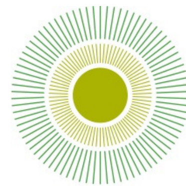
Care Navigator Implementation: A Community Perspective

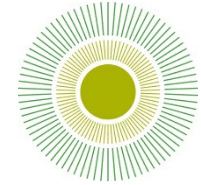
November 4, 2016

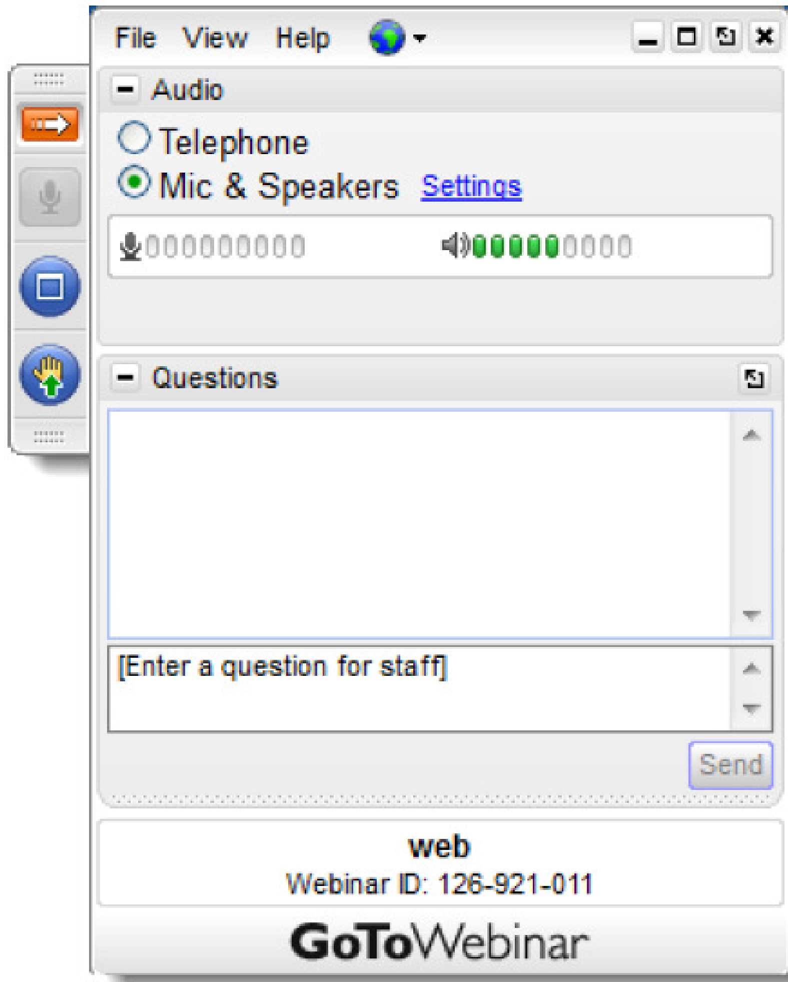


OneCareVermont

OneCareVT.org

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.

