Vermont Program for Quality in Health Care, Inc.

Integrated Communities Care Management Learning Collaborative

Final Evaluation Report

January 2017

Contents

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Introduction

Background on Integrated Care Management model

Persons with complex health conditions and psycho-social needs may benefit from a wide variety of medical and social services from many different providers. It is essential that the care provided to these persons is not "fragmented," with different agencies providing care in multiple locations without communicating adequately with each other. Fragmentation of care can cause confusion and challenges following care plans; over-treatment and uncontrolled costs through unnecessary tests or duplication of services; or under-treatment and poor outcomes based on incomplete information or misidentification of the person's primary health determinants.

In many communities throughout the country an Integrated Care Management (ICM) model has been implemented to make health care more person-directed, progressive, and non-episodic. The ICM model supports joint care planning with the person and his or her diverse providers across multiple organizations, with the goal of identifying and preventing the underlying reasons for poor health outcomes. These goals are detailed in a shared care plan, which is developed jointly with the participant and his/her diverse providers. Integral to the ICM is the recognition that, in the majority of cases, a person's primary health determinants are related to social, environmental, and behavioral factors. In fact recent data suggest that only 20% of health outcomes are determined by clinical health care.

Once a person's underlying reasons for poor health outcomes have been identified, a Lead Care Coordinator (LCC) guides joint care planning and helps the person define and work towards personal, social, emotional, and health-related goals. In addition to clinical support, the LCC helps coordinate essential community services based on identified needs, which may include housing, food insecurity, substance abuse, mental health, violence, economic issues, and/or transportation, among others.

The ICM model should produce these positive effects:

- Care is less fragmented
- Persons can access timely, appropriate, high-quality care
- Persons can engage more fully in their own care
- Communication between providers is better coordinated, improving continuity of care and lowering cost
- Systems and tools efficiently share and apply information about a person's care among their providers

Implementing the ICM model in Vermont

In 2014, the Integrated Communities Care Management Learning Collaborative (ICCMLC) began helping communities implement ICM in Vermont. The work was funded through a $45 million State Innovation Models (SIM) Testing grant from the federal Center for Medicare and Medicaid Innovation and implemented through a collaborative effort of Vermont Program for Quality in Health Care, the Green Mountain Care Board, and the Department of Vermont Health Access including the Vermont Blueprint for Health. Since the inception of the ICCMLC, the program has increased from 3 initial volunteer communities to 11 communities across the state. Significant connections have been established among a broad group of stakeholders including, but not limited to, hospitals, primary care practices, ACOs, community health teams, social services, mental health services, home health services, housing agencies, peer and advocacy organizations, and agencies on aging, with the goal of better coordinating care for identified persons with complex health conditions.

VPQHC's Role in the ICCMLC

Between March 2015 and December 2016, the Vermont Program for Quality in Health Care, Inc. (VPQHC) supported the work of the ICCMLC through a contract with the State of Vermont, Department of Vermont Health Access.

A VPQHC staff member was one of two Quality Improvement (QI) facilitators who provided support to "integrated care teams" in three pilot communities (Burlington, Rutland and St. Johnsbury) as they began participation in the ICCMLC in January 2015. After June 15, 2015, the QI facilitators began to provide support to eight additional Round 2 pilot communities (Brattleboro, Central Vermont, Middlebury, Morrisville, Randolph, Springfield, St. Albans and Windsor). The QI facilitators worked with the integrated care teams in each community to build capacity for effective team-based care, to coordinate learning opportunities related to integration of services on behalf of people who need the services, to implement promising interventions to enhance integration, and to measure the results of those interventions. The QI facilitators focused on providing support in implementing quality improvement methods, team facilitation, group dynamics, understanding and using data, and project management. The VPQHC facilitator worked closely with the ICCMLC Planning Team and community leaders on developing tools for statewide use, including shared care plans, educational materials, and reporting templates. The VPQHC facilitator also specialized in providing support to all pilot communities for data collection, presentation and interpretation.

A VPQHC staff member also supported the ongoing and final evaluation of the ICCMLC, which included advising on the design of data collection tools and surveys, data analysis, and presentation of final results of the evaluation.

Purpose of this report

This report will describe the work VPQHC was a part of through 2015-2016, with an emphasis on key measures that can be used to evaluate the success of the ICCMLC and recommendations to support the ongoing success of this program.

Community participation in the Vermont ICCMLC

Participating communities

Community name	Contact(s)
Burlington	Robyn Skiff
Brattleboro	Wendy Cornwell Jodi Dodge
Central Vermont	Heather Colangelo
Middlebury	Alexandra Jasinowski
Morrisville	Elise McKenna
Randolph	Lisa Delegato Patrick Clark
Rutland	Sarah Narkewicz
Springfield	Maureen Shattuck Tom Dougherty
St. Albans	Lesley Hendry
St. Johnsbury	Laural Ruggles Pam Smart
Windsor	Jill Lord

Organizations participating in each community

The following lists provide a snapshot of the organizations and members participating in each community coalition. The number of organizations ranged from 7 to 20 across each community, highlighting the excellent community engagement present in each ICCMLC team.

