

# Interagency Care Coordination Committee (IC3) Update

Briefing of the Recovering Warrior Task Force  
April 16, 2014

Briefers: IC3 Executive Secretariat and Work Group Co-Chairs

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# Background

- Vision: *Realize the full potential and achieve awareness of interagency coordination of complex care, benefits, and services to support Service members, Veterans, and their families*
- IC3 has been a chartered organization since November 2012 under the Joint Executive Committee (JEC)
- IC3 moved from concept to action with most initiatives
- Significant effort is required for IC3 to manage this complex network
  - About 150 total participants (Committee, Work Group, Subgroup members, and Executive Secretariat)
    - 30 members in formal Committee, led by 2 Co-Chairs representing VA and DoD
    - 8 Work Group Co-Chairs and 80 Work Group members
    - Co-Chairs and members represent VA and DoD, clinical and non-clinical care coordination support
  - 50+ programs in the Community of Practice (CoP) are using 15 unique systems in accordance with 240+ DoD/VA policies
  - Roughly 15 meetings per week, ongoing monitoring by Work Group Co-Chairs and IC3 leadership



# Overview of IC3 Current Status (1 of 2)

*Please provide an overview of IC3's current status, particularly any milestones reached since IC3's April 2013 briefing to the RWTF.*

IC3

## Established foundation and launched an interagency CoP

- **Launched Lead Coordinator (LC)** Feasibility Assessment in January 2013 and initiated ongoing analysis of concept
- **Built IC3 Co-Lab** (SharePoint site), a secure virtual space for interagency care coordinators to share information and collaborate
- Established **process for updating inventory of 50+ programs**, which will help identify CoP members, and allow care coordinators to connect and understand the breadth and depth of wounded Warrior services
- Initiated **case match process of patient populations in 8 DoD and VA care coordination programs** to better understand the population, populate initial Co-Lab client management pages, and identify potential issues in interagency care coordination
- Created a **mission and guiding principles** for the development of a virtual, interagency CoP supported by the Co-Lab
- **Launched the CoP** at an orientation event in March 2014 engaging over 50 program leads identified in the inventory



# Overview of IC3 Current Status (2 of 2)

*Please provide an overview of IC3's current status, particularly any milestones reached since IC3's April 2013 briefing to the RWTF.*

IC3

- Developed initial requirements for **electronic Interagency Comprehensive Plan (ICP)**, the future automated tool to coordinate patient care, benefits, and services
  - Facilitated a pilot of the Federal Case Management Tool (FCMT) with the Air Force in San Antonio from October 15 – December 15 2013 to inform requirements for ICP
- **Submitted overarching interagency guidance** through final concurrence as a memorandum of understanding (MOU), which will expedite implementation of key IC3 initiatives
- Created a **proposed list of IC3 Performance Metrics** in November 2013 that will be used to showcase IC3 progress and impact in improving interagency care coordination



# Lead Coordinator Feasibility Assessment (1 of 2)

*What lessons were learned from the Lead Coordinator (LC) pilot project? What is the status of the rollout of the Lead Coordinator role?*

IC3

- Background
  - **Implementation of LC concept began in January 2013 at three designated sites:** Washington, DC and Richmond, Virginia VA Medical Centers (VAMCs) and Walter Reed National Military Medical Center (WRNMMC)
  - **Joint LC Feasibility Assessment memo** was signed by PDSAD(HA) & COSVA and distributed throughout the National Capitol Region sites in January 2013 to **communicate clear expectations** for sites' involvement in the feasibility assessment and support upcoming implementation
    - A second memo was signed by PDSAD(HA) & COSVA in September 2013 to support the expansion to VISN 17/SAMMC
- Status of LC National Rollout
  - **LC Feasibility Assessment expanded** to include VISN 17 VAMCs and San Antonio Military Medical Center (SAMMC) in July 2013
  - CoP is **developing an implementation plan for full rollout** based on lessons learned



# Lead Coordinator Feasibility Assessment (2 of 2)

*What lessons were learned from the Lead Coordinator (LC) pilot project? What is the status of the rollout of the Lead Coordinator role?*

