Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 4

"Maintaining the Continuity of Care"

Index

Fourth In-Person Learning Session: Faculty Biographies

Lauran Hardin, MSN, RN-BC, CNL

Lauran Hardin is the Director of a Regional Complex Care Center serving hospitals, multiple providers and more than 1,000 high frequency/complex patients in the Mercy Health System. The Center's model of complex care has resulted in better patient navigation and outcomes, including decreased emergency room visits, hospitalizations, and costs for diverse vulnerable populations. She recently received an Innovation Grant from Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation, to develop and test replicable tools and processes for complex patients. Her innovative model of care earned her "Edge Runner" recognition from the American Academy of Nursing in June of 2015.

Hardin earned her Master's degree in Nursing from the University of Detroit Mercy, with certifications as a Clinical Nurse Leader, Pain Management and Hospice. She was awarded the National Clinical Nurse Leader Vanguard award from the American Association of Colleges of Nursing in January 2015. Hardin trained as a Facilitator with the Elisabeth Kubler-Ross Center, spent several years working in hospice and co-developed the first Pain and Palliative Care service in the region. Her background includes providing consulting, co-design and coaching in complex care transformation. Her special interests include the impact of trauma/loss on high frequency healthcare access and the economic potential of stabilizing complex patients through retraining/redesigning existing resources in the healthcare system.

Julia Sanders

Julia Sanders is the New England Market Lead with PatientPing, a health care technology start-up dedicated to building a national, connected community of providers to better coordinate and improve patient care. Prior to joining PatientPing, Julia led Primary Care transformation initiatives at Brigham and Women's Hospital, implementing an electronic referral management system and post-discharge follow-up tool across all 14 of BWH's Primary Care practices. Julia came to BWH from the Institute of Medicine in Washington, DC, where she worked on national health policy initiatives focused toward realizing the vision of a continuously learning health system, in which patients experience better care delivery and improved health outcomes at lower costs. Julia also worked as a Community Organizer in Denver, Colorado for President Obama's campaign for office in 2008. She graduated from Brown University with an ScB in Human Biology.

Sarah Narkewicz, RN, MS, CDE

Sarah Narkewicz is the Program Director for RRMC's Community Health Improvement Department. This position includes the oversight of the Bowse Health Trust, RRMC's grant funding operations, and managing the Blueprint's integration into the Rutland Hospital Service area. She is currently the acting CHT Manager and oversees 12 core team staff and contracts

for over 20 CHT and SPOKE staff. She is a Master Training for the Healthier Living Workshops and has been a leader since 2005. Her background includes teaching nursing and health promotion college courses, non –profit board leadership, and quality improvement consulting.

Sarah earned her Bachelor of Science in Nursing at the University of Vermont and a Master of Science in Nursing at the University of Connecticut. She has been a Certified Diabetes Educator for over 20 years and an ASQ Certified Quality Manger for over 10 years.

Sandra Knowlton-Soho, RN, MS

Sandy Soho is an ACO Clinical Consultant for OneCareVT. In this role, she works with community partners on quality improvement initiatives. The Rutland Care Coordination Toolkit training is one project that has been developed as a direct result of this Learning Collaborative.

Prior to joining OneCareVT, Soho worked for 23 years at Dartmouth Hitchcock Medical Center in Lebanon in a variety of roles including staff nurse, research coordinator, Director of Training and Outreach in the Clinical Trials Office and most recently as the Practice Manager for Palliative Care and Coordinator of Global Health Nursing Initiatives. She is a trained facilitator for the Cultural InSight program - Diversity and Cultural Competence in Health Care. Soho earned her Master's degree in Public Health from the University of Massachusetts-Amherst.

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 4
"Maintaining the Continuity of Care"
May 25, 2016 (Holiday Inn, Rutland, VT)
May 26, 2016 (Waterbury State Office Complex, Waterbury, VT)

AGENDA

8:30 AM - 9:00 AM	**Registration and Light Refreshments**
9:00 AM - 9:15 AM	**Welcome and Opening Remarks**
9:15 AM – 11:30 AM	**Care Coordination for People with Complex Needs: Sustaining the Intervention** Lauran Hardin, MSN, RN-BC CNL, Director Complex Care, Mercy Health, Grand Rapids, MI
11:30 AM - 12:00 PM	**Community Updates**
12:00 PM - 1:00 PM	**Networking Lunch**
1:00 PM - 2:00 PM	**Event Notification: An Overview of PatientPing** Julia Sanders, New England Market Lead, PatientPing
2:00 PM – 3:30 PM	**Breakout Sessions** Session A: Review of Key Interventions and Discussion of Core Tools with Lauran Hardin Session B: Training Care Staff of Core Tools with Sarah Narkewicz and Sandy Knowlton-Soho
3:30 PM – 3:45 PM	**Closing Remarks and Celebration** Jenney Samuelson, Assistant Director, Blueprint for Health

Care Coordination for People with Complex Needs:

Sustaining the Intervention

Lauran Hardin MSN, RN-BC, CNL

May 25 & 26, 2016

Where are we going today?

- Review of Principles
- Review of Tools
- Building Sustained Shared Intervention

What is Root Cause?

