



## **OneCare Vermont Care Coordination Toolkit**

Welcome to the OneCare Vermont Care Coordination Toolkit. This Toolkit, developed by OneCare Vermont, is designed to assist health service areas to identify and implement a care coordination program for complex patients with multiple chronic conditions, or to integrate additional elements of care coordination best practices into existing programs and services.

The Toolkit is made up of several modules with concentrations in different aspects of the care coordination process, as defined and outlined by the *Commission for Case Management Body of Knowledge*, to help you build your programs using endorsed processes and tools that care coordinators in the industry use to support population management activities in the practice setting.

We hope that this toolkit will serve as a resource for your teams, evolving with your own processes, and a mechanism for sharing with each other your learnings, best practices, tools, resources, recommendations for further review, and feedback that is essential to creating and sustaining a culture of cross-organizational, cross-continuum learning. If you have questions or comments regarding this resource please contact OneCare Vermont Operations Staff via email at [HelpDesk@OneCareVT.org](mailto:HelpDesk@OneCareVT.org) or telephone (802) 847-7220 and toll free 1-877-644-7176.

A special thank you to the following community partners for their contribution (s) to this toolkit: The Blueprint for Health, The California Quality Collaborative (Humbolt, Memorial Care), The Camden Coalition of Healthcare Providers, Dartmouth Hitchcock Medical Center, Hagan Rinehart and Connolly Pediatrics, North Carolina Community Care, the Springfield Community Health Team, The Vermont Chronic Care Initiative, and The Vermont Integrated Communities Care Management Learning Collaborative communities.

“OneCare Vermont would also like to thank The University of Vermont Medical Center for its leadership to improve the health of the people in the communities we serve by integrating patient care, education and research in a caring environment, as well as the James M. Jeffords Institute for Quality and Operational Effectiveness at The University of Vermont Medical Center for their dedication to supporting the organization's efforts to achieve the development of an Integrated Delivery System which provides high value health care to the communities we serve.”

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## Module 1: [\(back to table of contents\)](#)

### Introduction to Care Coordination

- **Purpose:** Complex individuals with multiple chronic conditions, limited functional status, and/or psychosocial challenges are vulnerable and more likely to experience adverse events and poor health outcomes. Complex patients also account for a disproportionate share of health care costs and utilization of the health care system. An opportunity exists to increase quality, decrease costs, and improve patient and provider experience of care for the highest health service utilizers by targeting high-risk Medicare, Medicaid, and commercially-covered beneficiaries who are attributed to providers in the OneCare Vermont network with appropriate care coordination services. As the OneCare Vermont network moves towards a capitated health system, decreasing costs for the highest utilizers will lead to a more financially sustainable health care system.
- **Statement:** 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 in care plan/treatment plan goals as a patient interacts with health providers and settings.

**In the OneCare Vermont (OCV) clinical model, patients are at the center of all care coordination activities. Attributes of patient (person) centered care include:**

- Whole person care
- Quality care
- Coordination and communication
- Support and empowerment

**Critical Elements of a Successful Care Coordination Programs:**

- Patients' connection to a regular source of primary care (i.e. PCMH, FQHC)
- One-to-one relationships between patients and trained care coordinators with their own patient panel
- Use of standardized assessment tools in building shared care plans
- Completion of a face to face visit within one month of engagement (enrollment)
- Use of motivational, open interviewing style to gather patient information and understand barriers from the patient view

- Two way communication between the care coordinator and patient at least monthly
- Shared action plans developed in partnership with patients and at least one active patient-defined goal per year
- Warm handoffs to support services tailored to the patient's needs e.g. transportation, food banks and other community services.
- Activities aim to avoid/redirect emergency department visits to more appropriate resources

