Vermont's
"Integrated Communities"
Care Management
Learning Collaborative

Working Together to Improve Care for Vermonters

July 2015 Kick-Off Webinar

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

Welcome and Introductions:

Community Contacts (for questions about participation):

- **St. Albans:** Candace Collins, Northwestern Medical Center, (802) 524-1211, ccollins@nmcinc.org
- **Middlebury:** Susan Bruce, Porter Medical Center, (802) 382-3406, sbruce@portermedical.org
- **Central Vermont:** Mary Moulton, Washington County Mental Health, marym@wcmhs.org
- Elise McKenna, Community Health Services of Lamoille County, (202) 285-5536, emckenna@hpdpconsulting.com
- **Windsor:** Jill Lord, Mt. Ascutney Hospital & Health Center, (802) 674-6711, jill.m.lord@mahhc.org
- **Springfield:** Trevor Hanbridge, Springfield Health Center, (802) 886-8998, thanbridge@springfieldmed.org
- **Randolph:** Jennifer Wallace, Gifford Medical Center, (802) 728-2783, jwallace@giffordmed.org
- **Brattleboro:** Wendy Cornwell, Brattleboro Memorial Hospital, (802) 257-8325, wcornwell@bmhvt.org

Welcome and Introductions (cont'd):

Quality Improvement Facilitator Contact Information:

- **Nancy Abernathey,** MSW, LICSW, Vermont Heath Care Innovation Project (VHCIP) Quality Improvement Facilitator; (802)238-0746, n.abernathey@gmail.com
  - ***Providing facilitation support to:*** St. Albans, Burlington, Rutland, Central Vermont, and Morrisville

- **Bruce Saffran**, RN, VHCIP Quality Improvement Facilitator; (802) 262-1306, BruceS@vpqhc.org
  - ***Providing facilitation support to:*** St. Johnsbury, Springfield, Brattleboro, Windsor, and Randolph

- **Alexandra Jasinowski,** Blueprint Facilitator, Porter Medical Center, (802) 388-5625, ajasinowski@portermedical.org
  - ***Providing facilitation support to:*** Middlebury

- **VHCIP Quality Improvement Facilitator #3 (TBD)**
  - ***Providing facilitation support to:*** TBD

Welcome and Introductions (cont'd):

State Contacts (for questions about statewide Learning Sessions):

- **Department of Vermont Health Access:** Erin Flynn, Senior Health Policy Analyst; (802) 878-7852; erin.flynn@state.vt.us
- **Green Mountain Care Board:** Pat Jones, Health Care Project Director; (802) 828-1967; pat.jones@state.vt.us
- **Blueprint For Health:** Jenney Samuelson, Assistant Director, (802) 654-8929, jenney.samuelson@state.vt.us

Welcome and Introductions (cont'd):

Today's Presenters:

- Stefani Hartsfield, Operations Manager, Support and Services at Home (SASH)/Cathedral Square Corporation; Hartsfield@cathedralsquare.org
- Miriam Sheehey, Assistant Director of Clinical Operations, OneCare Vermont; Miriam.Sheehey@OneCareVT.org
- Patty Launer, Community Health Quality Manager, Bi-State Primary Care Association; plauner@bistatepca.org
- Pat Jones, Health Care Project Director, Green Mountain Care Board; Pat.Jones@state.vt.us

Background:

- Vermont has several statewide health care reform work groups, including the Care Models and Care Management Work Group of the Vermont Health Care Innovation Project (also known as the State Innovation Model, or “SIM” Grant).

- This Work Group identified two key priorities:
  - …to better serve all Vermonters (especially those with complex physical and/or mental health needs), **reduce fragmentation with better coordination of care management activities**…
  - …[to] better **integrate social services and health care services** in order to more effectively understand and address **social determinants of health** (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters…

- The Work Group designed a Quality Improvement Learning Collaborative to act on these priorities.

