Monthly Care Coordinator Webinar: May 22, 2019

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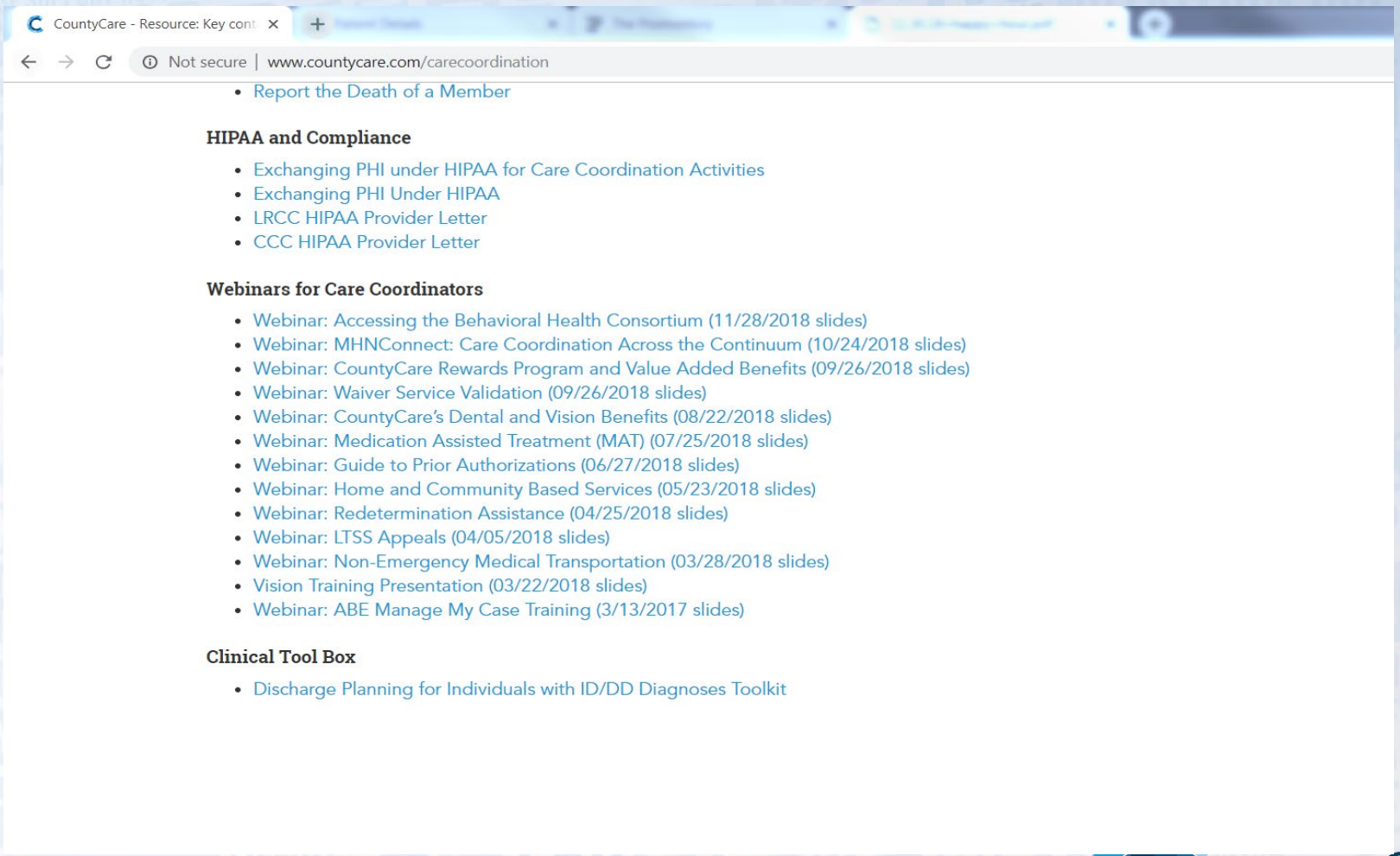
Webinar Agenda

1. NTOCC Presentation
2. HEDIS Spotlight
3. Care Coordinator Thank You Spotlight
4. Questions

Just a reminder…Visit CountyCare Care Coordination Website



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National Transition of Care Coalition (NTOCC)

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Improving Transition of Care Across the Continuum of Care

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

CountyCare's Monthly Care Coordination Webinar
May 22, 2019

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Meeting the Need of the Industry

- Founded on 2006
- Address the issues of poor transitions of care that negatively impact seniors
- Convene experts and apply evidence based clinical practice guidelines
- Mobilize resources to optimize appropriate coordination across all channels & care states
- Develop resources for the industry at no cost plus ensure they are available to all providers, patients and their family caregivers

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NTOCC Becomes a Coalition 2007

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Diverse Organizations and Professionals Advise and Support NTOCC

These groups represent over 200,000 health care professionals, 11,000 employers and 30,000,000 consumers throughout the United States.

