Binder Overview		
Tab	**Category**	**Documents**
1	General Overview	Key Dates, Attendees
2	Learning Collaborative Measures	Summary of Measures, Data Tool Examples
3	PDSA Worksheets	Worksheets
Action Period Materials		
4	Webinars	Add webinar slides as they occur
Session One Materials		
5	Pre-Session Materials	Reading Materials, Faculty Bios
6	Learning Session One	Agenda, Presentations & Handouts
7	Learning Session One Evaluation	Evaluation Form
Session Two Materials		
8	Pre-Session Materials	Reading Materials, Faculty Bios
9	Learning Session Two	Agenda, Presentations & Handouts
10	Learning Session Two Evaluation	Evaluation Form
Session Three Materials		
11	Pre-Session Materials	Reading Materials, Faculty Bios
12	Learning Session Three	Agenda, Presentations & Handouts
13	Learning Session Three Evaluation	Evaluation Form
Session Four (TBD) Materials		
14	Pre-Session Materials	Reading Materials, Faculty Bios
15	Learning Session Four	Agenda, Presentations & Handouts

Integrated Community Care Management Learning Collaborative:
Key Dates, 2015-2016

- **"Cohort 2" (West Coast Communities):** St. Albans, Morrisville, Central Vermont, Middlebury
- **"Cohort 3" (East Coast Communities):** Brattleboro, Grace Cottage, Randolph, Springfield, Windsor

Cohorts 2 & 3			
Date and Time	**Location**	**Topic**	**Expert Faculty**
June – August	Your Community	*"Pre-work Period"* Recruit community team members and use data to identify at risk people in your community and opportunities for improvements in care. **Note:** Training on the Plan-Do-Study-Act (PDSA) model for quality improvement will be offered at each community (scheduled by community lead and facilitator).	Quality Improvement facilitators will be available to assist communities as needed
Cohort 3: Tuesday; September 8th, 2015; 8:30 – 4:00 **Cohort 2:** Wednesday; September 9th, 2015 8:30 – 4:00	**Cohort 3:** Dartmouth Medical Center 1 Medical Center Dr., Auditorium G, Lebanon, NH 03766 **Cohort 2:** Sheraton Hotel & Conference Center 870 Williston Road Burlington, VT 05403 *Registration Information Forthcoming.*	*"Identifying and Engaging Individuals in Cross-Organizational Care"*	Kelly Craig, MSW Program Director, Care Management Initiatives Camden Coalition of Healthcare Providers Victoria DeFiglio, RN, BSN, Clinical Director, Cross-site Learning & Workforce Development
Action Period 1: September – November 2015	Your Community	Teams meet every two weeks to test and implement best practices using PDSA worksheets; collect and report data.	Quality Improvement facilitators will be available to assist communities as needed

Cohorts 2 & 3 (continued)			
Date and Time	**Location**	**Topic**	**Expert Faculty**
Wednesday; October 14th, 2015, 12:00 – 1:00	**Virtual (Webinar)** *Registration Information Forthcoming.*	*Proposed:* Follow up on one or more of the tools presented in the September learning session.	Kelly Craig, MSW *(invited)* Program Director, Care Management Initiatives Camden Coalition of Healthcare Providers
Cohort 3: Monday; November 16th, 2015 8:30 – 4:00 **Cohort 2:** Tuesday; November 17th, 2015 8:30 – 4:00	**Cohort 3:** Fireside Inn, West Lebanon, NH http://firesideinnwestlebanon.com/ *Registration Information Forthcoming.* **Cohort 2:** Sheraton Hotel & Conference Center 870 Williston Road Burlington, VT 05403 *Registration Information Forthcoming.*	*"Preparing to Deliver Integrated Care Management Across Organizations"*	Lauran Hardin MSN, RN-BC, CNL Director Complex Care, Mercy Health
Action Period 2: November – January 2016	Your Community	Teams meet every two weeks to test and implement best practices using PDSA worksheets; collect and report data.	Quality Improvement facilitators will be available to assist communities as needed
Wednesday; December 9th, 2015 12:00 – 1:00	Virtual (Webinar) *Registration Information Forthcoming.*	Proposed: *"Root Cause Analysis: Case Study Review"*	Lauran Hardin MSN, RN-BC, CNL *(invited)* Director Complex Care, Mercy Health

Cohorts 2 & 3 (continued)			
Date and Time	**Location**	**Topic**	**Expert Faculty**
TBD Pending Expert Faculty Availability	**Cohort 3:** Fireside Inn, West Lebanon, NH http://firesideinnwestlebanon.com/ *Registration Information Forthcoming.* **Cohort 2:** Sheraton Hotel & Conference Center 870 Williston Road, Burlington, VT *Registration Information Forthcoming.*	Proposed: *"Implementing Integrated Care Management Across Organizations: Using Shared Care Plans and Cross-Organizational Care Conferences"*	Jeanne W. McAllister, BSN, MS, MHA *(invited)* Associate Research Professor of Pediatrics, Indiana University School of Medicine
Action Period 3: January – March 2016	Your Community	Teams meet every two weeks to test and implement best practices using PDSA worksheets; collect and report data.	Quality Improvement facilitators will be available to assist
Wednesday; February 10th, 2016 12:00 – 1:00	Virtual (Webinar) *Registration Information Forthcoming.*	Proposed: *"Case Study Review with Expert Faculty"*	Kelly Craig, MSW *(invited)* Program Director, Care Management Initiatives, Camden Coalition of Healthcare Providers Lauran Hardin MSN, RN-BC, CNL *(invited)* Director Complex Care, Mercy Health Jeanne W. McAllister, BSN, MS, MHA

Overview of Potential Measures:
Integrated Communities Care Management Learning Collaborative

Qualitative Reporting by Each Team

Measures:

1. Identification of at-risk people:

Purpose: To assist teams in sharing effective strategies and lessons learned in identifying at risk people.

a. How did your team define at-risk people?
b. How did your team use data to identify their population?
c. How many people did your team identify?
d. Successes/barriers

2. Coordination Agreements

a. **Presence of agreements regarding information sharing between participating providers and community organizations:**

Purpose: To identify organizations and providers in each pilot area that should share information on at-risk people, to evaluate the presence of information sharing agreements between those organizations and providers, and to identify elements to include in the information sharing agreements (e.g., development of shared care plans, domains in shared care plans, and frequency of review and updates to shared care plans). To share strategies and lessons learned in establishing information sharing agreements between organizations and providers.

1. Participating providers and community organizations in your pilot community that have established or are in the process of establishing information sharing agreements
2. Elements in the information sharing agreements (e.g., development of shared care plans for at-risk people, qomains to be included in shared care plans, and frequency of review and updates to shared care plans)
3, Successes/barriers

b. **Presence of care coordination protocols between participating providers and community organizations:**

Purpose: To identify organizations and providers in each pilot area that should have care coordination protocols, elements to include in care coordination protocols, and strategies and lessons learned in developing/updating care c_oordination protocols.

1. Participating providers and community organizations in your pilot community who have developed or are in the process of developing care coordination protocols
2. Elements in the care coordination protocols
3. Successes/barriers

Mechanism for reporting: Each team provides a presentation at the October webinar; Power Point template will be provided.

Quantitative Measures to Evaluate Care for At-Risk People and Provider Experience

The following measures will be collected consistently across teams. More detail about the measures will be provided during the October webinar.

Process Measures (collected in the community}:

1. Presence of shared plan of care in at-risk person's medical record

2. Presence of lead care coordinator in at-risk person's medical record

3. Identification of single point of contact in at-risk person's medical record

Outcome Measures (collected statewide from claims data):

1. Avoidable ED Visits

2. Readmissions

3. Ambulatory Care Sensitive Admissions

Patient Experience:

1. Consider focus groups or interviews to ascertain experience of at-risk people with integrated care management.

Provider Experience:

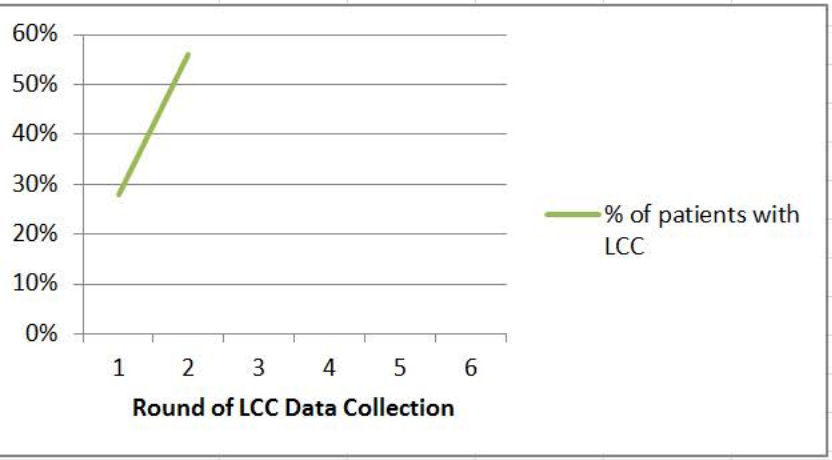
1. Measure provider experience with principles of team:..based care using existing survey tool.

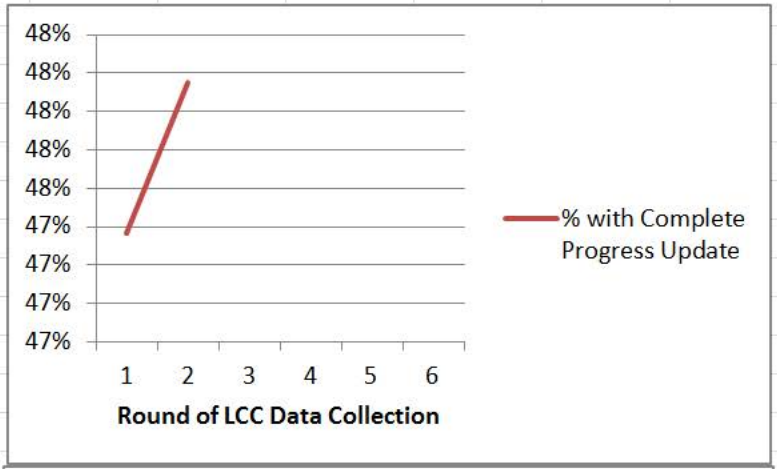
Columns	Code Book for Care Coordination Learning Collaborative Data Collection Tool	
A	Person/Patient Identification Number	
B-H	Lead Care Coordinator	
B	LCC Identified	"No" or "Yes" (choose from dropdown)
C	LCC Last Name	Last name of the Lead Care Coordinator
D	LCC First Name	First Name of the Lead Care Coordinator
E	LCC Organization	Organization that employs Lead Care Coordinator
F	Shared Care Plan	Is an up-to-date shared care plan included in the person's/patient's record maintained by the Lead Care Coordinator? 1. Shared Care Plan include, at a minimum, the following elements: • Date updated • Patient/family goal(s) • Clinical goal(s) • Action plan for achieving above goals • Overall current progress on reaching goals • Contact/communication information • Name of Lead Care Coordinator • List of members of care team and their organization 2. The 'Interval between care conferences' will compute automatically. To be considered up-to-date the Shared Care Plan should be updated no less frequently than the desired number of days between care conferences determined by the team. Response Key (choose from dropdown): • "None" if no Shared Care Plan has been developed for person/patient, or Lead Care Coordinator does not have copy; • "Partial" if any element is missing or out-of-date; • "Complete" if all elements are present and up-to-date.
G	Date of Most Recent Care Conference	Date of the most recent Care Conference defined as a regularly scheduled evaluation of participant/patient's progress by participating care organizations
H	Interval Between Care Conferences (days)	Will compute automatically the number of days since the most recent Care Conference