Brattleboro

A total of 16 organizations participated in the Brattleboro ICCMLC.

Brattleboro Housing Authority

Brattleboro Memorial Hospital

Brattleboro Memorial Hospital Community Health Team

Brattleboro Primary Care

Brattleboro Retreat

Groundworks

Health Care and Rehabilitation Services

One Care Vermont

Pine Heights

Private Practice

Senior Solutions

Support and Services at Home

Turning Point

Vermont Chronic Care Initiative

Vermont Department of Health

VT Blueprint for Health

Burlington

A total of 16 organizations participated in the Burlington ICCMLC.

Agency of Human Services

Blueprint Practice Facilitator

Champlain Housing Trust-Support and Services at Home

Champlain Valley Agency on Aging

Community Health Center

Community Health Team

Howard Center

Lund Center

One Care Vermont

Planned Parenthood of New England

Support and Services at Home

Thomas Chittenden Health Center

University of Vermont Medical Center Emergency Department

University of Vermont Medical Center Health Assistance Program

Visiting Nurse Association

VT Chronic Care Initiative

Central Vermont

A total of 12 organizations participated in the Central Vermont ICCMLC.

Agency of Human Services

Central Vermont Home Health and Hospice

Central Vermont Medical Center

Chittenden County Transportation Authority

Clara Martin Center

Council on Aging

Downstreet

Family Center of Washington County

One Care Vermont

The Health Center

United Way

Vermont Chronic Care Initiative

Vermont Department of Health

Washington County Mental Health Services

Middlebury

A total of 20 organizations participated in the Middlebury ICCMLC.

Addison County Home Health and Hospice

Bayada Home Health

Blueprint for Health - Porter Medical Center

Champlain Valley Agency on Aging

Counseling Service of Addison County

Healthfirst

Little City Family Medicine

Little City Family Practice

Middlebury Family Health

Mountain Health Center

One Care Vermont

Parent Child Center

Planned Parenthood of Northern New England

Porter Medical Center

Support and Services at Home Middlebury

Support and Services at Home Vergennes

Turning Point - Addison County

Vermont Chronic Care Initiative

Vermont Department of Health Middlebury

VT Blueprint for Health

Morrisville

A total of 8 organizations participated in the Morrisville ICCMLC.

Cambridge Family Practice

Community Health Services of Lamoille Valley

Copley Hospital

Lamoille County Mental Health Services

Lamoille Home Health and Hospice

One Care Vermont

The Manor

Vermont Chronic Care Initiative

Randolph

A total of 10 organizations participated in the Randolph ICCMLC.

Bayada

Blue Cross Blue Shield of Vermont

Capstone

Clara Martin Center

Council on Aging

Federally Qualified Health Center Dental

Gifford Medical Center

Randolph Area Community Development Corporation

Vermont Chronic Care Initiative

VT Blueprint for Health

Rutland

A total of 13 organizations participated in the Rutland ICCMLC.

Bayada

Blue Cross & Blue Shield of VT

Community Health Centers of the Rutland Region

Community Health Network

Council on Aging

Department of Vermont Health Access

Genesis Healthcare

Homeless Prevention of Rutland County

National Healthcare

One Care Vermont

Rutland Area Visiting Nurse Association and Hospice

Rutland Housing Authority

Rutland Regional Medical Center

Vermont Department of Health

Springfield

A total of 9 organizations participated in the Springfield ICCMLC.

Blue Cross Blue Shield of Vermont

Health Care and Rehabilitation Services

Neighborhood Connections

Senior Solutions

Springfield Medical Care Systems

Valley Health Connections

Vermont Chronic Care Initiative

Vermont Wellness

VT Agency of Human Services

St. Albans

A total of 14 organizations participated in the St. Albans ICCMLC.

Champlain Valley Agency on Aging

Community Health Team

Franklin County Home Health Agency

Franklin County Rehab

Max Bayard, MD

Medication Assisted Therapy

Northern Tier Center for Health

Northwestern Medical Center

One Care Vermont

St. Albans Primary Care

Support and Services at Home

Vermont Chronic Care Initiative

Vermont Department of Health

VT Blueprint for Health

St. Johnsbury

A total of 10 organizations participated in the St. Johnsbury ICCMLC.

Bi-State Primary Care

Caledonia Home Health

Community Connections

Corner Medical

Council on Aging

Kingdom Internal Medicine

Northeast Kingdom Human Services

Northeastern Vermont Regional Hospital

Northern Counties Health Care

Rural Edge

Windsor

A total of 7 organizations participated in the Windsor ICCMLC.