NTOCC's Mission & Vision

Mission

NTOCC's mission is to increase awareness about transitions of care among healthcare professionals, government leaders, patients and caregivers and to improve the quality of care, achieve safe and cost effective patient and family centric transitions and enhance clinical outcomes

Vision

The NTOCC Vision is to achieve optimal transitions of care across the healthcare industry in collaboration with patients and families

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NTOCC Priorities

Ensuring Focus on Transitions of Care & Care Coordination Improvement

- *Acute Care Readmissions*
- *Post-Acute Care*
- *Behavioral Health*
- *Chronic Care Management*
- *Opioid Abuse & Misuse*

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Health Care Needed A Transformation

The Current Process Is Not Working

The Vision

"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"

Critical Business Issues ?

- *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

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Health Care Policy Brings Innovation, Creativity, & Opportunity

New Models of Healthcare Delivery and Reimbursement

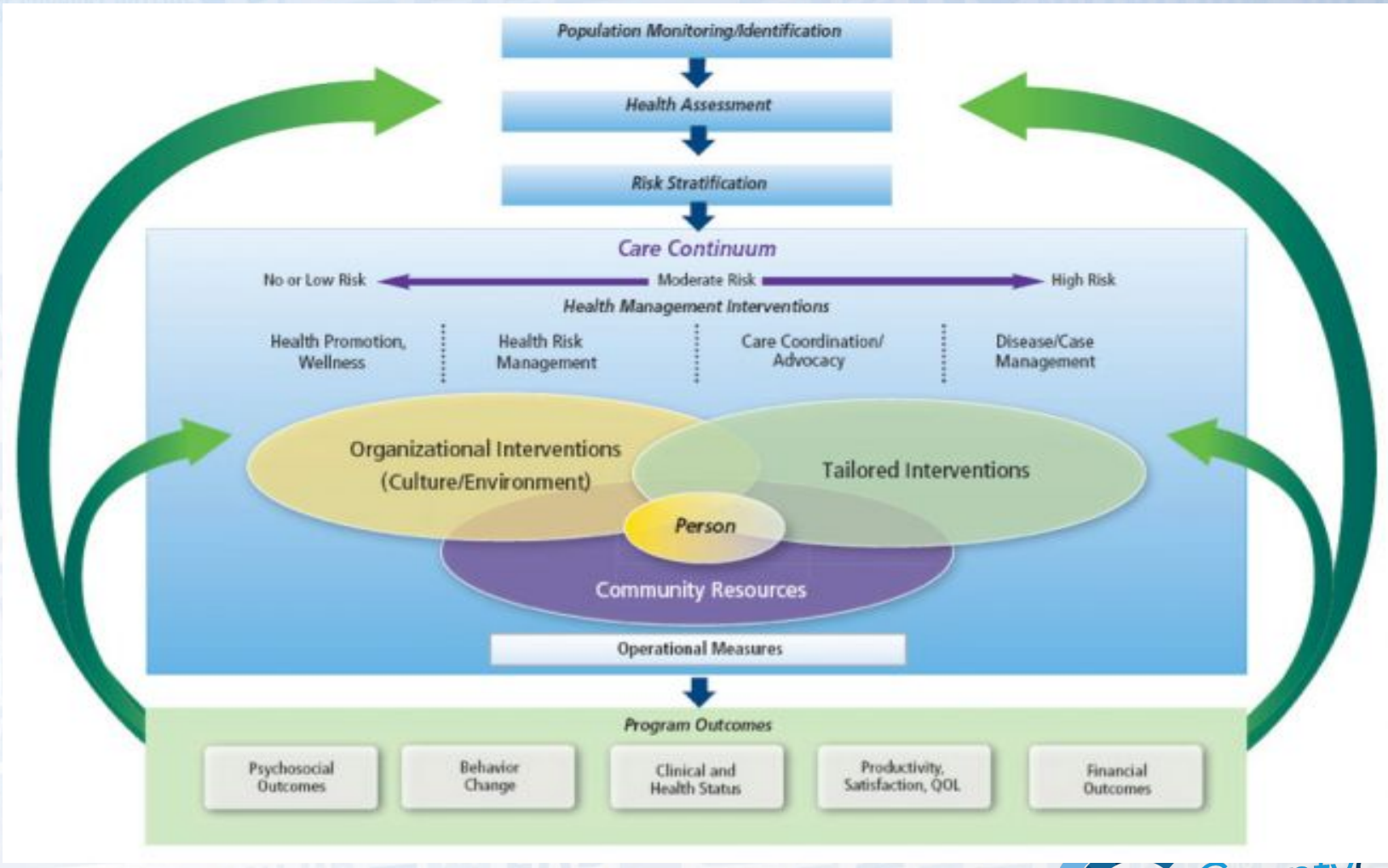
- Patient-Centered Medical Home (PCMH) Primary Care Practices
- Accountable Care Organizations (ACOs)
- Integrated Health Delivery Systems
- Population Health Management
- **Comprehensive Primary Care**
- Outcomes-Based Reimbursement With Shared Risk
- Value Based Purchasing of Health Care Services

