9/12/2024 VCHIP Care Coordination Collaborative Workgroup Meeting
Meeting Summary

25 Unique Meeting Participants, Representing the Following Organizations:

- Champlain Valley School District
- Department of Vermont Health Access (DVHA/VT Medicaid)
- Timber Lane Pediatric Primary Care
- UVM Children's Hospital Primary Care
- UVM Children's Hospital Specialty Care Center
- UVM Medical Center (PHSO)
- UVM Medical Center Patient & Family Advisor
- Vermont Child Health Improvement Program (VCHIP)
- Vermont Department of Health (VDH)
    - o Family and Child Health Division
    - o CSHN
- VITL-Vermont Health Information Exchange

Meeting materials:
PowerPoint slides used to support meeting facilitation
Jamboard used to facilitate collaboration:
https://jamboard.google.com/d/1hIls_vCT0kxZkzbFtpXvT9q3WR2k8Jy2ZMm3zdFwF2s/viewer?f=0

Meeting Objectives:

1. Illustrate the use of QI methodology to promote system level changes
2. Discuss the current state (process) for developing and sharing SPoC
3. Begin to conceptualize design workflows for utilizing VITLAccess

1. **Illustrate the Use of QI methodology to promote system level changes.**
   Brief review of trajectory of our collaborative pilot project.
    - Current Process– Care teams are developing SPoC in EHR or outside of EHR. Challenges exist with sharing the SPoC with families and other care teams
    - Pilot Project– Leverage Health Information Exchange (HIE) and introduce new functionality in VITLAccess to allow care teams to manually upload a PDF copy of a SPoC (or other care plan, such as an Asthma Action Plan) to share across health systems and care teams
    - Future (ideal)– Interoperability across systems where SPoC are developed within HIE (using data elements within the HIE) and seamlessly shared

   Our collaborative work supports a quality culture and our work is guided through the use of a couple frameworks. Those include the Quintuple Aim, which helps us understand why we embark on this work – to improve patient outcomes, address health equity, improve the patient experience, reduce costs, and improve clinician wellbeing. We hope to do this within the domains of quality by using the Model for Improvement. The model itself it three questions and a cycle that guide our way of doing things and guiding our improvement overall.

   Two quality improvement tools were demonstrated:
    - Plan, Do, Study, Act (PDSA) cycles
    - Block Diagram

Project Contacts:
Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu

Comments/Discussion during meeting:

- No Comments noted

2. Discuss the current state (process) for developing and sharing SPoC

Two teams were invited to share their current processes for developing and sharing SPoC:

Timber Lane Pediatrics:

Once the provider identifies the patient and refers to Timber Lane, they reach out to the family and schedule an intake with them, which is where our process begins.

a. Eco Map: gather info/assess areas of need and concern this naturally leads to next step
b. Goal setting: based on needs and supports they identified. Building off strengths. identify team players, insurance (important piece for next steps)
c. Create the SPoC that goes into the patient chart in the EHR system
d. Providers complete a "Continuity of Care" document which is sent out to VITL (this is the only document that has our shared plan)
[Timber Lane team notes: it would be great moving forward if everyone was using the same document that can be shared out to other key players besides the family and providers.]

UVM Children's Hospital Primary Care:

The team uses the UVM Health Network Population Health Service Organization (PHSO) integrative care management model that is specific for peds and has an elaborate assessment. Teams include all outside members, such as schools, that create goal setting and a plan that lives in the chart under an encounter. The provider would need to know where to look [for the plan] and it is not idea. The Epic piece is a challenge. This is not shared with outside members. Care team meetings are utilized to discuss the care plan. We do not have a HIPPA compliant way to share and we will use mail, fax or secure email to share, only upon request. The plan is reviewed periodically. Asthma action / seizure action plans are managed by primary care or specialist and will send them when requested.
There is an emphasis on social drivers of health and including families to decide the goal, plan and team members.
The SPoC lives in the EHR . There is another variation created at care conferences. These are 2 different documents.

Comments/Discussion during meeting:

- **Question for Timber Lane Peds team:**
  Can you elaborate on what the "Continuity of Care" document includes?
  Answer:
  Problem list, allergies, medications, immunizations

- **How can teams share plans in a responsible way that is HIPPA/FERPA compliant. How can teams have a Template in EHR and for all to know where it is.**
  - It was noted that for some teams, care plans would need to be compliant with NCQA, which may limit how easily templates could be adjusted.
  - It was stressed that ability to communicate [care plans] with schools is important.