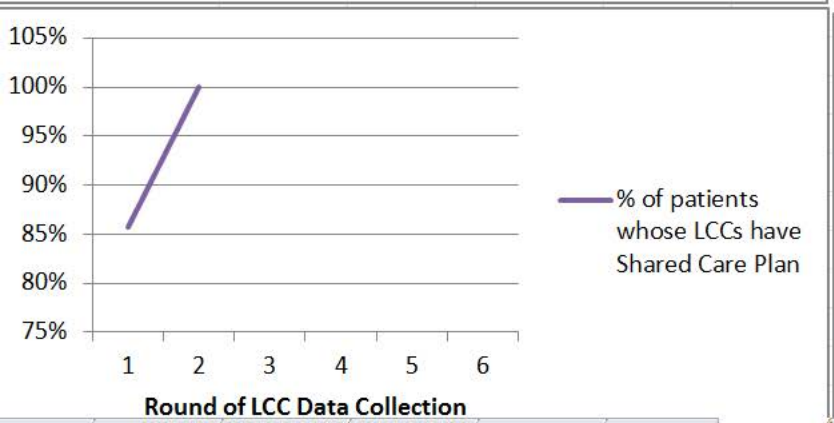
I-AB	Organizations (Please identify Other Organization in place holders in columns S-AB)	
I,K,M,O,Q,S,U,W,Y,AA	Participating In Care Team	"No" or "Yes" (choose from dropdown) for each listed organization for each enrolled individual.
J,L,N,P,R,T,V,X,Z,AB	Updated Progress Report on File	Does the Lead Care Coordinator have and up-to-date progress note from the listed organization for the identified individual? 1. Progress Reports include, at a minimum, the following elements: • Date of most recent visit • Treatment plan • Progress • Referrals (if applicable) • Date or deadline of follow-up (if applicable); Follow-up can be any significant next step in the person/patient's care such as an appointment or phone call with person/patient, or outreach or coordination with another organization on care team. If not follow-up is required, this should also be noted in progress report. 2. To be up-to-date, there should be a progress report in the LCC's record within 10 business of days of the "date of follow-up" as listed in previous progress report. If the progress report is missing or no progress report has been filed within the 10 business days, the file is considered out-of-date or incomplete. Additionally, if there is no date for follow-up and no note stating that follow-up is unnecessary, the file is considered out-of-date or incomplete. Response Key (choose from dropdown): • "None" if Lead Care Coordinator does not have an up-to-date progress report; • "Partial" if some but not all elements of progress update are present and up-to-date; • "Complete" if all elements are present and up-to-date.

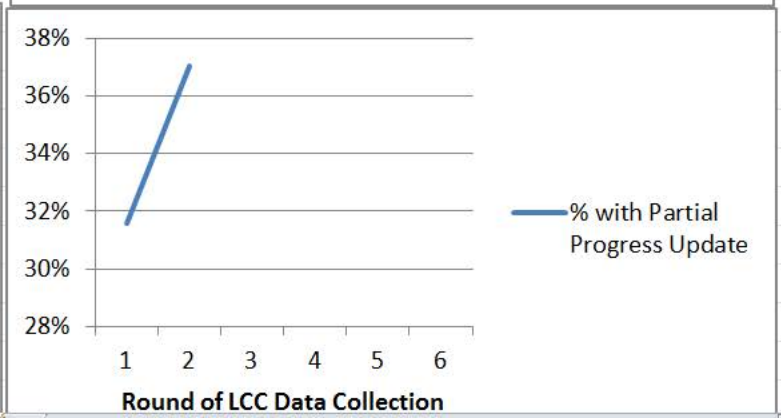
Progress on Lead Care Coordinator (LCC) and Up-to-date Shared Care Plan (SCP)

	Baseline	Round 2	Round 3	Round 4	Round 5	Round 6
% with Partial Progress Update	32%	37%	#N/A	#N/A	#N/A	#N/A
% with Complete Progress Update	47%	48%	#N/A	#N/A	#N/A	#N/A
% of patients with LCC	28%	56%	#N/A	#N/A	#N/A	#N/A
% of patients whose LCCs have Shared Care Plan	86%	100%	#N/A	#N/A	#N/A	#N/A









Diagnose Your Primary Care Practice

Write your Theme for Improvement

Overall Theme "Global" Aim Statement

Create an aim statement that will help keep your focus clear and your work productive:

We aim to improve: the randomness of urine drug screens for patients prescribe bup.
(Name the process)

In:
(Clinical location in which process is embedded)

The process begins with: the medical assistant pulls the list of patients to screened
(Name where the process begins)

The process ends with: the patient providing a urine sample at the clinic
(Name the ending point of the process)

By working on the process, we expect: to improve compliance with treatment plans.
(List benefits)

It is important to work on this now because: patients in the practice have figured out the drug urine screening process and it has been reported that they are selling some of their medication on the illicit market, this puts our practice and other patients at risk.
(List imperatives)

Example. Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

Plan → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures
Populate an excel spreadsheet with all of the patients names using an extract from the EMR.	MA John	12/15/2012	EMR and excel spreadsheet.	
Monday the excel spread sheet will be used to generate a random list of patients who will be assigned to come in each day of the week.	MA John	12/17/2012	Training on how to use the randomized sample feature in Excel.	
Each morning calls will be made to patients who are scheduled to come in that day for urine screens.	Nurse Jane	12/17/2012 to 12/21/2012		The number of patients who are screened. The number of patients who are no shows.

Do → **What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?**

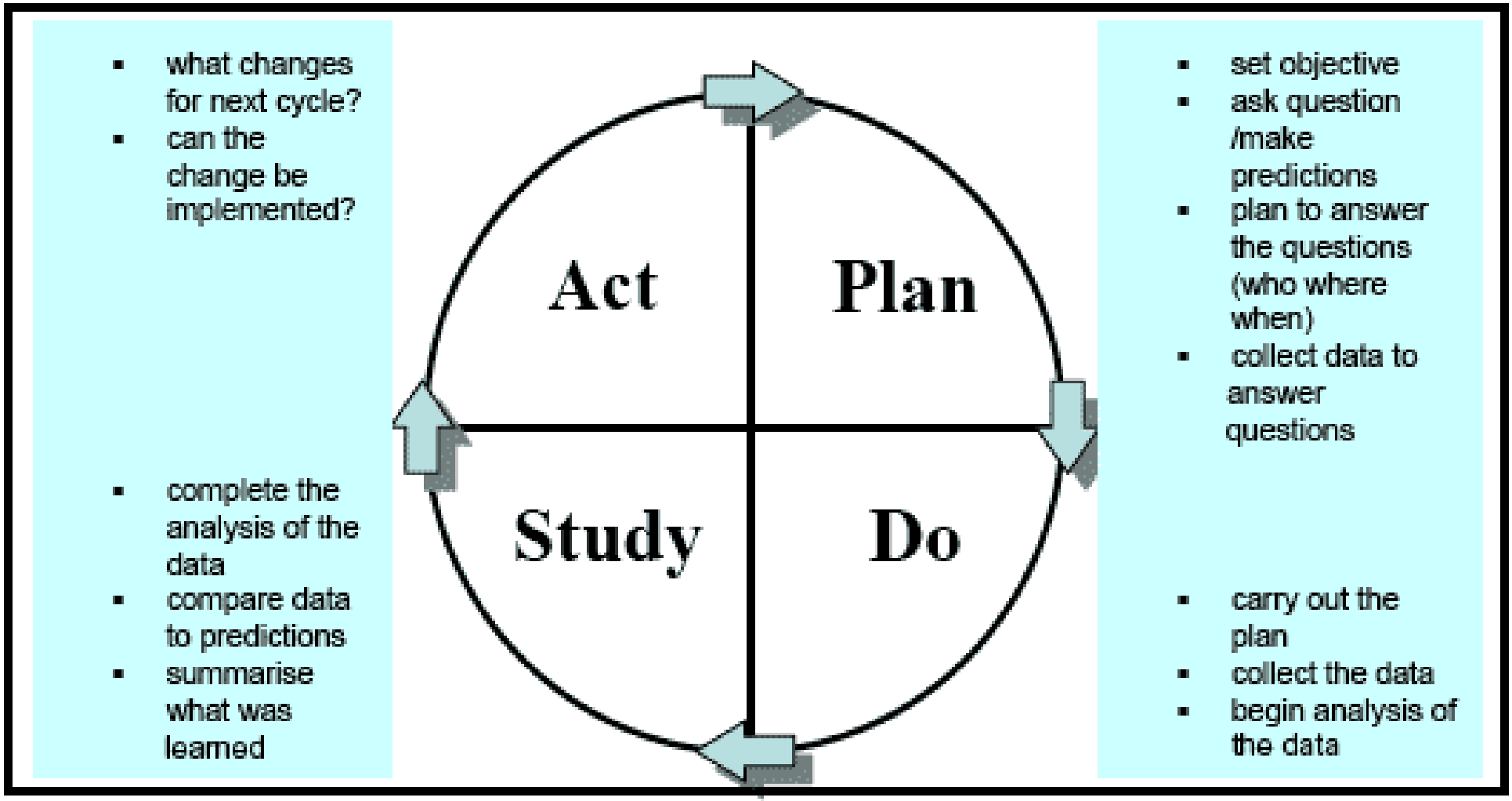
Patients were confused and some got angry, until the provider explained the new process and adherence to the treatment contract.
Transportation is a barrier. The nurse got called away repeatedly in the morning for triage and was late doing the calls on Tuesday morning.