IC3

- Lessons Learned
  - Overall, feedback for LC concept is positive; care coordinators agree LC role improves:
    - Communication and collaboration;
    - Ease of patient and knowledge transfer;
    - Efficiency in the delivery of available care, benefits, and services; and
    - Experience of SM/Vs with care coordination services
- At first use of LC tools took a considerable amount of time, but this decreased as familiarity with the tools increased
- CoP structure is required for a successful national LC implementation
- Expansion of LC requires
  - Engaging relevant DoD/VA decision-makers;
  - Action plan for comprehensive awareness training;
  - Electronic interim solution for ICP; and
  - Overarching guidance (MOU) followed by Service-specific directive/order



# Community of Practice

IC3

- *How is IC3 addressing the overlapping roles of the FRCs, RCCs, Nurse Case Managers, and other care providers/case managers/care coordinators in the care of RWs/Veterans?*
- *How will IC3 affect the elimination or consolidation of existing Service/DoD/VA programs for RW care, if at all?*

IC3 began preparing for discussions regarding case manager/care coordinator roles and program structure:

- To get more complete view of existing programs, updated the inventory of VA/DoD programs that provide care, benefits, and services to wounded Warriors
  - This “inventory” was identified as the IC3 Community of Practice, and includes all programs that would benefit greatly from increased synchronization and integration of care coordination
  - Over 50 program managers were invited to an orientation of the CoP to solidify their role in a future CoP, formally introduce program managers to their role in the CoP, and provide tools and processes to support their ongoing collaboration and communication
  - CoP members will continue to provide information and share knowledge to better coordinate care
- IC3 will continue to analyze roles and responsibilities of existing programs to identify areas for synchronization



# Complex Care Needs

*Is IC3 targeting all RWs or only RWs having the most complex care needs? If the latter, how will complex cases be defined?*

IC3

- IC3 focuses on the clients/patients, as identified by programs within the CoP, who would benefit from increased synchronization and integration of care coordination efforts
- IC3 does not define complex cases
  - Need for complex care coordination is determined by factors including both severity of a wound, illness or injury that is expected to result in prolonged recovery time, or extensive rehabilitation and complexity of care coordination needs involving health care, benefits, and services, including military, federal, or other governmental or community resources
  - SM/Vs in need of complex care coordination have longitudinal care and case management needs that will require an interdisciplinary team approach to achieve optimal recovery





# Overarching Guidance

*What is the status of formal coordination of the draft DoD interagency guidance that was expected to be completed by November 30, 2013?*

IC3

- Submitted overarching guidance into formal coordination in May 2013 and received concurrence on content
- At recommendation of DoD and VA General Counsels, revised policy into MOU format and resubmitted for formal coordination in October 2013
- Revised MOU based on comments received; processing for final signature
  - Joint Strategic Plan has March 31, 2014 as target date for completion
  - Converting the original “policy” document into an MoU and resubmitting for concurrence required additional time
- Continuing to research options for a single, joint, overarching policy applicable to both Departments as a parallel effort
- Identified 241 existing VA and DoD policies that may require revision
  - Once the MOU is approved, P&O Work Group will begin work to coordinate and track revision and realignment of existing policies starting with 45 which are in priority group 1



# Proposed IC3 Performance Metrics (1 of 3)

*What metrics will be considered to measure the success of IC3 and identify where further work is needed?*

IC3

Metric	Impact It Measures	Short-Term Dashboard	Long-Term Dashboard
1 % of VA and DoD medical facilities that can certify they have fully trained LCs and are ready for implementation	Indicates the degree of progress implementing the LC concept	√	
2 % of Care Coordination Team members from VA and DoD medical facilities actively using SharePoint	Indicates the level of engagement of care coordinators in the online CoP	√	
3 % of eligible SM/Vs with an active ICP by (date); % of eligible SM/Vs with a LC	Indicates the level of ICP usage among enrolled SM/Vs and how effectively SM/Vs and LCs are connected	√	
4 % of existing Tier 1 care coordination policies that have been revised to align with the new interagency MOU	Measures the level of progress in establishing new policy guidance that aligns with the IC3 and complex care coordination processes		√
5 Average % of available care, benefits, and services used by SM/Vs during the recovery, rehabilitation, and reintegration phase of the care coordination process	Provides insight into whether SM/Vs are taking full advantage of the care benefits and services they are eligible to receive		√



