to participant details.

The new data tool should be designed with input from communities, to ensure it is a tool that they feel will be useful to their internal tracking. Participant data will still be anonymous, but the tool should also allow for data entry from multiple users within the community who provide care for the participant, minimizing the burden of data entry for the coordinator. Notifications should be coded, to help

communities flag missing data or identify next steps (for example, that a participant's 6 month follow-up survey is due, or that the shared care plan should be updated), which will both support the goals of the ICCMLC and reduce the amount of missing data. Reports similar to those detailed above can also be automated, and be available to communities and the coordinating entity, to enable real time status reports whenever needed. If resources within the state are limited, VPQHC would be interested in supporting the development of this database, should funds be available.

Participant Survey

The main issue with the participant survey was the low response rate, so added emphasis on encouraging participants to take the survey, particularly at baseline/enrollment, will be helpful. Feeding data back to participants is often a useful way of encouraging participation by showing respondents how their data will be used. The addition of notifications to the data tool as mentioned above could also support a higher response rate.

In many cases, proxies helped the ICCMLC participant complete the survey due to limitations of the participant. It is important to consider the impact of proxies on the responses and try to minimize any biases inherent in this situation moving forward. Our suggestions for proxies within each community are:

- Train a set of proxy interviewers in neutral interviewing. Numerous studies have looked into the effect on responses by proxy interviewers, showing a range of effects, some slanting the responses more positively, some more negatively, depending on the type of health condition and relationship of the proxy to the respondent. Trained interviewers will minimize these effects.
- Avoid using the Lead Care Coordinator as a proxy, as many of the questions ask the respondent to assess the role provided by the Lead Care Coordinator.
- Encourage communities to support participants' independent completion of the online survey, while providing the support they need. For example, a Lead Care Coordinator could provide a computer, set up with the online survey to the participant, along with a brief tutorial on how to fill in responses, but leave the participant to complete the responses on their own.

There is a yearly cost for Survey Monkey, which has been the platform used to house the online survey. Some of the communities wished to keep their surveys internally – others used VPQHC's license to house the survey. Funds to support Survey Monkey were provided to communities, but may not be available from January 2017 on. The State of Vermont may consider either transferring all surveys to their State license, or identifying a free option for housing the survey moving forward.



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Currently, there is no identifying information on the survey. There has been some discussion of including fields for participant ID and ICCMLC community, which would enable a person-level analysis of their feedback over time (as ideally each participant completes a survey every 6 months). While this would provide some useful individual feedback for the participant's care team, the addition of identifying information may inhibit the participants' comfort in providing honest answers. It is our suggestion to maintain the Participant Survey as a population-level analysis tool, and that the Lead Care Coordinator encourage open communication with the participant regarding their concerns on an ongoing basis, in lieu of using the participant survey for this purpose.

As a note for the incoming State of Vermont staff, the primary contact for each ICCMLC community is the primary contact for the Participant Survey.

Conclusion

VPQHC is very grateful to have had the opportunity to participate in the tremendous work of the Vermont ICCMLC. We hope this report and our recommendations can continue to support a high level of care for patients with complex health conditions and psycho-social needs in 2017 and beyond.