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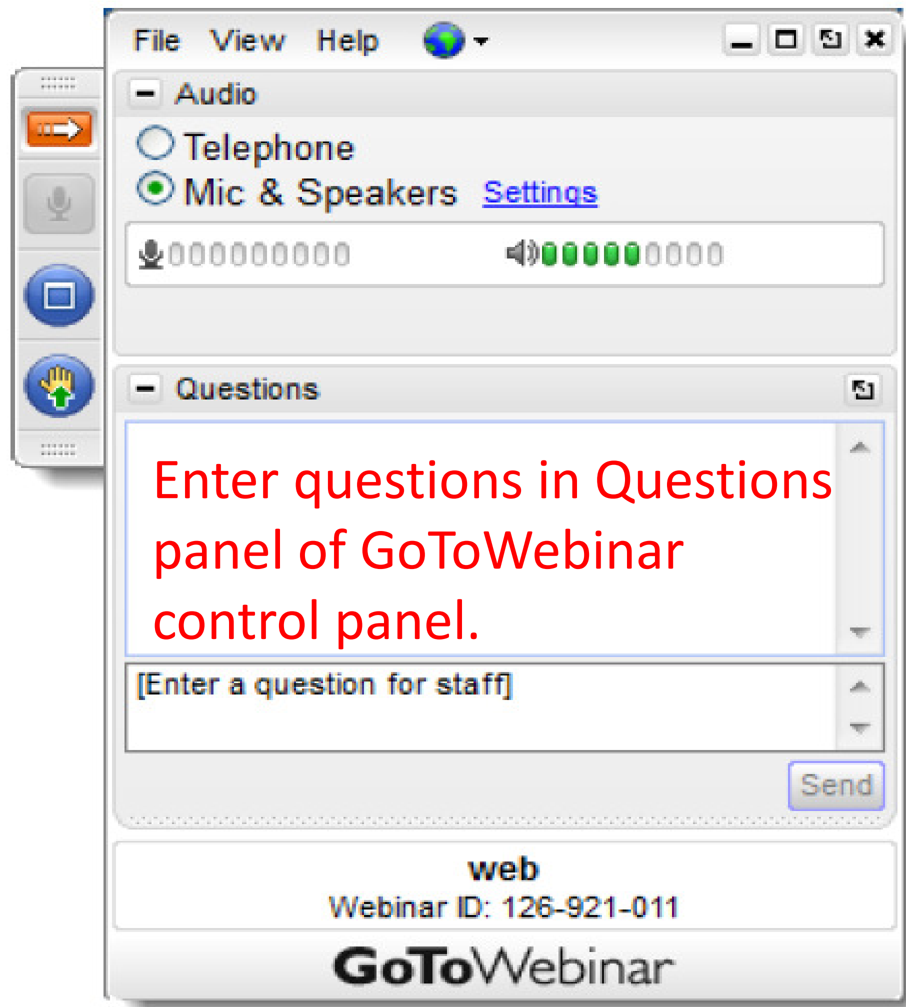
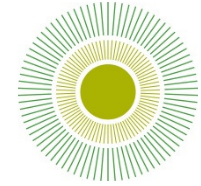


- All participants will remain muted for the duration of today's webinar. Please submit questions via the Questions pane in the webinar control panel.
- **This webinar is being recorded.** Slides and recording will be used for training purposes

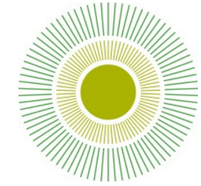
Learning Objectives



- Identify the steps needed to start CN implementation in your community
- Understand the CN User Roles to be identified in your community
- Knowledge of the time frame for CN roll out
- Gain information on current steps that can be taken to prepare for CN roll out in your community

- *This webinar is an introduction to content and more detailed information will be included in the December learning collaborative meeting*
- *Questions: please type your questions in the question box at any time during the Webinar*

Care Coordination Within An ACO



Insurers:

Medicare, Medicaid, BCBSVT

Medical Providers:

Patient attribution: PCPs and Specialists

Hospitals, HHA, SNF, MH Agencies

OneCare Vermont

Dartmouth-Hitchcock Medical Center
University of Vermont Medical Center

Patient

Triple Aim:

- ↑ Patient/Family Satisfaction
- ↑ Coordination of Care to ↓ Cost
- ↑ Quality

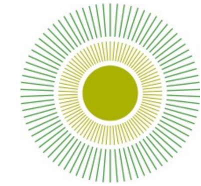
State and Federal Health Care Reform

(System Delivery and Payment)

Continuum of Care Providers:

Agencies on Aging, SASH, Community Organizations and VT State Agencies

Care Navigator Timeline



April
CN software initial set up for OCV

May
Focus Groups Held

June
Incorporated Focus Group feedback into CN

June 30th
CN initial training for RWJF communities

July and August
- System access to training version
- Onsite training with pilot communities

September
Go Live!
- Comprehensive training plan developed
- System enhancements

October
Regional teams begin to identify the top risk patients

November
Shared learning with care management learning collaborative

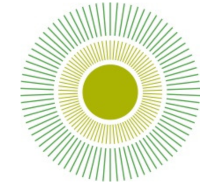
December
Community workflow assessment begins through ICCMLC Learning Session

January 2017
All interested communities beginning onboarding process; VMNG risk communities expand use of CN beyond top 5%