# Proposed IC3 Performance Metrics (2 of 3)

*What metrics will be considered to measure the success of IC3 and identify where further work is needed?*

IC3

Metric	Impact It Measures	Short-Term Dashboard	Long-Term Dashboard
6 % of care coordinators / LCs who are satisfied with the information they receive during SM/V transfers	Indicates whether care coordinators are collaborating with one another to reduce confusion in transfers	√	√
7 % of SM/Vs and their family members who indicate they are aware of the care, benefits, and services in the ICP	Measures clarity of communication between LC, SM/V, and family members	√	√
8 Qualitative Case Reviews (QCR) of 1-2 randomly selected SM/Vs from across the CoP	A quarterly vignette of the key issues articulated by an SM/V may provide key anecdotal insights into the performance of IC3	√	√
9 % of enrolled SM/Vs and family member and/or caregiver who could identify his or her LC	Indicates whether the LC is connected with the SM/V	√	√
10 % of SM/Vs who are contacted by his or her LC within 72 hours of enrollment	An indicator of efficiency and potential mitigation of SM/V confusion	√	√
11 Average SM/V assessment rating of the responsiveness of his or her LC and CMT (compared with baseline)	Indicates whether the SM/V perceives that he or she is being heard and responded to		√



# Proposed IC3 Performance Metrics (3 of 3)

*What metrics will be considered to measure the success of IC3 and identify where further work is needed?*

IC3

	Metric	Impact It Measures	Short-Term Dashboard	Long-Term Dashboard
12	Average SM/V satisfaction rating of LC hand-offs during the quarter	Provides insight into whether the IC3 is reducing confusion around key transition points		√
13	% of SM/Vs who achieve their originally stated (or subsequently modified) goals in their care plans	Indicates if the IC3 is helping SM/Vs achieve realistic outcomes in accordance with the goals in their ICP; if SM/Vs are not meeting their goals, LCs should help them evaluate/modify the goals to appropriately reflect where they want to be		√
<b>Demographic Data of Interest for Review:</b>				
14	% of SM/Vs: living independently; involved in meaningful activity; homeless; with substance abuse problems; unemployed; transitioned to veteran, VA care, or returned to full/modified duty	Provides IC3 leadership insight into the demographics of its population; these are not performance indicators	√	



# Interagency Comprehensive Plan

*What challenges remain for the planned rollout of a single Electronic Interagency Comprehensive Plan (ICP)?*

IC<sub>3</sub>

## Challenges to initiate rollout of electronic ICP:

- Determining course of action for additional requirements development (i.e., ensuring the right people are engaged in the process)
- Confirming acquisition strategy (e.g. one system, system of systems, etc.)
- Understanding the breadth of existing tools in both Departments and avoiding redundancies and confusion for users



# ICP Change Management

*How will the need for changes to the Electronic ICP be identified and how will those changes be implemented?*

IC3

- The new IC3 Tools, Technology and Change (TTC) Work Group will guide the process
  - Governance process of DoD and IT representatives will manage program requests for changes to the ICP
  - Prioritize change requests and execute as approved
  - TTC will continue to engage stakeholders throughout the ICP development
- Programs will identify changes to ICP to make sure it meets their needs



# IC3 Co-Lab

*Prior to the rollout of the single Electronic ICP, how will data/information be shared?*

IC3

- IC3 Co-Lab is a SharePoint site hosted on a secure DoD server
  - Serves as interim solution
  - Only available to invite CAC or PIV users
  - Secured to contain PII, not for PHI and no PHI will be posted
- Provides CoP members:
  - Secure, shared space to exchange the ICP Checklist (which is the interim, paper-based solution to automated ICP)
  - Database of client information to help identify if clients are participating in multiple programs
  - Directory of case managers/care coordinators in CoP programs to more easily identify and communicate with one another
  - Program pages which identify program points-of-contact
  - Training and professional development resources
  - Workspaces to collaborate and share information



# IC3 Vision Statement

*Realize the full potential and achieve awareness of interagency coordination of complex care, benefits, and services to support Service members, Veterans, and their families*

