How Safe is the Patient Journey Through the Healthcare Maze?

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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 ?

"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"

- ***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***

Needs

Optimum Health

Gaps

Health Care Policy Shaping Our Strategy

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

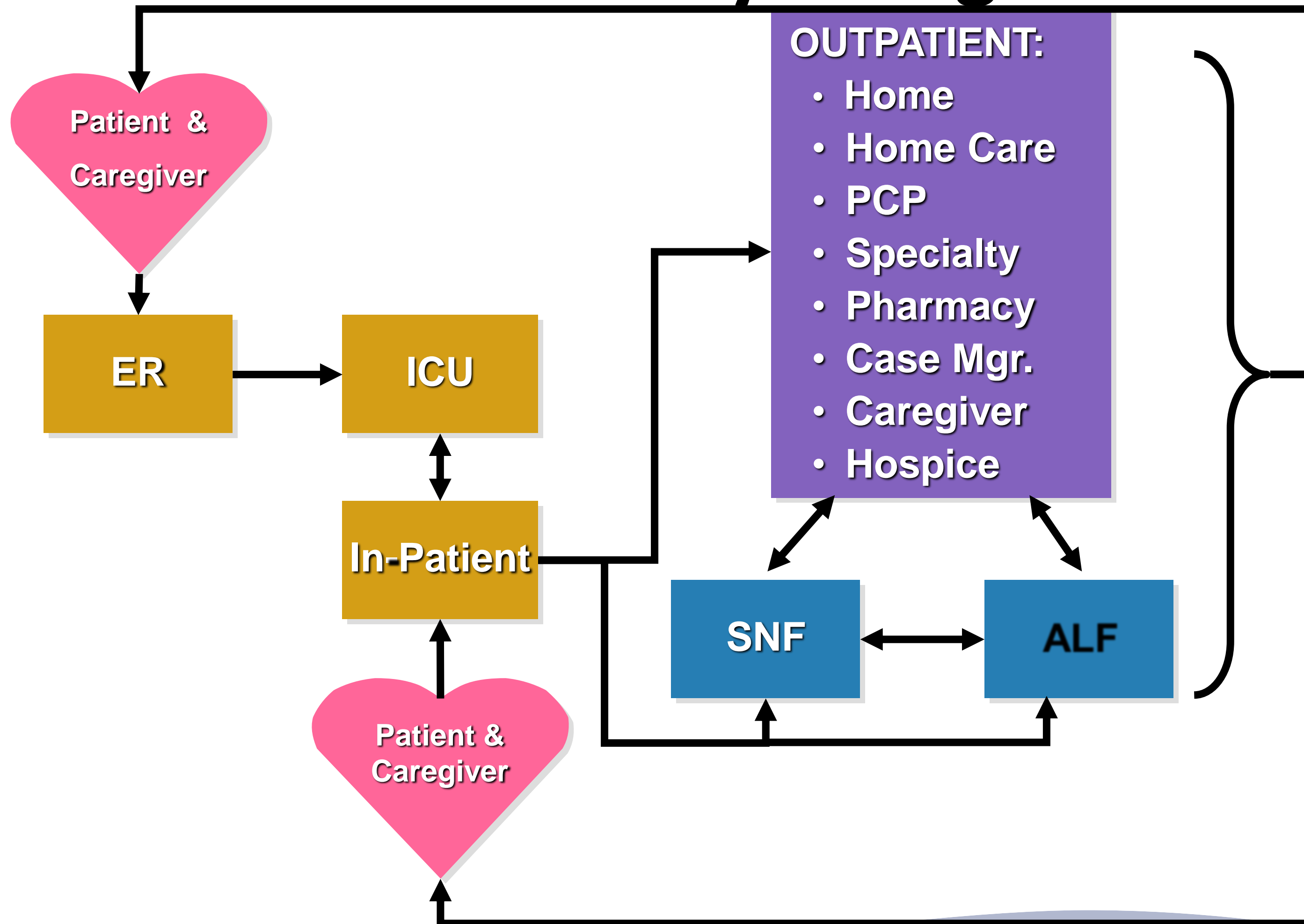
- Patient-Centered Medical Home (PCMH) Primary Care Practices
- Accountable Care Organizations (ACOs)
- Integrated Health Delivery Systems
- Population Health Management
- Comprehensive Primary Care
- Outcomes-Based Reimbursement With Shared Risk
- Value Based Purchasing of Health Care Services

