8/27/2024 VCHIP Care Coordination Collaborative Workgroup Meeting
Meeting Summary

35 Unique Meeting Participants, Representing the Following Organizations:
- Blue Cross and Blue Sheild of Vermont
- Champlain Valley School District
- Department of Vermont Health Access (DVHA/VT Medicaid)
- Howard Center
- Monarch Maple Pediatric Primary Care
- UVM Childrens Hospital Primary Care
- UVM Childrens Hospital Specialty Center
- UVM Medical Center (PHSO)
- UVM Medical Center Patient & Family Advisor
- Vermont Agency of Education (AOE)
- Vermont Child Health Improvement Program (VCHIP)
- Vermont Department of Health (VDH)
    - Family and Child Health Division
    - CSHN
    - Pediatric Palliative Care at CHSN
- VITL-Vermont Health Information Exchange

Meeting materials:
PowerPoint slides used to support meeting facilitation

Meeting Objectives:
1. Summarize and Review VCHIP-VITL Shared Plan of Care (SPoC) Pilot
2. Socialize key definitions
3. Discuss SPoC elements
4. Gather feedback on SPoC core elements that may influence pilot

1. **Summary of pilot project presented.**
   We aim to enable more effective communication and coordination of care [for Children and Youth with Special Health Needs in VT] through the electronic sharing of SPoC through VITLAccess. Using a quality improvement framework, this pilot work will support clinical teams in using their native technology [e.g. EHR] to develop a SPoC and then leverage the VITLAccess infrastructure to upload PDF copies of the SPoC so that it can be shared, and viewed, with other care partners electronically.

   As we work towards our goal of improving coordination of care, we are also focused on understanding key barriers and facilitators for developing and implementing interoperable care coordination tools, including SPoC. We will use this pilot work to guide future interoperability work.

   This work began with convening the VCHIP Care Coordination Collaborative meetings. Participant and collaborator feedback and design input is being obtained through workgroup meetings and additional project communications. Pilot user recruitment and testing will occur in mid-late fall of 2024 through early 2025, followed by evaluation of pilot project.

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

VCHIP Care Coordination Collaborative website will be resource for participants to access past meeting materials and summary notes.
https://www.med.uvm.edu/vchip/child_chronic_care_initiative/care_coordination/care_coordination_summit_meetings

2. **Introduction to key project definitions**
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 easy 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 pilot project. We acknowledge there are many definitions that may be embraced by our partners and collaborators. These shared definitions will attempt to be in alignment with others and will ultimately reflect the collaboration between our partners for use within this specific pilot work.

VCHIP is currently working on creating a SharePoint site where definitions document will be accessible for participants for additional feedback.

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

*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]*

Comments/Discussion during meeting:
- Question: Is needs assessment timeline only driven by the organization, or can the family ask for a needs assessment outside of the annual timeline?
- Consider identifying factors and time points that signal a need to complete needs assessment
- Consider removing "defined by organization" to be more inclusive of how/when a needs assessment is completed
- Suggested time points: first engagement with care coordinator or when there is a change in services
- Noted that "assessments" are happening with each encounter

- May be important to clarify that this definition refers to the use of a specific comprehensive tool (organization or practice endorsed tool), rather than continuous check in with family
- Noted that payers may have limits on how many assessments will be covered
- Recommendation made to connect with other work around the state with alignment of screening tools [e.g. Blueprint and SDoH screening tool]
- Vermont Certified Community-Based integrated Health Center (CCBHC) requires treatment plans (similar to a SPoC) be updated every 6 months

*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]*

Comments/Discussion during meeting:
- Children's Integrated Services (CIS) One-Plan is very similar to SPoC
- Some programs [Medicaid covered programs, CIS) may require the use of a specific care plan template
- Request from participant that care plan templates be made available for sharing among participants

*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.*

Comments/Discussion during meeting:
- No comments noted

*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.*

Comments/Discussion during meeting:
- No comments noted

3. **Discussion: Shared Plan of Care (SPoC) elements**
   As we create guidelines for developing core elements in our pilot, consider the following questions:

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What are the governing bodies that have SPoC requirements?

Comments/Discussion during meeting:
- Governing bodies identified by participants include:
    - Case Management Society of America
    - National Committee on Quality Assurance (NCQA)
- Important to consider that governing bodies may not differentiate between adult focused and pediatric focused SPoC, but rather provide guidance on elements to be included [e.g. goals; medical history; etc.]
- School nurses, per the Vermont Standard of Practice, are required to write an individual health care plan for students with special health needs. National School Nurse Association (NASN) may also require this.
    - [Standards of Practice: School Health Services Manual | Vermont Department of Health (healthvermont.gov)](#) and [Use of Individualized Healthcare Plans to Support School Health Services - National Association of School Nurses (nasn.org)](#)
    - School Support Teams (SSTs) are using educational tools, [e.g. 504 plan or IEP] as an alternative to SPoC. May contain some elements of healthcare, but different content.

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

The following table was created by the project team to organize the elements typically included within SPoC, as indicated by NCQA and participant sample SPoC templates.

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

Comments/Discussion during meeting:
- Use of language was highlighted as an important part of our work [e.g. diagnosis vs. problem list]
- Strengths based vs. deficit based
- Medicaid funded programs may have tools and templates that are required to be used. Project team may benefit from taking an inventory of Medicaid templates that come along with the different Medicaid programs.

4. **Gather feedback on SPoC core elements that may influence pilot**

An interactive whiteboard (link below) was introduced to provide an opportunity for asynchronous communication and feedback among participants in workgroup. The chart was pictured on the whiteboard, allowing participants to view on their own screen and manipulate sizing for optimal reading. The whiteboard will also be accessible to those unable to join the live workgroup session.

https://jamboard.google.com/d/17-x8CjZ0CUHDEeFuz98wKQhM7etZfscLXf7AriGjWfk/viewer?f=1

Comments/Discussion during meeting:
- Clarification around "informal supports" [as identified on whiteboard]
  - Informal support may include those supports that the family identifies as a key support such as grandparent, another relative, or family friend.
  - This support doesn't necessarily fit in other categories [community support, care team, primary caregiver] but is important to include
- Noted that informal supports are very important, and there are privacy considerations for non-HIPAA covered entities that should be considered

Would the use of VITLAccess to improve access to SPoC influence what elements should be included?

Comments/Discussion during meeting:
- Avoiding dual documentation should be a consideration
- Question: Will multiple care plans be combined, or pulled together, within VITLAccess?
  - This pilot will support the manual upload of a PDF with ability to categorize/name the document for ease of finding in VITLAccess
  - Multiple care plans will remain as separate documents, shared in one technology (VITLAccess)
  - Future work will address interoperability and, potentially, functionality for populating a SPoC or template
- Question: Language of interoperability relies on codes. As we think through the elements and how to make the connections, do the codes exist?
  - On coding side, codes for most of the elements are available, but not everything. The data standards are not sophisticated enough. While we don't

want to limit ourselves at this stage, going forward, we may have to slim back what is included for future interoperability.

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:
     ➢ **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