

8/13/2024 Care Coordination Collaborative Workgroup Meeting
Meeting Summary

24 Unique Meeting Participants, Representing the Following Organizations:

- Champlain Valley School District
- Department of Vermont Health Access (DVHA/VT Medicaid)
- Porter Pediatric Primary Care
- UVM Childrens Hospital Primary Care
- UVM Childrens Hospital Specialty Center
- UVM Medical Center (PHSO)
- Vermont Blueprint for Health
- Vermont Child Health Improvement Program (VCHIP)
- Vermont Department of Health (VDH)
- Vermont Family Network
- VITL-Vermont Health Information Exchange.

Meeting materials:

Powerpoint slides used to support meeting facilitation

Meeting Objectives:

1. Summarize and Review VCHIP-VITL SPoC Pilot
2. Socialize key definitions
3. Discuss patient populations
4. Identify criteria/guidance for selecting patients in VCHIP-VITL Pilot work

1. Summary of pilot project and timeline was presented.

Please refer to Powerpoint slides for more information. No questions or comments were noted during this topic presentation.

2. Introduction to key project definitions

It has been suggested that developing shared definitions is important to our work to help ensure we are all speaking the same language. We will start socializing these definitions and provide opportunities for workgroups, as well as those who are not here, to comment. Plan is to post on VCHIP Care Coordination Collaborative website to allow for access.

VCHIP has identified several commonly used terms and definitions related to care coordination functions and activities. The project team has synthesized existing definitions to establish a set of shared definitions that will be used throughout the project.

Definitions were presented and participants were provided an opportunity to comment.

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]



Project Contacts:

Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu

8/13/2024 Care Coordination Collaborative Workgroup Meeting
Meeting Summary

Comments/Suggestions during meeting:

- Important to add that care coordination provides culturally sensitive and culturally safe care and education
- Consider adding context on who performs the job (e.g. nurse or social worker)
- Crosswalk with Vermont payor's roles/descriptions for alignment
- Crosswalk with Patient Centered Medical Home definitions

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]

Comments/Suggestions during meeting:

- N/A

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]

Comments/Suggestions during meeting:

- This term comes from insurance industry and refers to activity completed by insurers
- Not relationship based, but provides episodic support

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]

Comments/Suggestions during meeting:

- Identifying the team that surrounds the family is key here
- Building an Ecomap can be part of this
- Include that this activity also identifies care gaps

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.

Comments/Suggestions during meeting:

- Note that this activity is medically focused
- Usually initiated and facilitated by medically based team(s)

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



Project Contacts:

Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu

8/13/2024 Care Coordination Collaborative Workgroup Meeting
Meeting Summary

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]

Comments/Suggestions during meeting:

- Seizure Action Plans, Metabolic Plans, Asthma Action Plans are important components (as Emergency Plans) but are not the whole thing

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.

Comments/Suggestions during meeting:

- Parent/caregiver input can be factored in here

General Comments/Suggestions related to concept of shared definitions:

- Consider adding *CSHN Care Consultants* to the definition list. Specific to Vermont and may help provide clarity around their role in care coordination.
- Case load was highlighted as an important aspect of care coordination but may not need a stand-alone definition.

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.



Project Contacts:

Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu

8/13/2024 Care Coordination Collaborative Workgroup Meeting Meeting Summary

[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

3. 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?

How can we identify these patients?

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

Comments/Suggestions during meeting:

- Having clear definition/criteria makes it easier for payor(s) to respond to needs. For example, kids diagnosed with ASD having multiple PT/OT services, including at school, makes it challenging to review and ensure there are not duplication of services.
- Clarity also can aid payors as some payors are looking to improve efficiencies such as removing prior authorizations for some patient populations.
- Algorithms can help identify those that may fall through the cracks or are not well known to the practice
- Needs assessments can help
- High need families may self-identify themselves

4. Identify criteria/guidance for selecting patients in VCHIP-VITL Pilot work

A framework for helping pilot practices think through patients in this pilot work was introduced (below). This table is to help pilot users think about the patient populations they may include in this pilot work as well as other criteria. In this pilot, it will be important that children and families included in the pilot phase have [or team can easily develop] a Shared Plan of Care as pilot practices will be uploading PDF versions of the SPoC into VITLAccess. It is also ideal to have an engaged care team that can access VITLAccess to help test workflows that will be developed. These workflows include logging into VITLAccess to upload a SPoC and/or log into VITLAccess to retrieve a SPoC.



Project Contacts:

Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu

8/13/2024 Care Coordination Collaborative Workgroup Meeting
Meeting Summary

The table below is pre-populated with ideas that were generated during June's Care Coordination Collaborative meetings.

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					

Comments/Suggestions during meeting:

- A column about a family's readiness to engage may be helpful
 - Families may need care teams to figure out what the barriers for engagement are
 - Readiness to engage may be impacted by Social Determinants of Health concerns
 - Children Adolescent Needs and Strengths was introduced as a tool to help support decision making and guide conversations around engagement.
<https://www.cdss.ca.gov/inforesources/foster-care/cans/the-cans-tool/cans-resources>;
https://www.cdss.ca.gov/Portals/9/ISU/CANS/CA_CANS_IP%20Rating%20Sheet_1.0_CW_ENGLISH.pdf
- Other criteria suggested: Kids receiving significant care out of state (i.e. Boston Children's)
- School perspective: kids with seizure plans, Type 1 Diabetes, and oncology engagement
- New immigrant arrivals may be an identified patient population
- Chronic infection diseases and Type 1 Diabetes also identified as patient populations at risk
- Suggestion that "2 or more specialists" may be too low and identify too many kids. Consider starting with 3.
- Suggestion to include a column/section for hospital admissions in a given year. Care teams may not pick this up if it's not flagged.



Project Contacts:

Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu

8/13/2024 Care Coordination Collaborative Workgroup Meeting Meeting Summary

- Consider genetic disorders. With many new gene therapies, needs get more complex and also may require out of state care.
- Noted that identifying a point person could be challenging.

General Questions/Comments:

- **Who are the pilot practices? Have they been recruited/identified?**

There has been interest from a few medical homes in Chittenden County. This interest was self-identified during the June Care Coordination Collaborative meetings. There is also interest within some of pediatric specialists. The project team is interested working with practices from all over Vermont to learn where this technology could make the most impact.

The team also recognizes that there are a lot of different patient populations that could be served and pilot users would be participating without any extra funding. The grid is workflow development. We anticipate looking at real workflows to see where we can create impact and help create building blocks for different needs and fundamental elements.

5. 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
- Shared documents (example: definitions list)
VCHIP will post to website above and pursue methods for promoting real-time edits and suggestions between meetings.
- Future Meetings:
 - **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)



Project Contacts:

Alyssa.consigli@med.uvm.edu michelle.rovnak@med.uvm.edu