Care Coordination Tools Training

Sarah Narkewicz RN MS
Blueprint Manager
Rutland Regional Medical Center
Sandra Knowlton-Soho, RN MS
Clinical Consultant
One Care VT
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Session L4
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• “The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.”
About the Hospital and Community

• Rutland Regional Medical Center (RRMC) is a rural hospital that serves 65,000 people in central Vermont.

• Rutland County is the second oldest county in the second oldest state in the nation.
Objectives

• Participants will:
  – Be able to identify patients with complex need who need a lead care coordinator
  – Define the role of a lead care coordinator
  – Practice using care coordination tools:
    • Eco Mapping
    • Camden Cards
    • Shared Care Plan
Objectives

• Participants will:
  – Understand the purpose and roles of team members for a Patient Centered Pre-Care Conference and Care Conference
  – Be able to state SMART patient goals
  – Practice:
    • Complete a mock Shared Care Plan
    • Assess a Shared Care Plan
Background: It Takes a Village

• Rutland’s year long collaborative effort to improve care coordination:
  – Many partners
  – Attend state level trainings and local meetings
  – Targeted patients with complex needs
  – New tools
  – New skills
  – New processes
  – Pilot new efforts, refine, and anchor
The Agencies

- Hospital (CHT, ED, QI, Case Management)
- Community Health Workers in Low Income Housing
- Home Health
- Mental Health
- Council on Aging
- Medicaid Case Managers
- Health Department
- Agency of Human Services
- BCBSVT
- Skilled Nursing Facilities
- Homeless Prevention Center
- ACO
About our Journey: The Experts

• Camden Coalition – Camden NJ
  – https://www.camdenhealth.org/
  – Dr. Jeff Brenner – Hot Spotters

• Lauran Hardin, MSN, RN, CNL, Director for the Complex Care Program at Mercy Health Saint Mary’s Grand Rapids Michigan

• Jeanne McAllister, Associate Research Professor of Pediatrics with Children’s Health Services Research at Indiana University School of Medicine
What is Care Coordination
What needs improving
Care coordination activities promote a holistic and patient-centered approach to ensure that a patient’s needs and goals are understood and shared among providers, patients and families to improve quality of care, patient care experience and patient engagement.

A Process

- Identify
  - Patients needing Lead Care Coordinator
- Engagement
  - Obtain Consents
- Assessments
  - Look back, Rutland cards Eco Map, Identify Root Cause
- Prioritize and Plan
  - Hold Care Conference
- Shared Care Plan
  - Communicate plan
  - Reassess - Update as needed
Who are Lead Care Coordinators

• Team members who have a trusted relationship with a patient:
  – Primary care RN
  – Community Health Team RN or Social worker
  – Community health workers
  – Case Managers
Lead Care Coordinator

- Responsible for patient engagement
- Responsible for assessment
- Convenes-facilitates the care conference
- Creates and updates shared care plan
- Communicates change in patient status with team members
Who Needs A Lead Care Coordinator

- 5% of population with complex multiple chronic diseases and social determinants of health needs
- 50 – 60% of population has chronic health conditions
- 40 - 50% of population is healthy
Systems to Identify Patients

- Use of panel management tools
  - Patients with co-morbidities (addiction, mental health and chronic health conditions)
  - Patients with frequent hospital use
  - Patients with poor treatment adherence
Table Discussion

• In groups of 3 or 4 come up with 3 ways that you can use data to identify patients who need a Lead Care Coordinator.
Obtaining Consent

• Allows communication with other care providers
• Written in plain language
• Identifies what type of information is shared
• Introduces the concept of the Care Team to the patient

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND SOCIAL SERVICES

I, __________________________, date of birth ______________________, authorize the use and disclosure of my health and treatment information by and among each of the participants of the Rutland Community Response Team, including the staff of each organization.

The means of this use of disclosure may be written, verbal or electronic.