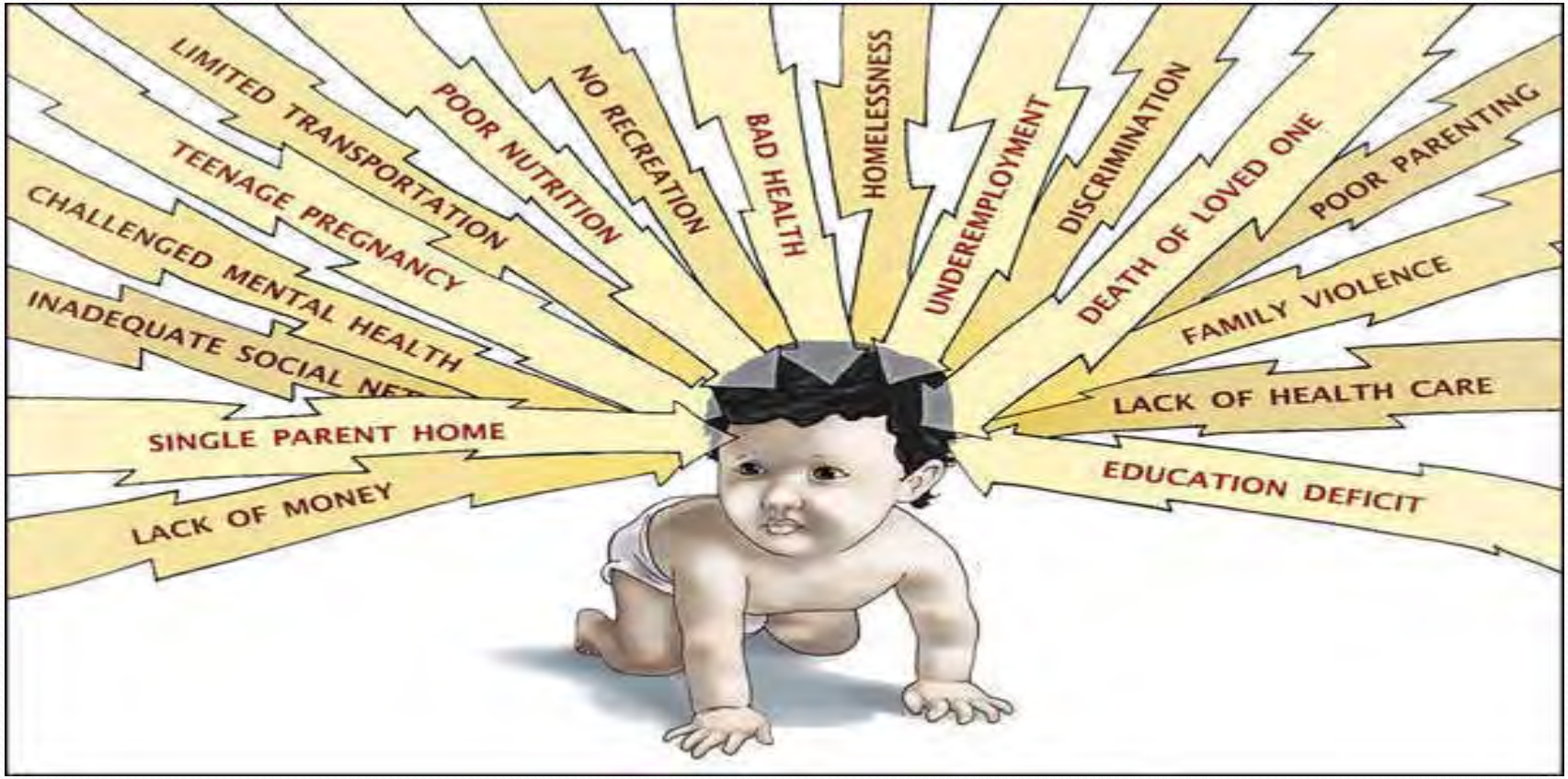
Medical Root Causes

- Lack of Evidence Based Treatment
- Lack of Symptom Management
- Polypharmacy and Medication Reconciliation
- Multiple Providers making Disease Management Plans
- Lack of Appropriate Referrals (Specialists, homecare, etc.)

Psychiatric Root Causes

- Lack of Diagnosis/Recognition
- Lack of Treatment
- Medication Issues
- Lack of Support Services
- Suicidality
- Unrecognized Trauma
- Co-occurring untreated addiction/overuse of narcotics

Trauma Informed Care



Social Root Causes

- Safety
- Housing
- Transportation
- Access to Food
- Access to Employment
- Labeling/Bias

System Root Causes

- Inaccurate Medical Record
- Lack of Access
- Hours of Operation/Capacity
- Formularies
- Barriers to Information Sharing
- Fragmented/Conflictual Plan of Care and Intervention

What is a Cross Continuum Team?

Cross Continuum Team Identification

- All providers impacting patient outcomes
- Doesn't have to be an official healthcare provider
- Helpful to have a Relationship for Life

Tools for Intervention

Tools

- Business Associates Agreement

Contract between a HIPAA covered entity and a HIPAA business associate (BA) that is used to protect personal health information (PHI) in accordance with HIPAA guidelines.

http://www.camdenhealth.org/cross-site-learning/resources/engagement/hospitalprovider-agreements-for-super-utilizer-interventions/

- One Contact Person/Relationship for Life

Referrals
Questions

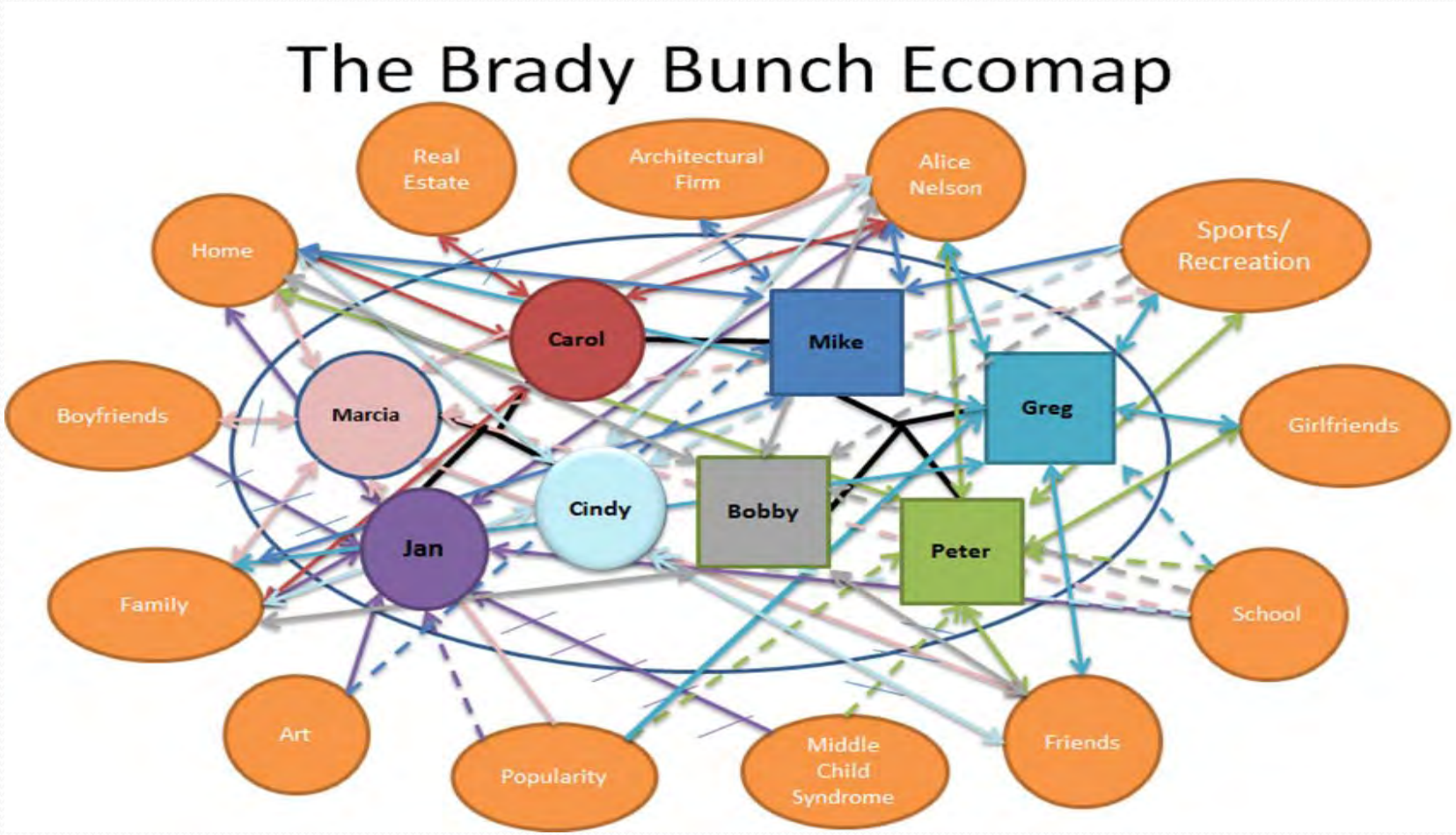
- Huddles/Care Conference

Coordinate care
Treatment planning
Identification of new opportunities for collaboration

- Integrated Consent/Team Release Form

Effective Record Review

Eco Map - Person and System



Camden Cards

Used with permission Camden Coalition

The Huddle/Cross Continuum Conference

Root Cause Tool

ROOT CAUSE ANALYSIS WORKSHEET

MEDICAL ROOT CAUSE examples

1. Is the person receiving the right treatment for this disease?
2. Are symptoms well managed?
3. Have appropriate referrals been made?
4. Has the patient seen the specialist she was referred to?
5. Do all providers agree on the disease management plan?