February - ongoing
Training and engagement of care team members

We are here

Care Navigator Community Utilization



St. Albans

23 Users (7 CCS)

NMC

NMC CHT

NCSS

CVAA

FCHH

3 Community PCP practices

Berlin

17 Users (3 CCS)

CVMC

CVHHH

WCMH

SASH

CV Council on Aging

OCV

CN Implementation Team

Bennington

29 Users (4 CCS)

SVMC CHT

Bayada

Bennington Project Independence

Bennington Council On Aging

Burlington

22 Users (4 CCS)

UVMMC CHT

Bayada

CVAAA

VNA

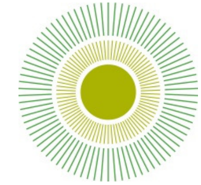
Howard Center

Goals of Software:
- Identification of high risk patients
- Identification of Care Team Members
- Care Team Communication
- Shared Care Plan Development

CCS = Care Coordination Supervisor
Has access to lists of patients and can assign patients

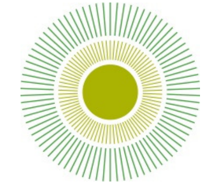
- CCS: Access to patients at TIN Level
- CCS OCV: Access to all OCV attributed patients

User Roles



- **Care Coordinator**
  - Assigned patients by Care Coordination Supervisor
  - Can only view patients that are assigned or added to the care team
  - Can add other care team members
- **Care Coordination Supervisor (CCS)**
  - Viewing of patient lists is based on “business unit”
  - Assign patients to care coordinators
- **Care Coordination Supervisor OCV (CCS OCV)**
  - Viewing of patient lists for all of OneCare
  - Assign patients to care coordinators

Care Navigator Community Implementation



1. Convene HSA community leadership → Intro to CN Training → 2. Convene core team → CN User Training #1 and CCS attend CCS Training

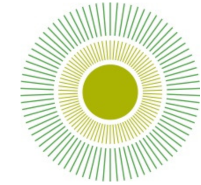
→ Convene core team to identify initial patients → Identify Care Team Members → Assign patients to LCCs → CN User Training #2 → Develop/Refine community specific CC workflow (process flow template)

→ Provide CC for initial 5 patients → Convene core group to debrief & revise processes as needed

Meet with engaged medical practices → Refine and Implement expansion plan & CC community workflow → Expand to additional patients and care team members (integrate with existing CN trainings) → Community-level monthly CC metrics monitoring

Update Stakeholders & future Care Team Members on progress, roll out, & expansion plans

Care Navigator Community Implementation



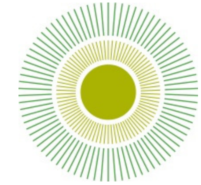
1. Convene Community Leadership

Goals:

- Define core team for CN implementation
- Identify lead point person for community

Update Stakeholders & future Care Team Members on progress, roll out & expansion plans

