It Takes a Community:
Synchronizing Care Around Patients’ Needs

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Current State of Play in Vermont

- Statewide foundation of primary care medical homes
- Community Health Teams providing supportive services
- Statewide transformation and learning network
- Local innovation through community collaboratives
- Maturing health information & data systems, comparative reporting
- Accountable Care Organizations representing the majority of health care providers
- Potential for a unified accountable health system and all payer model
Community Collaboratives (CC)

- Formed under the joint leadership of the ACOs and Blueprint for Health
- Focused on improving ACO and population health measures, including quality projects and coordinating health and community based services
- Leadership teams to identify local priority area based on state priorities
- Recommended Leadership teams includes: clinical leaders from independent and federally qualified health center (FQHC) primary care practices, local hospital, mental health agency, area agency on aging, home health agency, pediatrics, housing organization, plus additional locally selected members (recommended not to exceed 11)
- Involve additional community stakeholders
Workgroups of the Community Collaboratives

- Committees or workgroups were created to implement specific quality and coordination projects, for example:
  - Enhancing care coordination across organizations
  - Reducing emergency room use
  - Decreasing hospital admissions
  - Increasing hospice utilization
  - Addressing addiction
Supports Initiated for Community Collaboratives

Examples

- Staff - Clinical Quality Consultants, Project Managers, QI Facilitators
- All-field team meeting
- Integrated Communities Care Management Learning Collaborative
- Accountable Communities for Health Peer Learning Lab
VITL Summit
Interagency Care Coordination
October 6, 2016

Jill Lord, RN, MS, Director of Community Health Services, Project Manager Blueprint for Health
The Birthplace of Vermont

WINDSOR
Community Health Team in Windsor
A Process

Care coordination activities promote a holistic and patient centered approach to ensure that a patient’s needs and goals are understood and shared among providers, patients and families to improve quality of care, patient care experience and patient engagement in care plan/treatment plan goals as a patient interacts with health providers and settings.

- **Identify**
  - Patient needing Care Coordination
  - Lead Care Coordinator

- **Engagement**
  - Obtain Consents

- **Assessment**
  - Look back, Prioritizing cards, Eco Map, Identify Root Cause

- **Prioritize**
  - Hold Care Conference

- **Shared Care Plan**
  - Communicate plan
  - Reassess - Update as needed

Day 2: Track 2 – Laying the Course for Coordinated Patient Care
Our Process

- Analysis of top 5% risk patients
- Factors include complex care needs and high cost/utilization (ED and inpatient admissions)
  - Identified patients currently cared for by Community Health Team (CHT) partners
  - Follow-up done for patients not currently served by CHT
  - Selection of patients for interagency care planning
Our Process

- Attended Integrated Care Management Collaborative to learn best practice tools provided by national experts
- Provided five local in-services on use of best practice tools for community partners
- Obtained many copies of Camden cards to distribute to partners
- Invited partners to “play” with the tools as part of their practice
-Trialed an initial six patients with use of the entire process
Interdisciplinary Team Assignments

- Team reviews all patients and Lead Care Coordinator chosen for each patient
- Lead Care Coordinator speaks with patient to discuss program and get consent
Individual Care Plan

- Needs Based
- Person Centered – Use of Eco Maps and Camden Cards
- Informed Choices
- Agreed outcomes and goal setting should be the result in an individualized Care Plan
- Copy of care plan given to patient and all community partners involved in the Action Plan
Prioritizing Cards

- Family Relationships
- Health Insurance
- Housing
- Food & Nutrition

Urgent
Really Important To Me
Need to work on right now

Non-Urgent
Somewhat Important To Me

Safety
Budgeting/Finances
Transportation
Drugs or Alcohol
Utilities
Education & Jobs

Work with Health Care Team
Mental Health

Day 2: Track 2 – Laying the Course for Coordinated Patient Care
Shared Care Plan
Interagency Care Plan

- Strengths and Social Support
- Active Health Care Issues
- Individual/Family Goals
- Team Goals
- Financial/Insurance
- Inventory of Resources and Supports for Self-Management
- Action Plan

Intragency Care Management Plan of Care

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>DEA/Prescriber</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Lead Case Manager</td>
<td>Phone</td>
<td></td>
</tr>
</tbody>
</table>

A copy of this care plan was given to patient on:

- Strengths
- Social Supports
- Active Health Care Issues
- Individual Goals
- Family’s Goals
- Team Goals
- Financial Support
Lessons Learned

SOMETIMES YOU WIN
SOMETIMES YOU learn
Richness of the Tools

- **Eco Maps**
  - Patients revealed, without hesitation, the supports they had that may not ever been mentioned prior to using Eco Maps.
  - Patients were able to easily sort out and recognize what they needed to work on first, and what could wait until later.