Bayada

Blue Cross Blue Shield of Vermont

Cedar Hill

Mt. Ascutney Hospital and Health Center

One Care Vermont

Senior Solutions

Vermont Chronic Care Initiative

ICCMLC Learning Sessions

Throughout 2015 and 2016, the participating communities were supported with statewide In-Person Learning Sessions (LS), which were designed as opportunities to share best practices in care coordination and to encourage networking and shared learning among participants. Expert national faculty from leading organizations throughout the US that have helped to pioneer community-based care management presented content on key topics, tools and methods with proven records of effectiveness in implementing person-directed, interagency care and services. Eventually, as the number of communities expanded across the state, these learning sessions evolved to occur on two separate days in different locations across the state. The Round 1 learning sessions refer to those supporting the first "round" of communities (Burlington, Rutland, and St. Johnsbury), while the Round 2 learning sessions were initiated when the subsequent communities joined the ICCMLC.

Date	Title / Agenda	Location	Participants
1/13/15	Round 1 – LS 1 Care Coordination: Benefits to the Family, the Practice and the Provider Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management	Randolph, VT	85
3/10/15	Round 1 – LS 2 Care Coordination Framework for People with Complex Needs: Identifying Lead Care Coordinators and Developing Shared Plans of Care	Northfield, VT	91
5/19/15	Round 1 – LS 3 Working Together as an Integrated Multi-Disciplinary Care Team: Ten Steps toward Implementation of Shared Plans of Care	Northfield, VT	82
9/29/15	Round 1 – LS 4 Change Management: Using an Easy Tool Process Mapping – Skill, Development and Support	Montpelier, VT	90

Date	Title / Agenda	Location	Participants
9/8/15	Round 2 – LS 1	Dartmouth, NH	75
9/9/15	Care Coordination: Benefits to Community Members and the Cross-Organizational Community Team Identifying and Engaging People in Cross-Organizational Care Management	Burlington, VT	96
11/16/15	Round 2 – LS 2	Lebanon, NH	59
11/17/15	Understanding the Population and Root Cause Analysis Identifying and Building a Cross Continuum Team	Burlington, VT	73
3/16/16	Round 2 – LS 3	Burlington, VT	64
3/17/16	Creating and Implementing Shared Plans of Care Conducting Effective Care Conferences	Lake Morey, VT	56
5/25/16	Round 2 – LS 4	Rutland, VT	57
5/26/16	Care Coordination for People with Complex Needs: Sustaining the Intervention Event Notification: An Overview of PatientPing	Waterbury, VT	60
9/6/16	Round 2 – LS 5	Rutland, VT	37
9/7/16	Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations	Waterbury, VT	52

(LS = learning session)

ICCMLC Webinars

Webinars were also offered to participating ICCMLC communities to support additional learning on best practices for implementing the ICM model in Vermont. Expert national faculty from leading organizations throughout the US that have helped to pioneer community-based care management presented on key topics, tools and methods.

Core Competency Trainings

As greater numbers of new agency partners began participating in the project, the ICCMLC Planning Team identified a need to provide statewide training in care coordination skills and competencies. After a competitive bidding process, the Primary Care Development Corporation and the Vermont Developmental Disabilities Council were selected to deliver trainings starting in March, 2016. The Core Competency trainings featured content on care coordination skills and disability awareness, and included a train the trainer program.

ICCMLC Trainings Offered Locally by Participating Communities to Engage and Educate Community Partners

In order to sustain, share, and scale the work of the ICCMLC throughout the state, the ongoing engagement and training of new agency partners was identified as an important need. Participating communities were encouraged to develop and present local training sessions. The Rutland community assumed a leadership role in this process, developing training methods and materials that they shared statewide. Other communities developed trainings independently or with the help of the QI facilitators.

Feedback from participating ICCMLC Communities

Several communities offered additional feedback on some of the challenges, successes, and lessons learned, as well as some thoughts on the sustainability of their work. Many front line agency participants expressed enthusiasm for the power of the tools and methods in engaging persons with complex needs. Lead Care Coordinators were often surprised at the important personal information not contained in any clinical record, but shared by a person that they had already known for a period of time, once that person was encouraged within the program to share their 'story,' relationships, and most important priorities and goals. The prime benefit for many was the defining of manageable, time-limited accountabilities to work on goals that were determined to be important steps in achieving those priorities, and the continued engagement and participation of the person.

Lead Care Coordinator Self-Assessment Survey

A Lead Care Coordinator (LCC) Self-Assessment was made available online via SurveyMonkey from November 28 through December 12, 2016. The survey was intended to gauge the LCCs' self-perception of competency and comfort with using the tools and methods of the ICCMLC, and to solicit comments on the need for training and other assistance as the project continues in 2017.

Out of 96 people performing the LCC role statewide, 26 completed the survey. Results showed that:

- 64% were completely or very confident in their ability to use Eco-Mapping to improve care coordination for patients
- 69% were completely or very confident in their ability to use the Camden Cards to help patients identify and prioritize what's important to them
- 38% were completely or very confident in their ability to conduct a Root Cause Analysis
- 77% were completely or very comfortable explaining the purpose of care coordination to patients and families that could benefit from that approach
- 62% were completely or very confident in their ability to develop a shared care plan that describes patient goals, provides a strategy and timeline for meeting goals, and identifies a team member responsible for working with the patient to achieve each goal
- 50% were completely or very confident in their ability to plan and run a shared care conference

- 81% were completely or very confident explaining the informed consent process to patients and inter-agency partners

Results suggest the need for additional trainings on several of the key tools and processes of ICM, particularly root cause analysis, running a shared care conference, developing a shared care plan, and using Eco-Mapping. Some recommendations based on these results are provided in the Recommendations section below.