PSYCH ROOT CAUSE

1. Depression
2. Trauma
3. Anxiety
4. Addiction
5. Social Isolation

SYSTEM ROOT CAUSE

1. Access to care
2. Fragmented Fee-for- Service model
3. Eligibility criteria limit patient's options
4. Poor communication among providers
5. HIPPA restrictions
6. Provider coverage or vacation schedule
7. Capacity

SOCIAL ROOT CAUSE examples

1. Poverty
2. Violence
3. Housing
4. Transportation
5. Education
6. Childcare

Shared Plan of Care

Date:	Lead Care Coordinator:

PATIENT INFORMATION

Patient Last Name: First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Phone Number: ( )

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Address:	Social Security no.:	Marital Status: Single / Mar / Div / Wid / Sep

City:	State:	Zip:	Advanced Directive: ❑ Yes ❑ No

Diagnosis:	PCP Care Coordinator:	10 Year Medical Record Review Done: ❑ Yes ❑ No

PCP:

Care Team:

CARE PLAN

		PERSON(S) RESPONSIBLE	DUE DATE
Treatment Goals:			
Patient Goals:			
Shared Strengths:			
Potential Barriers:			
Action / Self-management Plan:			

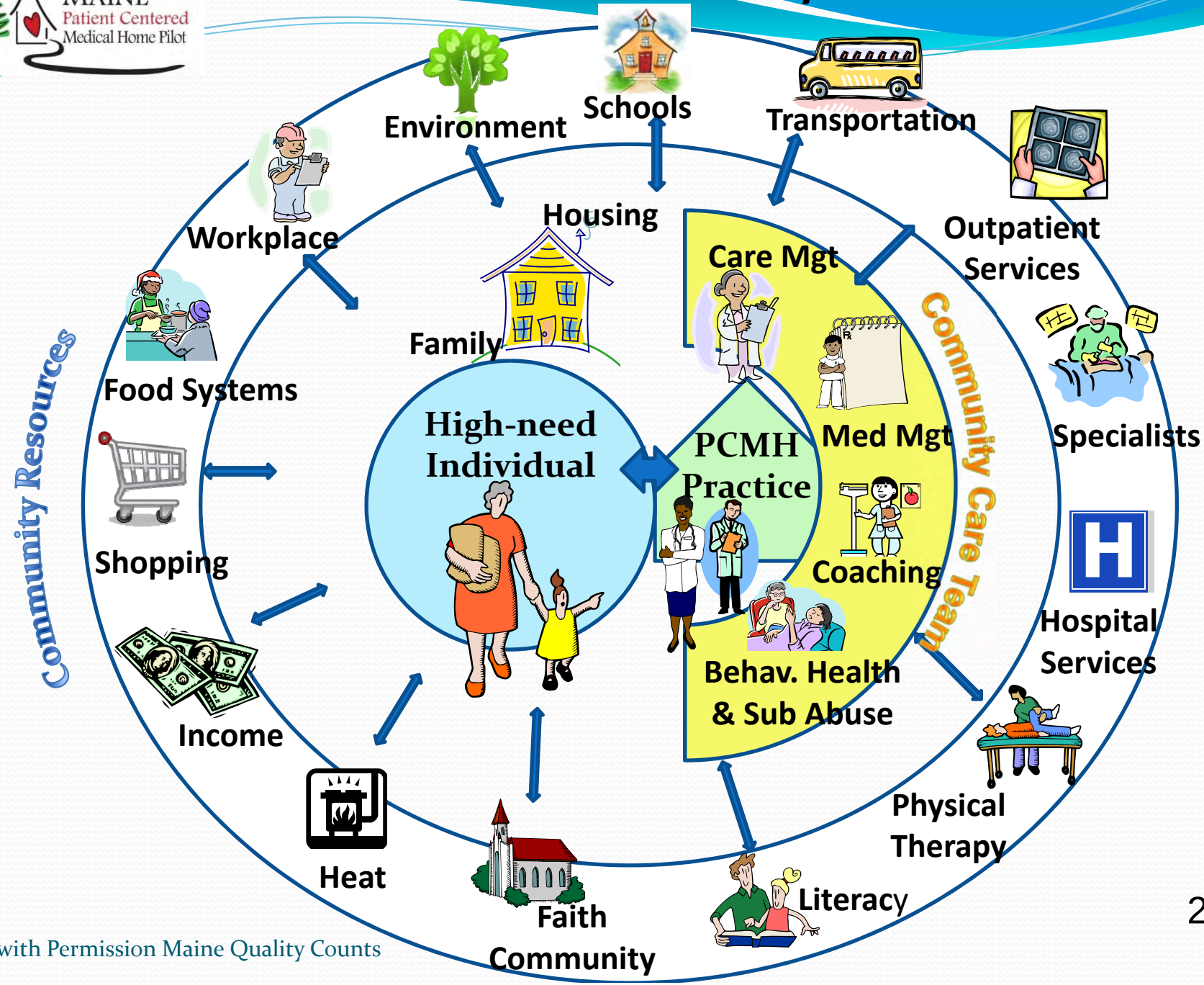
IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Embedding a Cross-Continuum plan

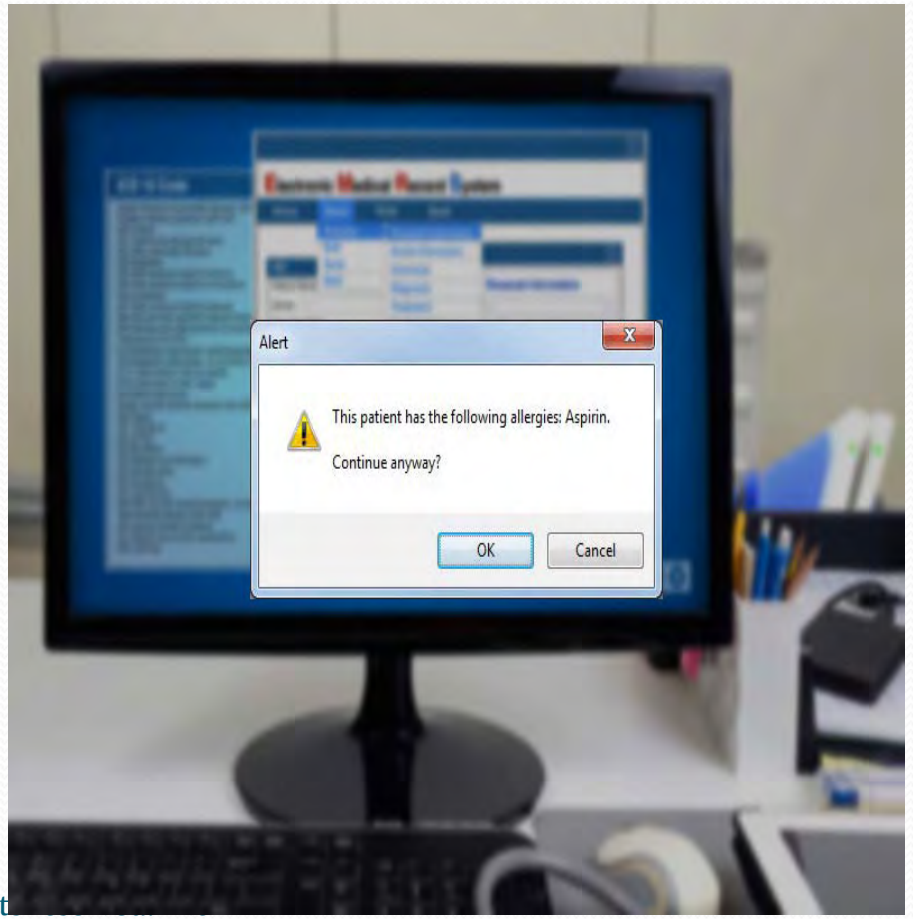
Where would a plan change outcomes?

Maine PCMH Pilot Community Care Teams



Options for Embedding Plans

- HIE
- Paper
- ED EMR options
- Inpatient EMR options
- PCP EMR options
- Shared Conferencing with interested parties



What drives your partners?

Identifying Partner Values

- Depth
- Time
- Access
- Role in the moment of care
- Drivers of Intervention

Key Information for Partners

- ED
- Inpatient
- Facilities
- Partner Agencies
- Community Care Teams
- PCP

Transitions of Care

CHANGES IN:

- Person Centered Understanding of Plan of Care
- Clinical Status
- Care Team
- Medication
- Disease Management
- Testing & Equipment
- Referrals & Resources

Facilitating Transitions

- Relationship for Life
- The Community Care Team
- Hand Off Report
- Visits in the next site of care
- Integration in the Shared Plan of Care

Care Plans as a Living Document

Short term vs long term:

- Members of the Care Team
- Medical Root Causes
- Psychiatric Root Causes
- Social Root Causes
- System Root Causes
- Goals and Resources

What are the elements of an effective plan?