Learning Collaborative Snapshot:

- 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 human service providers are invited to participate in the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models on behalf of communities across Vermont.**

What we want to do – Near-Term:

- Near-term goals are to:
  - On behalf of at-risk people, learn about and implement promising interventions to better integrate cross-organization care management;
  - Increase knowledge of data sources, and use data to identify at-risk people and understand their needs;
  - Improve communication between organizations;
  - Reduce fragmentation, duplication, and gaps in care; and
  - Determine if interventions improve coordination of care.

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What we want to do – Longer-Term:

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

Interface with Other Initiatives

- “Unified Community Collaboratives” (UCCs; also known as Regional Clinical Performance Committees or RCPCs) have been established by the Blueprint, ACOs, and health care and social service organizations in each health service area.
- UCCs/RCPCs set clinical and care management priorities for each health service area.
- Several UCCs/RCPCs have selected the Learning Collaborative as a performance improvement project to address their priorities and support cross-organization integrated care management.

Interface with Other Initiatives (cont'd)

- **The Learning Collaborative can support UCCs/RCPCs with:**
  - Skilled quality improvement facilitators
  - Expert national faculty
  - Tools for implementation, testing and evaluation of promising interventions to support integrated cross-organization care management
  - Shared learning opportunities through connection with other communities
  - Core competency training for front-line care managers

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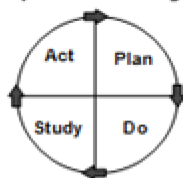
How we will do it – Learning Model:

Pre-Work
(June - August 2015)

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)
(September 2015)

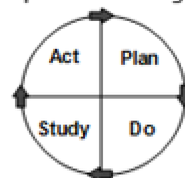
Action Period
community teams working together to implement change)



(September - November 2015)

Learning Session II
(Teams gather for a face-to-face meeting)
(November 2015)

Action Period
community teams working together to implement change)



(November 2015 - January 2016)

Learning Session III
(Teams gather for a face-to-face meeting)
(January 2016)

Spreading the Change

How we will do it – Community Commitment:

1. Form cross-organization Integrated Community Teams to improve care management for at-risk people.

2. Identify current care management services and needs in the community (including gaps in services).

3. Agree on criteria to define at-risk people; identify people in need of integrated care management; conduct outreach to those people and their families.; and identify lead care coordinators.

4. Establish more effective communication and integration between team members, on behalf of people in need of care management services, using interventions such as shared care plans, care conferences, and care management rounds.

5. Participate in shared learning opportunities, including in-person learning sessions, webinars, and skills training for front-line care managers.

6. Become familiar with performance measures to evaluate success of the interventions; collect, analyze and report data for those measures.

Who will do it – Potential Team Members:

- People in need of care management services and their families
- Primary Care Practices participating in ACOs (including care coordinators)
- Designated Mental Health Agencies and Developmental Services Providers
- Visiting Nurse Associations and Home Health Agencies
- Hospitals and Skilled Nursing Facilities (including their case managers)
- Area Agencies on Aging
- Community Health Teams and Practice Facilitators (Vermont Blueprint for Health)
- Support and Services at Home (including SASH coordinators and wellness nurses)
- ACOs (OneCare, CHAC, ACCGM/VCP)
- Medicaid: Vermont Chronic Care Initiative (including case managers)
- Commercial Insurers (BCBSVT, MVP, Cigna)
- Agency of Human Services
- Community Action Agencies
- Other organizations providing health or human services in your community

How Team Members will Benefit:

The Learning Collaborative will:

- Provide expert faculty and skilled Quality Improvement Facilitators to assist participating organizations in improving care management services for at-risk people;
- Help build "Integrated Communities" to serve broader populations;
- Create a statewide "Learning Community" to provide continuing education for front-line care management staff; and
- Connect participants with Vermont's Health Care Reform initiatives.