Participants in the ICCMLC

The sections below provide details on the number of persons who were provided care as part of the ICCMLC. Data are current as of November 2016.

Participant status

Participant status was defined in four ways following initial engagement. (Participant engagement includes signing consent, participation in at least one meeting with his/her LCC, and identification of personal priorities and relationships). Data are not provided for individuals who have not yet met the engagement criteria.

- Current: Participant and team are currently active in scheduled care conferences and recurring need-based updating of Shared Care Plan goals and tasks. Overarching goals, steps or tasks are not yet complete.
- Maintenance: Participant situation is currently stable, after having participated in Integrated Care Management with identified goals and tasks implemented or completed, and either no current need for regularly scheduled care conferences or updating of care plans; or less frequent need to do so, for example annually. Lead Care Coordinator remains aware of the participant's ongoing situation and remains alert to changes in situation might necessitate re-engagement. Participant remains aware that he/she should contact Lead Care Coordinator regarding any concerns or changes in stability.
- Withdrew: After engagement, participant has either stated that he/she no longer wishes to participate in Integrated Care Management, including ownership of goals, team support with goals and tasks, or sharing of information among agency partners; or is no longer engaged with or available to LCC, such as has moved away, is not reachable, or has "fired" their LCC. To be considered withdrawn, they must first have been engaged (see above definition).
- Deceased: After engagement, participant passed away.

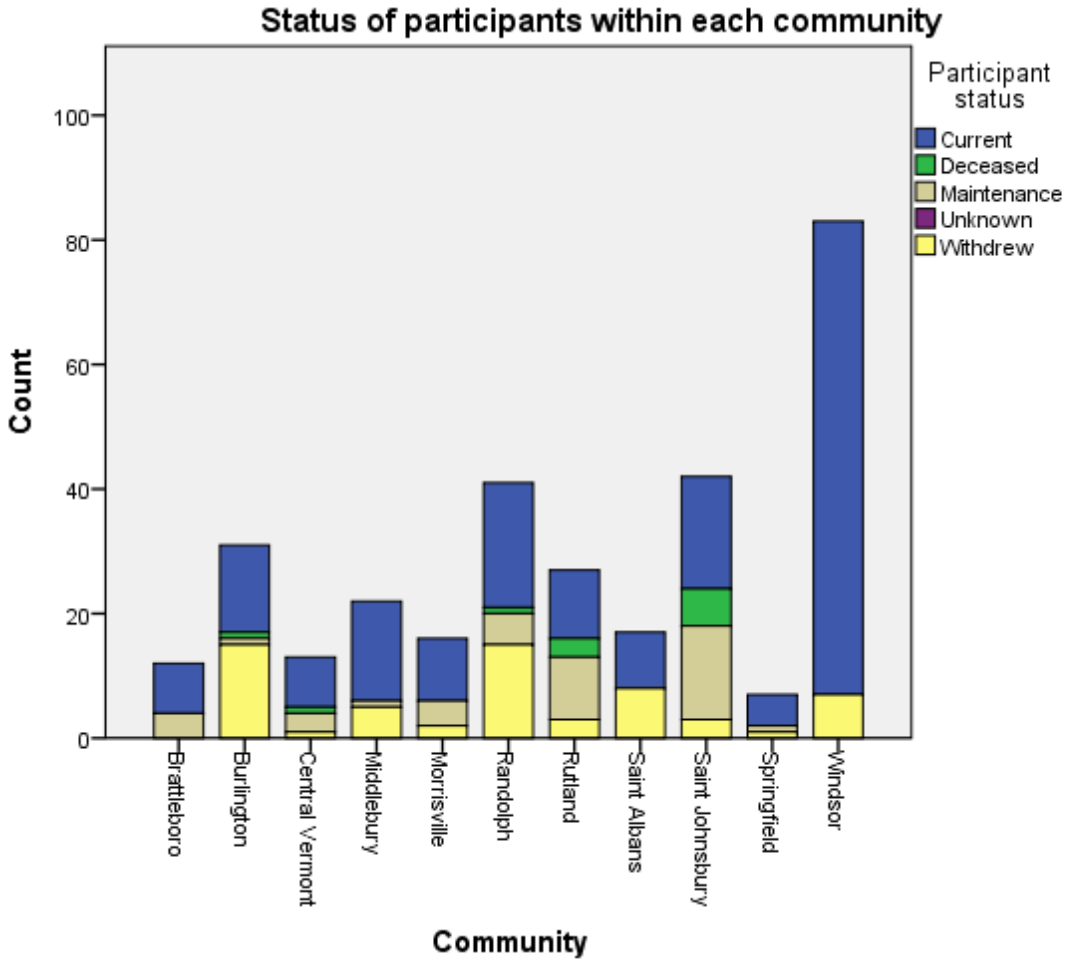
Based on data submitted bimonthly from participating ICCMLC communities, we have data on 311 participants, with 195 currently active and 44 considered in maintenance. Approximately 23% have been lost due to death or withdrawal (Table 1).

