Care Navigator Implementation: A Community Perspective

November 4, 2016

OneCareVermont

OneCareVT.org
Before we get started...

By default, webinar audio is through your computer speakers.

If you prefer to call-in via telephone, click “Telephone” in the Audio pane of your control panel for dial-in information.
Before we get started...

- All participants will remain muted for the duration of today’s webinar. Please submit questions via the Questions pane in the webinar control panel.

- This webinar is being recorded. Slides and recording will be used for training purposes.
Learning Objectives

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

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

**Insurers:**
Medicare, Medicaid, BCBSVT

**Medical Providers:**
Patient attribution: PCPs and Specialists
Hospitals, HHA, SNF, MH Agencies

**OneCare Vermont**
Dartmouth-Hitchcock Medical Center
University of Vermont Medical Center

**State and Federal Health Care Reform**
(System Delivery and Payment)

**Continuum of Care Providers:**
Agencies on Aging, SASH, Community Organizations and VT State Agencies

**Triple Aim:**
↑ Patient/Family Satisfaction
↑ Coordination of Care to ↓ Cost
↑ Quality
Care Navigator Timeline

**April**
- CN software initial set up for OCV

**May**
- Focus Groups Held

**June**
- CN initial training for RWJF communities
- Incorporated Focus Group feedback into CN

**June 30th**
- System access to training version
- Onsite training with pilot communities

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

**October**
- Regional teams begin to identify the top risk patients

**December**
- Community workflow assessment begins through ICCMLC Learning Session

**February - ongoing**
- Training and engagement of care team members

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

**November**
- Shared learning with care management learning collaborative

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

We are here
### Care Navigator Community Utilization

- **St. Albans**
  - 23 Users (7 CCS)
  - NMC
  - NMC CHT
  - NCSS
  - CVAA
  - FCHH
  - 3 Community PCP practices

- **Bennington**
  - 29 Users (4 CCS)
  - SVMC CHT
  - Bayada
  - Bennington Project Independence
  - Bennington Council On Aging

- **Burlington**
  - 22 Users (4 CCS)
  - UVMMC CHT
  - Bayada
  - CVAAA
  - VNA
  - Howard Center

- **Berlin**
  - 17 Users (3 CCS)
  - CVMC
  - CVHHH
  - WCMH
  - SASH
  - CV Council on Aging

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

### CCS = Care Coordination Supervisor
- Has access to lists of patients and can assign patients
  - CCS: Access to patients at TIN Level
  - CCS OCV: Access to all OCV attributed patients
User Roles

- **Care Coordinator**
  - Assigned patients by Care Coordination Supervisor
  - Can only view patients that are assigned or added to the care team
  - Can add other care team members

- **Care Coordination Supervisor (CCS)**
  - Viewing of patient lists is based on “business unit”
  - Assign patients to care coordinators

- **Care Coordination Supervisor OCV (CCS OCV)**
  - Viewing of patient lists for all of OneCare
  - Assign patients to care coordinators
Care Navigator Community Implementation

1. Convene HSA community leadership

Intro to CN Training

2. Convene core team

CN User Training #1 and CCS attend CCS Training

Develop/Refine community specific CC workflow

CN User Training #2

Assign patients to LCCs

Identify Care Team Members

Convene core team to identify initial patients

Convene core group to debrief & revise processes as needed

Meet with engaged medical practices

Refine and Implement expansion plan & CC community workflow

Expand to additional patients and care team members

Community-level monthly CC metrics monitoring

Provide CC for initial 5 patients

(process flow template)

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

Month 1 2 3 4 5 6
Care Navigator Community Implementation

1. Convene Community Leadership

Goals:

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

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

Month 1 2 3 4 5 6
Convene Community Leadership

St. Albans – Lesley Hendry
Tips and Opportunities

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

1. Convene HSA Community Leadership

   → Attend Intro to CN Training

2. Convene Core Team:
   Goals:
   • Identify CN User roles
   • Strategies for medical practice engagement
   • Care Navigator expansion plan for community