Convene Community Leadership

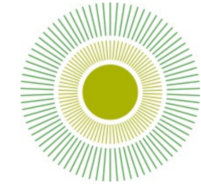


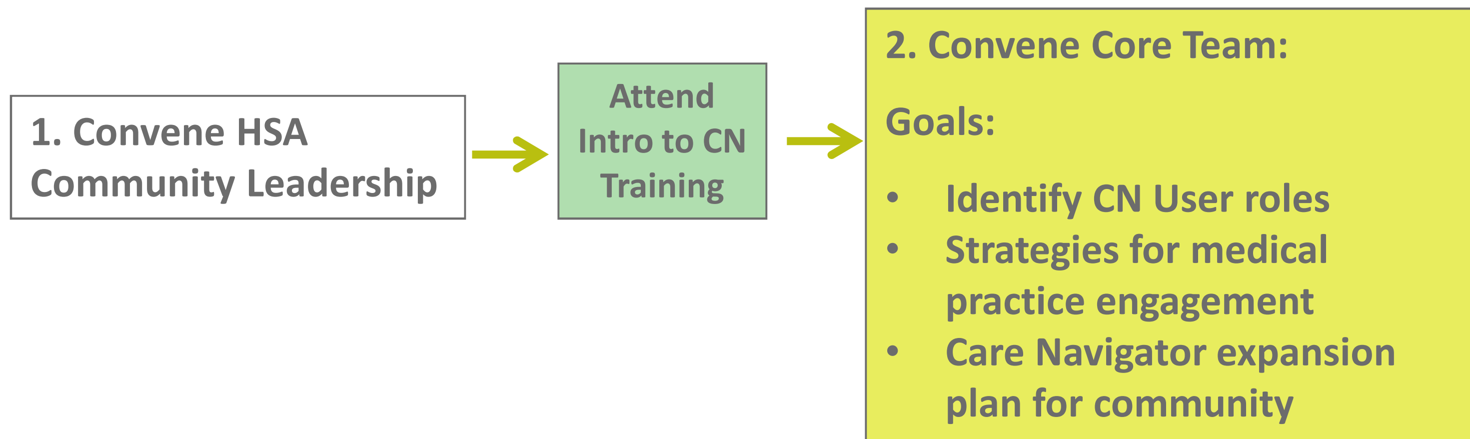
St. Albans – Lesley Hendry

Tips and Opportunities

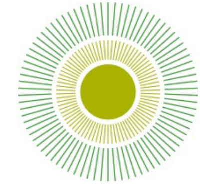
- Community leadership members in attendance
- Define Core Team for CN Implementation
- Involvement with primary care
- Identify lead point person for community
- How has your participation in ICCMLC informed this step?
- Integration with ICCMLC existing meetings?

Define Community CN Implementation Plan





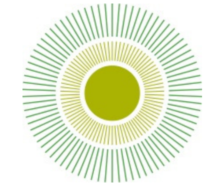
Convene Core Team



Bennington – Terry Reinertson, RN, BSN

Tips and Opportunities

- Identify organizations that work closest within HSA
- Identification of CN user roles in community
- Medical Practice Engagement
- Developed a phased approach of adding teams and individuals
- Expansion Plan



CARE NAVIGATOR ROLL OUT PLAN FOR BENNINGTON HSA

Phase I
Currently in progress with BP case managers, dietitian and spoke social worker

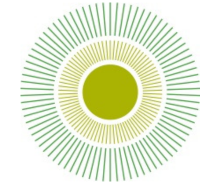
Phase II
SVMC Case Management – Billie Allard
SVMC Social Work – Billie Allard
SVMC Transitional Care – Billie Allard
VNA and Hospice – Ron Cioffi
Bayada – Kristi Cross
Manchester Home Services - Barbara Keough
Nurse Family Partnership
SASH – Kathy Cardiff

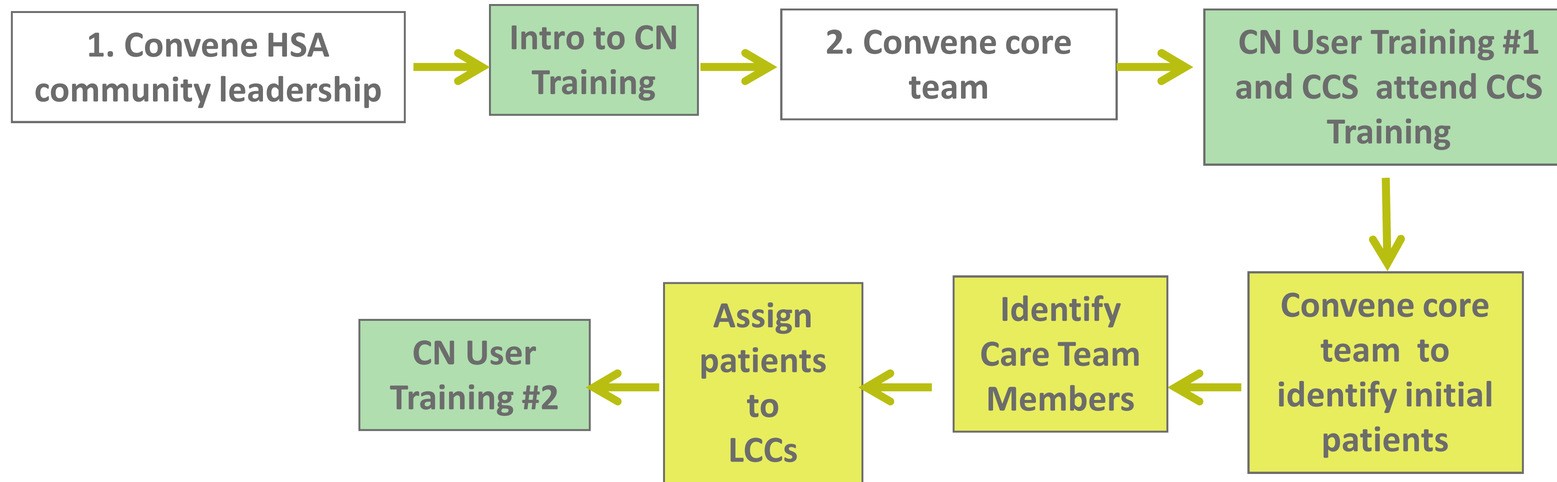
Phase III
VCCI – Cindy Ghosh and Sharon Moore
Council on Aging – Jennifer Plouffe
Children's Integrated Services – Kelly Belville
VCIL-Colleen Arcodia
Brain Injury Association
CLR
Bennington Health & Rehab
Crescent Manor
Vermont Veterans Home
UCS-**? Just BP staff or others at UCS**