Table 1. Participant status in the Vermont ICCMLC, November 2016

		Frequency	Percent
Valid	Current	195	62.7
	Deceased	12	3.9
	Maintenance	44	14.1
	Withdrew	60	19.3
	Total	311	100.0

Windsor had the highest number of participants followed by St. Johnsbury and Randolph (Figure 1). The number of participants is not correlated with the length of time the community has been participating in the ICCMLC.

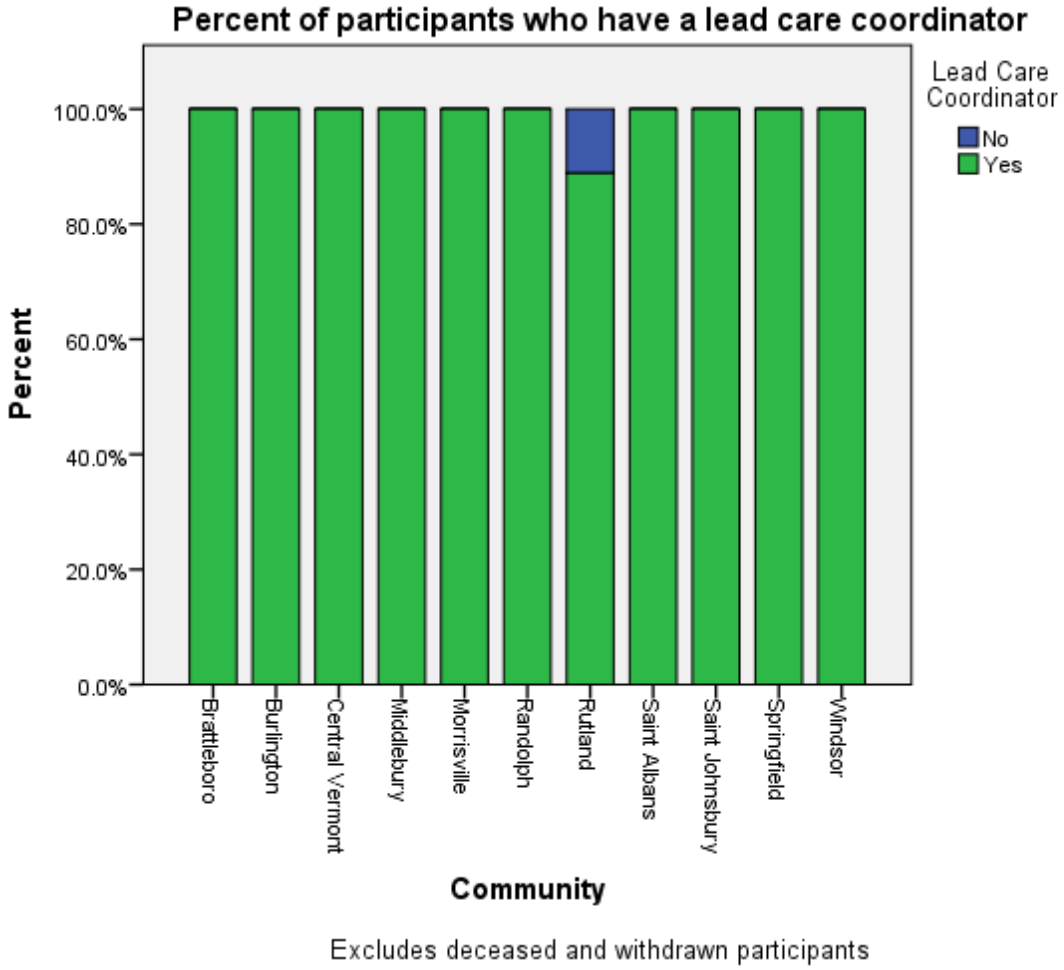
Figure 1. Participant status in the Vermont ICCMLC, by community – November 2016



Participants with a Lead Care Coordinator

One of the most important components of the ICM model is assignment of a lead care coordiantor, and most current and maintenance participants have been assigned a lead care coordinator as shown in Figure 2.

Figure 2. Proportion of participants within each community with a lead care coordinator – Vermont ICCMLC, November 2016.



