
# VCHIP Care Coordination Collaborative Workgroup Meeting: Defining SPoC Data Elements

August 27, 2024

# Disclaimer

This presentation is intended for use by the VCHIP Care Coordination Collaborative to guide the VCHIP-VITL Shared Plan of Care Pilot work. Slides should not be copied or used in other settings without approval from the project team.

# Project Team

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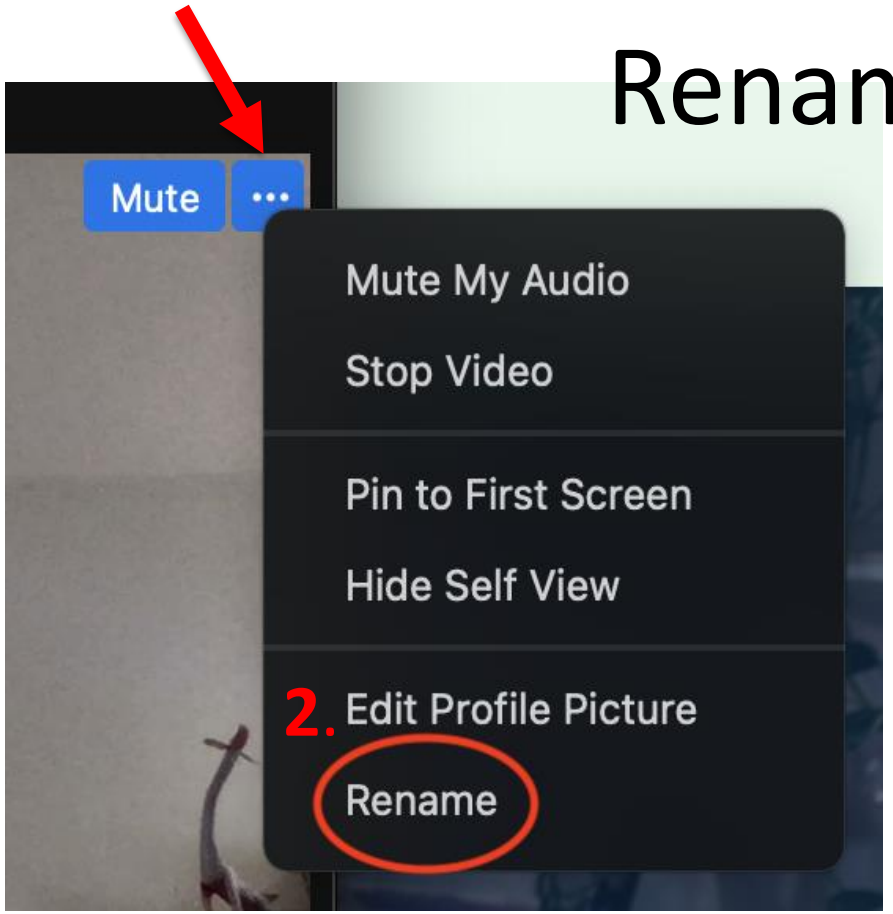
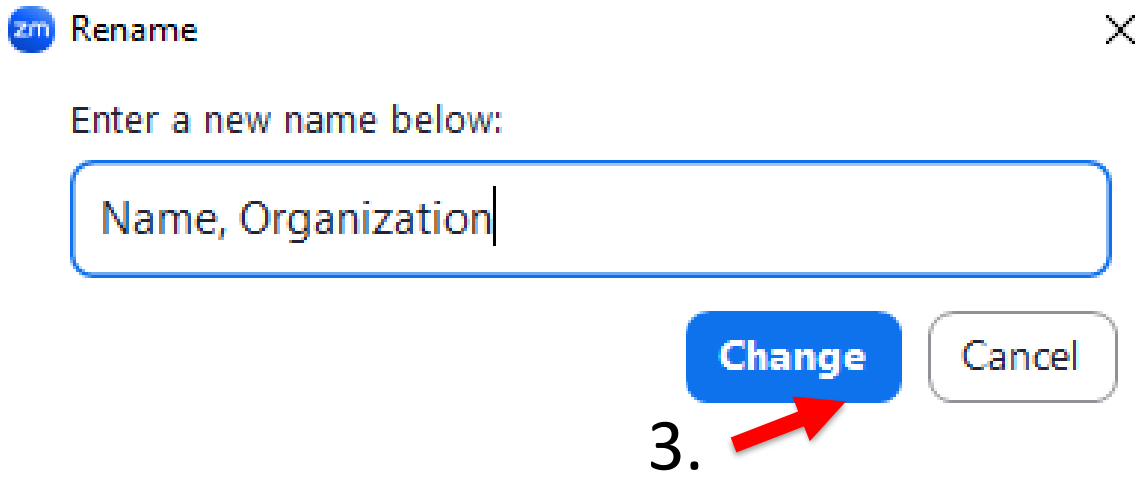
# Participants:  Who's Here?
# Rename to add your Organization

