How Safe is the Patient Journey Through the Healthcare Maze?

Cheri Lattimer, RN, BSN
Executive Director
National Transitions of Care Coalition (NTOCC)
Conflict of Interest Statement

No relevant financial relationships exist in regard to the content of this presentation.
Learning Objectives

- Relate to the gaps and barriers to safe patient journey in transitions of care programs
- Discuss 7 key elements for improving transitions and care coordination for patients and their family caregivers
- Assess the impact that social determinants of health have on adherence and readmissions
Health Care Needed A Transformation

The Current Process Is Not Working

The Vision

Critical Business Issues?

Needs

Optimum Health

Fragmentation & Silo’s of Care
Growing Cost of Chronic Care
Access to Care Options (24x7)
Inconsistent Approaches
Collaborative Team Practice
Whole Person Care Approach
Transitions of Care Facilitation
Technology Advancements
Regulatory/Gov’t Imperatives
Premium Increases, MLRs and Provider Payment

“To provide health care services and support to all consumers including health prevention, care coordination, and appropriate resource utilization. To promote quality of care to improve quality of life for our citizens. A commitment to processes that focus on education, consumer advocacy, clinical optimization of resources, patient safety, and technology to achieve superior clinical and financial outcomes with positive member and provider satisfaction”
Health Care Policy Shaping Our Strategy

Benefits of the Affordable Care Act for Americans

- **Rx Discounts For Seniors**
- **Protect Against Health Care Fraud**
- **Small Business Tax Credits**
- **Free Preventive Care**
- **Pre-existing Conditions**
- **Health Insurance Marketplace**
- **Consumer Assistance**

**Benefits for Women**
Providing insurance options, covering preventive services, and lowering costs.

**Young Adult Coverage**
Coverage available to children up to age 26.

**Strengthening Medicare**
Yearly wellness visit and many free preventive services for some seniors with Medicare.

**Holding Insurance Companies Accountable**
Insurers must justify any premium increase of 10% or more before the rate takes effect.

Courtesy: www.hhs.gov/healthcare/facts/timeline/index.html
Health Care Policy Brings Innovation, Creativity, & Opportunity

New Models of Healthcare Delivery and Reimbursement

- Patient-Centered Medical Home (PCMH) Primary Care Practices
- Accountable Care Organizations (ACOs)
- Integrated Health Delivery Systems
- Population Health Management
- Comprehensive Primary Care
- Outcomes-Based Reimbursement With Shared Risk
- Value Based Purchasing of Health Care Services
What These New Models Require

Processes to promote evidence-based medicine, patient engagement, and care coordination, including:

- Patient-centered philosophy and operations
- Coordinated and integrated care
- Use of evidence-informed medicine
- Use of health information technology for data sharing/reporting capabilities
- Continuous quality improvement processes
Transition Issues Dramatically Impact Patients & Their Family Caregivers

OUTPATIENT:
- Home
- Home Care
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Caregiver
- Hospice

ER

ICU

In-Patient

SNF

ALF

Patient & Caregiver
Transition Issues Dramatically Impact Patients & Their Family Caregivers & Providers

- Patient & Caregiver
- ER
- ICU
- In-Patient
- NO Transition/Discharge Care Plan
- NO Medication Reconciliation
- NO Personal Medicine List
- NO Coordinated Care Plan
- SNF
- ALF
- OUTPATIENT:
  - Home
  - Home Care
  - PCP
  - Specialty
  - Pharmacy
  - Case Mgr.
  - Caregiver
  - Hospice
- NO Care Plan
- NO Medication Reconciliation
- NO Personal Medicine List
NTOCC’s Seven Essential Interventions Categories

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Medications Management</td>
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<tr>
<td>2</td>
<td>Transition Planning</td>
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<tr>
<td>3</td>
<td>Patient and Family Engagement / Education</td>
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<td>4</td>
<td>Healthcare Providers Engagement</td>
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<td>5</td>
<td>Follow-Up Care</td>
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<td>6</td>
<td>Information Transfer</td>
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<td>7</td>
<td>Shared Accountability across Providers and Organizations</td>
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Continuum of Care & Spectrum of Services

How will you coordinate care beyond your service?
# Moving Towards A Collaborative Care Model

## Table 1: Conventional vs. Collaborative Care

<table>
<thead>
<tr>
<th>Conventional</th>
<th>Collaborative</th>
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<tbody>
<tr>
<td>Authoritarian</td>
<td>Collaborative</td>
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<tr>
<td>Autonomous practice culture</td>
<td>Team culture</td>
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<tr>
<td>Physician driven, with physicians accountable for care outcomes</td>
<td>Patient centered, with team members sharing responsibility for care outcomes</td>
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<tr>
<td>Episodic, fragmented</td>
<td>Continuous, coordinated</td>
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<tr>
<td>Primary care delivered in one-size-fits-all, 15-minute visits</td>
<td>Primary care delivered via individualized visits, phone calls, and online communication</td>
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<tr>
<td>Payment based on quantity (fee for service)</td>
<td>Payment based on value (considers both quality and cost)</td>
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<tr>
<td>Reactive, focused on illness</td>
<td>Preventive, focused on health</td>
</tr>
<tr>
<td>Communication is inconsistent</td>
<td>Communication is imperative</td>
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Improving Care Coordination Means Improved Communication & Strong Team Collaboration

No one *Professional* has the total responsibility for care coordination – *it is a team effort*
Creating the Collaborative Clinical Team

Collaboration among physicians, pharmacist, nurses, case managers, social workers, allied health and supporting staff is critical to achieving the goals of the team, the organization and changing the way we deliver healthcare today.
The Integrated Professional Team

- Patient & Family Caregiver
- Primary Care & Specialist
- Wellness or Health Coaches
- Lab and Radiology Professionals
- Rehab
- Administrative Staff
- Case Managers
- Community Health Workers
- Dietician
- Pharmacist
- Allied Health
- Hospitalist
- Nurses
- Mental Health
- Social Workers
- Patient Advocates
Professional Case Management Skills Are Required For Success in These New Models!