Phase IV-- these users will most likely only need user access allowing demographic information
BPI
Keene medical
Lincare
Kathy Dockum-self management/tobacco cessation coordinator Blueprint
Meals on wheels
Ladies first
Bennington rescue
Turning point
BROC
Economic services
Voc rehab

Phase V
At home senior care
Bennington Free Clinic
VA Medical Center

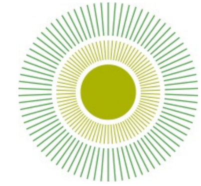
Identify Patients and Assign to LCCs





Update Stakeholders & future Care Team Members on progress, roll out, & expansion plans

Identify Initial Patients

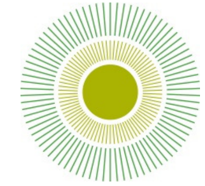


Burlington – Robyn Skiff

Tips and Opportunities

- Identification of patients
- Identification of care team members
- Assignment of Lead Care Coordinator
- How has your participation in ICCMLC informed this step?
- Integration with ICCMLC existing meetings?

Chittenden County Complex Care Team



Chittenden County Community Collaborative
1st Wednesday in Colchester

Planning Team
1st Tuesday 412 Farrell St.

Participant Identification Team
4th Monday at UVMMC

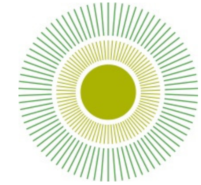
Chittenden South
Charlotte, Shelburne, Hinesburg, St. George