The participating organizations of the Rutland Community Response Team are as follows:
Assessment Tools

• Eco Mapping
• Use of 4 Domain Assessment Tool
• Ten Year Look Back
  – look for Root cause
• Camden Cards:
  – prioritizing from the patients' perspective
  – Move from ‘What’s the matter with the patient’ to:
  – ‘What matters to the patient’
Eco Map

• The goal is to identify who is involved in a patient’s life.
  – Determine who reaches out to engage the patient
  – Determine who is the LCC

• Who is supportive to the patient

• Who is causing strain or stress
  – Family and friends
  – Care team members
Eco Map Examples

**Court**
- 2007 - Company was sued. Lost 150,000 Fiscal year.

**Business**
- Own their own family run business. Successful the last 15 years until lawsuit.

**Friends**
- Many family friends. 2006 purchased land together with the Cottmans.

**Extended Family**
- Says they are willing to do anything for the family if needed.

**Church**
- Good influences all around. Helps as much as possible with the depression.

**Employment, Training**
- Not able to pay attention. May loose training opportunity due to lawsuit.

**School**
- Associated with school for certain events.

**Clubs**

**Family Counseling:**
Father severely depressed.

Family in counseling due to the depression of Bill, the Father. It is causing severe strain on the family.
Eco Map Example
Another Way to Eco Map

- Patient
- Family/Friends/Those not paid to be supportive
- Care team members/Providers/care coordinators/counselors/teachers/clergy/care taker/therapist/
The Mock Patient

- **Ruth** 54 year old who is unemployed, living with boyfriend in his apt., with son, and her sister.
- Health issue: poorly controlled diabetes, neuropathy, anxiety, depression, cognitive delays
- Services: primary care, diabetes educator, mental health counselor, transportation, Community Health Worker

Challenges:
- Unstable housing; homeless
- Lack of transportation
- No funds to pay utility bill = no refrigerator
- Sister can be violent and threatening
- Incomplete medical records

Ruth’s top priorities:
- Stable housing
- Transportation

Medical priorities:
- Diabetes Care
Hands on Practice

• In pairs:
  – One person role plays a patient
  – One person acts as the lead care coordinator

• Use the Eco Map to identify who provides positive relationship and who provides a strained relationship

• Switch Roles
Time for a Break
Be back at 11:00
RN Care Manager Assessment: The 4 Domains

Medical Neighborhood
- Access to Care
- Experience with Provider(s)
- Getting Needed Services
- Coordination of Care
- Medical Home / Services Risk

Social Support
- Home Environment
- Job & Leisure
- Social Support
- Social Relationships
- Social Support Risk

Medical Status & Health Trajectory
- Medications & Treatments
- Chronicity
- Symptom Severity & Condition Factors
- Diagnostic/Therapeutic Challenges
- Utilization Factors

Self Management & Mental Health
- Engagement / Coping
- Adherence to Treatment
- Mental Health History
- Mental Health Symptoms
- Self Management & Mental Health Risk

The Team = Patient, Providers, RN Care Manager, patient’s support network

Humboldt IPA PRIORITY CARE Domain Assessment Adapted from Care Oregon The 5 Domains and INTERMED Complexity Grid LAN02/2011
Factors Impacting Health: Why 4 Domains

- Health behaviors: 30%
  - Tobacco use
  - Diet & exercise
  - Alcohol use
  - Unsafe sex

- Clinical care: 20%
  - Access to care
  - Quality of care

- Social & economic: 40%
  - Education
  - Employment
  - Income
  - Family & social support
  - Community safety

- Physical environment: 10%
  - Environmental quality
  - Built environment
Look Back

• Medication reconciliation

• Record review:
  • Start with present and look back until you run out of new information
  • Confirm that all the diagnosis
  • Confirm other care team members
Significant Root Cause Issues

