Vermont's Integrated Communities Care Management Learning Collaborative

January 6, 2016

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.

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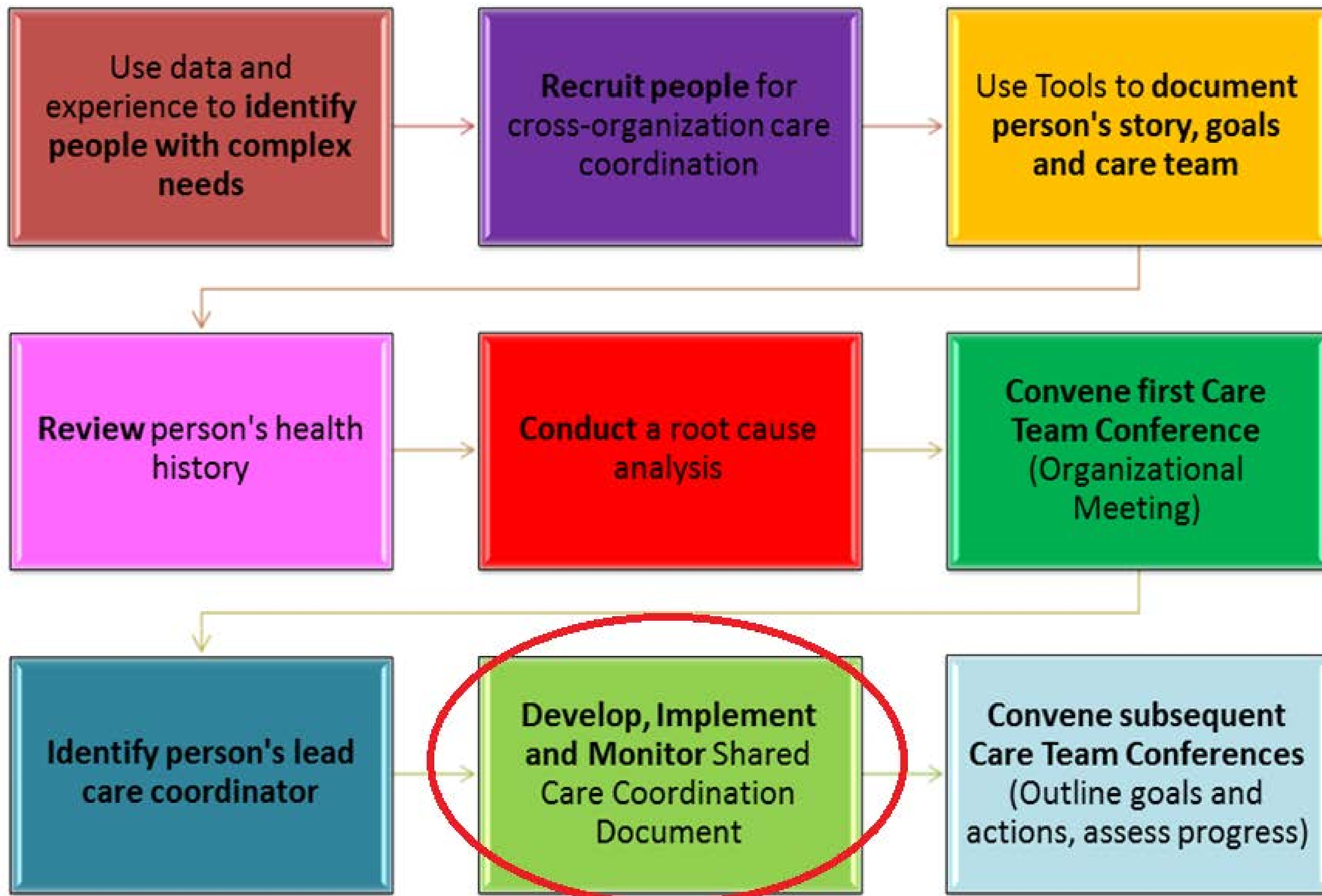
Overview of Today's Agenda:

Time Frame	Agenda Item	Speaker
12:00 – 12:10	Welcome & Updates	Pat Jones Health Care Project Director, Green Mountain Care Board
12:10 – 12:55	Shared Care Plans and Status • 12:10 – 12:15 Framework Review • 12:15 – 12:25 Rutland • 12:25 – 12:35 Burlington • 12:35 – 12:45 St. Johnsbury • 12:45 – 12:55 Principles	Lauran Hardin MSN, RN-BC, CNL Director Complex Care, Mercy Health System
12:55 – 1:00	Preview of Next Learning Session	Jenney Samuelson Assistant Director, Blueprint for Health

Key Interventions in Vermont's Integrated Communities Care Management Learning Collaborative *(order of interventions may vary)*



Case Study Exercise with Lauran Hardin

Lauran Hardin MSN, RN-BC, CNL
Director Complex Care
Mercy Health System
Grand Rapids, Michigan

Framework for Review

- Case Review
- Care Team formation & Composition
- Meeting schedule of the team
- Has a shared careplan been developed?
- How is the careplan managed/updated?
- How are you linking the plan in the Cross Continuum Team?