What These New Models Require

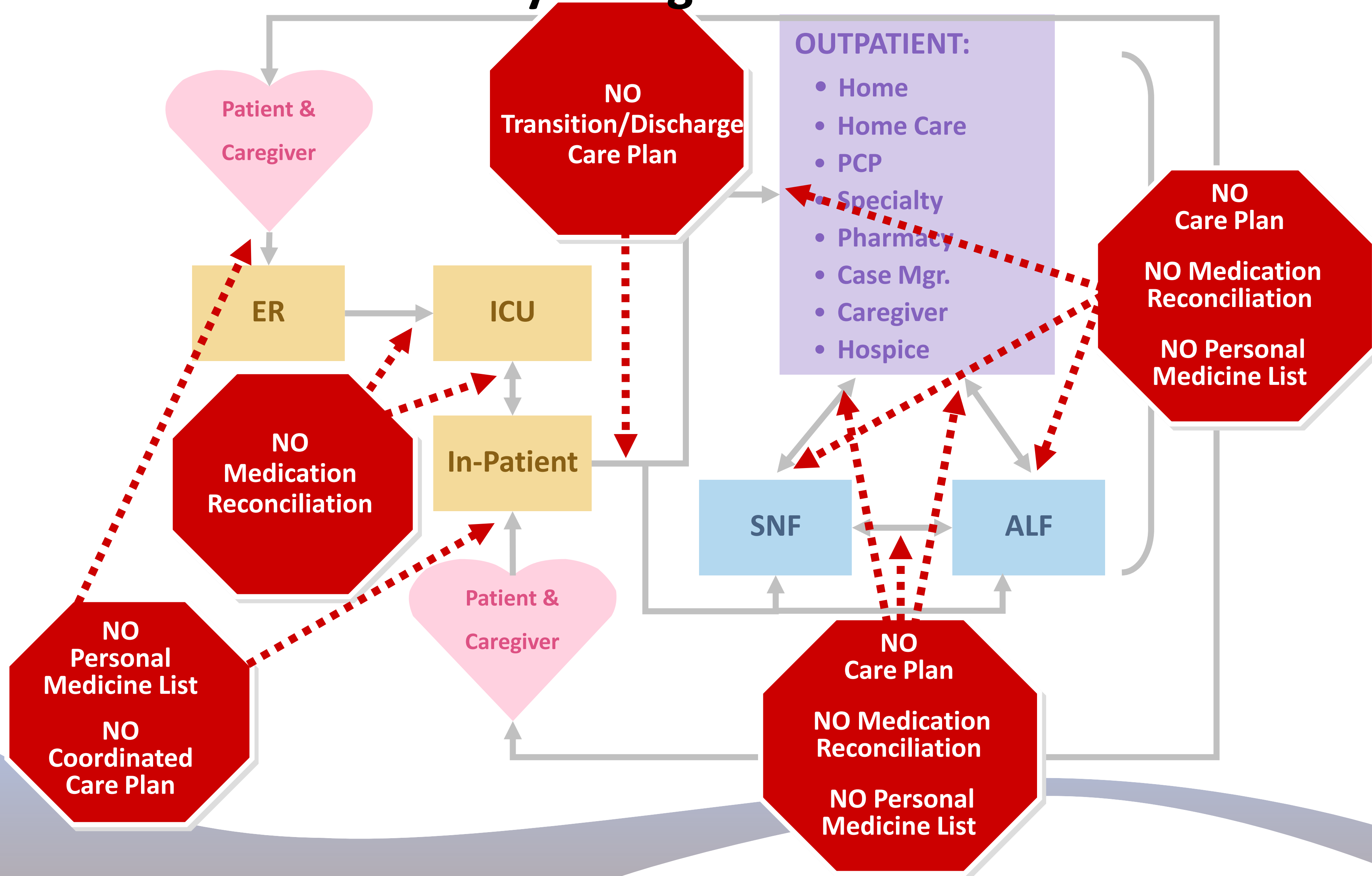
Processes to promote evidence-based medicine, patient engagement, and care coordination, including:

- 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



Transition Issues Dramatically Impact Patients & Their Family Caregivers & Providers