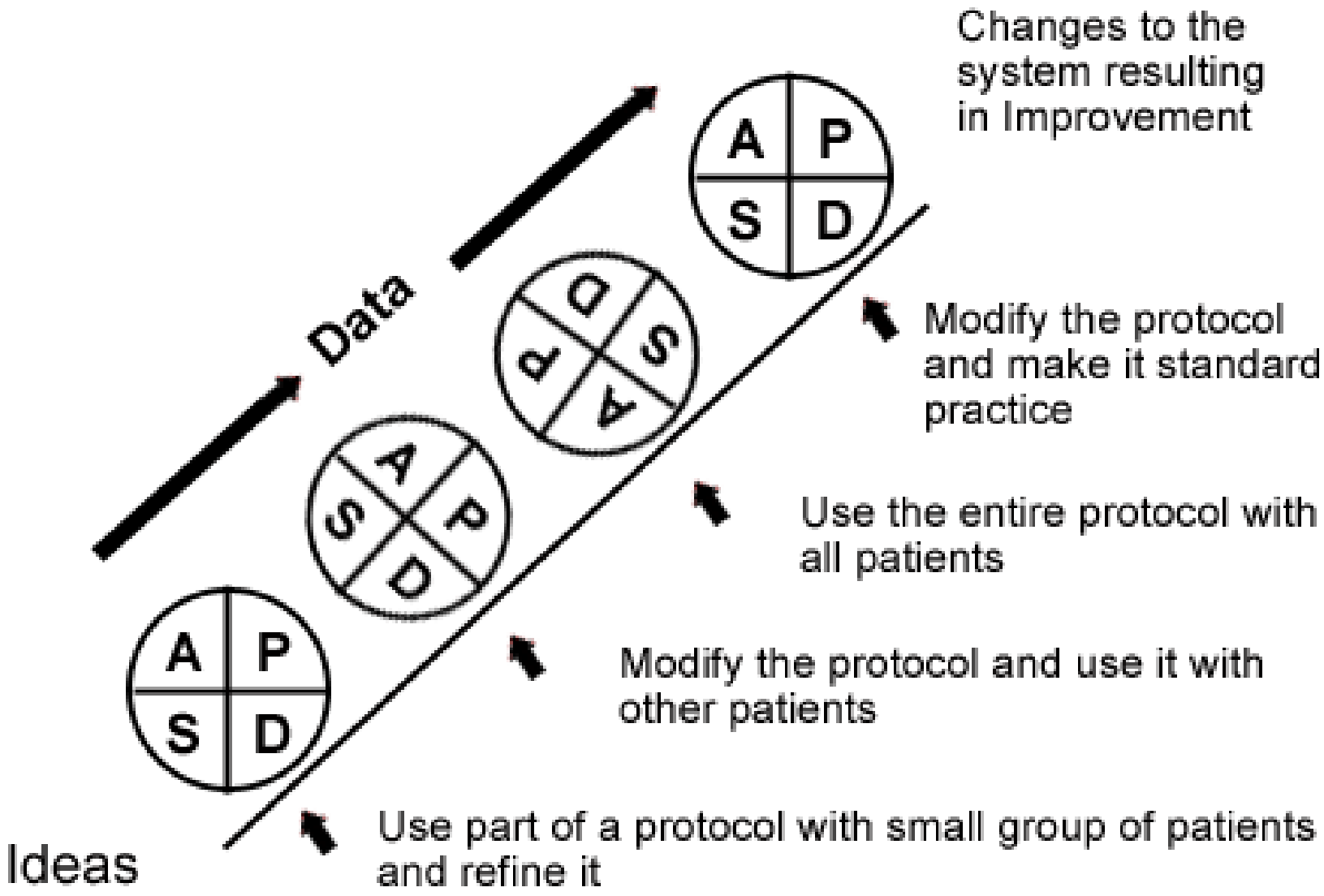
Study → **As we study what happened, what have we learned? What do the measures show?**

Of the 20 patients identified in the first week to be screened 17 came were able to make their appointments. Two came in the next day and we were unable to reach one. Patients were surprised by the request to come in outside of the 'regular schedule'. By Wednesday the nurse had developed a script on what to say, which made the patients feel more comfortable. Transportation was the barrier for the two patients on the second day who were not able to come as scheduled. The care coordinator developed a list of transportation resources, which the nurse used successfully on days three, four, and five. Once the patients understood the process the calls went smoothly and could probably be done by the patient support specialist. Individuals with transportation barriers can be referred to the nurse or care coordinator for resolution.

Act → **As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.**

Patient support specialists will need to be trained on the script for calling patients.
Patients inducted into to the program will need to be added to the spreadsheet.
Patients who leave the program will need to be added to the spreadsheet.
Monthly the list will need to be refreshed.
Newly inducted and unstable patients may need to be added to the call list more often than monthly.
Test the process with Dr. Jone's patients using the MA.


what changes for next cycle?
can the change be implemented?
Act
Plan
set objective
ask question /make predictions
plan to answer the questions (who where when)
collect data to answer questions
complete the analysis of the data
compare data to predictions
summarise what was learned
Study
Do
carry out the plan
collect the data
begin analysis of the data


Changes to the system resulting in Improvement
Data
Modify the protocol and make it standard practice
Use the entire protocol with all patients
Modify the protocol and use it with other patients
Use part of a protocol with small group of patients and refine it
Ideas
A
P
S
D

Now Try Your Own

1. Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

AIM:

Plan → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

Do → **What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?**

Study → **As we study what happened, what have we learned? What do the measures show?**
Act → **As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.**

2. Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

AIM:

Plan → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

Do → **What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?**

Study → **As we study what happened, what have we learned? What do the measures show?**

Act → **As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.**

3. Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

AIM:

Plan → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

Do → **What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?**

Study → **As we study what happened, what have we learned? What do the measures show?**

Act → **As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.**

4. Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

AIM:

Plan → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

Do → **What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?**

Study → **As we study what happened, what have we learned? What do the measures show?**

Act → **As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.**

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.

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
- **Morrisville:** 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:

- Nancy Abernathey, Quality Improvement Facilitator, Integrated Communities Care Management Learning Collaborative; n.abernathey@gmail.com
- Patty Launer, Community Health Quality Manager, Bi-State Primary Care Association; plauner@bistatepca.org
- Mary Lou Bolt, Community Health Team Manager, Rutland Regional Medical Center; mlbolt@rrmc.org
- Erin Flynn, Senior Policy Advisor, Department of Vermont Health Access; erin.flynn@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.

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.

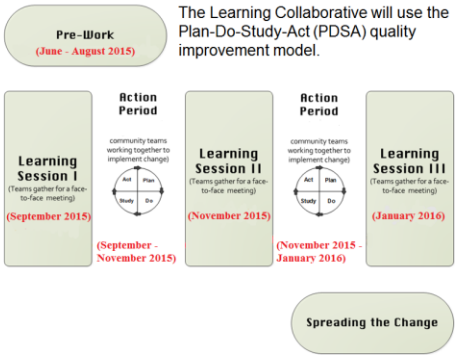
Interface with Other Initiatives

- "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

How we will do it – Learning Model:



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

Preview of Learning Session 1

Curriculum Objective: *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

Preview of Learning Session 2

Curriculum Objective: *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

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 8 and 9, 2015:** First In-Person Learning Session!

Questions and Answers

September 9th, 2015 Learning Session: Faculty Biographies

Nancy H Abernathey, MSW, LICSW

Nancy, a Licensed Clinical Social Worker, is the quality improvement facilitator for the Vermont Health Care Innovation Project and former Blueprint practice facilitator for the Vermont Blueprint for Health. In this role she assisted more than ten primary care practices with the NCQA Medical Home recognition process, helping with workflow redesign, panel management, care coordination and continuous quality improvement. She has been an active proponent of patient centered medical homes in Vermont for the past twenty-five years, beginning with efforts to develop medical homes in pediatric practices for children with special health needs. Prior to joining the Blueprint for Health Ms. Abernathey served as a Project Director at the Vermont Child Health Improvement Program at the University of VT College of Medicine. She has a BS in Urban Planning from the University of Utah and a Masters in Social Work from the University of Vermont. She is a recent graduate of the certification program in Primary Care Behavioral Health at the Center for Integrated Primary Care at the University of Massachusetts Medical School. She has also completed training programs in practice facilitation and health-care coaching at Dartmouth and with Health Team Works.

Kelly Craig, MSW, LSW

Kelly Craig is director of care management initiatives at the Camden Coalition of Healthcare Providers, where she supports the design, development, and expansion of a large community-based care management program that involves multidisciplinary outreach teams. Kelly oversees the program's objectives to improve healthcare access to medically and socially complex patients in Camden while also working to reduce healthcare costs. Previous work experience includes Prevention Point Philadelphia, where she was responsible for overseeing the daily operations of five medical clinics, which operated almost solely on volunteer labor. She is committed to improving healthcare quality and accessibility for all individuals, especially vulnerable populations. Kelly's academic background includes studies in addictions, health, and mental health with a community and policy focus. Kelly received her master's degree in social work from Temple University and undergraduate degree from the University of Central Florida.

Victoria DeFiglio, RN

Victoria DeFiglio is the Clinical Director at the Camden Coalition and a nurse by training. As is typical in any start up organization, she has worn many hats since she began three years ago. These hats include, assisting primary care practices to transform operations of patient care, and learning from hundreds Camden patients and families about the gaps that exist in our existing healthcare system. Prior to joining the Coalition, Victoria taught high school science in Saint Louis, Missouri. She now combines her love of teaching and nursing, overseeing the Coalition's Cross Site Learning and Workforce Development Department. Most of her time is spent on speaking and building curriculum to teach the "*Hotspotter* philosophy" to a broader audience.

Laural Ruggles, MBA, MPH

Laural Ruggles is the Vice President of Marketing and Community Health Improvement at Northeastern Vermont Regional Hospital. Laural has over 20 years' experience in healthcare administration, including medical office operations, marketing, and community health. She has been the Project Manager for the St. Johnsbury Blueprint for Health initiative since 2005, and is the architect of their local Community Health Team. She chairs the St. Johnsbury area Fit and Healthy Coalition, and is a member of the Caledonia/southern Essex Tobacco Coalition. She has a Master of Business Administration from Plymouth State College, and a Master of Public Health from Dartmouth College, Geisel School of Medicine.

Vermont Health Care Innovation Project

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 1
September 9th, 2015
Sheraton Burlington Hotel & Conference Center

AGENDA

8:30 AM - 9:00 AM	**Registration and Light Refreshments**
9:00 AM - 9:15 AM	**Welcome and Opening Remarks** Nancy Abernathey, MSW, LICSW, Vermont Heath Care Innovation Project (VHCIP) Quality Improvement Facilitator
9:15 AM - 9:45 AM	**Care Coordination: Benefits to Community Members and the Cross-Organizational Community Team** Laural Ruggles, VP Marketing and Community Development, Northeastern Vermont Regional Hospital
9:45 AM - 10:45 AM	**Identifying and Engaging People in Cross-Organizational Care Management** ➢ Triage (9:45 to 10:00) ➢ Initial Engagement (10:00 to 10:10) ➢ Authentic Healing Relationships (10:10 to 10:25) ➢ Personal Narratives (10:25 to 10:45) Kelly Craig, MSW Program Director, Care Management Initiatives Camden Coalition of Healthcare Providers Victoria DeFiglio, RN, BSN Clinical Director, Cross-site Learning & Workforce Development Camden Coalition of Healthcare Providers
10:45 AM – 11:00 AM	**Break**
11:00 AM – 12:00 PM	**Small Group Sharing: Personal Narratives**

12:00 PM - 1:00 PM	**Networking Lunch**
1:00 PM - 2:00 PM	**Goal Setting: Backwards Planning and Observing Normal Routine** Kelly Craig, MSW Program Director, Care Management Initiatives Camden Coalition of Healthcare Providers Victoria DeFiglio, RN, BSN Clinical Director, Cross-site Learning & Workforce Development Camden Coalition of Healthcare Providers
2:00 PM – 3:00 PM	**Community Team Break Out Session 2:** Practicing Tools for Goal Setting
3:00 PM - 3:15 PM	**Afternoon Break and Light Refreshments**
3:15 PM - 3:45 PM	**Community Team Report Out and Sharing Next Steps**
3:45 PM - 4:00 PM	**Closing Remarks** Jenney Samuelson, Assistant Director, Vermont Blueprint for Health