Rutland Case Study

Sarah Narkewicz

- **S.W:** 47 y/o female
- **MVP** insurance
- **Medical Dx**: Migraines, Fibromyalgia, Diabetes, OSA, GERD, COPD
- **Psych Dx**: Major Depressive Disorder, 3 previous suicide attempts
- **In the past year:**
  - 89 visits to ED in Rutland Regional Medical Center
  - 4 inpatient admissions to Dartmouth Hitchcock

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Rutland Case Study (cont'd)

- **Root Cause:** Mental Health, daughter with addiction
- **At the table:** PCP, Community Health Team, Rutland Regional Medical Center, ED, Dartmouth Hitchcock Neuro
- **Primary reason for ED visit:** Headache
- **Who we would like to have at the table**: (the above participants) and MD from ED, MD from Neuro at Dartmouth, MVP (insurer) case manager, BHT clinician
- **Other factors:** 4 year pattern of ED visits, system barriers related to Mental Health, and how and when to involve the family in care planning?

St. Johnsbury Case Study

Lew Apgar and Gidget Doty

- **P. S:** 58 y/o female (now 59)
- **Medicare/Medicaid**
- **Medical Dx:** COPD, Hypertension, Hyperlipidemia, Hepatitis C, Multinodular Thyroid Disorder, Charcot Marie Tooth Disease, Allergic rhinitis, Tobacco use Disorder (currently vaping), Migraine, Chronic Pain.

- **Psych Dx:** Polysubstance Abuse, Depression, Anxiety, Panic Disorder, Multiple Suicide Attempts. Self reports of OCD and ADD.
- ***Original Case presentation* - In the past year:**
  - 12 ER visits, mostly for COPD exacerbation vs Anxiety, one for Over Dose and one for Abscess Tooth.
  - 1 inpatient admission for Over Dose.

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St. Johnsbury Case Study

- **Root Cause:** Anxiety

- ***Originally* At the table:** PCP, CHT, NEKHS, Suboxone Provider/Counselor (out of area).
- Now at the table: PCP, CHT, NEKHS, local Hub and Spoke patient

- ***Original* Barriers to stabilization:** This patient is very difficult to reach. She only returns calls periodically and frequently no-shows her appts. Transportation is frequently listed as a reason she cancels.

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St. Johnsbury

Update January 2016

Current Team: Gidget Doty at CCC SJCHC, Lew Apgar at Community Connections, Lily Cargill, APRN at NEKHS, BAART, Dr. Jedlovszky for COPD.

- **Successes**
  - Obtained local Suboxone provider and counseling
  - No ER visits since May 2015
  - Stable treatment with COPD specialist
- **Current barriers to stabilization**
  - Still difficult to contact
  - Intermittent engagement (no shows)
  - Refuses to meet with team due to anxiety in being with a group

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Burlington Case Study
Kathleen Audy

Case Study Overview:

Key Characteristics:

- 53 yr old male
- Enrolled in Medicaid and VCCI
- Diabetic, blind, partial amputee

Why this patient?

- Multiple hospitalizations
- Numerous organizations involved
- Complex medical and social needs
- Difficulty sustaining improvements in health

Options for Embedding Plans

- What is your scope of influence?
- What resources do you have – HIE, EMR, Paper, Email, Ping
- Where will the plan change the outcome?

Triggering Events to Revise Plans

- Who is managing the plan?
- What is the interval for revision?
- What should trigger a revision?
  - General Plan
  - Acute Episode
  - Transition in Level of Care
- Setting the expectation for Revision

Questions?

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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: Robyn Skiff, Robyn.Skiff@uvmhealth.org

  -Rutland: Sarah Narkewicz, snarkewicz@rrmc.org

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

Or contact our Quality Improvement Facilitators, Nancy Abernathey at n.abernathey@gmail.com or Bruce Saffran at BruceS@vpqhc.org

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