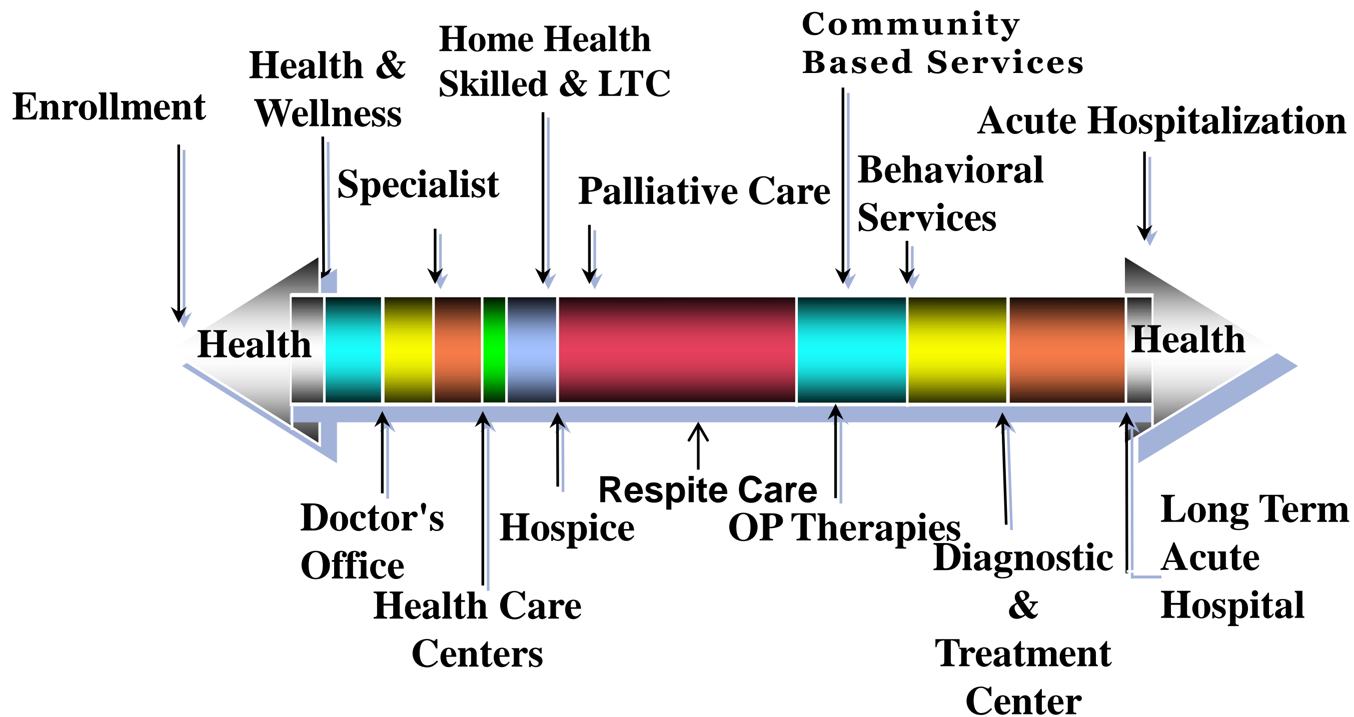
NTOCC's Seven Essential Interventions Categories

1	Medications Management
2	Transition Planning
3	Patient and Family Engagement / Education
4	Healthcare Providers Engagement
5	Follow-Up Care
6	Information Transfer
7	Shared Accountability across Providers and Organizations

http://www.ntocc.org/Toolbox/browse/

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

Conventional	Collaborative
Authoritarian	Collaborative
Autonomous practice culture	Team culture
Physician driven, with physicians accountable for care outcomes	Patient centered, with team members sharing responsibility for care outcomes
Episodic, fragmented	Continuous, coordinated
Primary care delivered in one-size-fits-all, 15-minute visits	Primary care delivered via individualized visits, phone calls, and online communication
Payment based on quantity (fee for service)	Payment based on value (considers both quality and cost)
Reactive, focused on illness	Preventive, focused on health
Communication is inconsistent	Communication is imperative

Source: Robert Wood Johnson Foundation (November 2011). Implementing the IOM Future of Nursing Report—Part II: The Potential of Interprofessional Collaborative Care to Improve Safety and Quality. Accessed at www.rwjf.org/humancapital

Improving Care Coordination Means Improved Communication & Strong Team Collaboration

