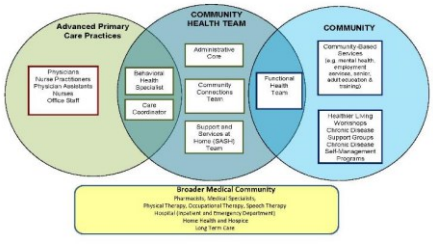
Caledonia & Southern Essex Learning Collaborative

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

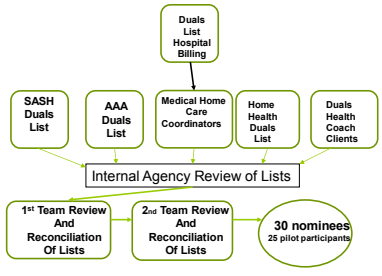
VHCIP Duals Project Overview

- 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



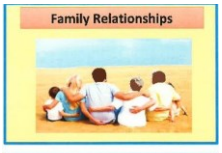
Interdisciplinary Team and Lead Case Manager

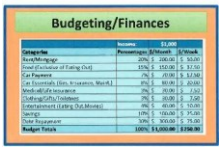
- Team reviews all nominated individuals to determine community partner with closest relationship to act as lead case manager
- Lead case manager visits with individual to discuss project and get signed consent to participate

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