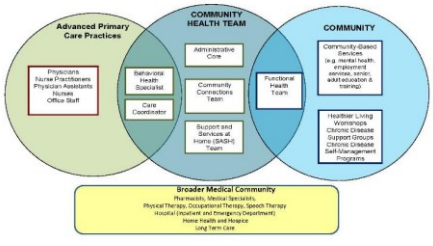
Caledonia & Southern Essex Learning Collaborative

Date: September 8 & 9, 2015
Laural Ruggles MPH MBA
Northeastern VT Regional Hospital

"Learning from others can prevent you from doing a lot of dumb s#$&."
~ Unknown

St. Johnsbury Area Community Health Team

Program Description



Our Community

- **30,000 people; Caledonia and s. Essex**
- **Collaborative Team:**
  - **AHS**
  - **Northeast Kingdom Human Services (mental health)**
  - **Northeastern VT Regional Hospital (primary care, inpatient, ER, Community Connections)**
  - **Northeastern Vermont Council on Aging**
  - **Northern Counties Health Care (FQHC & home health)**
  - **RuralEdge (housing and SASH)**
  - **VCCI**

Learning Collaboratives

- Institute for Health Care Improvement (IHI) Collaborative Model for Achieving Breakthrough Improvement
- Action-learning process for groups/teams
  - Shared aim
  - Use quality improvement tools
  - Bring systematic change to an organization or community

www.ihi.org

Tools and Lingo

- Lead Care Coordinator/Relationship for Life/BFF
- Root Causes: Medical, Psychiatric, Social, System
- Shared Care Plan
- Camden Cards/Domains of Care Planning
- Eco-maps

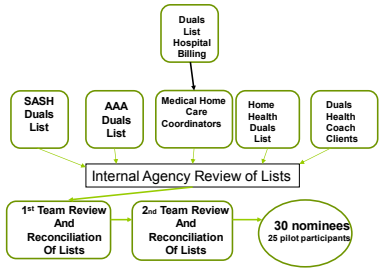
VHCIP Duals Project Overview

- Vermonters who are eligible for both Medicare and Medicaid are some of the most challenging and expensive persons to care for.
- Desired outcome is to provide better, person-centered care and reduce expenditures for Medicare and Medicaid by:
  - Hiring Health Coach to work with clients
  - Establish Dual Eligible Core Team to meet bi-monthly to discuss individuals' services, situations, and problem solve
  - Use flexible funds to fill gaps in service

Learning Collaborative Objectives

- Identify dually eligible individuals at risk of harm, unnecessary nursing home stays or hospitalization
- Assign the individuals to a community interdisciplinary team
- Assign a lead case manager to be the primary contact with the individual and their support network
- Use a comprehensive assessment and care planning process to identify individual strengths and needs
- Develop a comprehensive person-centered plan of services

Identify Pilot Population



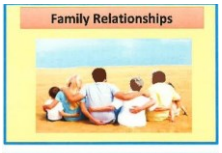
Interdisciplinary Team and Lead Case Manager

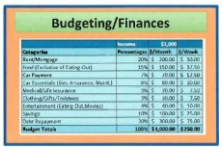
- Team reviews all nominated individuals to determine community partner with closest relationship to act as lead case manager
- Lead case manager visits with individual to discuss project and get signed consent to participate

Identify Individual Strengths and Needs

- Shared Care Plan
- Camden Cards
- Eco-maps

Camden Cards





- Health Education & Management
- Housing Assistance
- Mental Health
- Education
- Health Insurance
- Utilities
- Medication & Supplies
- Legal
- Family Relationships
- Relationship & Safety
- Budgeting/Finances
- Food & Nutrition
- Transportation
- Wild Card

Shared Care Plan

- Care Plan includes
  - Care Team members
  - Individual action plan and goal
  - Medical treatment plan
  - Identified lead case manager
  - Strengths of individual
  - Barriers for Individual

Lessons Learned

- Some of most complex individuals do not have a case manager
- Lead case manager may change as individual's needs change
- Some individuals have many community partners working with them without realizing this
- (Some) individuals may be reluctant to participate due to collaborative release

Challenges

- How do we share information across organizations
- Some agencies/organizations do not have capacity to provide timely services
- Lack of funding for preventative wellness
- Lack of funding for Dental Needs
- More dual eligible individuals in the community than the health coach has the capacity to serve
- Individuals may leave the project due to death, relocation, or choosing to remove themselves.

Opportunities

- Brings domains of medical/mental/social health together
- Find alternate funding sources when working together

Recent Accomplishments

- Alternative medicine (yoga) offered to a client with chronic pain from injury to spine
- One client regularly attending local fitness center for strength training for joint disease
- Another client seeing a personal trainer for weight loss and strength training (lost 15 more pounds)
- Partnership with VCIL improving e.g. ramp assessment done at client
- Health Coach has added more home visit clients; services include walking with clients in their neighborhoods

Case Study

B.L.- 25 year old male, former athlete, paraplegic, returned to the area without PCP

- *Services:*
  - Flexible Funds for shower seat and repairs to wheelchair lift on truck ($2163)
  - Lead care coordinator has weekly interactions by phone or visits
  - Lead care coordinator assisted in connecting with PCP and voc rehab
  - Lead care coordinator assisted in obtaining benefits and appt at wheelchair clinic
- *Outcome:*
  - Independent with activities of daily living
  - Independent transportation
  - Has been hospitalized once since returning to area, CCC at PCP office knows to contact individual if missed appt to prevent transportation or other factors from contributing to health decline
  - Working with voc rehab for eventual employment
  - Volunteering at Northeast Kingdom Youth Services
  - Coached spring baseball at Lyndon Institute

Final Words of Advise

"Don't get stuck in P"

Don't let *"Perfect is (be) the enemy of good"*
~ Voltaire

Vermont Health Care Innovation Project

Victoria DeFiglio & Kelly Craig

Sept 8, 2015

Camden Coalition of Healthcare Providers

Identifying & Engaging People in Community-Based Care Management

What would you like to learn today?

- Use the provided post-it notes to brainstorm
- Write down a topic, idea, or specific question you would like addressed today (one per post-it)
- We will collect and discuss throughout the course!

Camden Coalition
of Healthcare Providers

Hotspotting

“Hotspotting is segmentation. It’s taking big data sets, [and] segmenting them into a strategy so that you can target different pockets of need…

Hotspotting is making sure that people who are in need get their needs met… in a rigorous, data-driven way.”

Dr. Jeffery Brenner,
family physician &
founder, CCHP


HERBIVORE
• BAKED EGGS w spinach, goat's fetta, spanish onion, sun-dried tomato, pinenuts & nutmeg $13.5
• FITZROY FRESH SANDWICH w avocado, carrot, sweet cornichons, rocket & hummus $8-
CARNIVORE
• BAKED EGGS w smoked salmon, caramelized onions, spinach, tomato & light dill & spring onion cream cheese $14.5
• CROQUE-MONSIEUR w ham, extra sharp vintage cheddar & bechamel sauce $9-
• BIRCHER MUESLI w mixed berry compote, vanilla yoghurt, almonds & goji berries $7.5
• SMUSHED AVOCADO on organic multiseed sourdough w artichoke hearts, goat's fetta & lemon $8.5