- Psychiatric Illness
- Substance Use Disorder
  - Alcohol, Prescription Drugs
- Homelessness
- Access
- Cultural Preference
- Domestic Violence/Abuse/Trauma
- Electronic Health Record Challenges
- System Competency Challenges
<table>
<thead>
<tr>
<th>Family Relationships</th>
<th>Safety</th>
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<tbody>
<tr>
<td>Health Insurance</td>
<td></td>
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<tr>
<td>Housing</td>
<td></td>
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<tr>
<td>Food &amp; Nutrition</td>
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<tr>
<td>Work with Health Care Team</td>
<td></td>
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</tbody>
</table>

Prioritizing Cards

<table>
<thead>
<tr>
<th>Really Important To Me</th>
<th>Urgent</th>
<th>Non-Urgent</th>
</tr>
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<tbody>
<tr>
<td>Health Insurance</td>
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<tr>
<td>Housing</td>
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<tr>
<td>Food &amp; Nutrition</td>
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<tr>
<td>Work with Health Care Team</td>
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<table>
<thead>
<tr>
<th>Somewhat Important To Me</th>
<th>Urgent</th>
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<tbody>
<tr>
<td>Budgeting/Finances</td>
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<td>Transportation</td>
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<td>Drugs or Alcohol</td>
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<tr>
<td>Utilities</td>
<td></td>
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<tr>
<td>Education &amp; Jobs</td>
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<tr>
<td>Mental Health</td>
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Hands on Practice: Camden Cards

• In pairs:
  – Spend 15 minute with one person as the Lead Care Coordinator and one at the patient
  – Use Camden Cards to identify the top 3 priorities for the patient
  – Switch roles for 15 minutes
  – Sharing of Lessons Learned
A shared Care Plan leads to shared Care Team awareness
- Awareness of patient concerns
- Awareness of health risks
- Awareness of care barriers
- Coordination of shared plan actions
- Coordination of care
SHARED CARE PLAN

• Identifies a single contact person (LCC) and how to reach him/her
• Tells a story about the complex patient:
  Strengths, interests, short and long-term goals, clinical treatment goals
• Identifies agencies and individuals currently providing services
• Identifies strategies & timeline for achieving goals
• Specifies who on the team is responsible for achieving goals
• A tool to facilitate communication about the complex patient.
• Does not replace or include the details of clinical treatment plan
CLINICAL TREATMENT PLAN

- A patient may have many clinical treatment plans depending on how many providers they are seeing. These can include:
  - Primary Care
  - Specialists
  - Behavioral Health
  - Addiction Treatment
  - Physical Therapy
  - And others

- Each treatment plan will include the details of the goals and action plans for that part of the patient's care.

- The shared care plan includes the goal and target time frame (increase ROM by providing 6 sessions of PT; Decrease HA1C to 8 by F/U with Endo. q 3 mo)
# Shared Care Plan: Part 1

## Information from Eco Map and 10 year look back

<table>
<thead>
<tr>
<th>Date</th>
<th>8/12/2015</th>
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<tbody>
<tr>
<td>Lead Care Coordinator:</td>
<td>Name, Email and Phone Number:</td>
</tr>
<tr>
<td>PATIENT INFORMATION</td>
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<table>
<thead>
<tr>
<th>Mr.</th>
<th>Mrs.</th>
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<tbody>
<tr>
<td>Miss</td>
<td>Ms.</td>
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<table>
<thead>
<tr>
<th>Select one:</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<table>
<thead>
<tr>
<th>Is this your legal name?</th>
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<th>No</th>
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<tbody>
<tr>
<td>If not, what is your legal name?</td>
<td>Birth date:</td>
<td>Age:</td>
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<td>M</td>
<td>F</td>
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<table>
<thead>
<tr>
<th>Street address:</th>
<th>Cell Phone:</th>
<th>Home Phone:</th>
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<tr>
<th>P.O. box:</th>
<th>City:</th>
<th>State:</th>
<th>ZIP Code:</th>
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</table>

| PCP: | Life Long Influencer: | Diagnosis: |

<table>
<thead>
<tr>
<th>Care Team:</th>
<th>Organization, Name, Email and Phone Number:</th>
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Shared Care Plan: Part 2
Information from the Rutland Cards and Care Conference