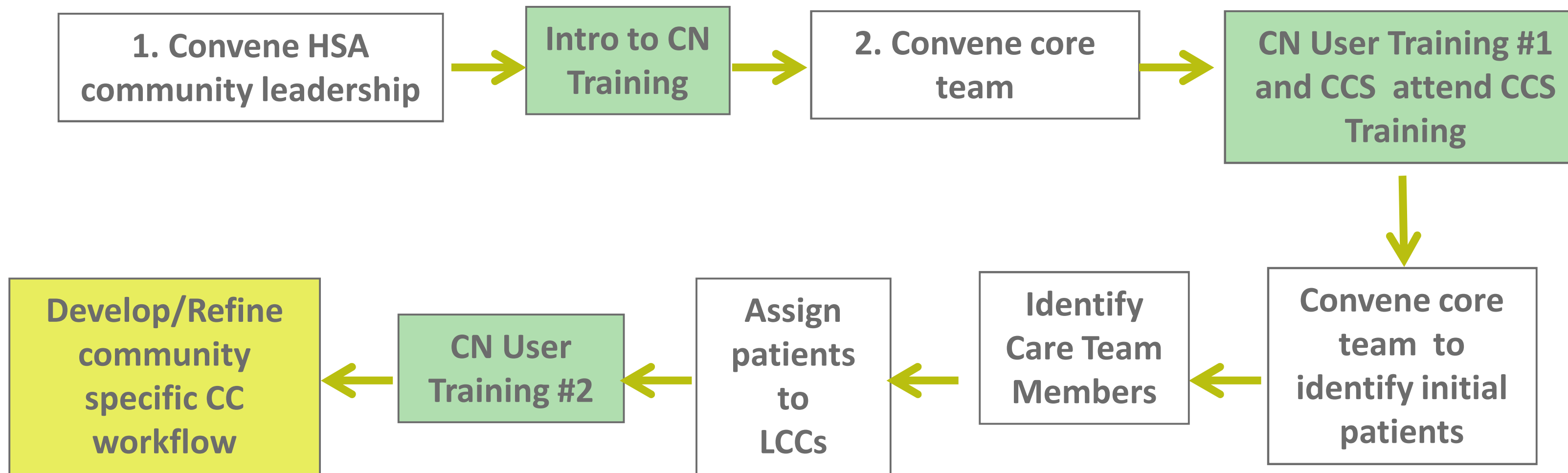
Chittenden North
Milton, Colchester

Chittenden West
2nd Monday at CHCB
Burlington, NNE, Winooski, South End

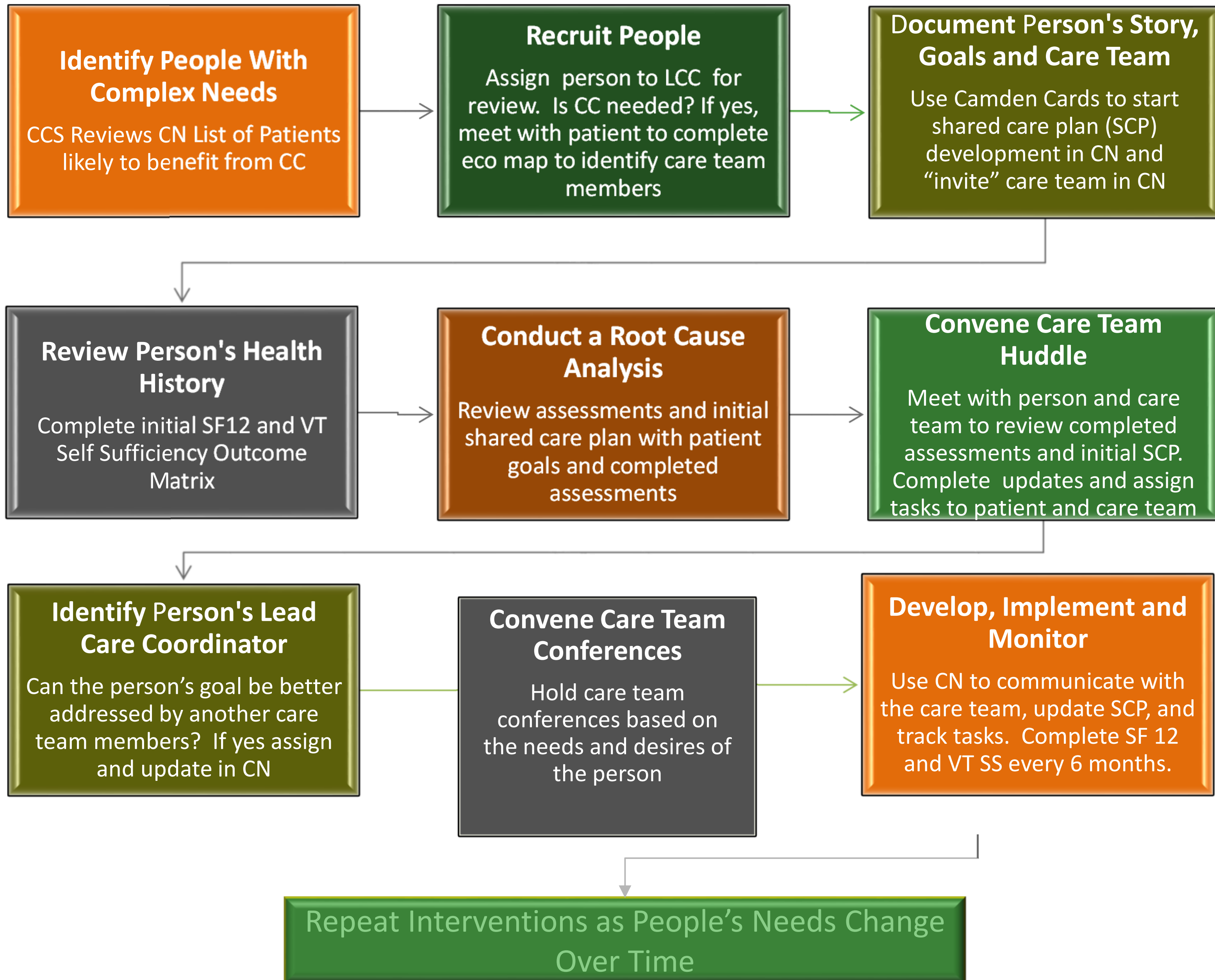
Chittenden Central
Williston, Essex, Richmond, So. Burl, Jericho