Intervention Paradigms

Traditional Medical

Diabetes

Heart Failure

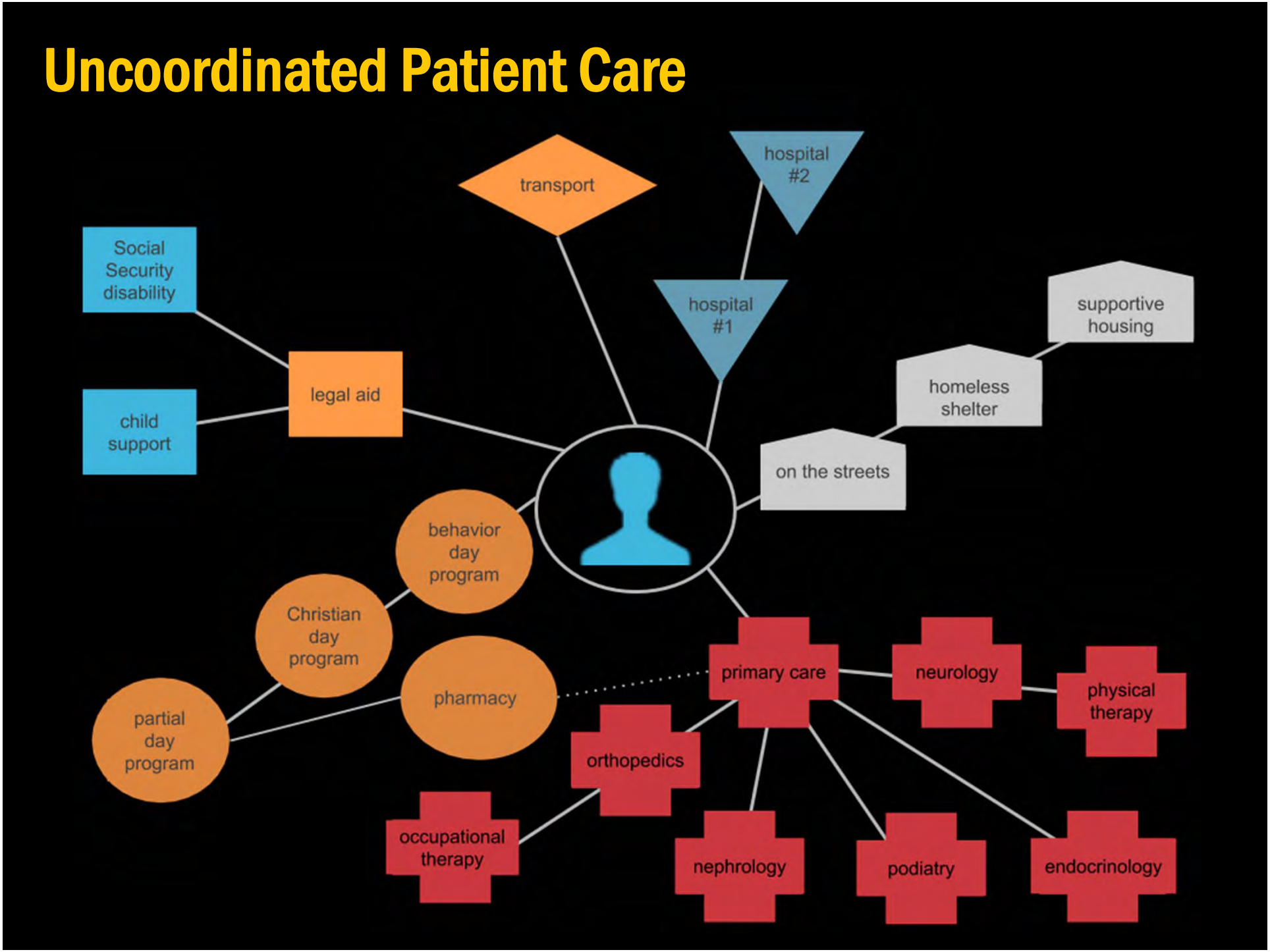
COPD

ESRD

Hotspotting

Complex

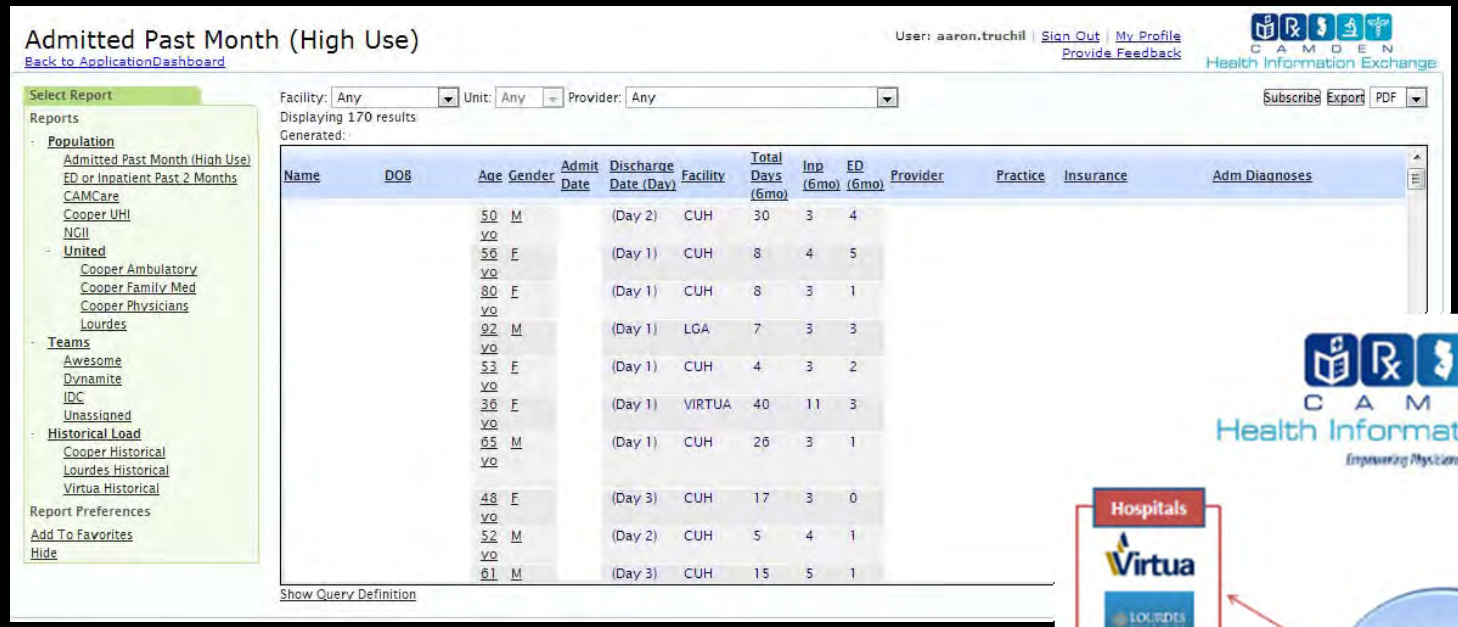
Uncoordinated Patient Care

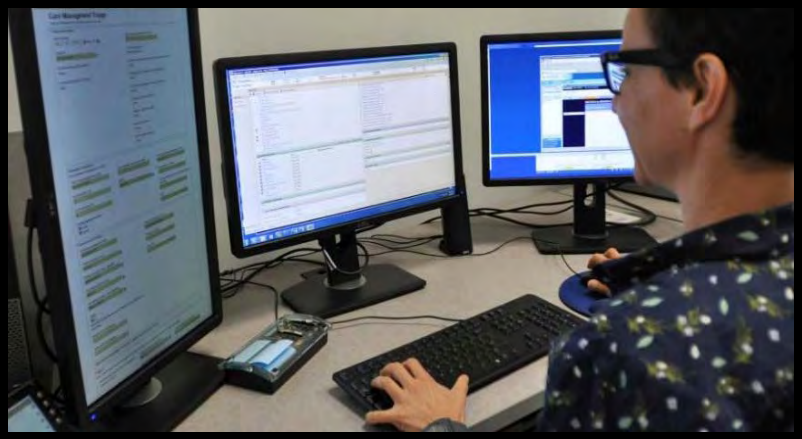


§ 1 Patient Engagement

Patient Relationships

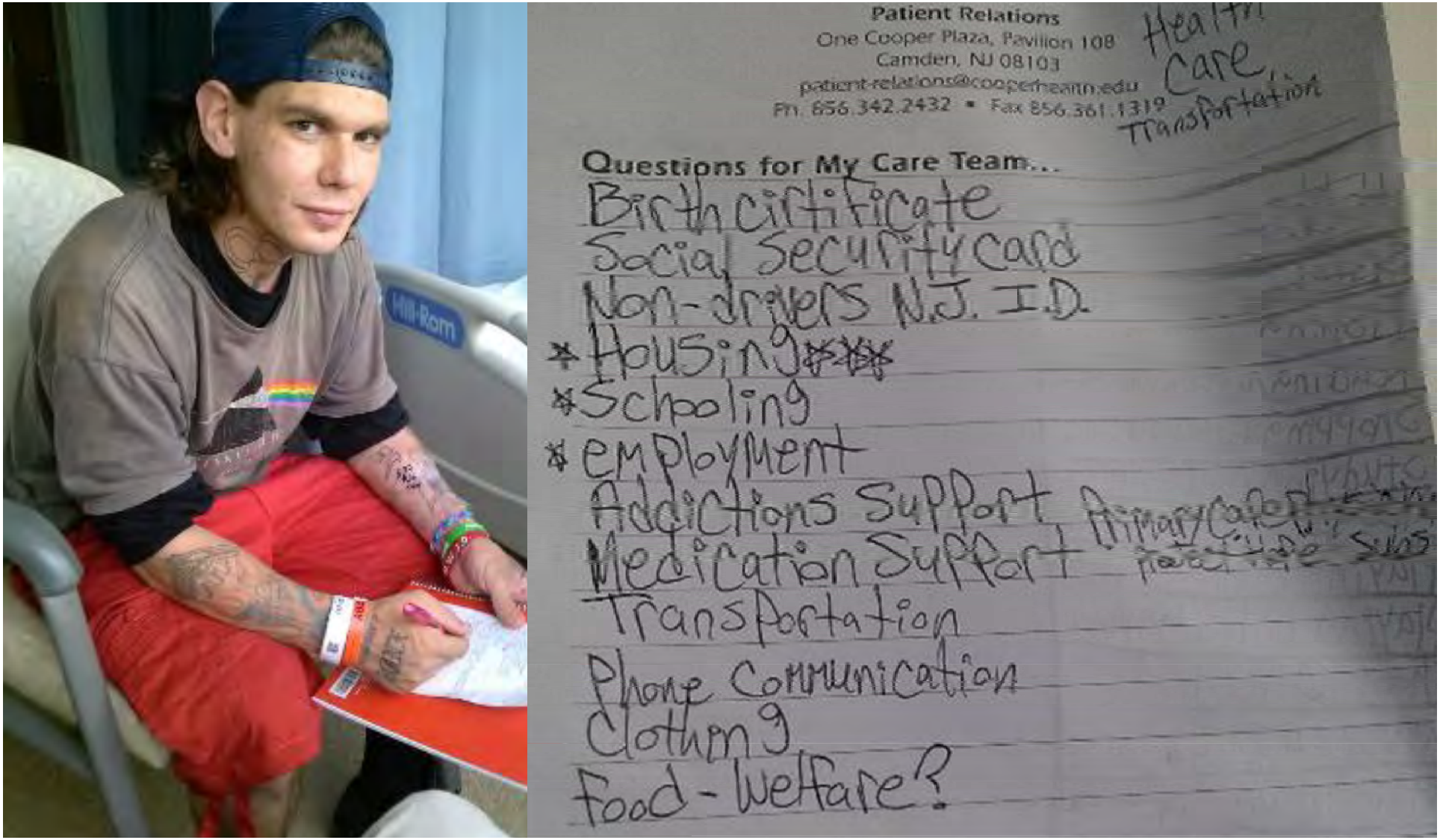
Data Driven Process to Identify High, Cost High Needs Patients