Shared Plan Framework

- What is important to the patient/patient goal
- Situation – one sentence summary of key issues
- Root cause Medical
- Root Cause Psych
- Root Cause Social
- Root Cause System
- Cross Continuum Team with Contact Information
- Recommendations – evidence based, short, what is helpful in the moment of care

Managing Plans

Lead Role with Plan Maintenance

- Monitor Patient Ping/Healthcare visits
- Monitor changes in the cross continuum team
- Convene the group at intervals based on stability
- Update the plans in the embedded sites
- Transition maintenance based on Triage

Triage and Cadence of Review

- Tool
- By Stability
- By Needs Assessment

What needs are Driving Instability?

Complexity Index:

- Instability in 1 Root Cause driving frequency = 1 point
- Instability in 2 Root Causes driving frequency = 2 points
- Instability in 3 Root Causes driving frequency = 3 points
- Instability in 4 Root Causes driving frequency = 4 points

Common Causes of Instability

- Acute vs Chronic
- End Stage Disease
- Disease Management
- Symptom Management
- Psychiatric/Suicidality
- Addiction
- Safety/Trauma
- Resources/Access
- Lack of Consistency and Boundaries

What is the degree of Frequency?

Triage Index:

- <3 ED/IP visits in 12 months = Annual Conference and Plan Review = 1 point
- 3 – 8 ED/IP visits in 12 Months = Bi-Monthly Conference and Plan Review = 2 points
- 8 – 15 ED/IP visits in 12 Months = Monthly Conference and Plan Review = 3 points
- >15 ED/IP visits in 12 Months = Weekly Conference and Plan Review = 4 points

Let's Practice....

Group Exercise

- Practice in Team with Tool and Actual Patients

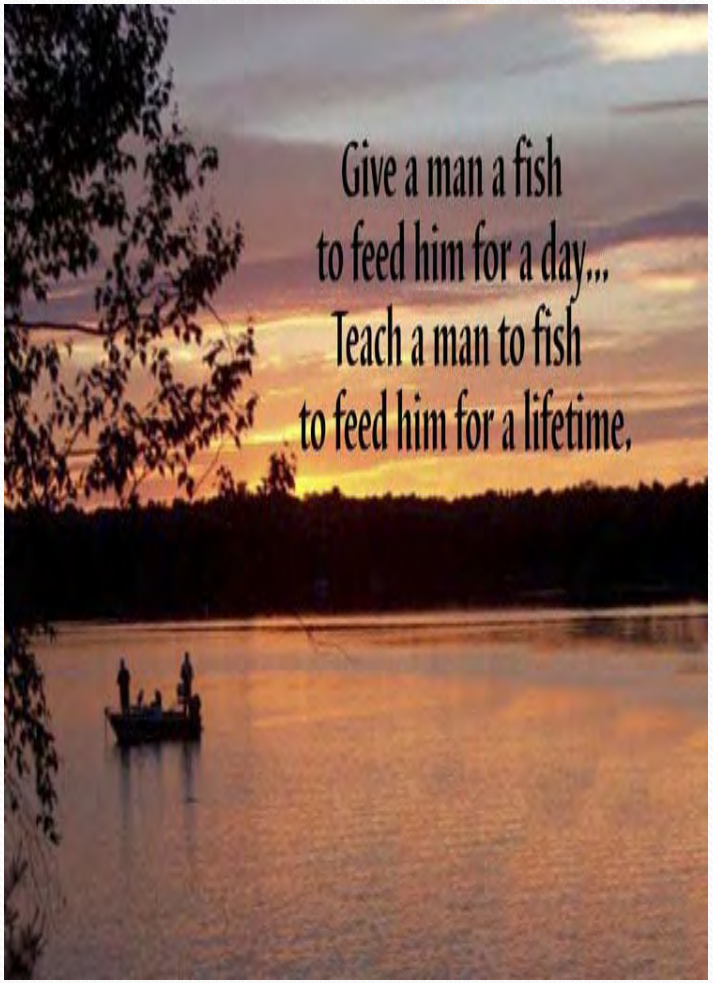
Report Out

Celebrating Success

Graduation

- Acknowledge the accomplishments
- Share the success
- Warm hand off to relationship for life
- Leave the door open

Questions?



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Patient: DOB:	MRN : Insurance:

Relationship for Life/Plan Manager	
Triage Index (score 1 to 4)	
Complexity Index (score 1 to 4)	
Cadence of Care Conference review	
Most Important to Patient:	
Cross Continuum Care Team	Medical Root Causes
PCP: **PCP CM**: S**pecialists**: **Agencies in the Home:** **Other Key Contacts/Supports**: **Primary Decision Maker**: Self	**Dx**: **Symptom Management:**
Psych Root Causes	Social Root Causes
Dx: **Suicide/Homicide Hx:** None noted **Addictions Hx:** none noted **Traumas:** none noted	**Housing**: (as of add date) **Transportation:** none noted **Barriers:** none noted **Legal***:* none noted
System Root Causes	**Considerations**:
Referrals Needed: ☐Accesses Multiple Health Systems:	**Responds well to**:

Patient: DOB:	MRN : Insurance:

Consecutive years >3 ED/IP visits in 12 months (prior to intervention):			
Program Year	# IP/Obs Visits	# ED/UC Visits	Root Cause Visit Trends
12m prior to Intervention			
1			
2			

Plan Maintenance History			
Date	Staff	Status	Issue
			Shared Care Plan loaded in _____

Triage Index:

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Complexity Index:

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- Instability in 3 Root Causes driving frequency = 3 points
- Instability in 4 Root Causes driving frequency = 4 points

Conference Frequency:

Consider cadence of Shared Conferencing based on frequency of healthcare visits and number of root causes driving instability

- ≤2 Points = Annual conferencing and review
- ≥4 Points = Bi-Monthly conferencing and review
- ≥6 Points = Monthly conferencing and review
- 8 Points = Weekly conferencing and review

PATIENTPING

Connecting providers to seamlessly coordinate patient care

AGENDA

1. Introductions
2. PatientPing Refresh and Services
3. Vermont Rollout Update
4. Implementation Overview
5. Discussion and Next Steps