<table>
<thead>
<tr>
<th>Care plan</th>
<th>Person Responsible</th>
<th>Due Date</th>
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<tbody>
<tr>
<td>Patient Goals (lifestyle)</td>
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<tr>
<td>Treatment Goals:</td>
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<td>3.</td>
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<td>Strengths/Preferred Activities:</td>
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<tr>
<td>Potential Barriers:</td>
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<tr>
<td>Action/Self Mgt Plan:</td>
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<tr>
<td>Communication Style Preference:</td>
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<tr>
<td>Tips to Avoid Triggers/Behavior:</td>
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<tr>
<td>Mobility:</td>
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<tr>
<td>Care Plan Last Updated:</td>
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IN CASE OF EMERGENCY
Name of local friend or relative:
Pre-Care Conference

• What is it:
  – Meeting or meetings to get the care team members to share the current status, challenges, successes, and agree on future strategies that are focused on the patients priorities.

• Negotiate priorities

• Agree who will attend the care conference
  – Patients may not feel comfortable with many providers in a room at once
Role of the Lead Care Coordinator:

Pre-Visit Planning

- Care Coordinator sets an agenda with the patient/family
- Confirm attendance and participants and make sure family acknowledges and accepts all attendees
- Identify key problem solving agenda items
- Establishes an Agenda
- Ascertain if any issues family/patient does not want to discuss with the whole team
Why a Care Conference?

- Getting team members on the same page
- Uncertain who is involved in care
- Specific problem solving agenda
- Need to share critical information (new diagnosis)
- Transitions (educational, facility, life stage)
- To set Goals and Next Steps with Accountability
Care Conference: The Space

- Enough room for everyone to be at the table
- Family should be seated in central position next to supportive person
- Privacy is important—windows, interruptions to a minimum
- Space should establish comfort and sense of safety
- Priority for all team members to be on time
- Accessible, comfortable to needs of the family
- For pediatric care conferences we recommend child not be present unless they are an active participant (if possible)
Care Conferences

- Introductions/Contacts
- Set Agenda
- Set Roles: Facilitator
- Start with Strengths
- Ecomap if available
- Discussion
- Minutes Recorded
- Update Plan with Next Steps & Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting
Wrapping Up

- Minutes Recorded
- Update Plan with Next Steps & Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting
Outcomes of Shared Cared Planning

- Builds community collaboration and communication across services
- Builds knowledge base of services and system of care
- Determines most appropriate referrals, reduces duplication and fragmentation of care.
- Builds the capacity of primary care to provide long term chronic care management
- Addresses systems issues and barriers proactively (i.e. financing, poverty, access to care)
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<td>Specific</td>
<td>Measurable</td>
<td>Attainable</td>
<td>Realistic</td>
<td>Timely</td>
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<td>What specifically do you want to do?</td>
<td>How will you know when you’ve reached it?</td>
<td>Is it in your power to accomplish it?</td>
<td>Can you realistically achieve it?</td>
<td>When exactly do you want to accomplish it?</td>
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Example of SMART Goals

• Goal: Weight loss
  – The patient will walk one mile 5 days a week for one month.

• Goal: Control Blood Pressure
  – The patient will start taking new medication once a day for one month and then have a follow up Dr. Apt.

• Goal: Have more social interactions
  – The patient will go to a meal site on Wednesday at the Senior Center.
### Shared Care Plan: Part 2

**Information from the Rutland Cards and Care Conference**

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**Care Plan Last Updated:**

**IN CASE OF EMERGENCY**

Name of local friend or relative:
**Practice Completing Shared Care Plan**

- Pick one of the priorities identified by use of the Camden Cards and create a SMART Goal
- Share SMART goal with your partner
- Does it meet the criteria?
- Fill in the second part of the Shared Care Plan
Wrapping Up

• Give completed Shared Care Plan to another group. You are now caring for the patient.
  – What does the SCP tell you about the patient?
  – How will you support the shared care plan?
  – What else do you want to know?

• Questions?