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

Population Health Conceptual Framework



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

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

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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

Financial Concerns over Poor Care Transitions

Hospital readmissions within 30 days after discharge are estimated to account for more than $17 billion in avoidable Medicare expenditures.

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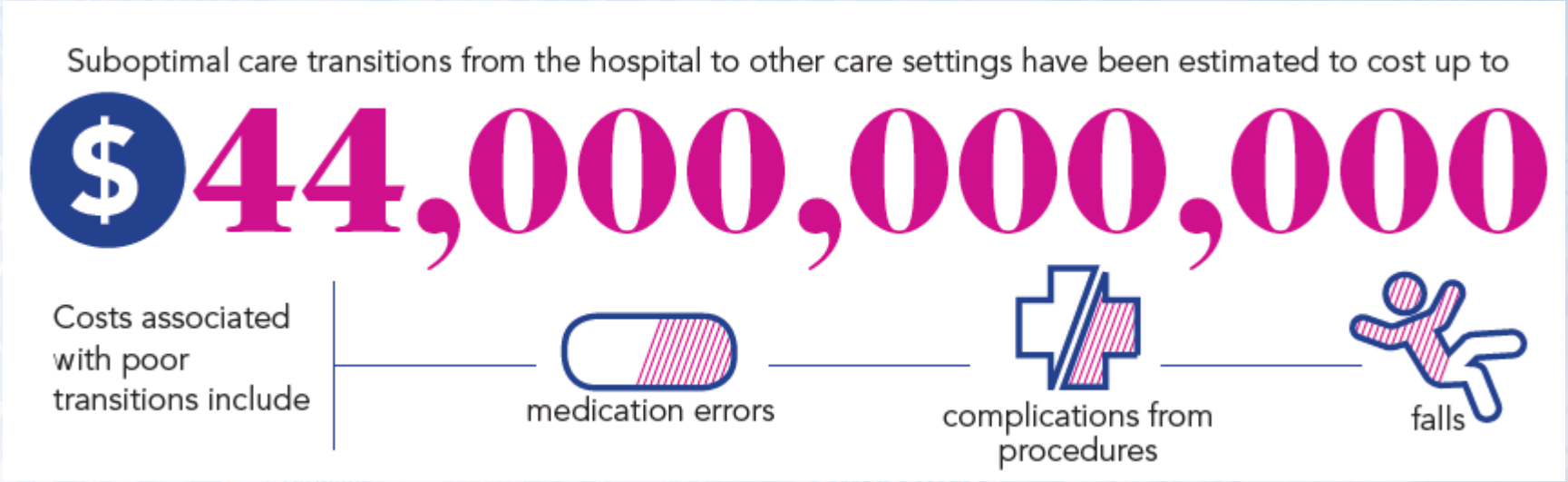
https://www.lacunahealth.com/care-management

Financial Costs of Poor Transitions



New payment models – such as bundled payments and shared savings programs for Accountable Care Organizations – create financial incentives for providers to coordinate transitions and provide care in less intensive settings.