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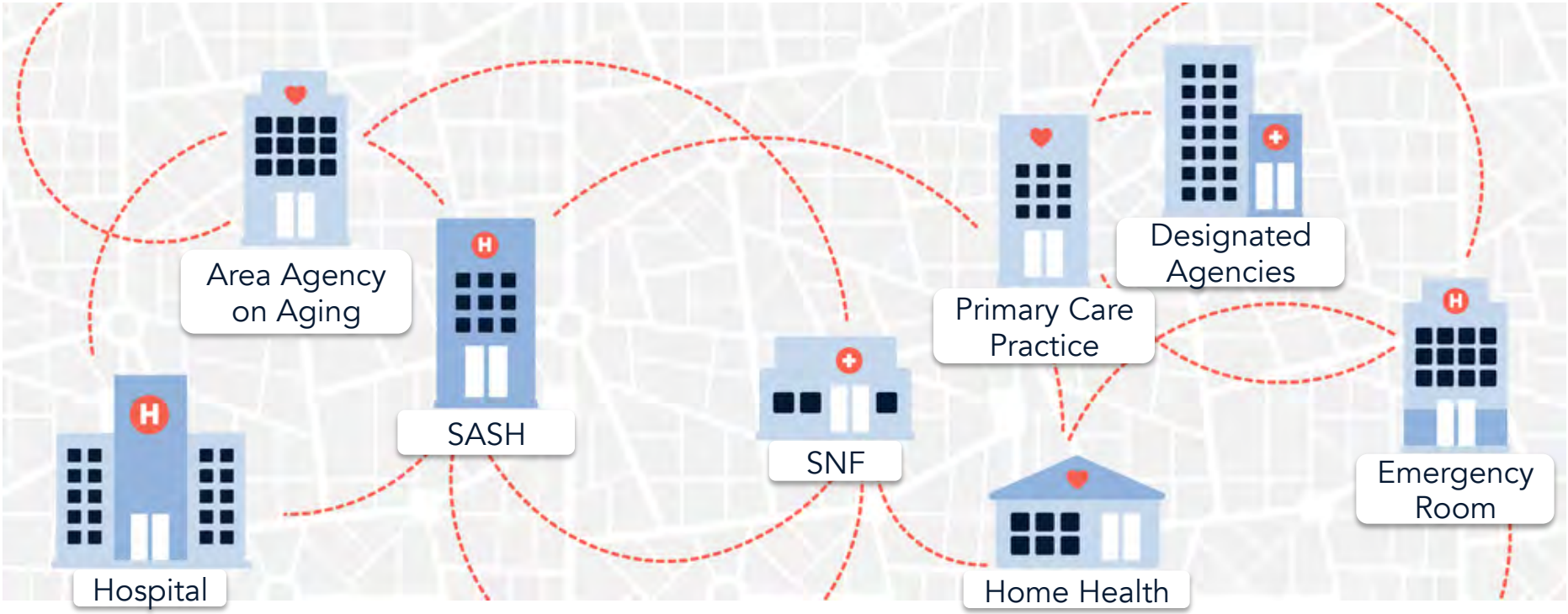
THE PATIENTPING VISION: COORDINATE CARE EVERYWHERE

Our vision is to create a national care coordination community



By connecting providers through real-time admission and discharge notifications, we aim to help providers transform the way care is delivered

OUR PRIORITIES

1

Providing immediate, actionable data to help facilitate safer care transitions across the entire care continuum

2

Our community: Aim to provide outstanding user experience and support

PATIENTPING SERVICES

Admitting Facility

"Ping" sent to attributed caregiver

"Care Instructions" sent to admitting facility

Attributed Caregiver

Care Instructions

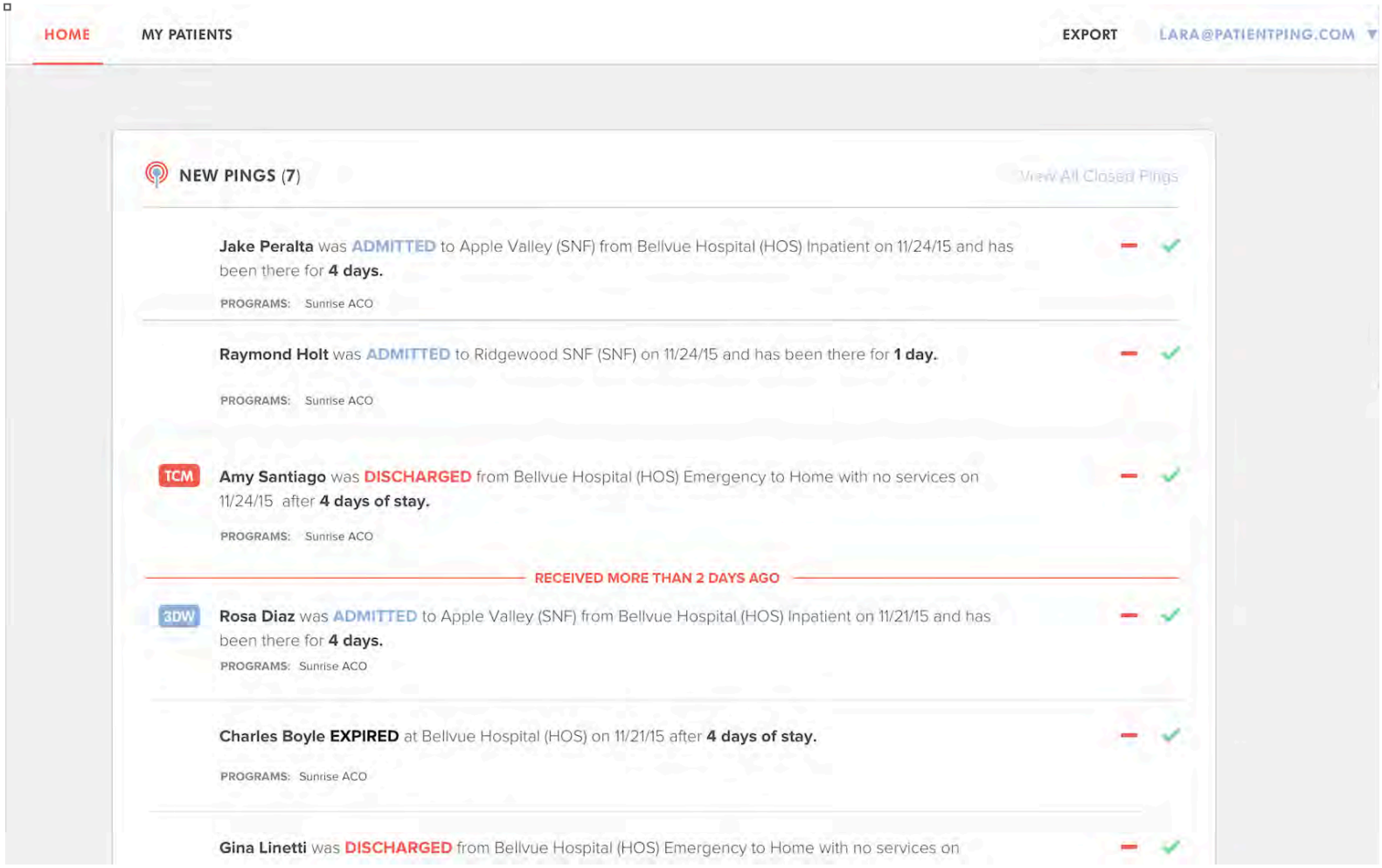
- Care Programs
- Care Team Info
- Care Instructions
- Visit History