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# Today's Objectives

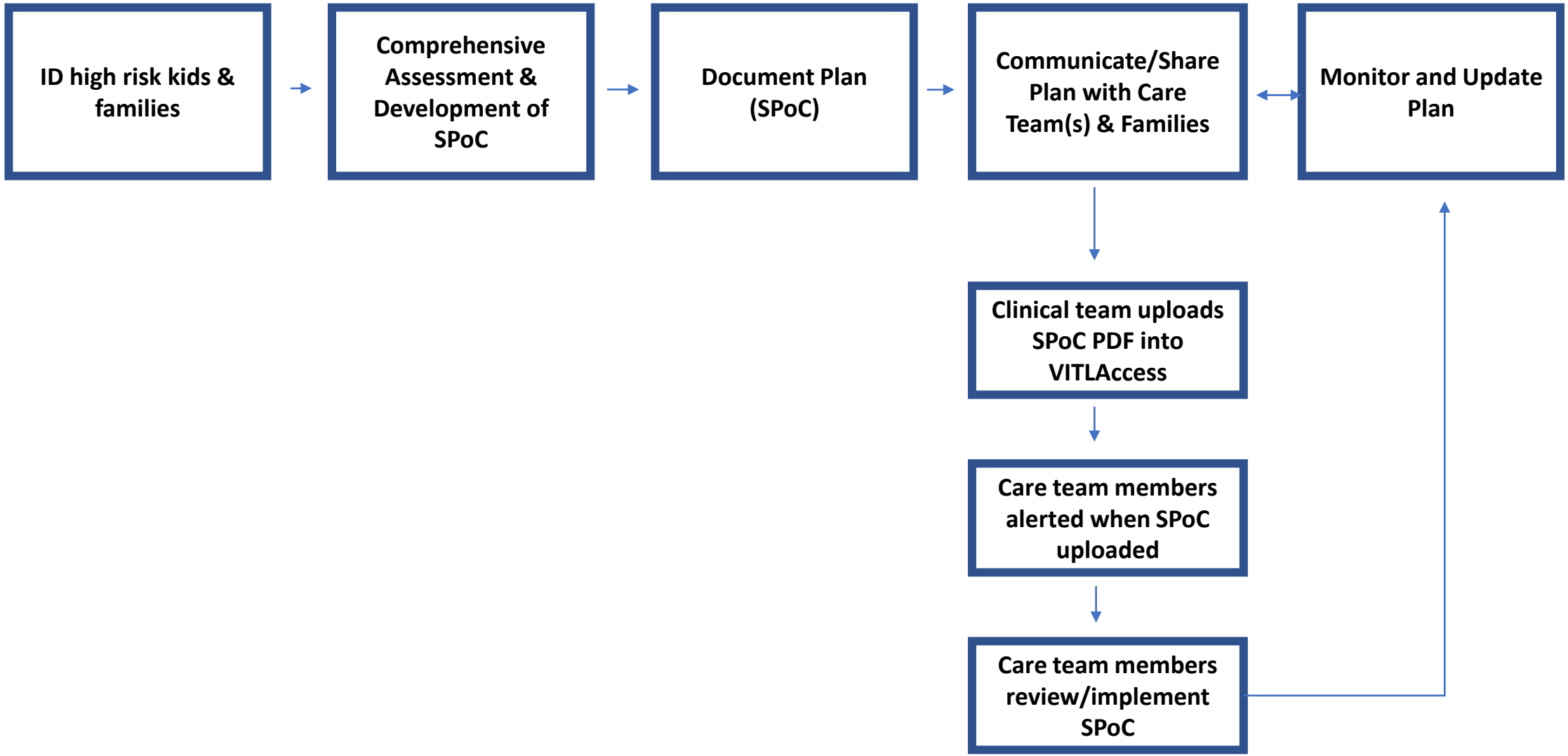
- Summarize and Review VCHIP-VITL SPoC Pilot & Roadmap
- Socialize key definitions
- Discuss SPoC elements
- Gather feedback on core elements of SPoC that may influence pilot implementation