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

Month 1 2 3 4 5 6
Convene Core Team

Bennington – Terry Reinertson, RN, BSN

Tips and Opportunities

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

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

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

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

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

Phase V
At home senior care
Bennington Free Clinic
VA Medical Center
Identify Patients and Assign to LCCs

1. Convene HSA community leadership
2. Convene core team
   - CN User Training #1 and CCS attend CCS Training
   - Convene core team to identify initial patients
   - Identify Care Team Members
   - Assign patients to LCCs
   - CN User Training #2

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

Month
1  2  3  4  5  6
Identify Initial Patients

Burlington – Robyn Skiff
Tips and Opportunities

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

Chittenden County Community Collaborative
1st Wednesday in Colchester

Planning Team
1st Tuesday 412 Farrell St.

Participant Identification Team
4th Monday at UVMCC

Chittenden South
Charlotte, Shelburne, Hinesburg, St. George

Chittenden North
Milton, Colchester

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

Chittenden Central
Williston, Essex, Richmond, So. Burl, Jericho
Community Specific Care Coordination Workflows

1. Convene HSA community leadership
2. Convene core team
   - CN User Training #1 and CCS attend CCS Training
   - Develop/Refine community specific CC workflow
   - Assign patients to LCCs
   - Identify Care Team Members
   - Convene core team to identify initial patients

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

Month | 1 | 2 | 3 | 4 | 5 | 6
ICCMLC Care Coordination Workflow
(Order of Interventions May Vary)

Identify People With Complex Needs
CCS Reviews CN List of Patients likely to benefit from CC

Recruit People
Assign person to LCC for review. Is CC needed? If yes, meet with patient to complete eco map to identify care team members

Document Person's Story, Goals and Care Team
Use Camden Cards to start shared care plan (SCP) development in CN and “invite” care team in CN

Review Person's Health History
Complete initial SF12 and VT Self Sufficiency Outcome Matrix

Conduct a Root Cause Analysis
Review assessments and initial shared care plan with patient goals and completed assessments

Convene Care Team Huddle
Meet with person and care team to review completed assessments and initial SCP. Complete updates and assign tasks to patient and care team

Identify Person's Lead Care Coordinator
Can the person's goal be better addressed by another care team members? If yes assign and update in CN

Convene Care Team Conferences
Hold care team conferences based on the needs and desires of the person

Develop, Implement and Monitor
Use CN to communicate with the care team, update SCP, and track tasks. Complete SF 12 and VT SS every 6 months.

Repeat Interventions as People’s Needs Change Over Time
Community Specific Workflows

Berlin – Heather Colangelo
Tips and Opportunities

- Initial use of workflow
- How has your participation in ICCMLC informed this step?
- Integration with ICCMLC existing meetings?
Staff considers current caseloads and associated risk score & identifies who is likely to benefit from CC

CC Supervisor assigns a preliminary LCC based on appropriateness within Navigator

Is CC already in place?

NO

Introduce Care Navigator to patient & treatment team members

Complete initial SF12 and VT Self Sufficiency Outcome Matrix

YES

LCC enters current Care Plan into Care Navigator and use CN to communicate with team & patient

LLC introduces Care Navigator & uses Eco Map to ID patient priorities and care team members

LLC enters gathered data into CN and invites team members

Team members obtain CN training

LCC assigns Camden Cards, SF12 and Self-Sufficiency Matrix

Does the patient desire a different LCC? Or does team believe the goals would be better address with another?

NO

Assign a new LCC based on patient’s needs and goals

YES

LCC convenes Care Team: Review findings, complete chart review and Root Cause Analysis.

Hold a “huddle” then a Shared Care Conference with Patient

Complete a Shared Plan of Care

ALWAYS REPEAT STEPS/INTERVENTIONS AS NEEDED
Next Steps

All Communities

Pre-work

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

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

Attend December in person learning session -
Save the Date – December Learning Sessions!

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

**December 15th:**
Vermont Veteran’s Home  
325 North St, Bennington, VT 05201

**December 16th:**
Department of Vermont Health Access  
312 Hurricane Lane, Williston, VT 05495

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