- **Camden Cards**
  - Assisted the patient to focus on what is important and engages the patient/family in an action plan.
  - Assisted the care coordinator to match programs with community partners and services with patient/family needs.
Richness of the Process

- Formal involvement with other agencies increased trust with families.
- Interagency involvement added insight and information for more comprehensive and successful care plan.
- Communication was improved.
- Patients were viewed as the experts and central to decision making, i.e., shift in focus to patient-centered approach.
Case Study #1

66 yr. old female retired factory worker who lives alone in a mobile home in rural Vermont. Active health issues include Chronic Depression, Diabetes T2 poorly controlled, Morbid Obesity, PTSD, OB, Polycystic Ovarian Syndrome, and Arthritis right knee. Patient walks with 2 canes.

Services included:
- Care coordinator/CDE did home visits weekly for several weeks, training patient to participate in her own self care management.
- VNA, PT, HHA in home to oversee education on DM, self management, wound care, and help with personal care.
- SASH was involved for financial support assistance, and wellness nurse for self management support.
- Ottauquechee Health Foundation and Stagecoach provided grants to support her transportation challenges.
- Home Behavioral Health and Eldercare visits and psychiatric medication intervention
- Aging in Hartland assisted pt. with prescription pick up, getting her groceries and light house cleaning.
Case Study #1 (Continued)

Challenges:
✓ Negative attitude and skepticism re: options of care for pain control and depression.
✓ Patient's weight - 380# and she does not fit into a regular sized car – refuses to wear a seat belt.
✓ Dismissed the importance of portion control and SMBG.

Outcome:
✓ A1c dropped from 8.9% to 7% with no insulin changes from initial dosing and subtle diet modification. Checks fs 2x daily.
✓ Wounds have healed. Patient reports less hopelessness, daily “crying jags,” and improved pain control.
Case Study #2

54 year old man, paraplegic, living in subsidized housing at one of the SASH hub sites. Primary issue is wound care that is long standing and he is currently using a wound vac. Very upbeat positive person who is in need of a strong circle of support. Identified by Community Health Team as high utilizer of services, complex care needs, multiple agency assist.

**Services included:**
- VNH- three times a week dressing change and wound monitoring.
- VNH- Home health aid scheduled three times a week.
- VNH Choices for Care PCA every morning for two hours.
- Consumer directed Choices for Care services; two workers employed by him through ARIS.
- PT and OT were involved through VNH- not in at present.
- SASH Coordinator – almost daily check-in and support.
- Mental Health Counselor- home visit weekly.

SASH Coordinator identified as Lead Care Coordinator due to strong relationship and regular contact. SASH Coordinator did an Eco-Map with him to identify circles of support. Used Camden cards to identify areas of need and his priorities for coordination of care.
Case Study #2 (Continued)

Patient Goal: “Healing my wounds is most important to me so I do not have to stay in bed as much. Being in bed all the time is no way to live.”

Areas of Importance: Cards chosen included Self-Care, Food and Nutrition, Identification, Medication and Supplies, Education, and Mental Health.

✓ Self-care: “Consistency of HHA’s that I can count on and have confidence in.”
✓ Nutrition: “I do not have noon time help and often miss lunch.”
✓ Supplies: “Wound care staff and VNH staff need to communicate with the company that sends my supplies for my wound vac.”
✓ Identification: “I need a new non-drivers ID for Vermont.”
✓ Education and Mental Health: “I have trouble focusing and think that I have Attention Deficit Disorder. I can’t get organized.”
Case Study #2 (Continued)

Planned Interventions:

- Secure funds for a small fridge and microwave for his room. PCA will fill with ready made meals weekly.
- Secure funds for a non-medical ride to DMV to get an ID. Needed to open a local bank account, access health care and obtain meds at pharmacy.
- Address concerns of ADD with mental health counselor and physician.
- Obtain seat cushion for wheelchair that will help him to sit in electric wheelchair more comfortably.
- Share care plan with all medical and non-medical providers.
 Opportunities

"IF OPPORTUNITY DOESN'T KNOCK, BUILD A DOOR."
~Milton Berle
Opportunities

- There is an opportunity to measure the impact of interagency care management through comparison of the ranking of risk and healthcare costs/ utilization at baseline and after the interventions of the interagency care management team.

- Experience gained through study and lessons learned will be used to evolve ongoing interagency care management system development and individual care.

- Critical team members participate from the continuum of care—SASH, CHT, free clinic, inpatient, Senior Solutions, Home Health, HCRS, VCCI, SEVCA.