How Team Members will Benefit – Quality Improvement Facilitator Support:

Skilled quality improvement facilitators can support communities, upon request, by:

- Providing training on the Plan-Do-Study-Act model of quality improvement for cross-organization community teams;
- Assisting with bi-weekly community meeting facilitation, agenda development, minutes, identification of action steps, and follow-up;
- Assisting with implementation of tools/processes to be tested;
- Creating templates and assisting with data collection for measures of progress/success;
- Helping to coordinate in-person learning sessions and monthly webinars; and
- Mapping work flows and processes so that successful interventions can be sustained

Proposed Timeline:

- **Pre-Work Period:** Recruit organizations, attend quality improvement training, use data to identify improvement priorities and at-risk people – June-August 2015
- **Bi-Weekly Community Team Meetings:** Starting in late July, meet twice a month (or more) for at least six months.
- **Monthly Educational Webinars:** 1 hour (during months without in-person learning sessions)
- **1st In-Person Learning Session:** September 2015; full-day
- **First Action/Measurement Period:** Sept.-Nov. 2015
- **2nd In-Person Learning Session:** November 2015; full-day
- **Second Action/Measurement Period:** Nov. 2015-Jan. 2016
- **3rd In-Person Learning Session:** January 2016; full-day
- **Third Action/Measurement Period:** Jan.-March 2016
- **Core Competency Training for Care Managers:** Late 2015-Early 2016
- **Final Results and Next Steps:** September 2016

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Preview of Learning Session 1

<u>Curriculum Objective</u>: *Using data to identify people in need of integrated care management services; using engagement and outreach tools to ensure person-directed care; engaging in team building and cross-community learning.*

Time	Topic
8:30-9:00	Registration
9:00-9:15	Welcome and Opening Remarks
9:15-10:00	Cross-Organization Care Coordination: Benefits to the Person and the Providers *(Team from Round 1 Community)*
10:00-10:15	Break
10:15-11:45	Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management *(Camden Coalition of Healthcare Providers)*
11:45-12:30	Community Breakout Session 1
12:30-1:15	Lunch
1:15-2:15	Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management *(Camden Coalition of Healthcare Providers)*
2:15-2:30	Break
2:30-3:15	Community Breakout Session 2
3:15-4:00	Community Report Out and Closing Remarks

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Preview of Learning Session 2

<u>**Curriculum Objective:**</u> *Establishing a process for identifying lead care coordinators; learning more about the person's health and social needs; developing a shared care coordination document; building a cross-organization care team; engaging in team building and cross-community learning.*

Time	Topic
8:30-9:00	Registration
9:00-9:15	Welcome and Opening Remarks
9:15-10:30	Care Coordination Framework for People With Complex Care Needs *(Lauran Hardin, MSN, RN-BC CNL, Director Complex Care, Mercy Health, Grand Rapids, MI)*
10:30-10:45	Break
10:45-12:00	Identifying Lead Care Coordinators and Developing Care Coordination Documents *(Lauran Hardin)*
12:00-1:00	Lunch
1:00-2:00	Community Team Break Out Sessions
2:00-3:00	Co-Managing Care (*Team from Round 1 Community)*
3:00-3:15	Break
3:15-4:00	Community Report Out and Closing Remarks

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Preview of Learning Session 3

Curriculum Objective: *Implementing, using and updating a shared care coordination document in a cross-organization team; conducting care conferences; engaging in team building and cross-community learning.*

Time	Topic
8:30-9:00	Registration
9:00-9:15	Welcome and Opening Remarks
9:15-10:30	Working Together as an Integrated Multi-Disciplinary Care Team: Ten Steps Toward Implementation of Shared Care Coordination Documents
10:30-10:45	Break
10:45-12:00	Cross-Community Discussion Groups
12:00-1:00	Lunch
1:00-2:00	Working Together as an Integrated Multi-disciplinary Care Team: Negotiated Actions and Accountability, Ensuring that Care Coordination Document is Accessible, Monitoring and Oversight of Care Coordination Document
2:00-3:00	Community Team Break-Out Sessions
3:00-3:15	Break
3:15-4:00	Community Report Out and Closing Remarks

Next Steps:

- **Summer 2015:**
  - Pre-work within pilot communities
  - Preliminary identification of at-risk people who could benefit from integrated care management from multiple organizations
  - Background reading suggestions
- **September 2015:** First In-Person Learning Session!

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Questions and Answers