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

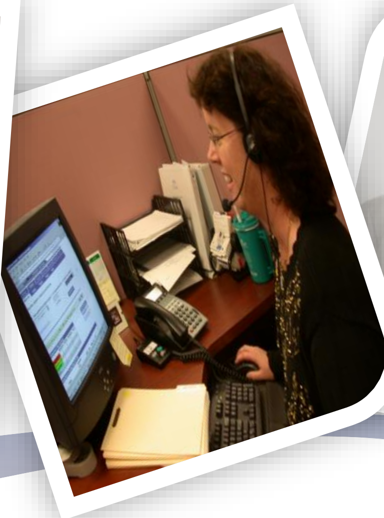
Creating the Collaborative Clinical Team

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

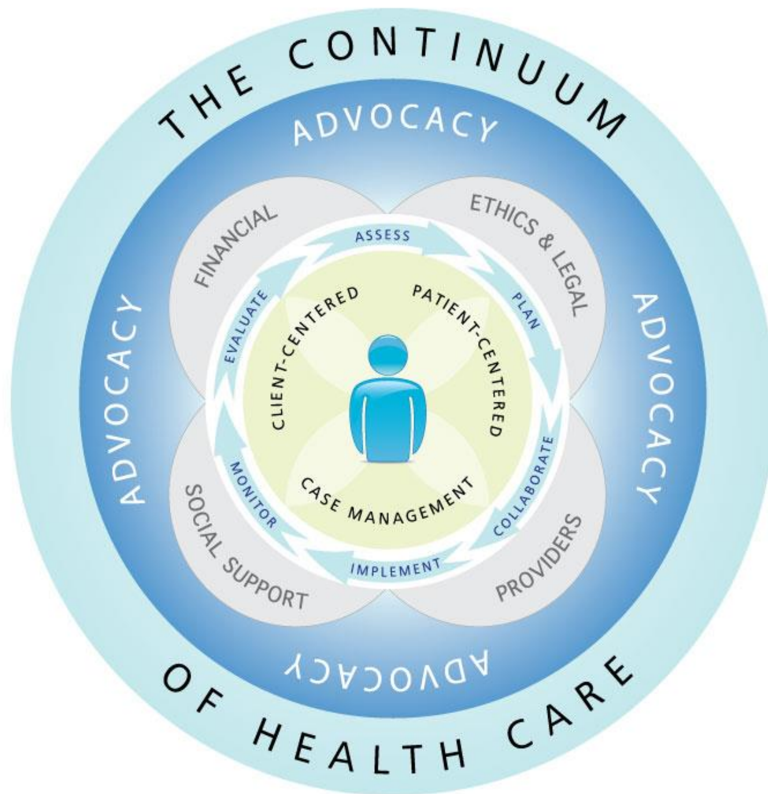
http://www.crystalgraphics.com/

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

www.cmsa.org – CMSA Standards of Practice 2016

Integrated Medical & Behavioral Care Delivery & Coordination

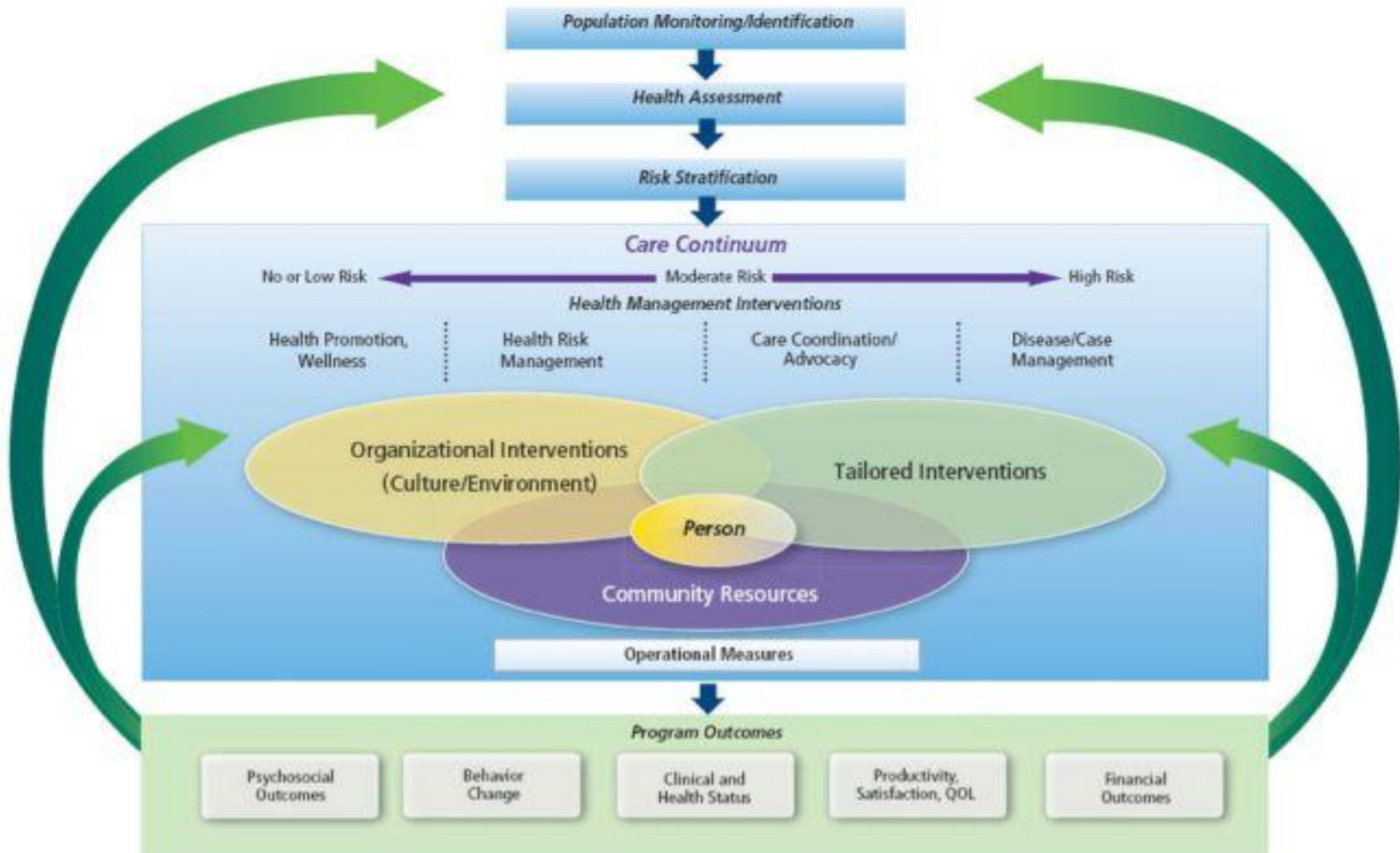
- Psychiatrist-supervised systematic diagnostic assessment with baseline symptom documentation
- Initial agreed upon clinical and functional goals
- First line evidence-based intervention through primary care clinician
- Care management behavioral activation and follow-up with outcome measurement under 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

Case Management Society of America & Cartesian Solutions, Inc.™©

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

Population Health Conceptual Framework



http://www.populationhealthalliance.org/research/understanding-population-health.html

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:

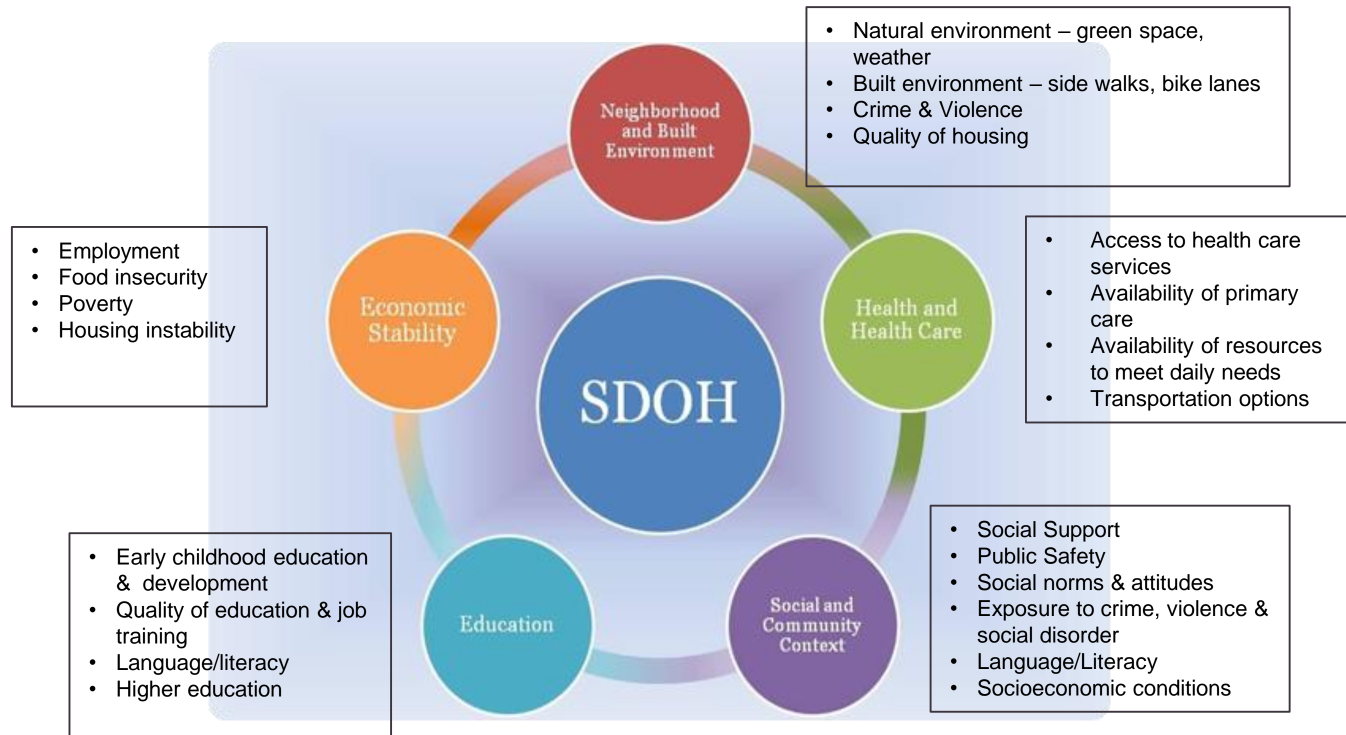
- Clinical Care
- Genes & Biology
- Physical Environment
- Health Behaviors
- Social & Economic Behaviors

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

CHCS Center for Health Care Strategies, Inc Brief October 2017

Healthy People 2020



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

- Employment
- Food insecurity
- Poverty
- Housing instability

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

- 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*

American Academy of Family Physicians, Social Determinants of Health Guides to Social Needs Screening Tool and Resources

Don’t Reinvent The Wheel

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?
   - I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - I have housing today, but I am worried about losing housing in the future
   - I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - Bug infestation
   - Mold
   - Lead paint or pipes
   - Inadequate heat
   - Oven or stove not working
   - No or not working smoke detectors
   - Water leaks
   - None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - Often true
   - Sometimes true
   - Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - Often true
   - Sometimes true
   - Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)
   - Yes, it has kept me from medical appointments or getting medications
   - Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - Yes
   - No
   - Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?
   - Never
   - Rarely
   - Sometimes
   - Fairly often
   - Frequently
8. How often does anyone, including family, insult or talk down to you?
   - Never
   - Rarely
   - Sometimes
   - Fairly often
   - Frequently
9. How often does anyone, including family, threaten you with harm?
   - Never
   - Rarely
   - Sometimes
   - Fairly often
   - Frequently

The EveryONE Project

CMS

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool Important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper, we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

Center for Medicare and Medicaid Innovation

https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools/assessment-action.html#screen

https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

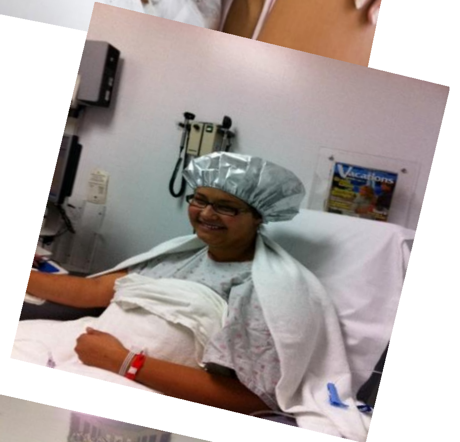
Shared Decision Making – A Standard of Care of All Patients

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

Home Health

LTC

PCP/Medical Home

Community Health Center

Hospital

Health Plan

Specialist

Area Agencies on Aging

Pharmacy

Hospice

Employer

Patient & Caregiver

Adherence

Assessment & Support

Coordination & Care Plan

Advocate

Motivational Interventions

Non-Adherence

Behavior Health Change

Medication Reconciliation

Assessment

Care Plan

Facilitation

Motivational Advocacy

Facilitation

Assessment & Support

Prescription

Assessment & Care Plan

Increase Productivity

Health Promotion

Adherence

Assessment & Support

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

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