**Goals and Objectives of Care Coordination Activities:**

- Improve access to needed services
- Educate patients on the benefits of a medical home and the best use of the health care delivery system
- Advocate on behalf of the patient and family
- Apply best practices for disease management initiatives
- Negotiate appropriate behaviors and set goals with patients to achieve best outcomes
- Provide education, support and resources tailored to the individual's need
- Monitor patient compliance and outcomes and follow up as needed
- Redirect patients with repeat unnecessary emergency department (ED) visits to appropriate service delivery settings
- Collaborate with other service providers
- Participate in the PCP-led health care team
- Coordinate services across providers and delivery settings
- Meet care and service requirements for specific populations

Definitions Related to Care Coordination:

Care Coordination	Programs that apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care coordination is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services; It is understood that in order to support individuals and to strengthen community support systems, care coordination services need to be culturally competent, accessible and personalized to meet the needs of each individual served.
Care plan	Over-arching, longitudinal blueprint of all sites and all team members' (including patients) prioritized concerns, goals, and interventions
Care Conference	Multidisciplinary meetings of health and social service professionals to plan treatment for specific patients with chronic and complex care needs
Care Coordinator	The individual who provides care coordination to high risk individuals
Goal	A defined outcome or condition to be achieved in the process of patient care. Includes patient defined goals (e.g., prioritization of health concerns, interventions, longevity, function, comfort) and clinician-specific goals to achieve desired and agreed upon outcomes
Health concerns	The issues, current status, and 'likely course' identified by the patient or team members that require intervention(s) to achieve the patient's goals of care, any issue of concern to the individual or team member
Interventions	Actions taken to maximize the prospects of achieving the patient's or providers' goals of care, including the removal of barriers to success. Instructions are a subset of interventions
Outcomes	Status, at one or more points in time in the future, related to established care plan goals
Patient instructions	Information or directions to the patient and other providers including how to care for the individual's condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines, and a summary of best practice. Detailed list of actions required to achieve the patient's goals of care
Plan of care (POC)	Discipline-specific set of related problems or health concerns. Different plans of care require reconciliation into a single care plan. Examples: acute care POC and home care POC
Responsible clinicians	Parties who manage and/or provide care or service as specified and agreed to in the care plan, including clinicians, other paid and informal caregivers, and the patient

Transitions of Care	The process[es] of moving patients from one level of care to another, usually from most to least complex; however, depending on the patient's health condition and needed treatments, the transition can occur from least to most complex
Treatment plan	Focuses on a specific health concern and typically managed by one clinician. Example: physical therapy treatment plan

**Articles and Resources:**

Agency for Healthcare Research and Quality, *The Roles of Patient Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care* (Dec., 2010)

[AHRQ 2010](#)

Arnold Milstein and Elizabeth Gilbertson, *American Medical Home Runs*, Health Affairs (Sept-Oct., 2009)  
[Milstein and Gilbertson 2009](#)

Atul Gawande, *The Hot Spotters*, The New Yorker (Jan. 24, 2011)  
[Atul Gawande 2011](#)

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Coordination Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions, Agency for Healthcare Research and Quality (2012)  
[AHRQ 2012](#)

Randall Brown, *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Conditions* (March, 2009)  
[Randall Brown 2009](#)

The Robert Wood Johnson Foundation, *The Synthesis Project, Care Management of Patients with Complex Health Care Needs* (Dec., 2009)  
[RWJF 2009](#)

The Commonwealth Fund, *Vermont's Bold Experiment in Community-Driven Health Care Reform* (May 10, 2018)  
[Commonwealth Fund 2018](#)

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### Change Ideas for Targeted Care Coordination

**Introduction to the Care Coordinator Roles:** As complexity of care increases, and the demand for accountability grows within new models of care, the function of care coordination is increasing in importance. Care coordinators at the health service area (HSA) level play a crucial role in health care delivery improvement programs, and bring immense value to the medical home and community. The roles, though, will look different across settings and providers. According to The Agency for Healthcare Research and Quality (AHRQ) “Care coordination means different things to different people; no consensus definition has fully evolved”. <http://archive.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/chapter2.html>