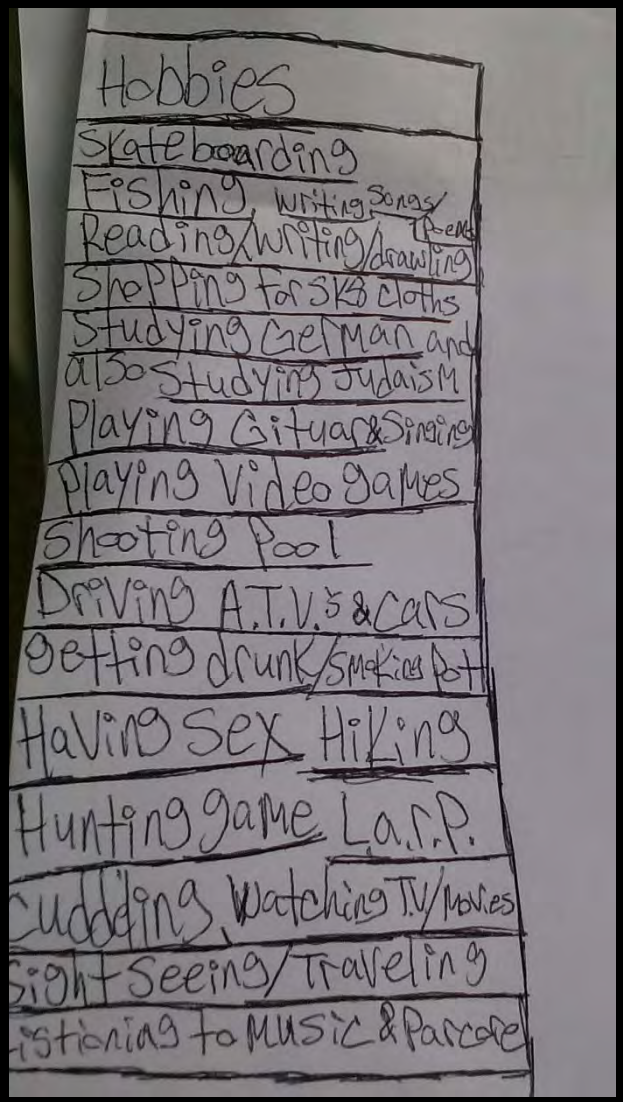
Bedside Engagement

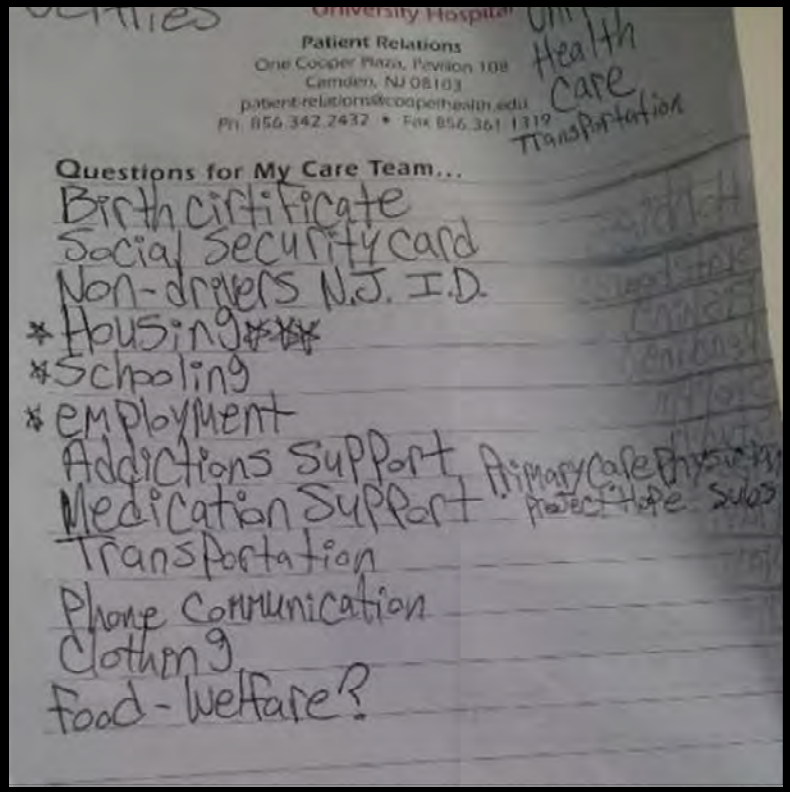
PATIENT ENROLLMENT



Initial Bedside Care Planning: Building rapport and trust

Bedside Care Planning



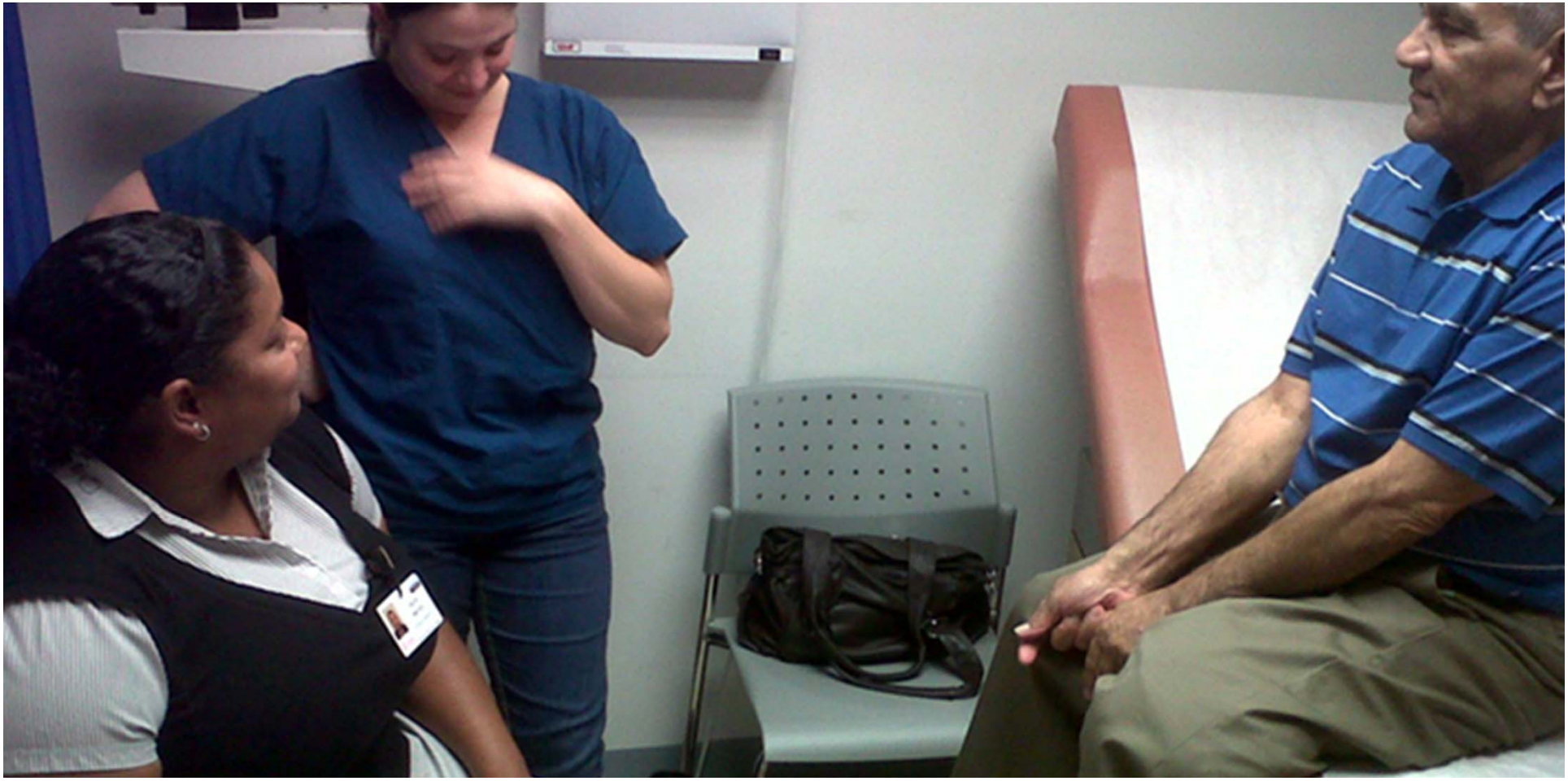


Therapeutic Relationships Are The Best Pill

- Acceptance framework
  - **Unconditional Positive Regard (Carl Rogers)**
  - **Empathy**
  - **Harm reduction**
  - **Motivational interviewing**
- Trauma-informed care: What happened to you?
- Hospital-Home-Practice-Community Based Services
- Holistic, Bio-Psycho-Social, patient-centered approach

Home Visits within 3 days post discharge, then minimum weekly visit for duration of intervention

Camden Coalition of Healthcare Providers



Accompaniment to PCP and specialists within 7 days post discharge

Graduation: Average duration of intervention is close to 90 days but varies with complexity

Lessons Learned

Hiring the right people

Task-shifting

Training

“Fail Fast”

Why?

Qualitative Evaluation at CCHP

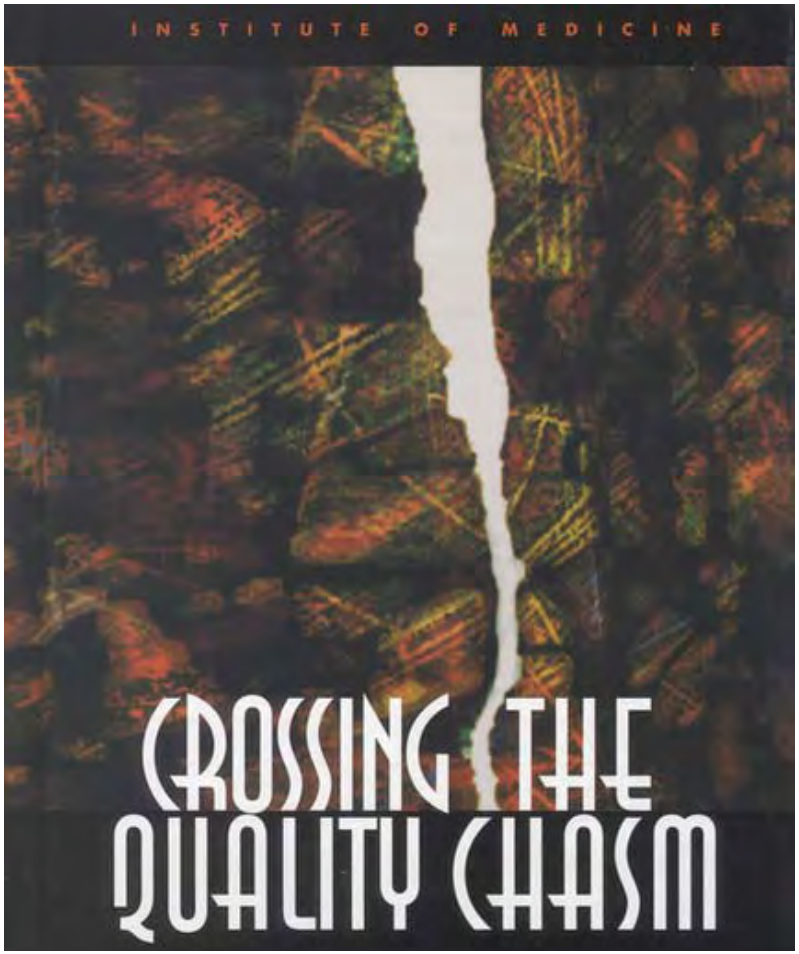
- Useful for describing complex phenomena
- Explores the how, and why, behind an effect or phenomenon
- Gives more recognition to the individuals in the processes
- Creates a feedback loop to the intervention

How?

Interviews gathered & coded, become **data**

From which we extract **themes.**

Authentic Healing Relationships



Robert Wood Johnson Foundation

THE SYNTHESIS PROJECT
NEW INSIGHTS FROM RESEARCH RESULTS

ISSN 2155-3718

RESEARCH SYNTHESIS REPORT NO. 19
DECEMBER 2009

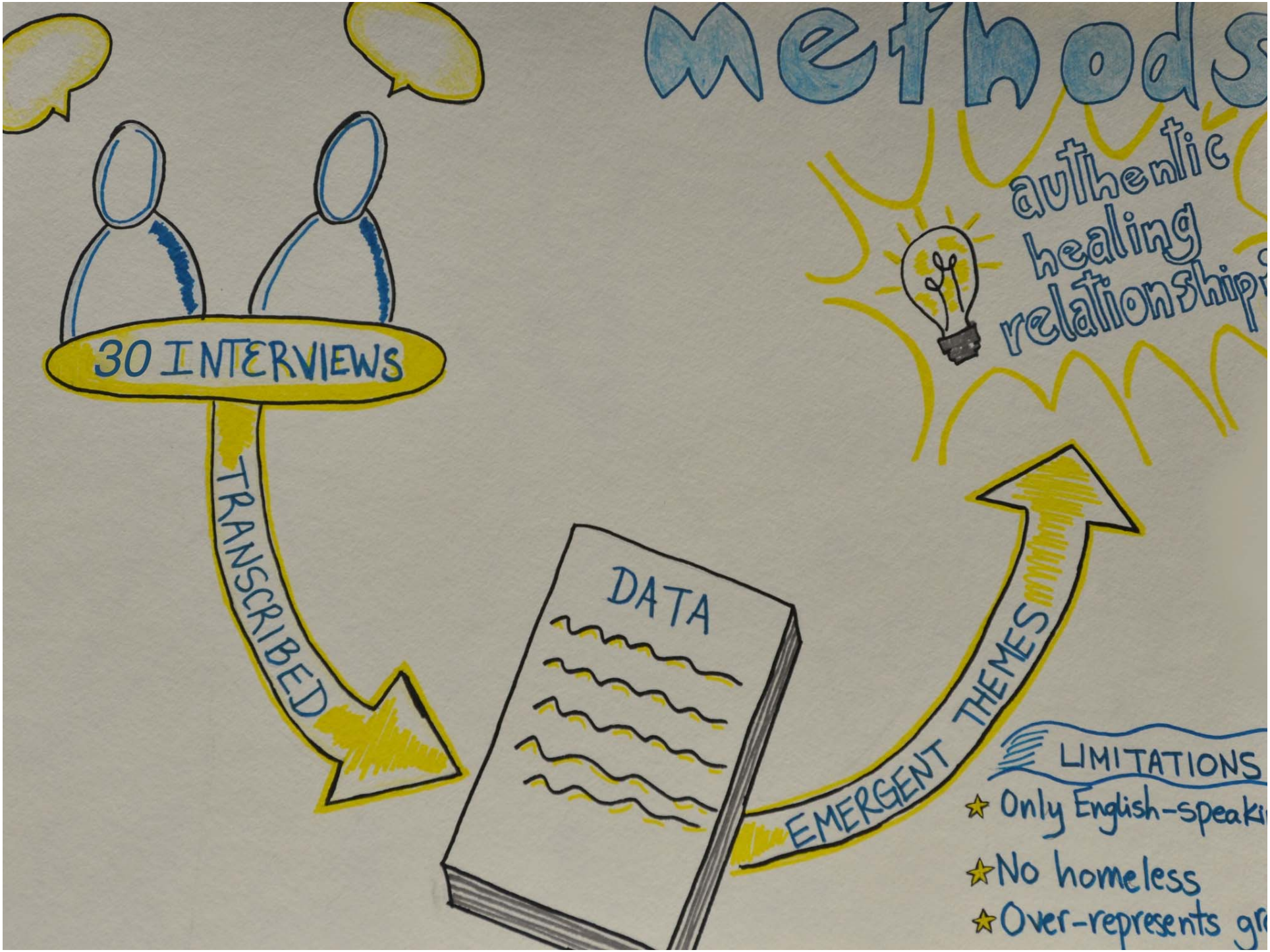
Thomas Bodenheimer, MD, MPH
Rachel Berry-Millett, BA
Center for Excellence in Primary Care,
Department of Family and Community Medicine,
University of California, San Francisco

