VCHIP Care Coordination Collaborative Workgroup Meeting: Defining Patient Populations

August 13, 2024

Project Team

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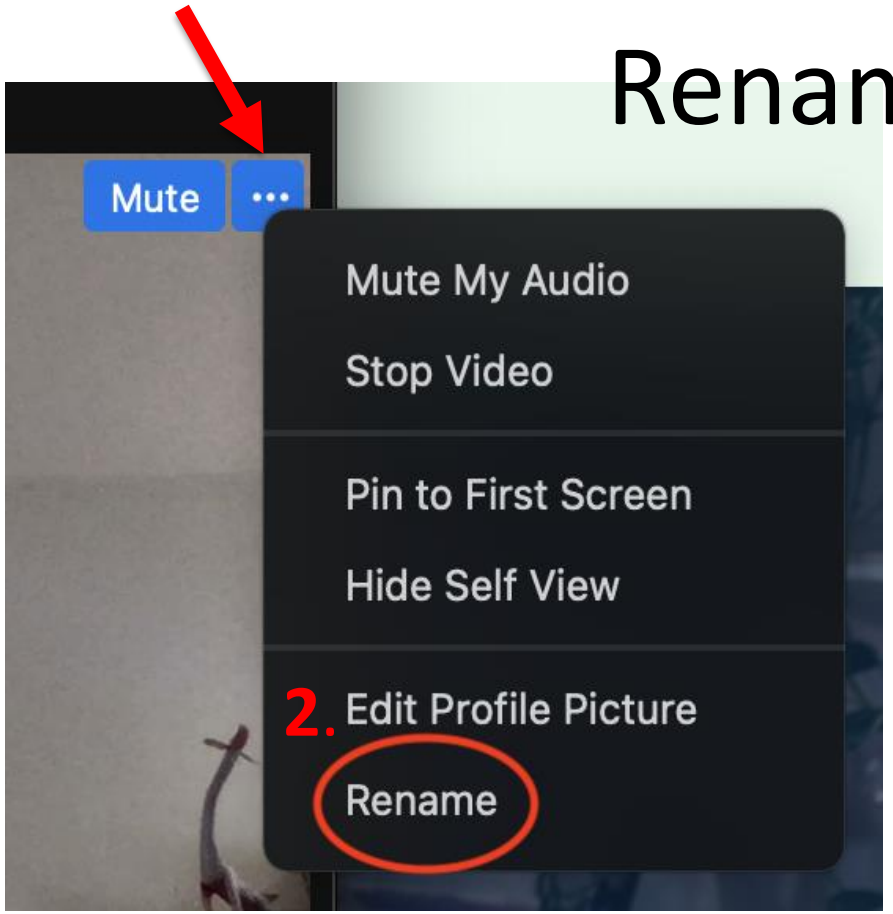

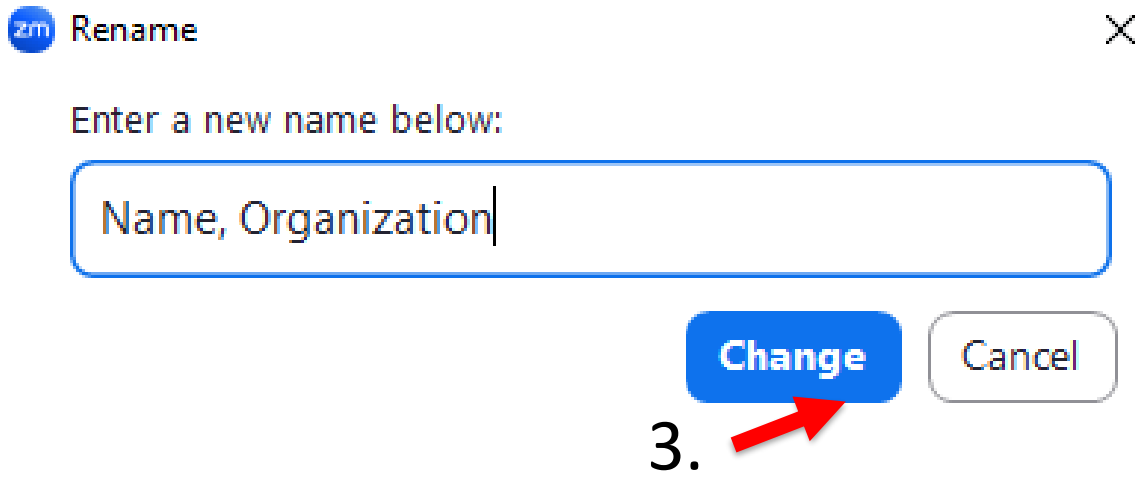

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Today's Objectives

- Summarize and Review VCHIP-VITL SPoC Pilot & Roadmap
- Socialize key definitions
- Discuss patient populations
- Identify criteria/guidance for selecting patients in VCHIP-VITL Pilot work

VCHIP Care Coordination Collaborative

Care Coordination Collaborative Meetings bring together interdisciplinary partners to advance our shared vision of optimizing care coordination services for children and youth with special health needs.