https://www.lacunahealth.com/care-management

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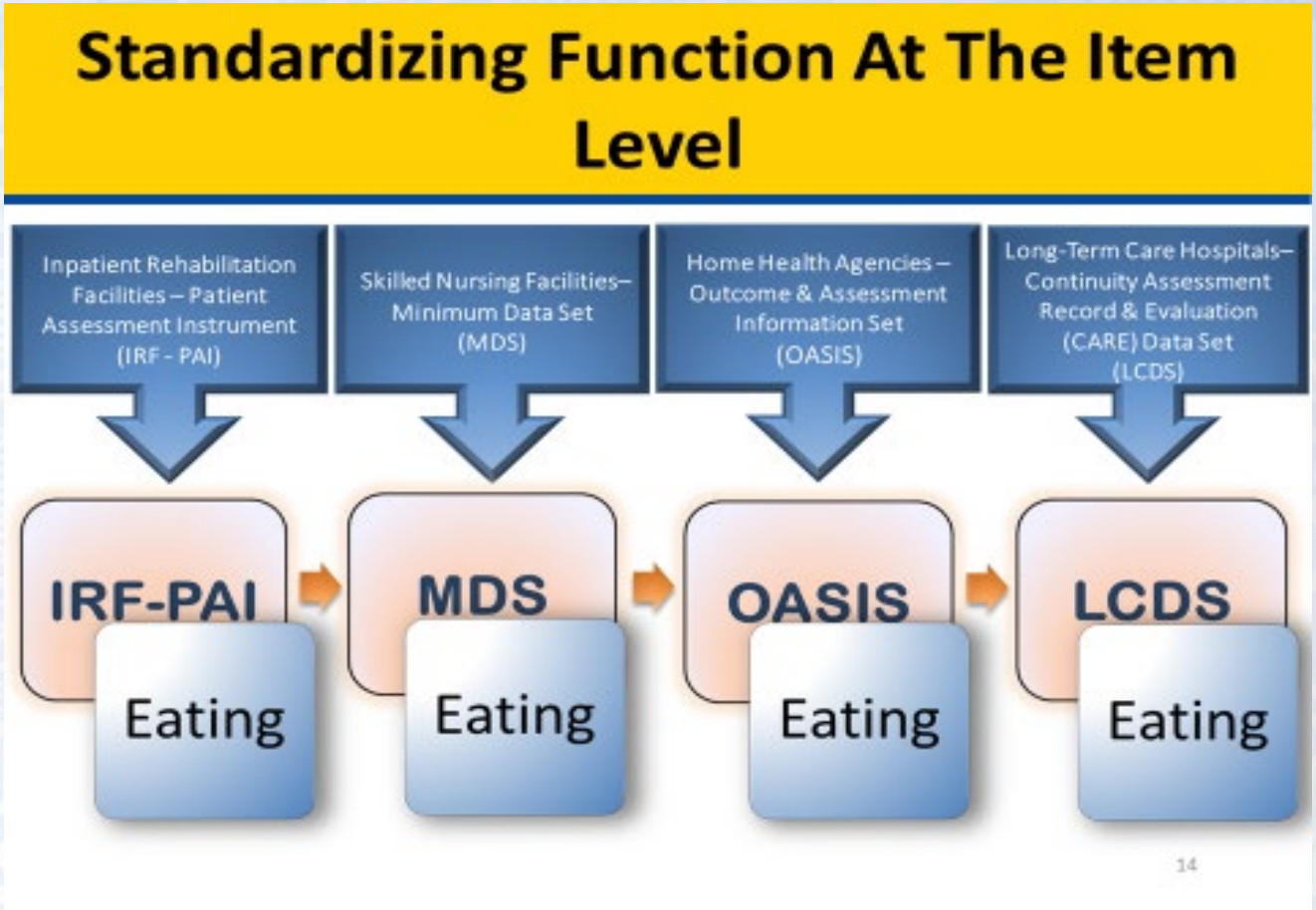
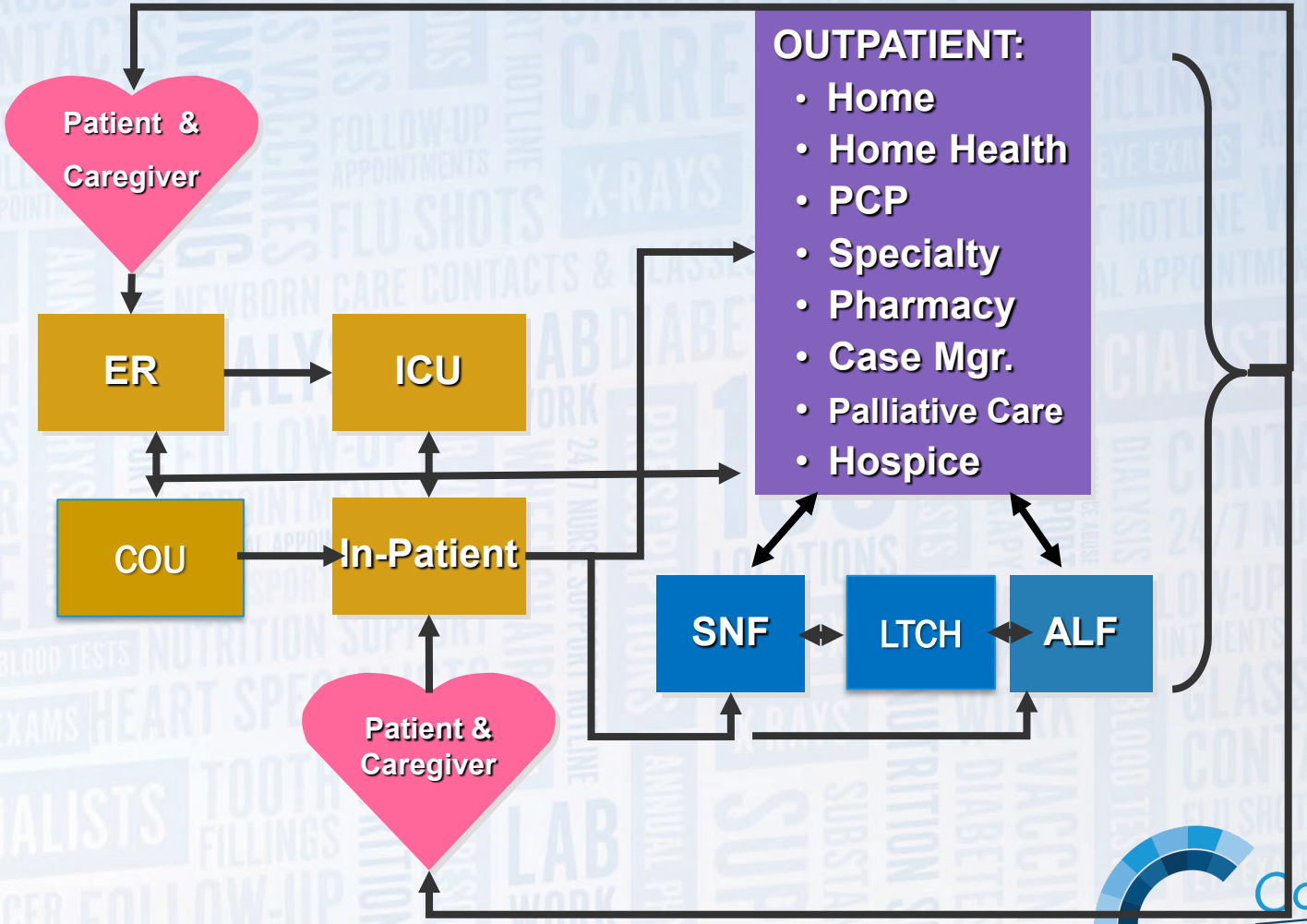
IMPACT – Standardization of Assessment Data