# 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.

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



# 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

# 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

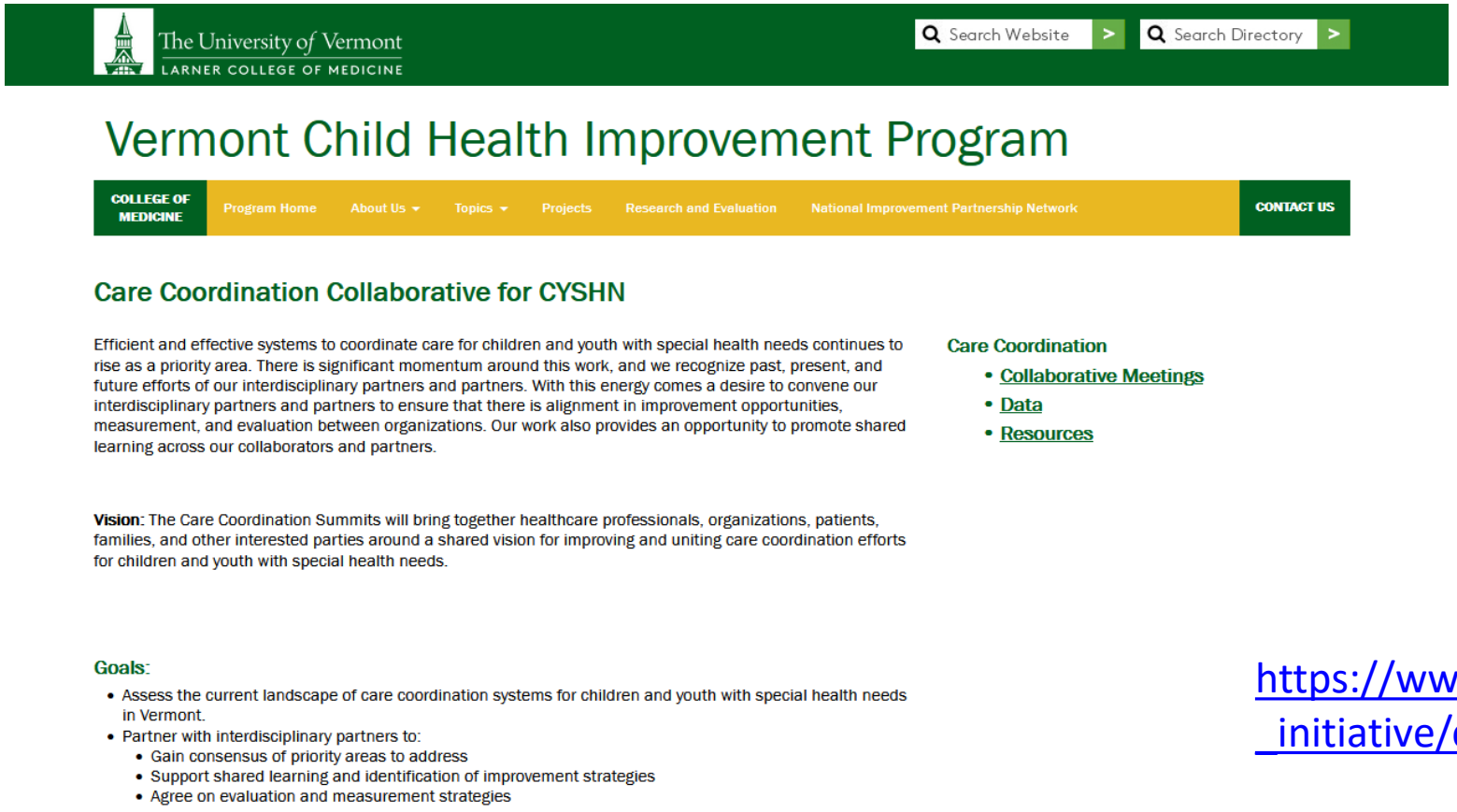
Sept 2024-Spring 2025

8

## EVALUATION

Late Spring 2025

# Catching Up




https://www.med.uvm.edu/vchip/child_chronic_care_initiative/care_coordination

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# Catching Up


https://www.med.uvm.edu/vchip/child_chronic_care_initiative/care_coordination/care_coordination_summit_meetings