Community Specific Care Coordination Workflows

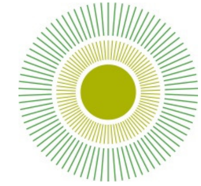




Update Stakeholders & future Care Team Members on progress, roll out, & expansion plans


ICCMLC Care Coordination Workflow
(Order of Interventions May Vary)
Identify People With Complex Needs
CCS Reviews CN List of Patients likely to benefit from CC
Recruit People
Assign person to LCC for review. Is CC needed? If yes, meet with patient to complete eco map to identify care team members
Document Person's Story, Goals and Care Team
Use Camden Cards to start shared care plan (SCP) development in CN and "invite" care team in CN
Review Person's Health History
Complete initial SF12 and VT Self Sufficiency Outcome Matrix
Conduct a Root Cause Analysis
Review assessments and initial shared care plan with patient goals and completed assessments
Convene Care Team Huddle
Meet with person and care team to review completed assessments and initial SCP. Complete updates and assign tasks to patient and care team
Identify Person's Lead Care Coordinator
Can the person's goal be better addressed by another care team members? If yes assign and update in CN
Convene Care Team Conferences
Hold care team conferences based on the needs and desires of the person
Develop, Implement and Monitor
Use CN to communicate with the care team, update SCP, and track tasks. Complete SF 12 and VT SS every 6 months.
Repeat Interventions as People's Needs Change Over Time