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/-IMPACT-Act-Standardized-Patient-Assessment-Data-Elements.html

Transition Issues Dramatically Impact Patients & Their Family Caregivers



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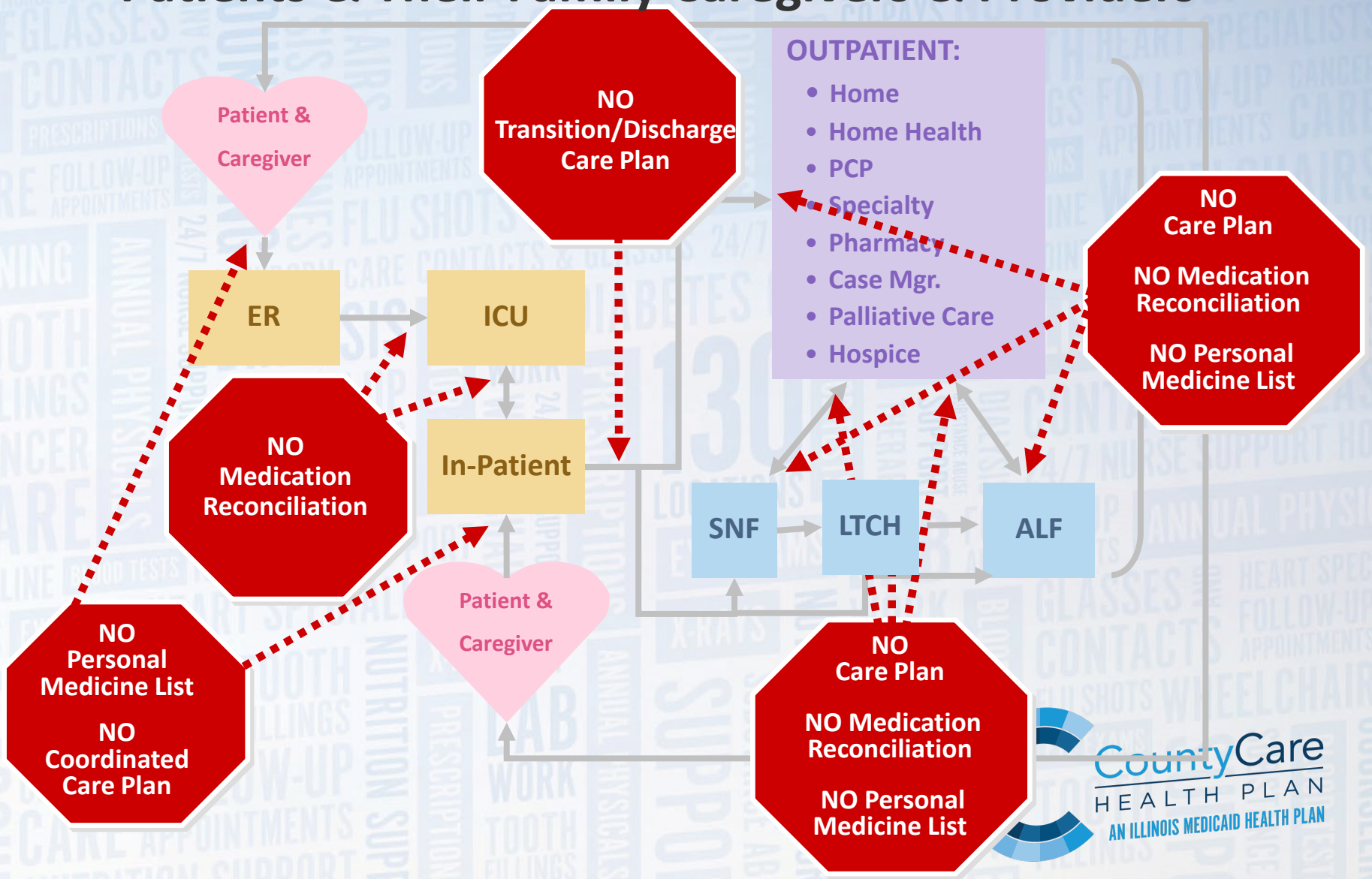
Transition Issues Dramatically Impact Patients & Their Family Caregivers & Providers