- Knowledge and experience with care coordination
- Focus on patient-centered processes – clinical & non-clinical issues
- Assessment, planning, implementation, facilitation across care continuum
- Knowledge of population-based care management strategies
- Meaningful communication with patient, family, care team – addressing health literacy
Integrated Medical & Behavioral Care Delivery & Coordination

- Psychiatrist-supervised systematic diagnostic assessment with baseline symptom documentation
- Initial agreed upon clinical and functional goals
- First line evidence-based intervention through primary care clinician
- Care management behavioral activation and follow-up with outcome measurement under psychiatrist review
- Treatment to target-care escalation based on follow-up findings (psychiatrist involvement and treatment change)
- Symptom stabilization and return to primary care follow-up
Innovative Health
Information Technology

- Technology Enabled Transitions
- Using data analytics and the EHR to shift from event based treatment to continuity of care
- Approach to a preventive medicine comprehensive wellness focus
- Integrated and interactive transfer of information in a timely and effective manner to providers, patients and family caregivers
- Understanding data in forming new interventions or programs
- Make it more than a financial business move but a focus of improving the patient-experience and becoming the change agent for a failing healthcare system
Let’s explore the importance of assessing the social determinants of health and how they can impact the outcome of a transition plan, impact the patient journey and contribute to an avoidable hospital readmission

“Our health is also determined in part by access to social and economic opportunities; the resources and support available in our homes, neighborhoods, and communities; the quality of our schooling, the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships.”

*Social Determinants of Health | Health People 2020*
Overall Health is Determined By:

- Clinical Care
- Genes & Biology
- Physical Environment
- Health Behaviors
- Social & Economic Behaviors
Social Determinants of Health in Populations with Complex Needs

- SDOH can account for up to 40% of individual health outcomes.
- Compared to other industrialized nations, the US spends much less on social services and more on health care.
- Individuals with unmet social needs are more likely to be:
  - Frequent ED users,
  - Have repeat “no-show” to medical appointments
  - Have poor glycemic and cholesterol control than those able to meet their needs
Healthy People 2020

- Employment
- Food insecurity
- Poverty
- Housing instability

- Access to health care services
- Availability of primary care
- Availability of resources to meet daily needs
- Transportation options

- Natural environment – green space, weather
- Built environment – side walks, bike lanes
- Crime & Violence
- Quality of housing

- Early childhood education & development
- Quality of education & job training
- Language/literacy
- Higher education

- Social Support
- Public Safety
- Social norms & attitudes
- Exposure to crime, violence & social disorder
- Language/Literacy
- Socioeconomic conditions

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
How Important Are Social Determinants of Health (SDOH)

SDOH as defined by the American Academy of Family Physicians are the conditions which people are born, grow, work and age.

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities
- Education & health literacy
- Family and social support
- Housing and transportation
- Occupation and job security
- Socioeconomic status
- Spiritual/religious values
- Neighborhood safety & recreational facilities
- Linguistic and other communication capabilities
Don’t Reinvent The Wheel
Shared Decision Making – A Standard of Care of All Patients

Shared Decision Making (SDM) is a process of communication in which clinicians and patients work together to make optimal healthcare decisions that align with what matters most to patients. SDM requires three components:

- Clear, accurate and unbiased medical evidence about reasonable alternatives – including no intervention- and the risks and benefits of each;
- Clinical expertise in communicating and tailoring that evidence for individuals patients; and
- Patient values, goals, informed preferences, and concerns, which may include treatment burdens

www.qualityform.org – National Quality Partners Action Brief
I am the Patient
Ask Me
It is complicated but only working together as a collaborative team addressing **ALL** the care needs of the patient & family caregiver can improve this process.
How Well Do You Know Your Patients and their Family Caregivers?

- Do they want the same outcomes as their care team?
- Do we really understand issues for our patient and their family caregiver?
- So we know the specifics of their world?
- Do we care about those specifics or are we tuned to a check list of what needs to be done to meet performance measures and/or get reimbursed?
- Are we focused on the patients’ safety & journey or only on how to prevent a readmission?
- How do we define success?
  - Clinical Indicators
  - Health Status
  - Adherence
  - Cost Containment – Length of Stay, Meets Criteria
Winning Strategies

• Focus on patient-centered care
• Continuous quality improvement
• Effective **Team** practice with financial and performance measure alignment including patient measures
• Commitment to data analytics to inform operational strategies/changes and improve utilization and quality care
• Cultural sensitivity, social determinates and population health focus
• Integrating behavioral health care with primary care
• **Team** leadership and communication

*Never assume, assess, communicate, communicate & communicate*
Q&A and Contact Information

- Cheri Lattimer RN, BSN - Executive Director NTOCC
- Phone: 501-240-4677
- Email: cheri.lattimer@gmail.com