Ping

- Patient Name
- Patient Status
- Facility
- Length of Stay
- Visit History

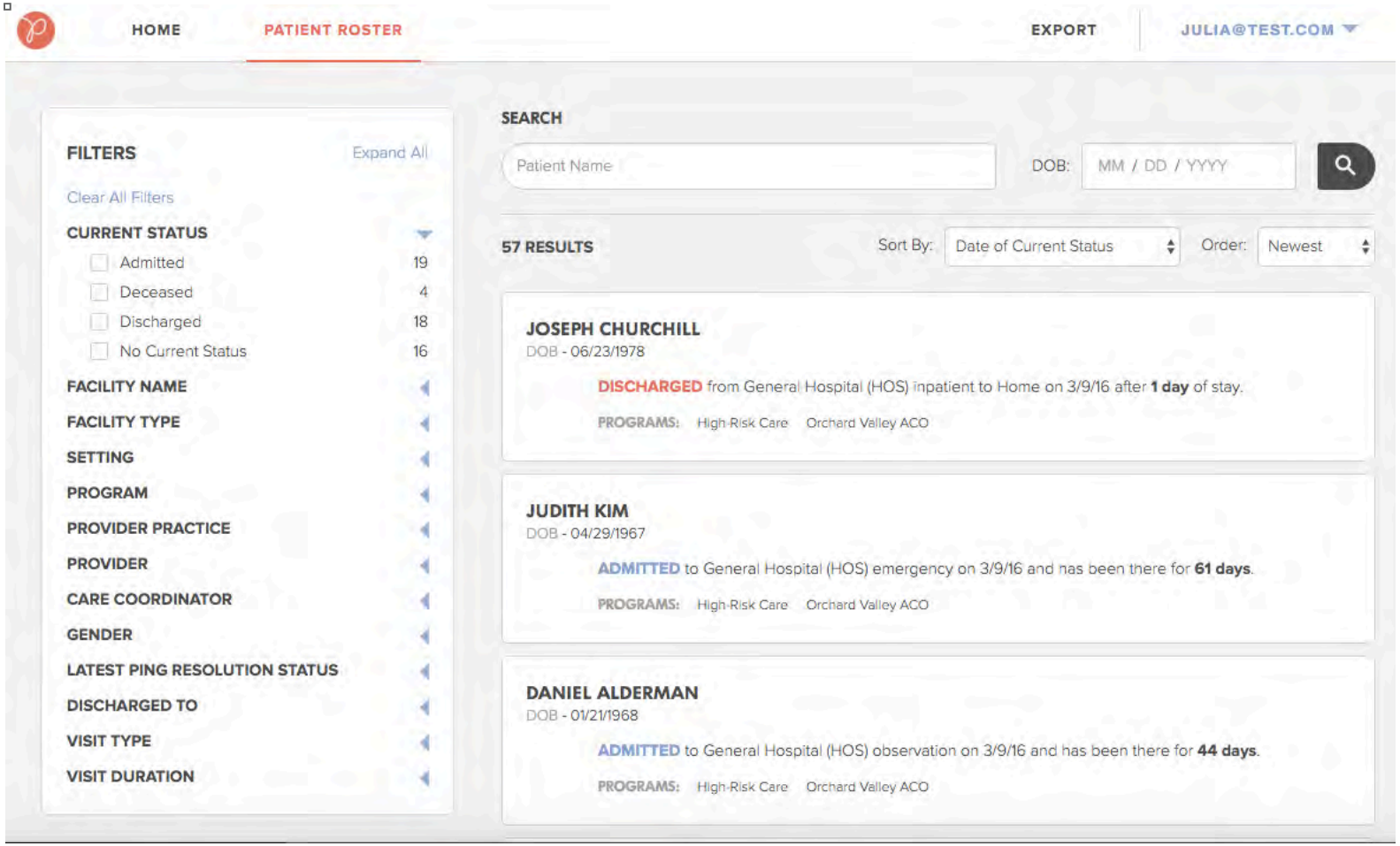
REAL-TIME PINGS

Lightweight panel to track patient visits anywhere



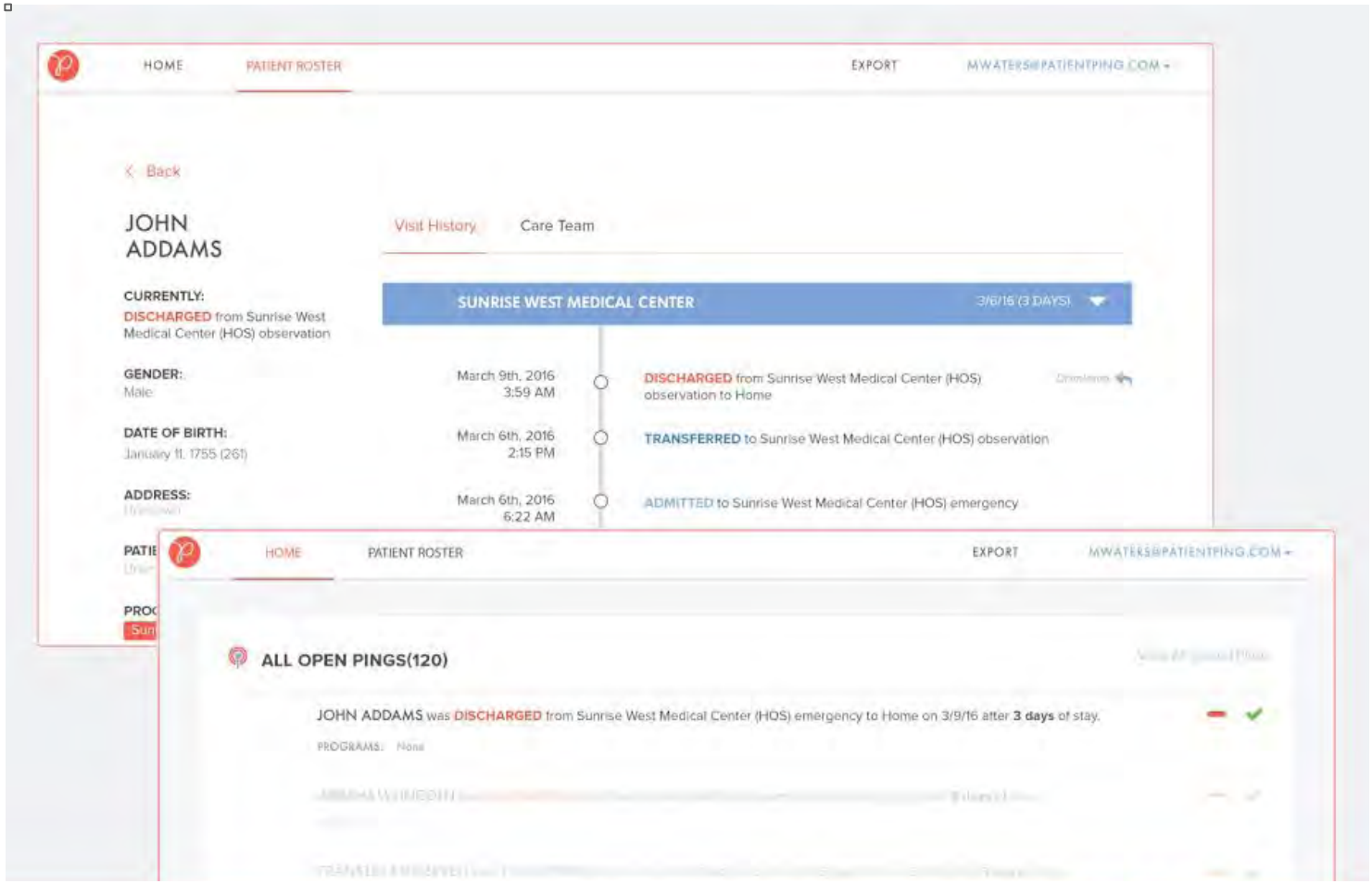
REAL-TIME PINGS

Filters to target specific patient events



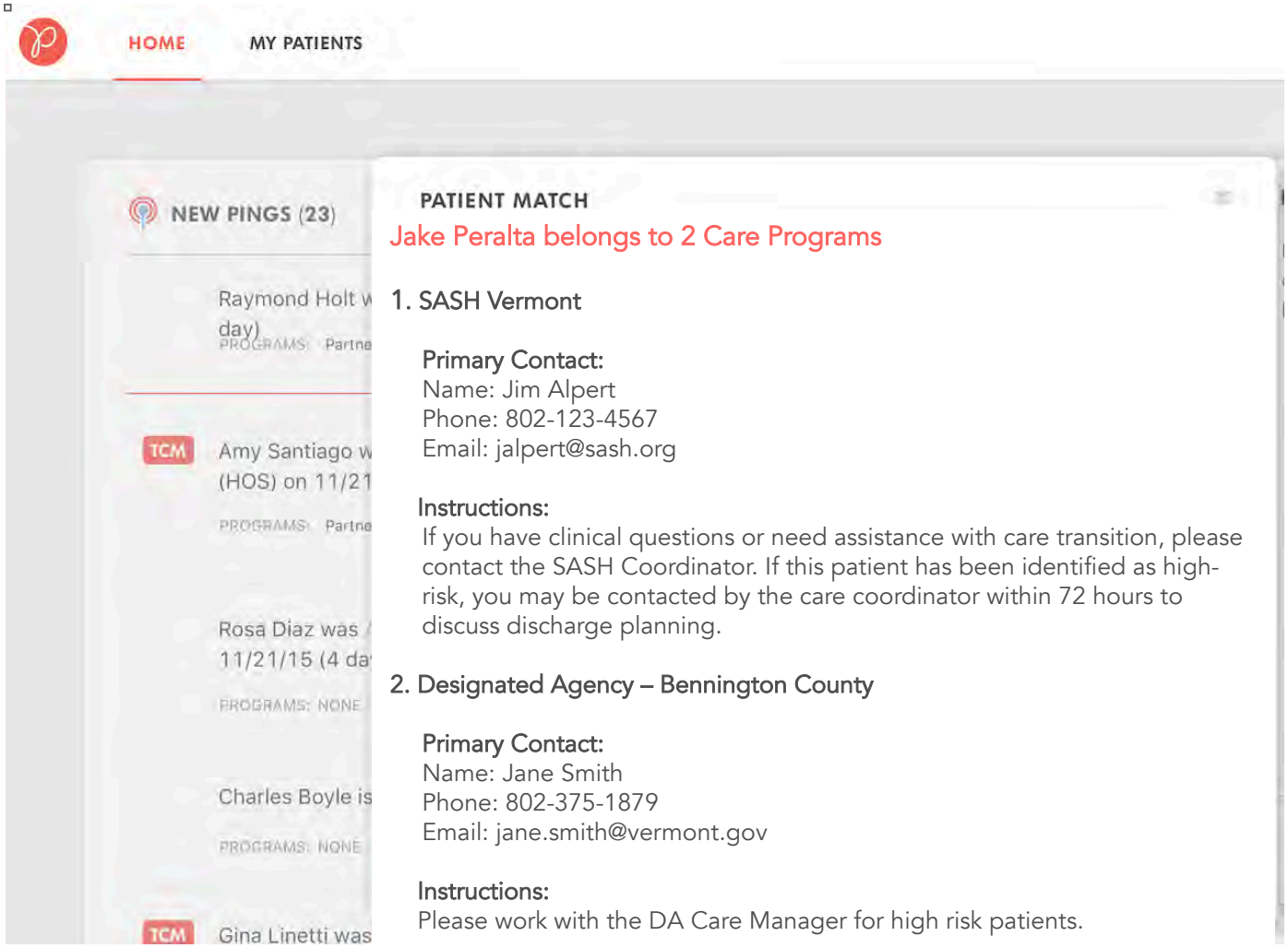
PATIENT PROFILE AND VISIT HISTORY

Visibility across full care continuum regardless of system



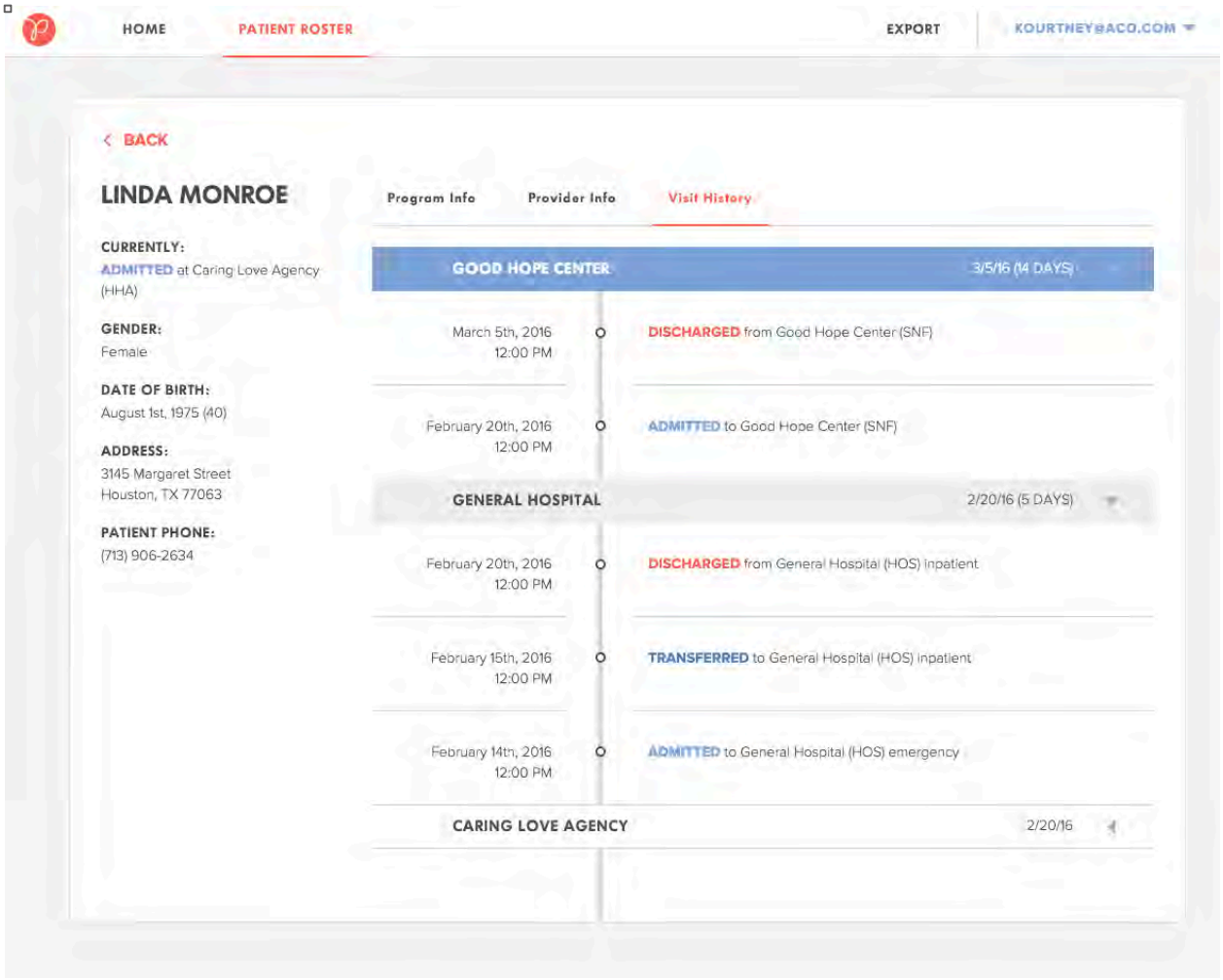
CARE INSTRUCTIONS AT ADMISSION SITE

Automatically share care information with full care team



VISIT HISTORY AT ADMISSION SITE

View all settings where your patients have previously received care



SAMPLE BLUEPRINT SCENARIO

Lead Care Coordinator

Pings back to LCC

Organization 1

Patient Population 1

Organization 2

Patient Population 2

Organization 3

Patient Population 3

Pings back to LCC

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VERMONT ROLLOUT

- Live community members:
  - VITL – 15 hospital feeds flowing
  - OneCare – Roster loaded and Pings flowing
  - CHAC – Roster loaded and Pings flowing
- Community members in discussion:
  - VNAs of Vermont
  - Bayada
  - Statewide SNFs
- Launch timeline for new community members:
  - Now!