Care management of patients with complex health care needs

Generating Hypotheses About Care Needs of High Utilizers: Lessons from Patient Interviews

Dawn B. Mautner, MD, MS,[1,2,*] Hauchie Pang, MPH,[3,**] Jeffrey C. Brenner, MD,[4,5] Judy A. Shea, PhD,[6,7] Kennen S. Gross, PhD,[4,5] Rosemary Frasso, PhD, MSc, CPH,[3] and Carolyn C. Cannuscio, ScD, ScM[6,8,9]

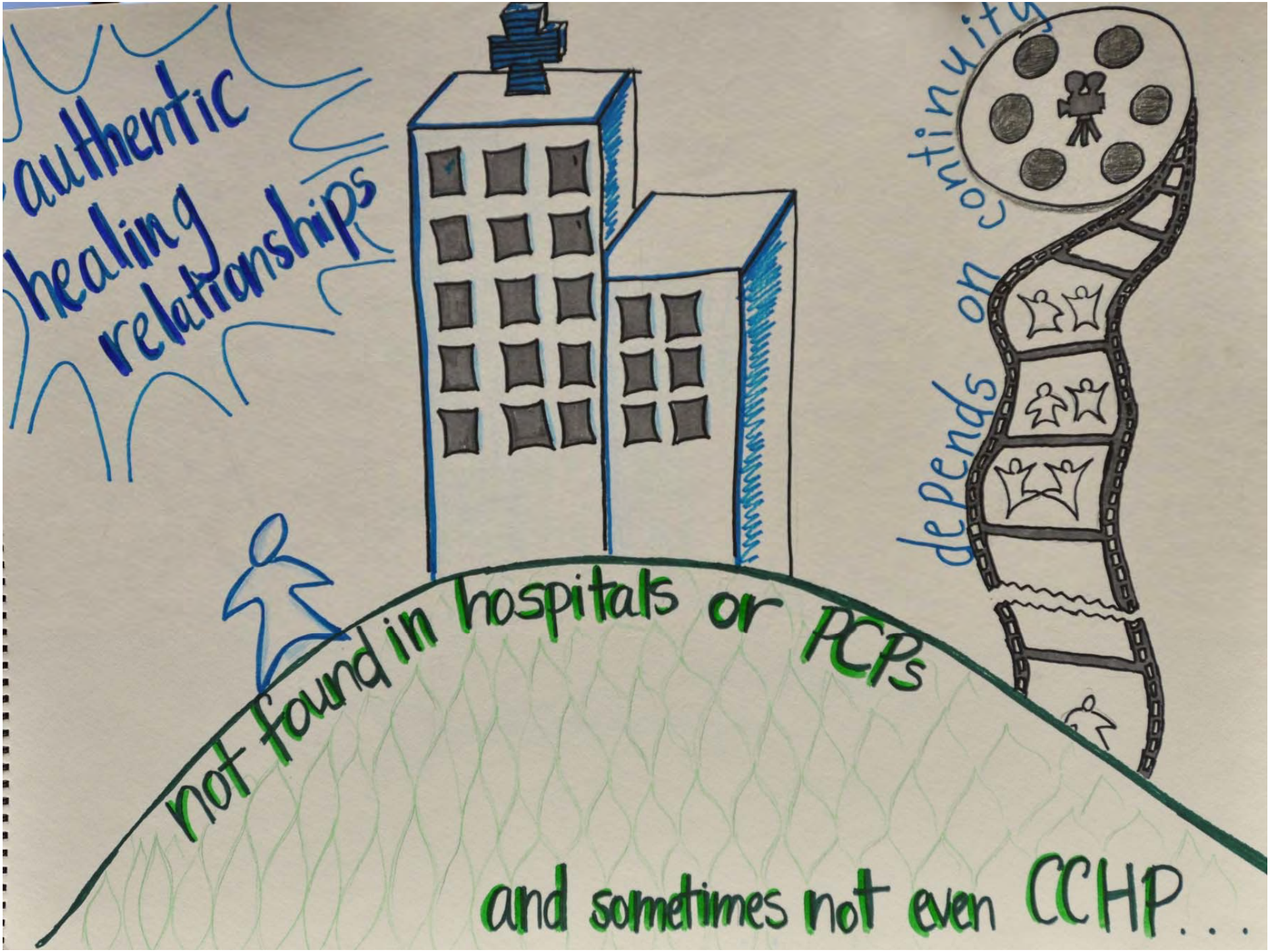
Population Health Management

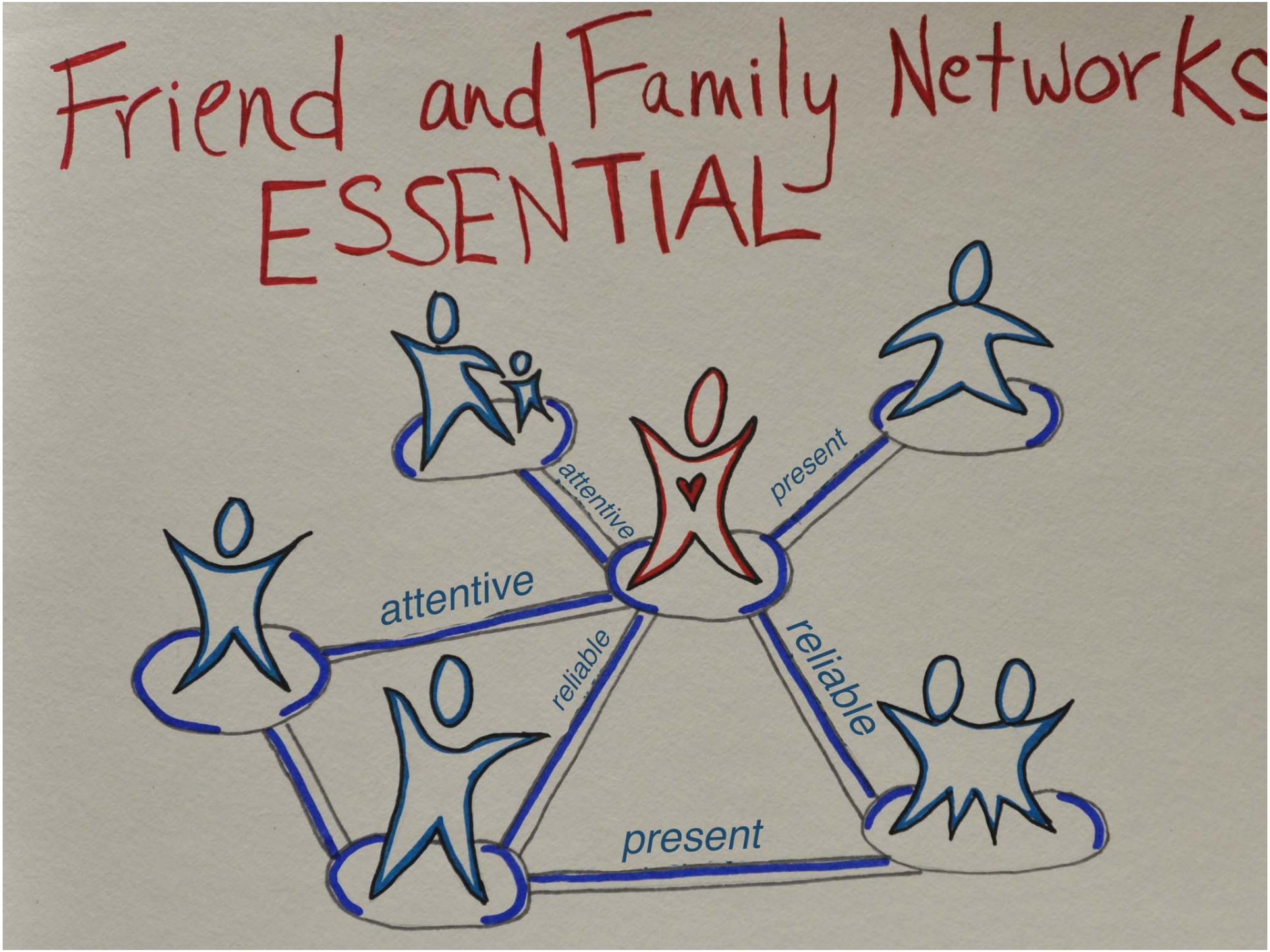

methods
30 INTERVIEWS
TRANSCRIBED
DATA
EMERGENT THEMES
authentic
healing
relationship
LIMITATIONS
Only English-speaki
No homeless
Over-represents gr

CCHP forms aythentic healing relationships

- SECURE
- GENUINE
- CONTINUOUS

linked with motivation...


authentic healing relationships
depends on continuity
not found in hospitals or PCPs
and sometimes not even CCHP...