At the practice level, the role (s) may depend on the payment model and whether care coordination will be reimbursed as its own function under the local model. Without payment linked to care coordination functions, it is often difficult for clinical practices to invest in a dedicated position. In many instances, case management is being referred to by other terms, such as care coordinators, patient navigators, or health coaches. While there may be an opportunity to increase knowledge and awareness to create competency in case management, there is also an opportunity to take a leadership role in developing new care models in a rapidly changing landscape, and to fulfill loosely defined care coordination functions within the new models. Please see below for a brief description of some of the more common roles encountered in today's care coordination landscape:

- **Case Manager:** Individual assigned to the at-risk, complex, and/or chronic disease patient populations to conduct not only care coordination activities, but also assessments, care planning, care transitions and prevention activities for at-risk, complex, and chronic disease patients. *The Commission for Case Manager Certification* is the first and largest nationally accredited organization that certifies case managers. Candidates must hold a current, active, and unrestricted licensure or certification in a health or human services discipline that within its scope of practice allows the professional to conduct an assessment independently. License must be active through the last date of test administration; or Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served (*CMSA Standards of Practice for Case Management*). *The Commission* promotes a common body of knowledge and skills within the field of practice. (Please note: Individuals in other roles may or may not have healthcare backgrounds, licensure, or certification).
- **Care Coordinator:** Individual who typically assumes the role of assuring that the patient's care plan activities are efficiently completed. Duties might include pre-visit communication with the patient, making referral appointments, and follow up phone calls for test results or medical equipment procurement.
- **Community Health Worker (CHW):** A frontline health worker who is a trusted member of and/or has a close understanding of the community served. This relationship enables the worker to serve as a liaison between the community and health/social services with an emphasis on cultural competence of service delivery.
- **Patient Navigator:** A member of the healthcare team who helps patients "navigate" the healthcare system and get timely care, coordinate patient care, connect patients with resources, and helps patients understand the healthcare system.
- **Health Coach:** An individual who helps patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.

The challenge for health care organizations in implementation of these new care delivery models is who they will select to provide care coordination (e.g., unlicensed personnel, registered nurses, social workers) and how they will educate, train and develop those care coordinators to fulfill all of the corresponding roles and functions.

**Small Tests of Change:** The change ideas below will provide examples of the processes and tools that care coordinators can use to support population management activities at the practice setting. The overall process is iterative and cyclical, its phases being revisited as necessary until the desired outcome is achieved.

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### **Care Coordination Process - Stratifying Risk**

Due to the size and complexity of the OneCare network's attributed population, it is important to use tools and processes that stratify the population to enable prioritization of care coordination activities and interventions. Within our network, the entire population is grouped into risk categories to identify individuals who are at various risk levels for unnecessary and/or high cost utilization of healthcare services (low risk, medium risk, high risk, or very high risk). This is done for all of the participating payers and is done individually for each payer based on Medicare, Medicaid, and Commercial historical claims data depending on the program (s) your organization is enrolled in. The OneCare Vermont analytics team produces regular reports on care coordination activities to identify areas of interest or growth. The goal is to stratify the population and identify patients that will benefit from the targeted care coordination interventions.

The Stratifying Risk phase involves the classification of a client into one of four population health risk categories –Healthy/well majority, early onset/stable chronic illness, full onset chronic illness, and complex/high cost in order to determine the appropriate level of intervention based on the patient's situation and interests. This classification allows the implementation of targeted risk category-based interventions and treatments that enhance patient outcomes and experience.

OneCare stratifies risk using the Johns Hopkins ACG risk scoring, which is based on claims data.

Health Catalyst, OneCare Vermont's informatics platform, provides OneCare Vermont with a data warehouse to combine claims data from Medicare, Medicaid, and Blue Cross Blue Shield (BCBS) with clinical data from the Vermont Health Information Exchange (VITL).