Participants with a Shared Care Plan

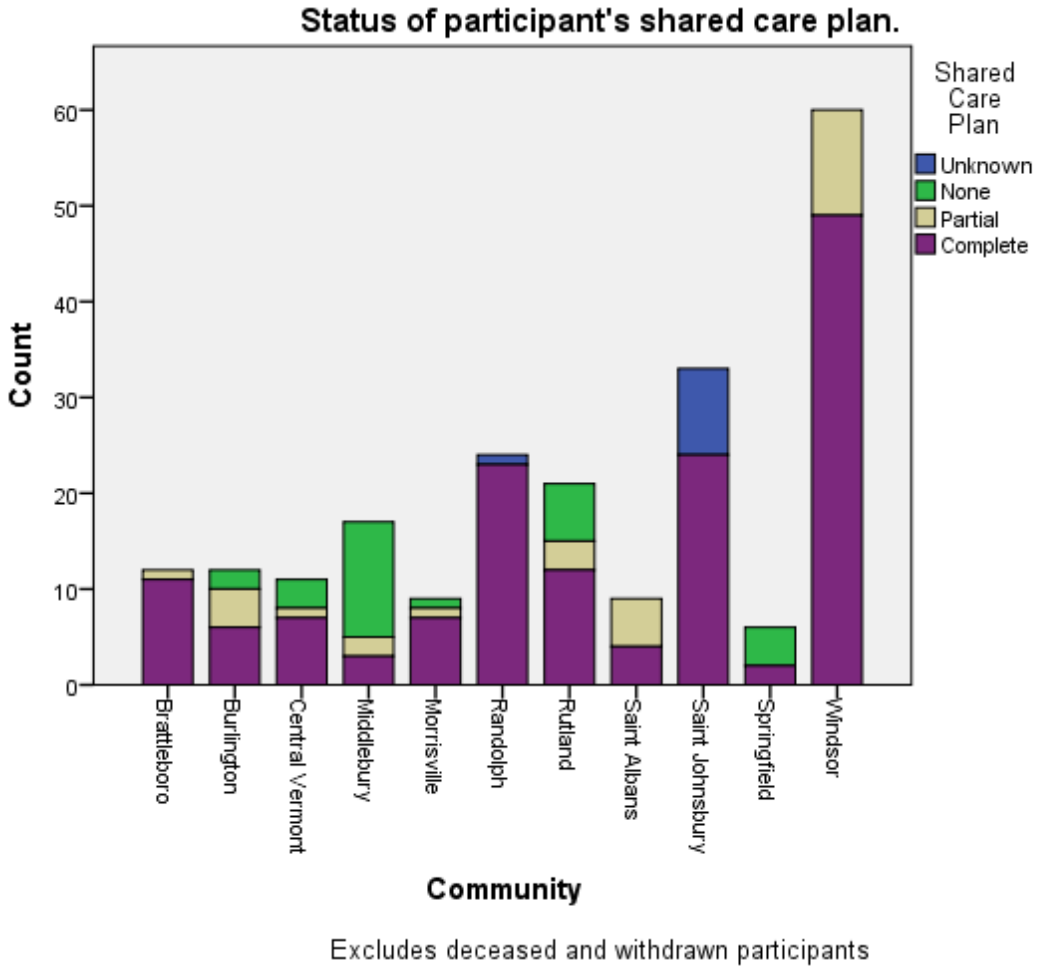
A shared care plan should be completed for each participant within two months of their enrollment into the ICCMLC. Table 2 only includes data on participants with a status listed as "current" or "maintenance", and who have been enrolled for a minimum of 2 months. While the majority of participants have a completed shared care plan (69.2%), with another 13.1% having a "partially" completed shared care plan, ideally this number should be at 100%.

Table 2. Vermont ICCMLC participants with a shared care plan – November 2016.

		Frequency	Percent
Valid	Complete	148	69.2
	None	28	13.1
	Partial	28	13.1
	Unknown	10	4.7
	Total	214	100.0

Figure 3 describes the status of shared care plans across communities.

Figure 3. Status of Vermont ICCMLC participants' shared care plan, by community – November 2016.



Participants who had a Shared Care Conference

Every participant in the ICCMLC should have a shared care conference to ensure care is adequately coordinated among providers, ideally within the first two months of enrollment. Including those only considered current and enrolled for more than 2 months, 81 participants (47.6%) have not had a shared care conference. Additionally, of those with a complete or partial shared care plan, 41.4% (58/140) did not have a shared care conference. Although these numbers are lower than ideal, there is some concern regarding inconsistent documentation of these conferences in the bi-monthly reporting, therefore the true number could be higher.

Feedback from participants in the ICCMLC

With input from ICCMLC participating communities and ICCMLC leadership, and after a literature review of patient feedback surveys, VPQHC developed a Participant Survey for individuals obtaining care under the ICCMLC model. The original intent of the survey was that it would be provided to every participant at enrollment and then at subsequent 6 month intervals. However the survey was not available at participant enrollment within the initial three pilot communities, and logistical challenges along with survey fatigue in those and other communities inhibited the wide-spread use of the survey.

There were a total of 60 surveys received, including all communities except Middlebury and St. Albans. The following provides a summary of the pooled responses, noting whether the response is impacted by the length of time participating in the ICCMLC if relevant.