- Found new funding sources when working together.
Opportunities (Continued)

- Recognition that changes do not occur overnight, they come in small steps and should be celebrated.
- Listen, listen, listen and hear what’s important in a patient-centered approach.
- Patients are able to accomplish realistic goals when they have an active role in the plan.
- It may take more than one patient encounter to use the tools and build and document the action plan in the EMR.
Questions
VITL Summit
October 6, 2016
Jeremiah Eckhaus, MD

Central Vermont Medical Center
Berlin: A bit about us

• Population of Health Service Area: 33,000
• Collaborative Team
  o Jeremiah Eckhaus, MD
  o Kari Little, LICSW, CHT Patient Navigator
  o Colleen Donegan, RN
  o Walter Ziske, CHT Panel Coordinator
  o Monika Morse, Practice Facilitator
A bit about our project.....

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Our Plan, Do, Study, Act Cycle

- **Plan**: UVMHN Goal
  - Goal: Reduce CHF Readmissions by 5%

- **Do**: Develop Primary Care CHF Outpatient Clinic: Start with one practice, one provider, one complex diagnosis.

- **Study**: Reduced ER Visits & Inpatient Admissions, Increased Hospice Utilization & Advanced Directives

- **Act**: Expand Practice Wide- Replicate Across the Medical Group
Preliminary Chart Review

- 18 Patients with diagnosis of Heart Failure
- 10 – had no documented Advanced Directive
- 13 Inpatient Admissions (9 CHF)
- 17 Emergency Room Visits (9 CHF)
- Patient X utilization
  - 6 Inpatient 5 ER -no Advanced Directive
- Patient Y utilization
  - 7 Inpatient 9 ER
- None under care of Community Health Team
Aim Statement...

- Improve outpatient primary care management of patients with heart failure to reduce emergency room utilization and inpatient admissions
What We Did...

- Designed CHF Outpatient Primary Care Clinic
  - Schedule with EHR Template
  - Huddle- review scheduled patients (w/CVHHH)
  - 1 hour patient visits
  - Nurse assessment, risk index, health confidence
  - Co- visits for patients with : Provider & Patient Navigator (CHT)
  - Post visit: Navigator teach back & Health Confidence
  - Aligned educational materials with hospital & HH
A bit more about the Patient Navigator

• This role is engaged in care coordination and social work: supporting the patient, caregivers and families in all settings. This might include home, long term care, primary care or specialty care.

• The navigator facilitates communication between the patient, the medical team, caregivers, family and community services.

• Main responsibilities are to coordinate outpatient, specialty and inpatient care, communicate with community agencies, monitor transitions of care, risk stratify this population, communicate with PCP about risk and changes in risk

• Communicate with other care team members and provide support
Project Team
What We Did...

- Co-Visits with Provider
- Care Coordination Between Visits
- Panel Management
  - Patient Panel, Chart Reviews & Data Collection
- Group Visits
  - Pathophysiology
  - Nutrition Education
  - Mindful Eating
  - Advanced Directives/Palliative Care & Hospice
Measures and Results...

- **6 Month Data Review**
  - 75% reduction in overall number of hospital admissions
  - 57% reduction in overall number of ER visits
  - 50% increase in Advanced Directives
  - $11,042 Cost Savings/Patient
Day 2: Track 2 – Laying the Course for Coordinated Patient Care

CHF Pilot ED/Inpatient visit improvement

- **Post 11/5/2015 - 5/5/2016**
- **Percent Reduction**

- **ED Admission Any DX**
  - Pre: 9
  - Post: 4
  - Reduction: 56%

- **Inpatient Admissions Any DX**
  - Pre: 7
  - Post: 3
  - Reduction: 57%

- **ED Admissions for CHF**
  - Pre: 4
  - Post: 2
  - Reduction: 50%

- **Inpatient Admissions for CHF**
  - Pre: 4
  - Post: 1
  - Reduction: 75%
Day 2: Track 2 – Laying the Course for Coordinated Patient Care
Measures and Results...

• 6 Month Data Review
  o Decreases in mean IP admissions and ER visits per patient (any diagnosis and CHF only)
  o Statistical analyses showed that these decreases were not statistically significant (all p-values > 0.05)
  o Non-significant results due to low sample size; increasing number of patients receiving intervention may show significant results
Lessons Learned

- This small pilot showed very promising results: there is much more to be learned
- We CAN impact costly utilization through care management
- Co-visits with the provider provides detailed insight into the plan of care enhancing follow up interventions with patients
Next Steps

• Can we expand practice wide???
• Can we expand MGP Wide???
• Challenges: Resources?!
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