OneCare's analytics platforms allow OneCare to track and trend patients and population risk over time, identify and fully characterize high-risk patients and population segments, identify rising-risk patients, and use risk scores to effectively predict cost and utilization. The risk scores will

also be used for risk adjustment of cost measures, and many other metrics that are typically presented with adjustment for risk. In addition, the data and information generated by the apps will ultimately be used by OCV to evaluate provider performance, identify drivers of high cost so that cost reduction plans may be implemented, and supply the information for the care coordination program, Care Navigator, in order to improve quality of care and patient outcomes.

### ***Articles, Tools & Resources***

- [Behavioral Health four Quadrant Clinical Integration.pdf](#)
- [Proactively Identifying the High Cost Population.pdf](#)

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### **Care Coordination Process - Screening**

The Screening phase focuses on the review of key information related to an individual's health situation in order to identify the need for health and social services. The care coordinator's objective in screening is to determine if a client would benefit from such services.

In such situations, a care coordinator or other identified individual representing the primary care practice (if applicable) reviews the automatically generated risk classifications and gathers key information from the medical record-to the extent possible-relevant to the "4 Domains:" Social Support, Medical Neighborhood, Self-Management and Mental Health, and Medical Status and Health Trajectory.

As an additional step, it may be helpful to use the following questions as needed to engage clinicians in a conversation about patient identification and engagement:

"This is a patient who had high intensity health care 3 months ago. I need to find out if this is someone who needs care coordination and if they might engage with my outreach.

- Would you be surprised if this patient were hospitalized or had an ER visit in the next 6 months? Why or why not?

- Do you feel that, with your backing, this patient will engage in care coordination (assuming they are not already in it)? What might help them engage?
- Given your knowledge of this patient longitudinally, what do you think is the most critical area to focus on? (Medical: what? Social: what? Financial? Behavioral Health? Other?)”

Screening promotes early intervention and the achievement of desired outcomes. For complex patients, the likelihood of involvement with multiple agencies performing a “care coordination” function is high, which highlights the need for effective documentation and communication as possible goals are developed, and further assessment and interventions are explored.

***Tools & Resources:***

[Care Coordinator to PCP Conversation Tool.pdf \(DHMC\)](#)

[Root Cause Analysis \(RCA\) Worksheet.pdf](#)

[Chart Review Tool.pdf](#)

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### **Care Coordination Process - Assessment & Planning**

OneCare Vermont works with network participants to establish effective methods of identifying the beneficiaries most likely to benefit from care coordination interventions. Once identified, it is recommended that recipients who agree to participate are given a comprehensive health assessment, which documents conditions and problems, interventions, goals and other care coordination activities. Identifying the people most likely to be impacted by the care coordination services you provide is an ongoing process, likely to require many tests of change. Individuals engaged in care coordination will vary by the level of intensity required to provide effective services. Patients may also be deferred from care coordination for a variety of reasons: refusal to participate; because their conditions are already managed optimally; or because interventions are not likely to impact their health outcome or quality of life (e.g., a patient with end-stage renal disease).

The Assessing phase involves the collection of information about a client's situation similar to those reviewed during screening, however to greater depth.

The care coordinator has two primary objectives while assessing:

- Identifying the client's key problems to be addressed, as well as individual needs and interests.
- Developing a comprehensive case management plan of care that addresses these problems and needs.

Additionally, the care coordinator seeks to confirm or update the client's risk category based on the information gathered. Using standardized assessment tools and checklists, the care coordinator engages the patient through face-to-face or telephonic outreach, and gathers information directly from the patient/caregiver/support system, as well as the clinicians involved in the patient's care.

A comprehensive plan of care for an individual client describes:

- The client's problems, needs, and desires, as determined from the findings of the client's assessment.
- The strategies, such as treatments and interventions, to be instituted to address the client's problems and needs.
- The measurable goals – including specific outcomes – to be achieved to demonstrate resolution of the client's problems and needs, the time frame(s) for achieving them, the resources available and to be used to realize the outcomes, and the desires/motivation of the client that may have an impact on the plan

The care plan is then to be shared with the patient, family/caregiver, primary care provider (s), and among organizations involved in care delivery to facilitate more effective cross continuum team-based interventions.