2a. 98.3% know who their care coordinator is

2b. 98.3% know how to contact their care coordinator

3a. 95.0% agree that their care coordinator/team explains things in a way that is easy to understand; 5.0% neither agree nor disagree

3b. 93.3% agree that if they asked for something, their care coordinator/team helped them get it; 6.7% neither agree nor disagree

3c. 90.0% agree that their Care Team helps them know what to do when they feel sick or need help; 10% neither agree nor disagree

3d. 96.7% agree their Care Coordinator/team know who else is helping with their care; 3.3% neither agree nor disagree

3e. 85.0% agree their Care Coordinator and team members communicate well with each other; 6.7% disagree; 8.3% neither agree nor disagree

3f. 91.7% agree their Care Coordinator/team does a good job coordinator their care; 1.7% disagree; 6.7% neither agree nor disagree

4. 72.4% responded that their Care Coordinator/team created a shared care plan for them; ** positively correlated with length of time participating in ICCMLC

5. 69.0% have a copy of their shared care plan; ** negatively correlated with length of time participating in ICCMLC, suggesting they appear to lose it

6a. 86.7% helped create their shared care plan; 2.2% disagree; 11.1% neither agree nor disagree

6b. 79.5% know what their shared care plan says; 6.8% disagree; 13.6% neither agree nor disagree; ** no correlation with length of time participating in ICCMLC

7a. 87.0% chose the goals for their shared care plan; 2.2% disagree; 10.9% neither agree nor disagree; ** no correlation with length of time participating in ICCMLC

7b. 89.1% agreed their Care Coordinator/team talked with them about progress on goals in shared care plan; 10.9% neither agree nor disagree

7c. 84.8% agree they can change a goal on their shared care plan; 2.2% disagree; 13.0% neither agree nor disagree; ** everyone who neither agreed nor disagreed had participated for over 12 months

8a. 82.1% agree their LCC asks them about things that make it hard for them to take care of their health; 5.4% disagree; 12.5% neither agree nor disagree; **no correlation with length of time participating in ICCMLC

8b. 91.1% agree their LCC talks with them about what they want for their future; 3.6% disagree; 5.4% neither agree nor disagree

8c. 89.3% agree their LCC respects their wishes if they don't want to share all of their information with certain members of their care team; 1.8% disagree; 8.9% neither agree nor disagree

8d. 92.9% agree their LCC asks them what is working well in their health care; 1.8% disagree; 5.4% neither agree nor disagree

8e. 86.0% agree their LCC knows their strengths in caring for them; 14.0% neither agree nor disagree

8f. 94.7% agree their LCC asks them about things that affect my well-being; 1.8% disagree; 3.5% neither agree nor disagree

Overall, participant feedback suggests that participants feel supported by their Care Team and Lead Care Coordinator, and have had overall positive experiences with the ICCMLC.

Recommendations

Given our contract with the State of Vermont ends in December 2016, VPQHC provides the following recommendations for the ICCMLC moving forward.

State of Vermont Leadership

VPQHC recommends the leadership continue and expand statewide adoption of Integrated Care Management as a standard of care through ongoing state support and reinforcement of ICCMLC concepts, goals and methods.

Based on the currently available data, leadership may wish to consider emphasizing the importance of developing a shared care plan within 2 months of a participant's enrollment in the ICCMLC. While the majority of participants have a completed shared care plan (69.2%), with another 13.1% having a "partially" completed shared care plan, ideally this number should be at 100%.[1]

Also regarding the shared care plan, leadership may also wish to consider suggesting the Lead Care Coordinator purposely review, update, and ensure the participant has a current copy at periodic intervals. Based on data from the Participant Survey, participants may lose track of their shared care plan the longer they stay in the ICCMLC. The shared care plan should ideally be a living/breathing document, that the participant feels ownership of, and can regularly access online. The Care Navigator plans available to some participants may fulfill that role, however will not be immediately universally available.

The number of participants who had a shared care conference to ensure care is adequately coordinated among providers appears to be inadequate. Almost 50% of participants who should have had a shared care conference have not had one (based on process data from the "Data Tool"). There also appear to be participants with complete or partial shared care plans, who have not had a shared care conference. We recommend leadership review the accuracy of these data with communities, and encourage either improved reporting or increased uptake in the shared care conferences.

Participants have found the wide variety of education opportunities extremely valuable in developing and implementing best practice for ICCMLC. We recommend leadership continue their support of shared learning sessions, and may wish to consider the following topics, highlighted based on participating community feedback from earlier learning sessions:

- A refinement of evidence based best practices for ICM based on organizations' experience using its tools and methods

[1] When the analysis did not exclude those enrolled within the past 2 months, the results did not differ significantly.

- Change management training to facilitate community wide adoption of ICM
- Strategies for leaders to move toward broad community ownership of ICM
- Integration of the LCC in the referral process
- Strategies for forming patient experience panels to contribute advice and insight to the work
- Strategies for including MD or ED staff in shared care planning
- Scaling ICM to new partners and patients
- Support for the implementation and use of care navigator, including the integration of EMRs

Data collection, reporting, and interpretation are essential toward evaluating the effectiveness of the ICCMLC. Please see our more detailed comments on the evolution of the data tool and participant survey that will support a strong evaluation moving forward.