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/

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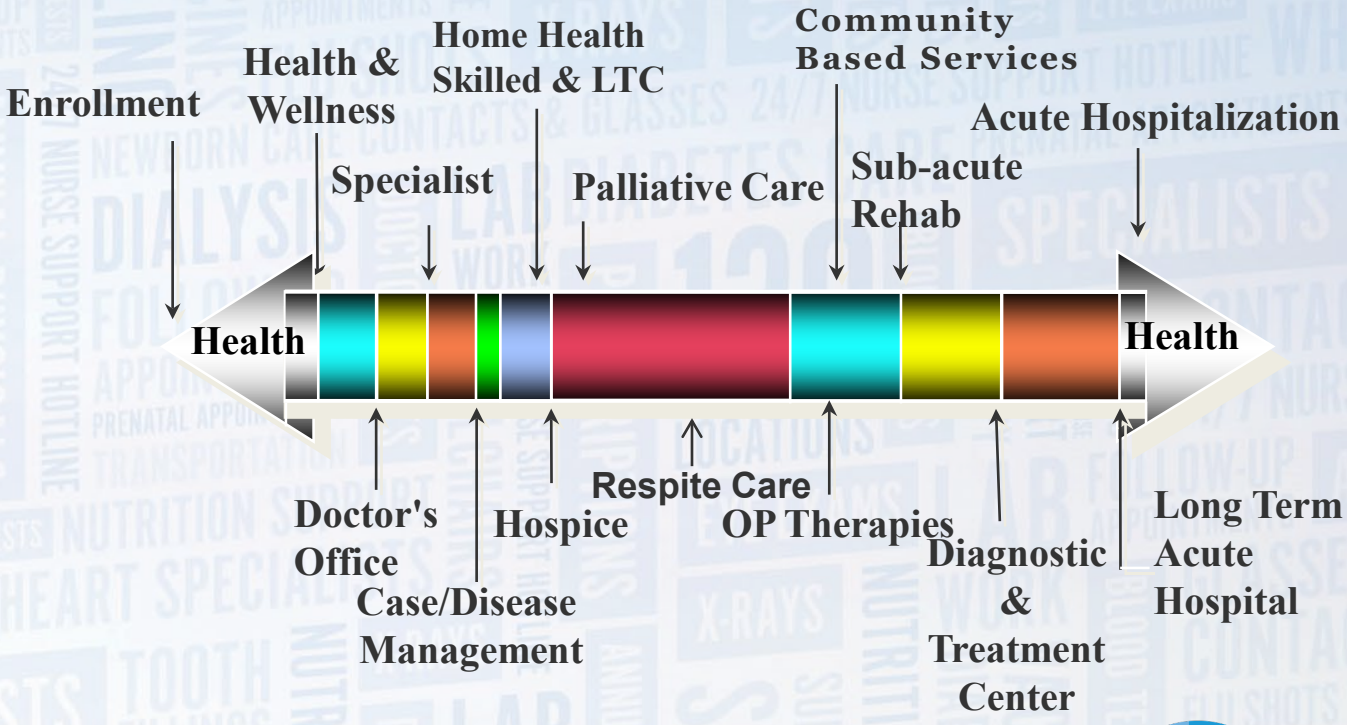
Continuum of Care & Spectrum of Services

How will you coordinate care beyond your service?



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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*

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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/

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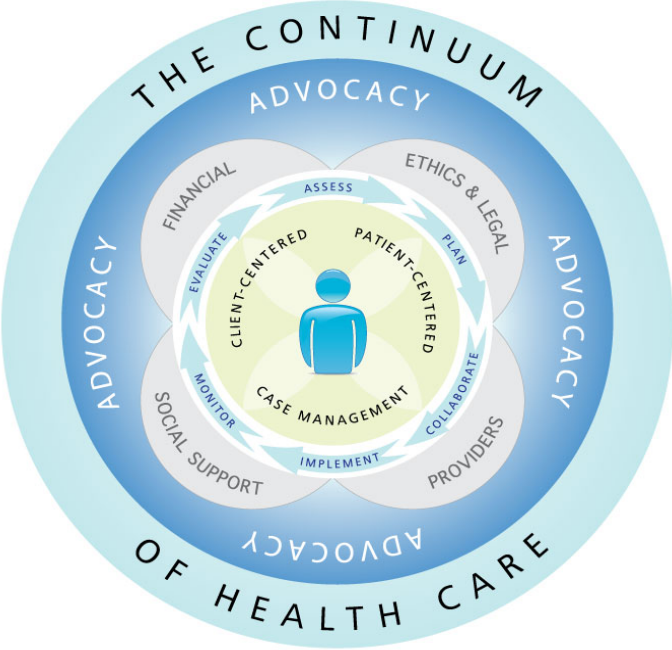
Role of the Professional Case/Care Manager

- A complete assessment of Medical, Behavioral, Social and Health system issues and concerns
- Patient and family advocacy identifying and supporting patient preference
- Defining and improving educational & knowledge deficits
- Development of a plan of care that supports the patient and family in working with their care team, including SDOH
- Collaboration with the pharmacist in developing the patients medication lists and understanding the medication regime
- Assisting the patient and family in recognizing “red flags” for symptom escalation
- Enhancing care coordination and access to care options
- Communication, motivational support, health coaching and clarification of miscommunication



www.cmsa.org – CMSA Standards of Practice 2016

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Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