ACO ROLLOUTS - OVERVIEW

- CHAC
  - All member organizations have launched
    - BVHC; CHCRR; CHSLV; GHC; MHC; LRHC; NCHC; NOTCH; SMCS; THC; Remote Monitoring
  - All Medicare, Medicaid, and Commercial lives are included on PatientPing roster
  - Care Coordinators/Managers across organizations are logging in and acting on Pings on a regular basis
- OneCare Vermont
  - Launched with pilot roster of top 5,000 high utilizers across ACO population
  - Central OneCare staff are logging in to view Pings
  - Next rollout step: Pending RWJF grant confirmation for 4 participating communities

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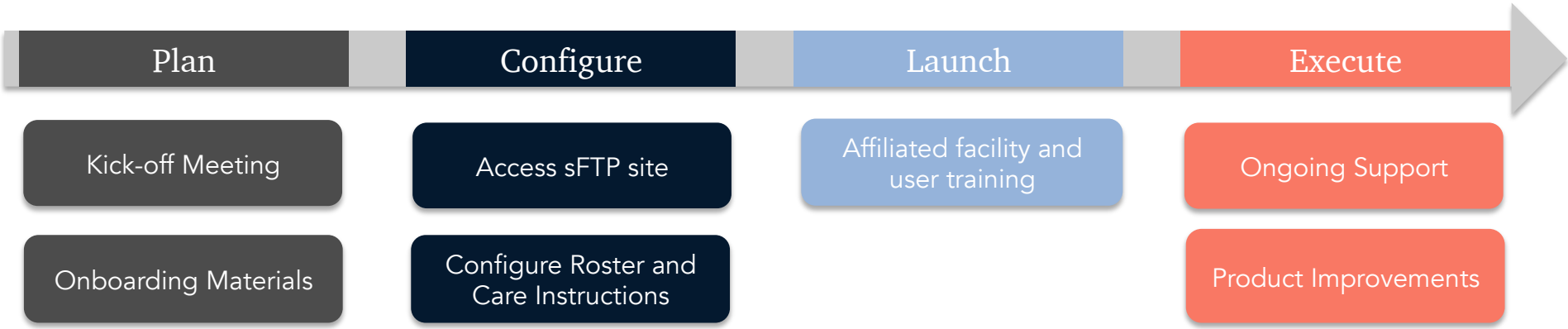
IMPLEMENTATION PROCESS



ROLL-OUT TIMELINE*

** Represents typical configuration timeline, subject to change based on deployment-specific factors*

ONBOARDING STEPS

1. Configure patient roster
   - PatientPing provides template
   - Compile list of patients for whom you would like to receive Pings
2. Transfer patient roster
   - PatientPing provides sFTP credentials
3. Compile admit/discharge care instructions
   - PatientPing provides template
   - Email admit/discharge care instructions to PatientPing
4. Provide user accounts
   - Compile list of users who will access Pings
5. Provide facility list (as needed)
   - Email PatientPing a list of any new PAC facilities to onboard

ROSTER CREATION

Compile your patient roster to receive Pings

Fields to include in your patient roster:

- Patient ID*
- Patient name*
- Patient DOB*
- Patient gender*
- Patient address
- Patient phone
- Patient attributed provider details (Name, Phone, Fax, Email)
- Patient practice details (FQHC, Primary Care practice, etc.)
- Patient program details (SASH, DA, ACO etc.)
    - Patients can have multiple, unlimited program assignments
    - Each program to which a patient is attributed would receive Pings on that patient's care

CARE INSTRUCTIONS

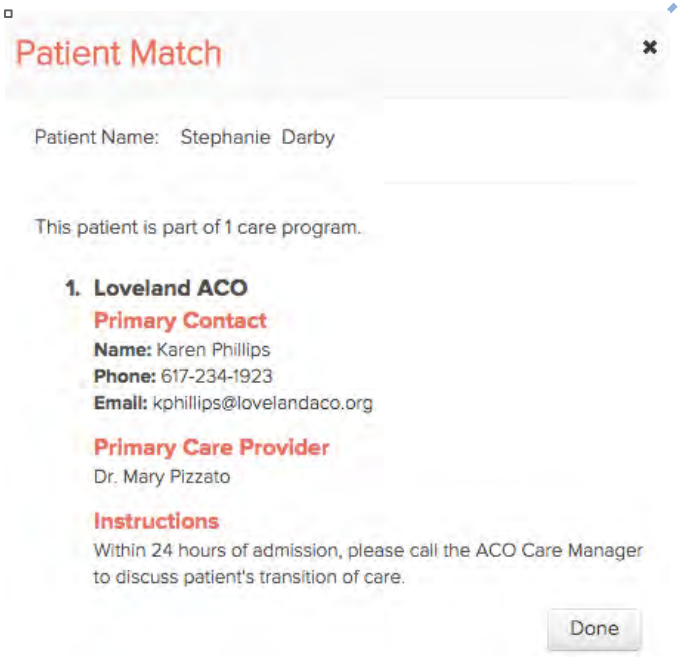
Design tailored care instructions for your patient populations

Care instructions can be designed at the practice-specific or program-specific level. They can be as detailed or generalized as needed to fit your patient population.

Fields to include in your care instructions:

- Program or practice name
- Contact name
- Contact phone
- Contact fax
- Contact email
- Instructions to be followed at the point of admission
- Instructions to be followed at the point of discharge

SAMPLE CARE INSTRUCTIONS



Purpose	Admit Instructions	Discharge Instructions
Share information across care settings	Please contact [ACO Care Coordinator Name], the [ACO Name] Care Coordinator, at [Phone Number] to discuss the details of the patient's prior hospitalization.	Please contact [ACO Care Coordinator Name], the [ACO Name] Care Coordinator, at [Phone Number] to discuss the patient's discharge instructions.
Request action be taken	Call [ACO Care Coordinator] to discuss any transition of care out of your facility in advance of transition.	Please have the patient's nurse contact [ACO Care Coordinator] to discuss a warm handoff.
Guide future care transitions	Preferred HHA: Loveland Home Care Preferred Hospice: Good Home Hospice Preferred Neurologist: Eve Levine, MD	Upon discharge, fax the PCP's office, [Fax Number], the following: Discharge Summary, Discharge Instruction Sheet, and Discharge Medication List
Provide conditional contacts	Call [ACO Care Coordinator] with questions or concerns. If you have clinical questions, please contact [RN Care Coordinator] at [Phone number].	Call the PCP office contact [office contact] at [Phone Number], to schedule a transition of care appointment within 24 hours of discharge.
Coordinate specific conditions	Please contact [High Risk RN] at [Phone Number] within 2 hours if CHF or COPD patients show signs of deteriorating health.	Please notify [High Risk Nurse] within 24 hours of discharge.

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FREQUENTLY ASKED QUESTIONS

- I participate in an ACO, but I want Pings on my patients who aren't in the ACO too.
  - Not a problem. All we need from you is the roster of patients for whom you'd like to receive Pings.
- I can't separate out my ACO patients from my non-ACO patients. Can I send you everyone?
  - Yes! We will take care of splitting your roster into two populations:
    1. Patients attributed to an ACO roster that we have loaded
    2. Patients not attributed to an ACO roster that we have loaded
- Who is responsible for paying for Pings on my patients?
  - You will responsible for paying for Pings on your patients who are *not* attributed to CHAC or OneCare Vermont (top 5,000).

FREQUENTLY ASKED QUESTIONS

- What if I want Pings on my patients, but I'm not affiliated with an ACO?
  - All we need from you is the roster of patients you'd like to track.
- How much do Pings cost?
  - $.10 PMPM
  - The state of Vermont will subsidize 70% of this cost.

UPCOMING WEBINARS!

PatientPing is hosting introductory webinars:

June 7th, 8am
June 8th, 12pm
June 9th, 12pm

Sign up at www.patientping.com/vermont

NEXT STEPS

PatientPing

- ❑ Send meeting follow-up materials
- ❑ Schedule check-in to review team-specific onboarding questions (as needed)
- ❑ Send contracting materials to interested groups/teams
- ❑ Provide Community Teams with sFTP credentials

Community Teams

- ❑ Review meeting materials with internal team
- ❑ Sign up for webinars!
- ❑ Schedule time to think through implementation with Julia and The Blueprint team
- ❑ Complete contracting process with Matt
- ❑ Compile and transfer patient roster
- ❑ Provide admit/discharge care instructions to Julia
- ❑ Determine user accounts and send to Julia

CONTACT PATIENTPING

Contact Matt Rose and Julia Sanders with questions

Matt: 508-826-9969 or mrose@patientping.com
Julia: 603-475-4420 or julia@patientping.com

We will respond to any inquiries within 24 hours

Welcome to the PatientPing community!

https://care.patientping.com