Without staffed QI Facilitators, it will also be essential to have an identified state point of contact for addressing any community needs, problems, etc. on an ad hoc basis.

Participating Communities

Without the same level of statewide support, it is essential that all participating communities draft Local Sustainability Plans. These Sustainability Plans should include:

- Agency partner recruitment and training sessions
- Continued process and outcome data collection and reporting
- Continued adoption of the Care Navigator electronic Shared Care Plan
- Mutual agreements for privacy and information sharing policy and practice among all agency partners

Participating communities should continue to attend any shared learning opportunities the statewide leadership presents, such as in-person learning sessions and webinars, to increase their knowledge of and insight into ICM principles and methods. Outside of organized shared learning activities, communities should also seek to maintain and expand collaborative communication and mutual support with other participating communities throughout the state.

The results from the LCC survey suggested some discomfort with the tools and processes used for ICM, such as Eco-mapping, Camden Cards, and Root Cause Analysis (RCA). VPQHC recommends communities retain a primary focus on the goal of each tool and method over any proscribed or regimented perspective on their use. For example, teaching LCCs that the goal of using RCA for 'discovering what we may have been missing as a cause of a person's frequent utilization' may be more instructive and less intimidating than 'review the record for the last 10 years and be sure to identify root causes from 4 domains.' Consider emphasizing the 'why' of the method of analysis for the purpose of the goal of insight into the person's situation over the specific terminology of the process and tools.

Data Tool

The "Data Tool" was developed to collect process data on ICCMLC participants from each participating community. It is currently sent bi-monthly as an excel file to the QI Facilitator (often after several reminders were sent out to communities), and often has large amounts of missing data. Our recommendation is to replace the Data Tool with a cloud-based database, that will allow for ongoing data entry by multiple users and a clear record of changes made to participant details.

The new data tool should be designed with input from communities, to ensure it is a tool that they feel will be useful to their internal tracking. Participant data will still be anonymous, but the tool should also allow for data entry from multiple users within the community who provide care for the participant, minimizing the burden of data entry for the coordinator. Notifications should be coded, to help communities flag missing data or identify next steps (for example, that a participant's 6 month follow-up survey is due, or that the shared care plan should be updated), which will both support the goals of the ICCMLC and reduce the amount of missing data. Reports similar to those detailed above can also be automated, and be available to communities and the coordinating entity, to enable real time status reports whenever needed. If resources within the state are limited, VPQHC would be interested in supporting the development of this database, should funds be available.

Participant Survey

The main issue with the participant survey was the low response rate, so added emphasis on encouraging participants to take the survey, particularly at baseline/enrollment, will be helpful. Feeding data back to participants is often a useful way of encouraging participation by showing respondents how their data will be used. The addition of notifications to the data tool as mentioned above could also support a higher response rate.

In many cases, proxies helped the ICCMLC participant complete the survey due to limitations of the participant. It is important to consider the impact of proxies on the responses and try to minimize any biases inherent in this situation moving forward. Our suggestions for proxies within each community are:

- Train a set of proxy interviewers in neutral interviewing. Numerous studies have looked into the effect on responses by proxy interviewers, showing a range of effects, some slanting the responses more positively, some more negatively, depending on the type of health condition and relationship of the proxy to the respondent. Trained interviewers will minimize these effects.
- Avoid using the Lead Care Coordinator as a proxy, as many of the questions ask the respondent to assess the role provided by the Lead Care Coordinator.
- Encourage communities to support participants' independent completion of the online survey, while providing the support they need. For example, a Lead Care Coordinator could

provide a computer, set up with the online survey to the participant, along with a brief tutorial on how to fill in responses, but leave the participant to complete the responses on their own.

There is a yearly cost for Survey Monkey, which has been the platform used to house the online survey. Some of the communities wished to keep their surveys internally – others used VPQHC's license to house the survey. Funds to support Survey Monkey were provided to communities, but may not be available from January 2017 on. The State of Vermont may consider either transferring all surveys to their State license, or identifying a free option for housing the survey moving forward.

Currently, there is no identifying information on the survey. There has been some discussion of including fields for participant ID and ICCMLC community, which would enable a person-level analysis of their feedback over time (as ideally each participant completes a survey every 6 months). While this would provide some useful individual feedback for the participant's care team, the addition of identifying information may inhibit the participants' comfort in providing honest answers. It is our suggestion to maintain the Participant Survey as a population-level analysis tool, and that the Lead Care Coordinator encourage open communication with the participant regarding their concerns on an ongoing basis, in lieu of using the participant survey for this purpose.

Conclusion

VPQHC is very grateful to have had the opportunity to participate in the tremendous work of the Vermont ICCMLC. We hope this report and our recommendations can continue to support a high level of care for patients with complex health conditions and psycho-social needs in 2017 and beyond.

For any questions regarding this report, please contact mail@vpqhc.org.