- **Question for Timber Lane and UVM Children's Hospital Primary Care:**
  Have either of you developed a process to communicate with schools (or is it available as needed/requested by the family/school?)
    - **UVM Children's Hospital Primary Care:** One document to share with school is not a solution. Care team document that was created together should be shared. Release of information is done in well child visits and need to check for active HIPPA before any releases.
    - **Timber Lane Pediatrics**
      We have a very similar process at TLP

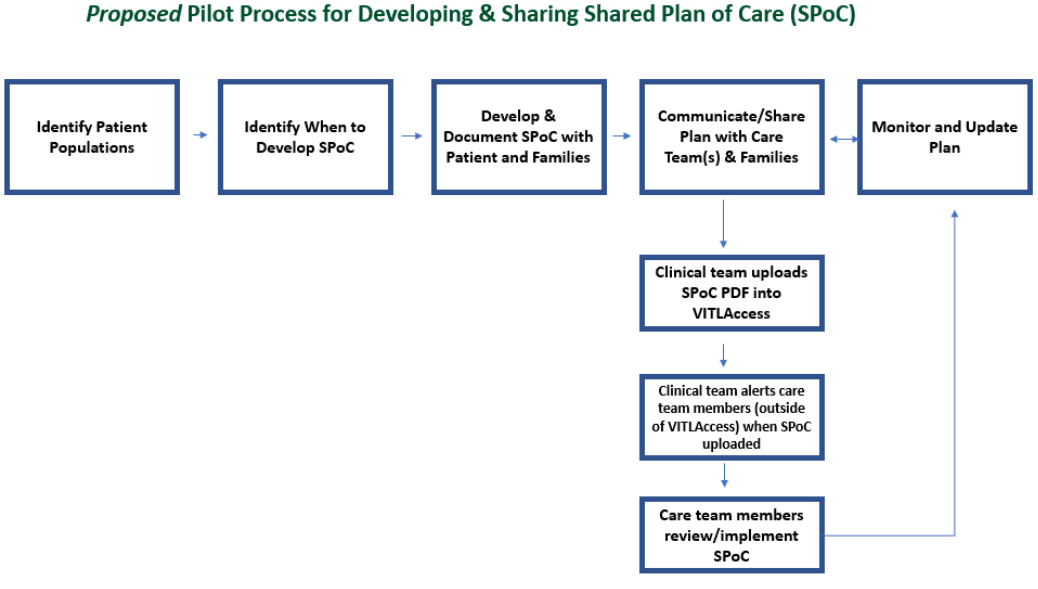
- **Question/discussion around Eco Mapping process and if the EcoMap is shared:**
  Timber Lane shares that they use a paper copy [to create the EcoMap] at intake, which is then scanned into the EHR as a PDF and then paper copy is shredded. This just lives in our system. With parent approval, it could be shared with right releases.

- **Parent and Family Advisor comment:**
  Parents advocate for what information is given to school vs. the medical team. School nurse is the liaison of this information. Parents want to sometimes keep things private. During care conferences, parents will often lead the medical conversation.

  Timber Lane adds that before a care conference meeting they will talk with families about what to share ahead of time. School nurse and special education team often have different information.

3. **Begin to conceptualize design workflows for utilizing VITLAccess**

The following model was shared as a potential workflow:



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Comments/Discussion during meeting:

- **Could parents have access to VITL to view this as well?**

Parents would not have real time access to the data in VITL but could make a records request and this would be included in what would be delivered to them (within 30 days).

Jamboard Interactive Whiteboard Activity facilitated after introduction of proposed Pilot workflow: https://jamboard.google.com/d/1hIls_vCT0kxZkzbFtpXvT9q3WR2k8Jy2ZMm3zdFwF2s/viewer?f=0

4. **Next Steps and Future Meetings**
    - Project team will collate information collected during today's meeting. Meeting materials and notes will be shared widely with the Care Coordination Collaborative list. This will allow those who were unable to join today a chance to provide feedback as desired as well as those who participated another chance to add input.

    - VCHIP will post meeting materials to website within 2 weeks of meetings: https://www.med.uvm.edu/vchip/child_chronic_care_initiative/care_coordination

    - Future Meetings:
        - **Thursday**, September 26, 2024, 12-1pm (Workflow Design)
        - **October dates TBD**