***Tools & Resources:***

**"Camden Cards" (The Camden Coalition of Healthcare Providers)**

- [Backwards Planning User Guide.pdf](#)
- [Backwards Plan Board.pdf](#)
- [Domain Cards with Pictures.pdf](#)

[ECO Map.pptx](#) (Hagan, Rinehart & Connolly Pediatrics)

[ECOMAP Instructions.pdf](#)

[ECO-Map Template-Example.pdf](#) (Hagan, Rinehart & Connolly Pediatrics)

[Goals and Barriers Guidelines.pdf](#) (DHMC)

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### **Care Coordination Process - Implementation and Follow up Activities**

The implementing phase centers on the execution of the specific care plan activities and interventions that are necessary for accomplishing the goals set forth by the patient and care team.

Care Coordination in primary care involves deliberately organizing patient care activities and sharing information among all of the participants concerned with an individual's care to achieve safer and more effective care. Examples of specific care coordination activities include establishing accountability and agreeing upon responsibilities, communication, assistance with transitions of care, assessment of patient goals, creating a proactive care plan and supporting the patient's self-management goals by linking them to community resources and working to align resources with the patient needs.

During this phase, the care coordinator organizes, secures, integrates, and modifies (as needed) the services and resources necessary to meet the patient's needs and interests. The care coordinator shares information on an ongoing basis with the patient and the patient's support system, the healthcare providers/clinicians, the insurance company/payer, and community-based agencies.

The Following-Up phase focuses on the review, evaluation, monitoring, and reassessment of a patient's health condition, needs, ability for self-care, knowledge of condition and treatment regimen, and outcomes of the implemented treatments and interventions. The care coordinator's primary objective is to evaluate the appropriateness and effectiveness of the care plan and its effect on the patient's health condition and outcomes.

During this phase, the care coordinator gathers sufficient information from all relevant sources, shares information with the patient, healthcare providers, and others as appropriate, and documents in the patient's health record the findings, modifications made to the care plan, and recommendations to proceed.

Care coordinators are encouraged to maintain an accurate assessment and regularly review goals, process and outcomes data to identify barriers, stimulate improvement, and track progress towards the achievement of jointly established goals. This information is then used to adjust initiatives and update the care plan and case status accordingly.

***Tools & Resources:***

[Shared Care Plan Example 1.pdf](#)

[Shared Care Plan Example 2.pdf](#)

[Care Conference Process Flow.pdf](#)

Client Perception of Care Questionnaire related reading (CPCQ):

<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-CPCQ-for-pre-enrollment-and-graduation.pdf>

<https://www.camdenhealth.org/wp-content/uploads/2012/10/Developing-summary-scores-of-HRQOL-for-population-based-survey-Horner-Johnson-et-al-2009.pdf>

**Patient Action Plans** (Vermont Chronic Care Initiative):

- [VDH Asthma Action Plan.pdf](#)
- [VCCI Back Pain Action Plan.pdf](#)
- [VCCI CHF Action Plan.pdf](#)

- [VCCI COPD Action Plan.pdf](#)
- [VCCI Diabetes Action Plan.pdf](#)
- [VCCI Healthy Living Action Plan.pdf](#)
- [VCCI High BP Action Plan.pdf](#)
- [VCCI High Cholesterol Action Plan.pdf](#)
- [VCCI Kidney Disease Action Plan.pdf](#)
- [VCCI Mental Health Action Plan.pdf](#)

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### Care Coordination Process - Transitional Care & Post Transition Communication

There is increasing national awareness of medical errors and quality deficiencies that occur during transitions in care. The Joint Commission on Accreditation of Healthcare Organizations is one nationally-recognized organization that has increased its focus on coordination of care after hospitalization. The Institute of Medicine (IOM) is also addressing strategies that may improve outcomes for patients as they transition from one setting to another, and advocates health care models that are patient-centric and collaborative.