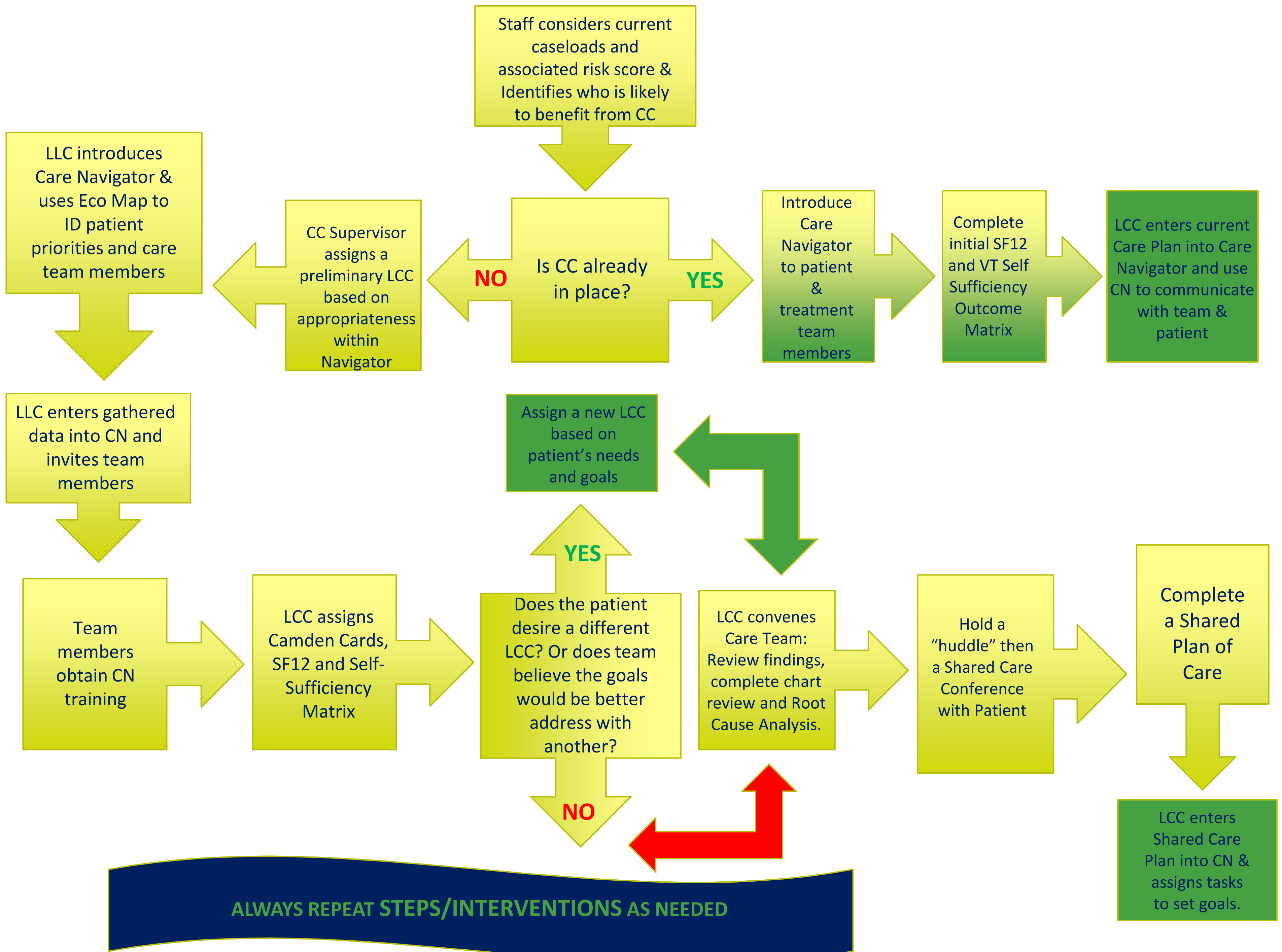
Community Specific Workflows



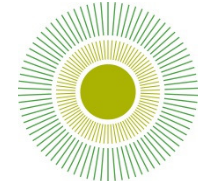
Berlin – Heather Colangelo

Tips and Opportunities

- Initial use of workflow
- How has your participation in ICCMLC informed this step?
- Integration with ICCMLC existing meetings?


Staff considers current caseloads and associated risk score & Identifies who is likely to benefit from CC
LLC introduces Care Navigator & uses Eco Map to ID patient priorities and care team members
CC Supervisor assigns a preliminary LCC based on appropriateness within Navigator
NO
Is CC already in place?
YES
Introduce Care Navigator to patient & treatment team members
Complete initial SF12 and VT Self Sufficiency Outcome Matrix
LCC enters current Care Plan into Care Navigator and use CN to communicate with team & patient
LLC enters gathered data into CN and invites team members
Assign a new LCC based on patient's needs and goals
YES
Team members obtain CN training
LCC assigns Camden Cards, SF12 and Self-Sufficiency Matrix
Does the patient desire a different LCC? Or does team believe the goals would be better address with another?
LCC convenes Care Team: Review findings, complete chart review and Root Cause Analysis.
Hold a "huddle" then a Shared Care Conference with Patient
Complete a Shared Plan of Care
NO
LCC enters Shared Care Plan into CN & assigns tasks to set goals.
ALWAYS REPEAT STEPS/INTERVENTIONS AS NEEDED

Next Steps



All Communities

Pre-work

Review CN roll out and begin to think how you will complete the pre-work for implementation:

- Identify initial community leadership team and core team in your community – don't reinvent the wheel if you can use one of your ICCM groups. Do you need any new members such as primary care?
- Thinking about your ICCM process for identifying lead care coordinators, define a process for identifying CN roles - care coordinators, care coordination supervisors and care coordination supervisors
- Identify initial people receiving care coordination services to include in a pilot from your ICCM list cross matched to make sure they are OCV attributed patients – (Randolph, Springfield, and St. J?)
- Document your initial test of a community specific workflows for your first pilot teams

Attend December in person learning session -

Save the Date – December Learning Sessions!

We will continue discussion of Care Navigator implementation at the Integrated Communities Care Management Learning Collaborative's December learning sessions. Registration links for these events will be distributed shortly.

December 15th:

Vermont Veteran's Home

325 North St, Bennington, VT 05201

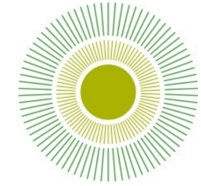
December 16th:

Department of Vermont Health Access

312 Hurricane Lane, Williston, VT 05495

We look forward to seeing you then! Please contact Jennifer.Le@Vermont.gov with any questions about the December learning session.

Contact Information:



Maura Crandall: Maura.Crandall@onecarevt.org

Lesley Hendry: lhendry@nmcinc.org

Terry Reinertson: Teresa.Reinertson@svhealthcare.org

Robyn Skiff: Robyn.Skiff@uvmhealth.org

Heather Colangelo: HeatherC@WCMHS.ORG