We aim to work collaboratively with our partners to create a pilot that leverages technology to share and access Shared Plans of Care across care teams.

VCHIP – VITL Pilot

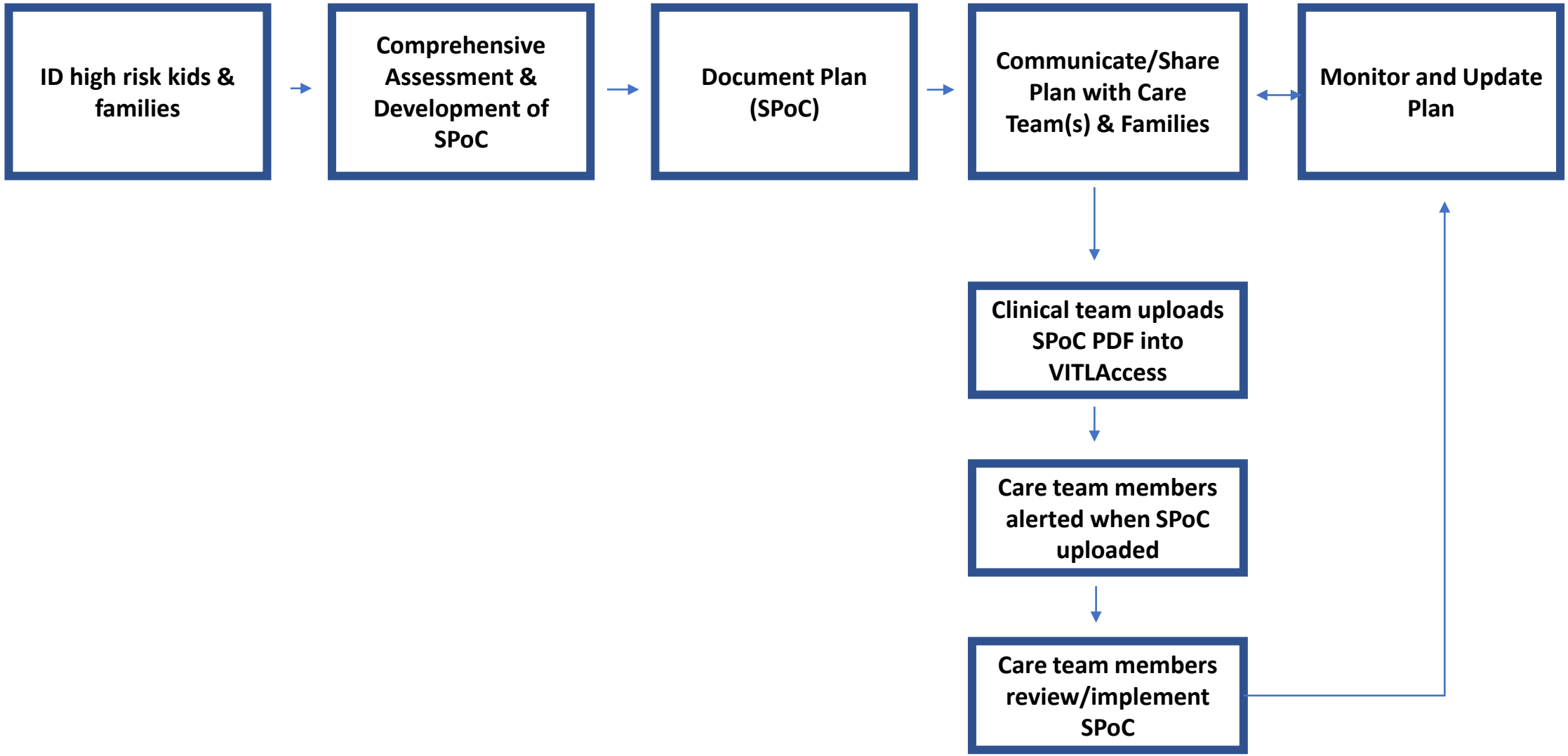
What do we hope to achieve?

- Improve the communication among care teams
- Improve coordination for patient and families
- Improve care team experience
- Obtain and share data in a timely way

What do we hope to learn?

- Priority areas for future infrastructure design
- How to share appropriate health information with all care team members
- Prevent inappropriate sharing of health information

Proposed Pilot Process for Developing & Sharing Shared Plan of Care (SPoC)



SPoC PILOT ROADMAP

1

RE-CONVENE COLLABORATIVE MEETINGS

June 2024

2

PARTICIPANT & COLLABORATOR FEEDBACK AND DESIGN SURVEYS

August 2024

3

INTERACTIVE WORKGROUP MEETINGS

Identify target population(s)