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# 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 and may include identifying the team that surrounds the family, building an Ecomap, and identifying care gaps. [references 1,2]

- 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 2]

# Shared Definitions

- An **Emergency Care Plan** is a condition or specialty specific plan of care that provides care teams or caregivers with information and instructions for managing a specific condition or event. Examples include Asthma Action Plans, Seizure Action Plans, Metabolic Plans, etc. An Emergency Care Plan can be a component within a Shared Plan of Care, but for the purposes of our pilot, it is not considered a true Shared Plan of Care.

- An **element** of the Shared Plan of Care refers to a specific component or category found within the Shared Plan of Care. Each element includes specific patient level data to help guide care.

# SPoC Considerations

- Variety of care plan templates
- Narrowly focused vs. comprehensive
- Commonalities in elements
- Requirements & recommendations by governing bodies

# SPoC Pilot

- Gather SPoC data element standards from governing bodies and collaborators
- Gain consensus on guidance/criteria for core elements of SPoC that meet standards and improve access and use of care coordination tools in Vermont
- Support future interoperability design

# Considering Core Elements

As we create guidelines for developing core elements in our pilot, consider:

- What are the governing bodies that have SPoC requirements?
- What, if any, information is missing from the list of elements that should be included?  What information is unnecessary?
- Would the use of VITLAccess to improve access to SPoC influence what elements should be included?

# Shared Plan of Care Elements

**NCQA Requirements (within SPoC)**

- Problem list
- Expected outcomes/prognosis
- Social and/or community services
- Treatment/goals
- Medication Management
- SPoC revision date

**Additional Elements (within SPoC)**

- Care team member contact information
- Who received copy of SPoC and how they received it
- Emergency care plans

**Other NCQA Requirements**

- Actionable, developed with patients
- Shared with care teams and patient
- Must provide documentation that patient received copy (written or electronic copy)

# Considering Core Elements

- Are there other governing bodies that have SPoC requirements?

# Considering Core Elements

| Element | Description/Data |
|---|---|
| Patient Demographics & Preferences | • Patient Name<br>• Patient date of birth<br>• Patient MRN<br>• Primary Caregiver(s) name<br>• Primary contact information<br>• Primary language of patient<br>• Primary language of caregiver(s)<br>• Preferred contact/communication method<br>• Interpreter needs |
| Medical and Health Related Social Needs (HRSN) | • Diagnoses/Medical history<br>• Problem list<br>• HRSN concerns (e.g. food insecure) |
| Educational & Community Supports | • School Nurse<br>• Special Education Case Manager<br>• School support services (SLP/OT/PT)<br>• Community partners |
| Medical Interventions/Care Planning | • Active medications<br>• Emergency plans (condition specific)<br>• Durable medical equipment (DME)<br>• Referrals |
| Health Maintenance & Outcomes | • Clinical data (e.g. lab values)<br>• Health Questionnaire Scores (e.g. PHQ-9) |
| Goals/Care Planning | • Actionable patient and clinician developed goals<br>• Treatment goals & status<br>• Targeted outcomes & prognosis<br>• Identified barriers & potential intervention<br>• Date(s) of follow up |
| Care Team Contact info | • Primary care [list names and contact info]<br>>receives SPoC (yes/no)<br>>needs to take an action (yes/no)<br>• Specialists [list names and contact info]<br>>receives SPoC (yes/no)<br>>needs to take an action (yes/no)<br>• Community partner(s) [list name and contact info]<br>>receives SPoC (yes/no)<br>>needs to take an action (yes/no) |
| Documentation | • Method SPoC was shared<br>• Whom SPoC was shared with (includes family) |

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# Considering Core Elements

- What, if any, information is missing from the list of elements that should be included?  What information is unnecessary?

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# Considering Core Components

- Would the use of VITLAccess influence what elements should be included?

# Next Steps

Interactive Workgroup Meeting Timeline

- **Thursday**, September 12, 2024  12-1pm (Workflow Design)
- **Thursday**, September 26, 2024  12-1pm (Workflow Design)

# References

[1] 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.

[2] 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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