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Healthy Minds. Strong Communities.

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State of Ohio Learning Community Basics

Presented by:
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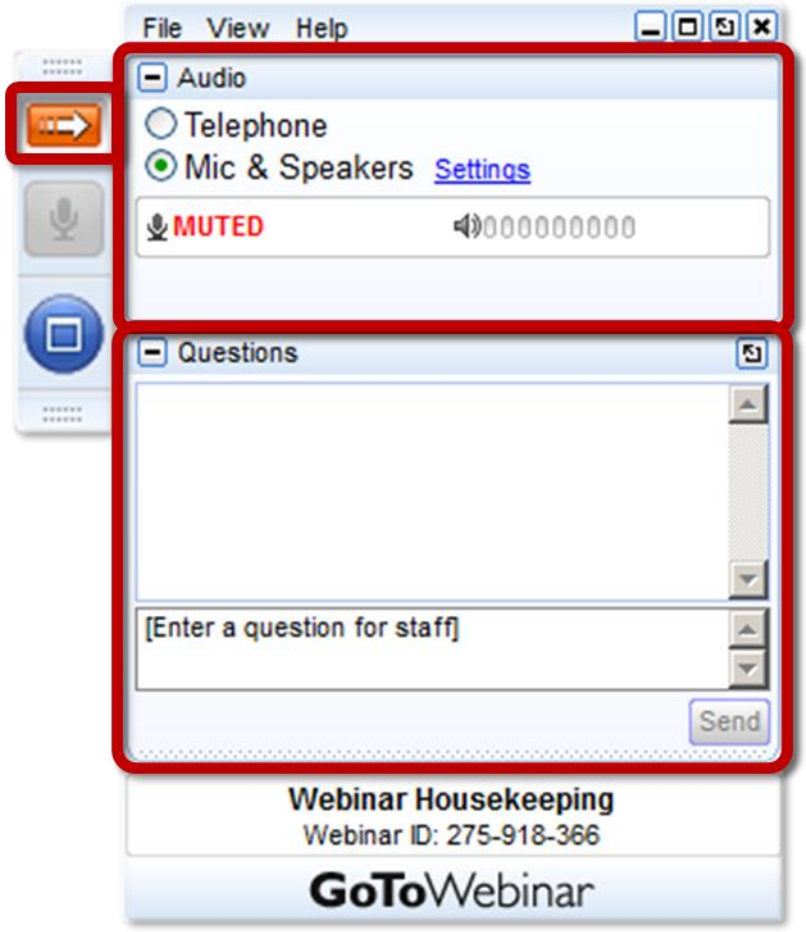
Asking Questions



Your Participation

Open and close your control panel

Join audio:

- Choose "Mic & Speakers" to use VoIP
- Choose "Telephone" and dial using the information provided

Submit questions and comments via the Questions panel

Note: Today's presentation is being recorded and will be provided within 48 hours.

What is a Learning Community?

- **Collection of like-minded organizations and/or individuals with a common mission related to a common topic**
- **The expertise is generally available within the group**
- **Expert facilitators organize and manage the meeting and bring needed expertise if it is not available in the group**

What is a Learning Community?

- **Active involvement of all parties – need people at all levels of implementation**
- **Learning Community members are key to setting the agenda and defining topics to be discussed**

Benefits to Participating in a Learning Community

- **Reduce the amount of time it takes to bring research into practice**
- **Learn from others in areas of need**
- **Teach others from your successes (and failures)**
- **Consistent support and coaching from facilitators**
- **Access to needed resources**
- **Increase experience with cycles of quality improvement**
- **Key up on the day to day happenings in Ohio with the SPA and Health Homes**

Ohio Learning Communities

- **Integrated Care Learning Community**
- **Health Homes Learning Community**

What's the difference?

Integrated Care Learning Community

Facilitators: Jeff Capobianco and Suzanne Daub

Objectives:

- **Increase knowledge and application of integrated primary and behavioral health care strategies.**
- **Stimulate dialogue and best practice sharing among organizations serving Ohio who are pursuing integrated care models.**
- **Identify learning and resource needs for organizations implementing integrated care.**
- **Foster networking and relationships that strengthen organizational capability for integrated care.**
- **Identify potential organizations that can meet Ohio Health Home requirements in the future.**

Prerequisite: Interested in or providing integrated health care

Health Home Learning Community

Facilitators: Kathleen Reynolds, Joan King

Objectives:

- **Extend learning and implementation strategy development for Phase 1 Health Homes.**
- **Foster dialogue and best practice sharing among certified Health Homes and organizations under review for certification.**
- **Identify learning and resource needs for Ohio Health Homes.**
- **Support work plan refinement and implementation for Ohio Health Homes.**

Prerequisite: Current designation as an Ohio Health Home and/or providing onsite primary care by 1/1/14

Learning Community Activities

- **Monthly contact with content determined by participants**
  - Face to Face Meetings – quarterly
  - Webinar - quarterly
  - Group Coaching Call – quarterly
- **Individuals coaching calls - monthly**
- **Site visits**
- **Agency-based Case to Care Training (10 across the state – 8 still available)**

Poll Question:

Does Your Organization Need a Case-to-Care Training Session?

Poll Question:

Does Your Organization Need a Site Visit?

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Key Dates – Integrated Care LC

October 29	**Learning Community Orientation Webinar**
November 14	**Face to Face Kick Off - Columbus, Ohio**
December 19	**Webinar**
January 16	**Group Coaching Call**
February 20	**Face to Face Meeting**
March 20	**Webinar**
April 17	**Group Coaching Call**
May 15	**Face to Face Meeting**
June 19	**Webinar/Group Coaching Call**

(Revised Content Schedule Issued after this Orientation Call with content for each session based on participant feedback)

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Key Dates – Health Home LC

October 23, 2013	**Learning Community Orientation Webinar**
November 20	**Face to Face Meeting – Columbus**
December 17	**Individual Organizational Coaching Calls/Site Visits**
December 18	**Webinar**
December 19	**Organizational Coaching Calls/Site Visits**
January 28	**Organizational Coaching Calls/Site Visits**
January 29	**Group Coaching Call**
January 30	**Organizational Coaching Calls/Site Visits**
February 25	**Organizational Coaching Calls/Site Visits**
February 26	**Face to Face meeting – TBD**
February 27	**Organizational Coaching Calls/Site Visits**

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Key Dates – Health Home LC

March 25	**Organizational Coaching Call/Site Visits**
March 26	**Webinar**
March 27	**Organizational Coaching Calls/Site Visits**
April 22	**Organizational Coaching Calls/Site Visits**
April 23	**Group Coaching Call**
April 24	**Organizational Coaching Calls/Site Visits**
May 27	**Organizational Coaching Calls/Site Visits**
May 28	**Face to Face Meeting**
June 24	**Organizational Coaching Calls/Site Visits**
June 25	**Webinar/Coaching Call**

Participant Poll

Poll Question:

Should the Face to Face Learning Community meetings rotate between cities or always be at the same location (Columbus)?

Using the Continuum of Integration In Ohio

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Continuum of Integration

	Co-Located		Integrated	
Key Element: Communication	**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	**In separate facilities, where they:**	**In same facility not necessarily same offices, where they:**	**In same space within the same facility, where they:**	**In same space within the same facility (some shared space), where they:**	**In same space within the same facility, sharing all practice space, where they:**

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Continuum of Integration

•Have separate systems •Communicate about cases only rarely and under compelling circumstances •Communicate, driven by provider need •May never meet in person •Have limited understanding of each other's roles	•Have separate systems •Communicate periodically about shared patients •Communicate, driven by specific patient issues •May meet as part of larger community •Appreciate each other's roles as resources	•Have separate systems •Communicate regularly about shared patients, by phone or e-mail •Collaborate, driven by need for each other's services and more reliable referral •Meet occasionally to discuss cases due to close proximity •Feel part of a larger yet ill-defined team	•Share some systems, like scheduling or medical records •Communicate in person as needed •Collaborate, driven by need for consultation and coordinated plans for difficult patients •Have regular face-to-face interactions about some patients •Have a basic understanding of roles and culture	•Actively seek system solutions together or develop work- a- rounds •Communicate frequently in person •Collaborate, driven by desire to be a member of the care team •Have regular team meetings to discuss overall patient care and specific patient issues •Have an in-depth understanding of roles and culture	•Have resolved most or all system issues, functioning as one integrated system •Communicate consistently at the system, team and individual levels •Collaborate, driven by shared concept of team care •Have formal and informal meetings to support integrated model of care •Have roles and cultures that blur or blend

Key Contacts: Health Home LC

General questions:

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Key Contacts: Integrated Care LC

General questions:

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Homework

After the webinar, please respond to brief questions that will help shape the November meeting agendas:

- **Successes/challenges for your organization**
- **Priority topics & questions you have**
- **Priority stakeholders you want to engage**