The Transitioning phase focuses on moving a patient across the health services continuum or levels of care depending on the patient's health condition and the needed services/resources. In order to maintain continuity of care, this phase's activities entail the complete execution of the patient's transition through communication with key individuals (including sharing of necessary information) at the next level of care or setting, the patient, caregiver and/or social support system, and members of the healthcare team.

During this phase, the case manager prepares the patient and the patient's support system either for discharge from the current care setting/facility to home or for transfer to another healthcare facility or a community-based clinician for further care, educates the patient about post-transition care and needed follow-up, summarizes what happened during an episode of care, secures durable medical equipment (e.g., glucose meter, scale, walker) and transportation services (if needed), and communicates these to the patient, to the patient's caregiver, and to key individuals at the receiving facility or home care agency (if applicable) or those individuals assuming responsibility for the patient's care.

Three key focus areas of review and teach back for the patient and/or patient's support system are:

1. Medication self-management: the patient and/or patient's support system are knowledgeable about medications and have a system to manage medication.
2. Primary care and specialist follow-up: the patient and /or support system completes a follow-up visit with their physician or specialist physician within a week of discharge.
3. Knowledge of red flags: the patient and/or support system are knowledgeable about indications that their condition is worsening and how to respond.

The Communicating Post Transition phase involves communicating with a patient/support system for the purpose of checking on how things are going post transition from an episode of care, including the patient's comfort with self-care, medications intake, availability of post-transition services (e.g., home health services), and presence of any issues or concerns.

The care coordinator also follows up on issues and problems identified and seek resolution on these issues. Depending on the issue or concern identified, the care coordinator may engage other healthcare professionals to reach a resolution.

***Articles, Tools & Resources:***

[Care Transitions Measure \(CTM-15/CTM-3\)](#)

[CMS Partnership for Patients](#)

[Eric Coleman et al Randomized Controlled Trial for the Care Transitions Intervention](#)

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### **Care Coordination Process - Evaluation Phase**

At the patient level, the Evaluating phase calls for measuring the results of implementing the care plan (e.g., the objectives, goals, treatments and interventions, and return on investment). Evaluation may focus on several types of outcomes of care, including: clinical, financial, quality of

life, experience and satisfaction, physical functioning, psychosocial, emotional, self-care coordination ability, and knowledge of health condition and plan of care.

The OCV analytics team will produce a high-risk report quarterly report by HSA with the aim of completing the initial feedback loop to organizations for the review of high cost, high needs patients. The total number of high-risk patients appropriate for, engaged in, pending and referred to care coordination services will be reported.

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### Care Coordination Process - Care Coordinator Advanced Tools

**Motivational Interviewing:** is a method that works on facilitating and engaging motivation within the client in order to affect behavior change. Using a collaborative communication style that improves understanding of the patient's concerns, strengths and preferences, MI enhances efforts by the care coordinator to engage, educate, and empower self-care coordination behaviors. The MI model offers professionals tools to generate change and to support patients in informed decision making.

<http://www.motivationalinterviewing.org>

**Advanced health care planning:** is an important aspect of developing pathways of care that ensure provision of high quality care while avoiding unnecessary and unwanted care in the final phases of life for people living with advanced chronic disease. By introducing elements of advanced care planning earlier in the course of illness, we may see improved quality of life, health system efficiency and health resource use. Such results are achieved by coordinating care and facilitating communication between patients, families and providers; by enhancing patients' sense of personal control; and by assisting patients with advanced care planning and decision-making that reflected their personal values and preferences.

[Vermont Dept of Health Advance Directives for Health Care Rule](#)

[Start the Conversation](#)

[Vermont Ethics Network](#)

**Trauma-Informed Care:** is a trauma-informed approach that can be implemented in any type of service setting or organization. Realizing the connections between adverse childhood events and health and social problems patients face later in life is likely to improve efforts towards prevention and recovery, and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization."

[Springfield Ace's Workgroup Resource Packet.pdf](#)