August 2024

4

INTERACTIVE WORKGROUP MEETINGS

Develop SPoC content & elements

August2024

5

PARTICIPANT & COLLABORATOR FEEDBACK AND DESIGN SURVEYS

September 2024

6

INTERACTIVE WORKGROUP MEETINGS

Design workflows for pilot

September 2024

7

TESTING

Pilot users selected to test and refine workflows

Sept 2024-Spring 2025

8

EVALUATION

Late Spring 2025

Shared Definitions

- **Care Coordination** involves patient and family-centered, assessment-driven, team-based activities designed to meet the needs of children and youth that address interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes and efficient delivery of health-related services and resources both within and across systems. Care Coordination includes non-clinical functions. [references:1,2,3,4,5]

- **Care Management** refers to the more intensive clinical management provided by a specifically skilled registered nurse or other licensed health worker to an identified high risk patient population. [references 4,6]

- **Case Management** addresses utilization of resources and supports insurance, payment issues, and health resources needed for care transitions (i.e. discharge from hospitalization or similar transitions). [reference 7]

Shared Definitions

- A **Needs Assessment** refers to a specific, comprehensive activity, completed by a member of the care team documenting the identified needs, beliefs and goals of the family and child and how they can be best addressed by the health care system. This activity is usually completed annually, or at another period defined by the organization and may drive the development of a Shared Plan of Care. [references 5,8]

- A **Care Conference** is a multidisciplinary meeting that brings together the care team, including the family, to work together to solve a patient's clinical or social concerns, address care planning needs, develop shared plans of care, and communicate changes in patient care with the entire care team. This activity may drive the development of a Shared Plan of Care.

- A **Shared Plan of Care** (SPoC) is a concise yet comprehensive, integrated, and user-friendly compilation of child and family specific information and goals that guides care and facilitates its coordination among the family and their lead clinical team in concert with the appropriate "constellation" of subspecialists and community resource providers. This document is reviewed and updated at regular intervals. [reference 8]

Shared Definitions

- A **High-Risk Patient** may be determined by several variables including [reference 6]:
  - High utilizer of health care services;
  - Specific diagnosis or condition;
  - Medical and/or social complexity;
  - Involvement with programs such as foster care or DCF;
  - Behavioral health concerns;
  - Health related social needs;
  - Family self-identification;
  - Or care team identified.

Considering Patient Populations

As we create patient populations to focus on in our pilot, consider:

- Which patients are at the greatest risk of health decline?
- Which diseases or conditions can we be providing better coordination of care?
- Which patient groups are you already using care templates or Shared Plans of Care with?

Identifying Patient Populations

How can we identify these patients?

- High utilizer of health care services (example: # of specialists seen)
- Care team designation
- *Risk stratification algorithms*

Patient Population Framework

Identified Patient Population	Pre-existing Care Plan Template	Other Assessments or Criteria Driving the Development of SPoC	Who Generates SPoC	Who Receives SPoC (Medical Home Neighborhood)	Who Needs to Take Action
Child/youth with Asthma	Asthma Action Plan				
Child/Youth in foster care	Health Intake Questionnaires	Case Planning & Supplemental Placement Information Form			
Child/Youth seen by 2 or more specialists	Specialty Specific Shared Plans of Care				
Child/Youth with Intellectual and Developmental Disability (IDD)					
Child/Youth identified by care team		Health Related Social Need assessments			
Other					

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Patient Population Framework

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Next Steps

Interactive Workgroup Meeting Timeline

- **Tuesday**, August 27, 2024 12-1pm (Focus: Defining SPoC elements)
- **Thursday**, September 12, 2024 12-1pm (Workflow Design)
- **Thursday**, September 26, 2024 12-1pm (Workflow Design)

References

[1] Antonelli RC, McAllister JW, Popp J. Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework. New York, NY: The Commonwealth Fund; 2009
[2]Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee. Patient- and family-centered care coordination: a framework for integrating care for children and youth across multiple systems. Pediatrics. 2014;133(5)
[3] "Care Coordination Measures Atlas Update", Agency for Healthcare Research and Quality, June 2014,https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html
[4]Safety Net Medical Home Initiative. Horner K., Schaefer J., Wagner E.(2013). Care Coordination: Reducing care fragmentation in primary care. In K. E. Phillips & V. Weir (Eds.) Safety Net Medical Home Initiative Implementation Guide Series. 2nd ed. Seattle, WA: Qualis Health and The MacColl Center for Health Care Innovation at the Group Health Research Institute.
[5]VanLandeghem, et al; 2020; The National Care Coordination Standards for Children and Youth with Special Health Care Needs; https://www.nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/ last accessed July 8, 2024.

[6] Bachman, et al; 2015; The Care Coordination Conundrum and Children and Youth with Special Health Care Needs, https://ciswh.org/wp-content/uploads/2016/03/Care-Coordination-Conundrum.pdf last accessed July 31, 2024.

[7] American Academy of Ambulatory Care Nursing. CCTM vs. Case Management https://www.aaacn.org/practice-resources/care-coordination-transition-management-cctm/cctm-vs-case-management last accessed July 8, 2024.

[8] McAllister, Jeanne W. "Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs: An Implementation Guide." Lucile Packard Foundation for Children's Health, May 2014; https://lpfch.org/wp-content/uploads/2024/02/achieving_a_shared_plan_of_care_implementation.pdf

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