Friend and Family Networks
ESSENTIAL
attentive
present
attentive
reliable
reliable
present

Genuine Healing Relationships

"They showed me how to bring myself back"

"She talked to me as a person, not as a patient"

"Just to have them come around and sit and talk… is what I enjoyed… to know that they were interested in me"

Recommendations

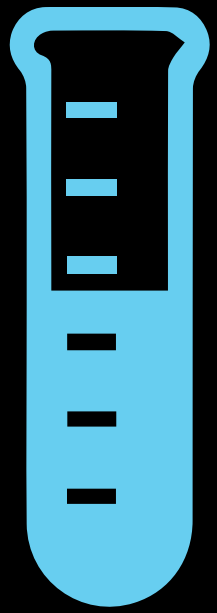
- Further develop tools for identifying, replicating, monitoring, and sustaining authentic healing relationships in health care delivery
- Care for patients with frequent hospitalizations should include techniques from attachment theory, motivational interviewing, trauma informed care, and harm reduction
- Care management should expand beyond on individual behavior change to include family and friends

Conclusion

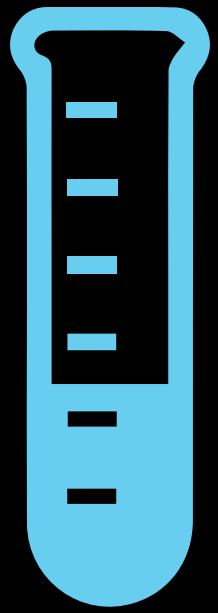
- Sheds new light on importance of a continuous healing relationship in decreasing hospitalizations and improving outcomes
- Three core elements of authentic healing relationships as security, genuineness, and continuity
- AHR linked with motivating patient involvement in their own treatment
- AHR not readily found in the traditional health care system

Questions?

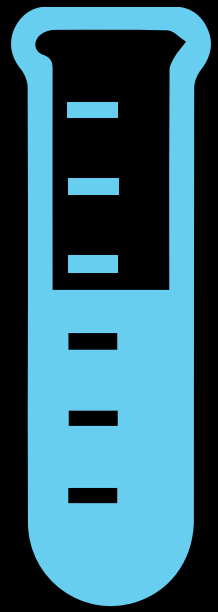
§ 1 Test tubes



IMPORTANCE



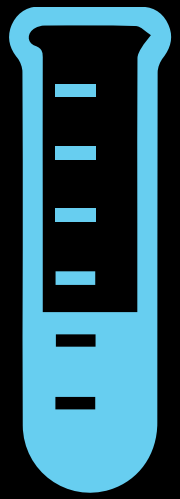
BELONGING



SECURITY

BELONGING= The deep desire to feel accepted and cared for

IMPORTANCE= The deep desire to feel signifant and recognized



SECURITY= The desire to know what's coming next, and to have controlled surroundings

BOOM
Significance
Significance

Breakout I

OPTION A: Test tube sharing

In your groups, please share :

A time you had a strong emotional reaction to a patient.

Please consider:

- What were your test tubes at the time?
- What were the patient's test tubes?
- Name one strategy you can use when coping with this feeling in the future.
- What are structures you can put in place to talk about test tubes on your teams?

OPTION B: Personal Narratives

In your groups, share the answers to the following:

- What motivates you to do this work?
- What keeps you up at night?
- Pick up to four defining moments in your life and share them with the group.

§ 1 Backwards Planning

C-O-A-C-H

"Taking people from where they are to where they want to be"

Connect tasks with vision and priorities

Observe normal routine

Assume a coaching style

Check backwards plan

Highlight progress with data ("I can")

	NEED TO WORK ON	DON'T NEED TO WORK ON
NOW		
LATER		

Backwards Planning: Gameboard

- Socialize with my friends & family
- Find a good friend
- Feel like my life matters to someone else

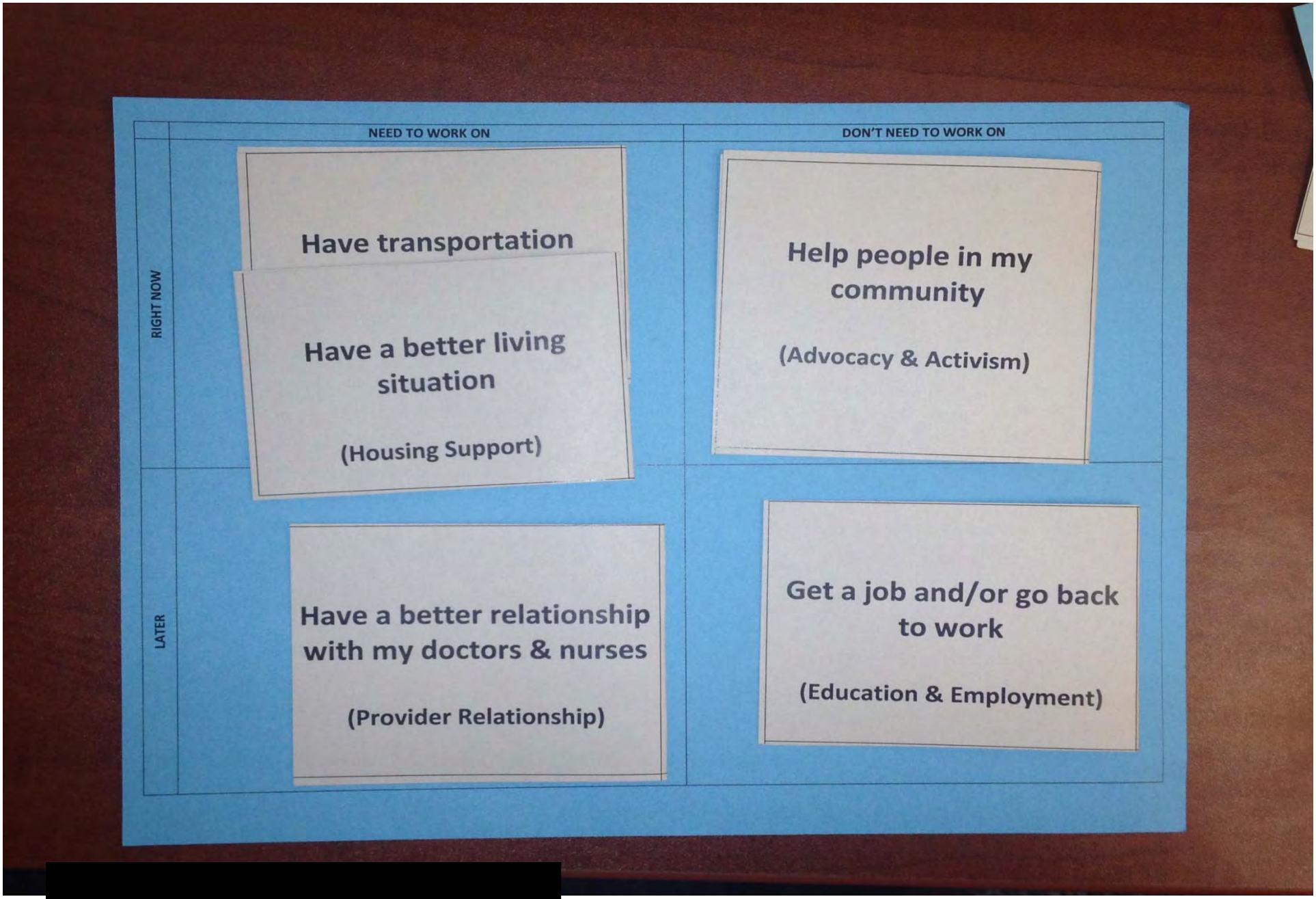
Have support

- To feel better about myself
- To have more energy & motivation
- Have fun & not worry all the time

Talk to someone about my mental health

- Have spending money
- Get an education
- Work hard at a job I like

Get a job and/or go back to work


NEED TO WORK ON
DON'T NEED TO WORK ON
RIGHT NOW
LATER
Have transportation
Have a better living situation
(Housing Support)
Help people in my community
(Advocacy & Activism)
Have a better relationship with my doctors & nurses
(Provider Relationship)
Get a job and/or go back to work
(Education & Employment)

	RIGHT NOW	LATER
NEED TO WORK ON	• Crisis • Deadline • Top priority	• Open-ended Questions
DON'T NEED TO WORK ON	• Open-ended Questions	• Highlight strengths

§ 1 OBSERVE NORMAL ROUTINE

KEY POINT

Before taking **ANY** next steps with a patient….ask questions to find out their normal routine.

One of your patients is a diabetic who is also an amputee. She needs to arrange transportation to get to one of her appointments, and you notice she also has Medicaid. The appropriate next step is to…

A) Pull out the Logisticare information from your bag, and give it to the patient.

B) Ask, "how do you normally get to appointments?"

C) Give her a cab voucher.

Bernard calls you after he takes his insulin out of the refrigerator. He tells you the name of the insulin, and describes that it's usually clear, but now he sees "little floaty things in it."

Ask, "who would you call if I didn't pick up the phone?"

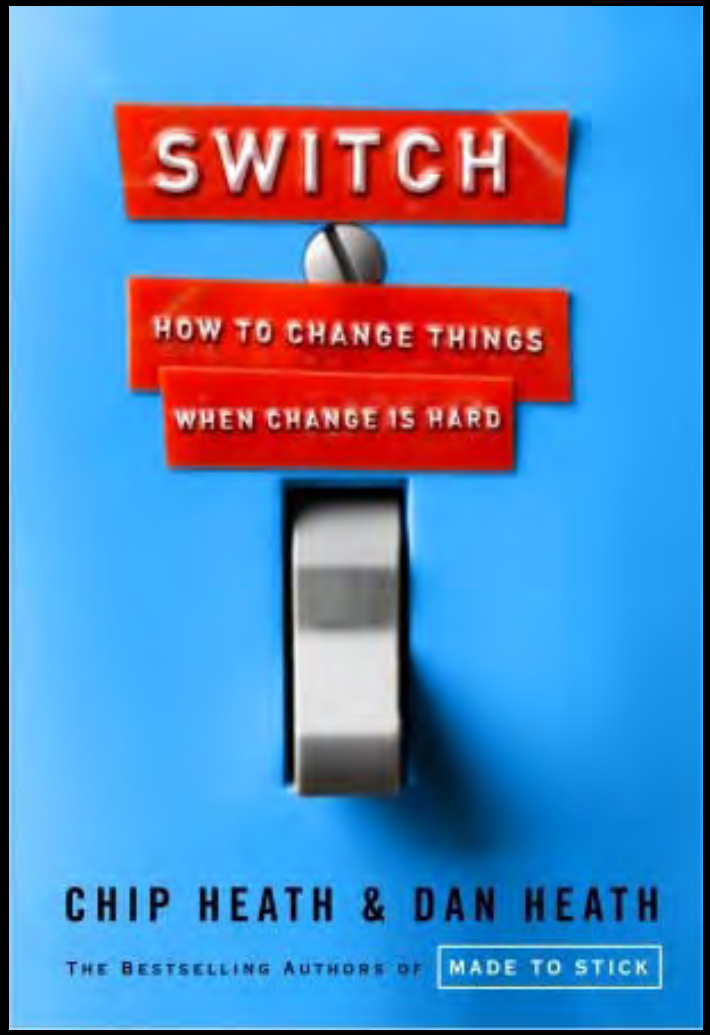
MARK'S VIDEO: IMPACT OF "O" IN THE FIELD

“Real Play”

- Share something you want to change (10-minutes a person)
- Responder may only ask open-ended questions!
- After the exercise, please record:
  - 1. What emotions came up for you when sharing and when responding?

BREAK

“Brightspotting”



“Brightspotting” Activity

How can you highlight “brightspots” at the:

- **Individual level**
- **Team level/community level**
- **State-wide level**

Breakout 2

What are your next steps?

- **Pick 1-2 strategies you learned today to implement in your community.**
- **You will share out to the large group.**

Camden Coalition
of Healthcare Providers

Thank You!