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Innovative Health Information Technology

- Technology Enabled Transitions
- Using data analytics and the EHR to shift from event based treatment to continuity of care
- Standardization of patient assessment data
- 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
- Telehealth, remote health visits, & health wearables/monitoring
- 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

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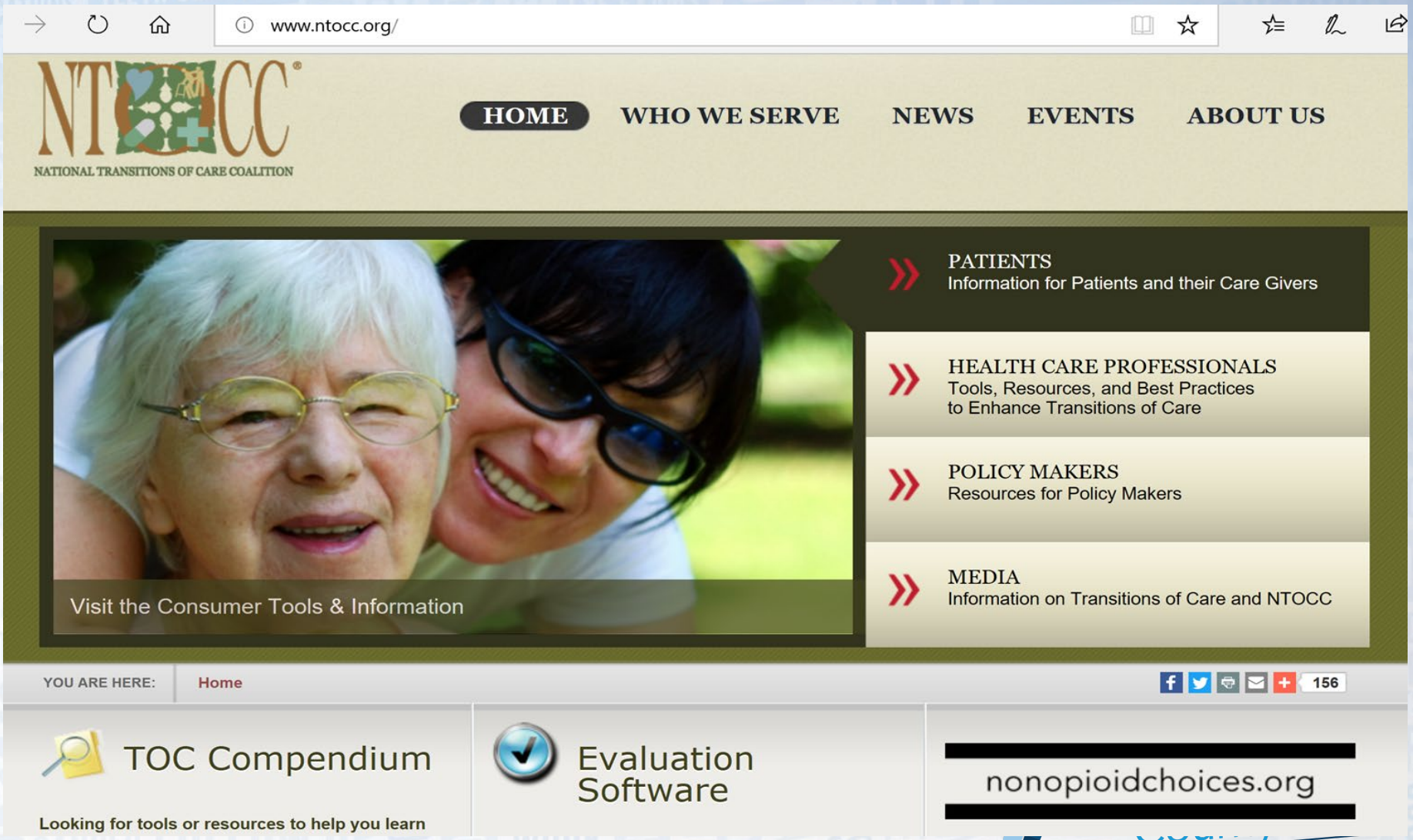
NATIONAL TRANSITIONS OF CARE COALITION

Resources & Support for Improving Transitions of Care

NTOCC.org



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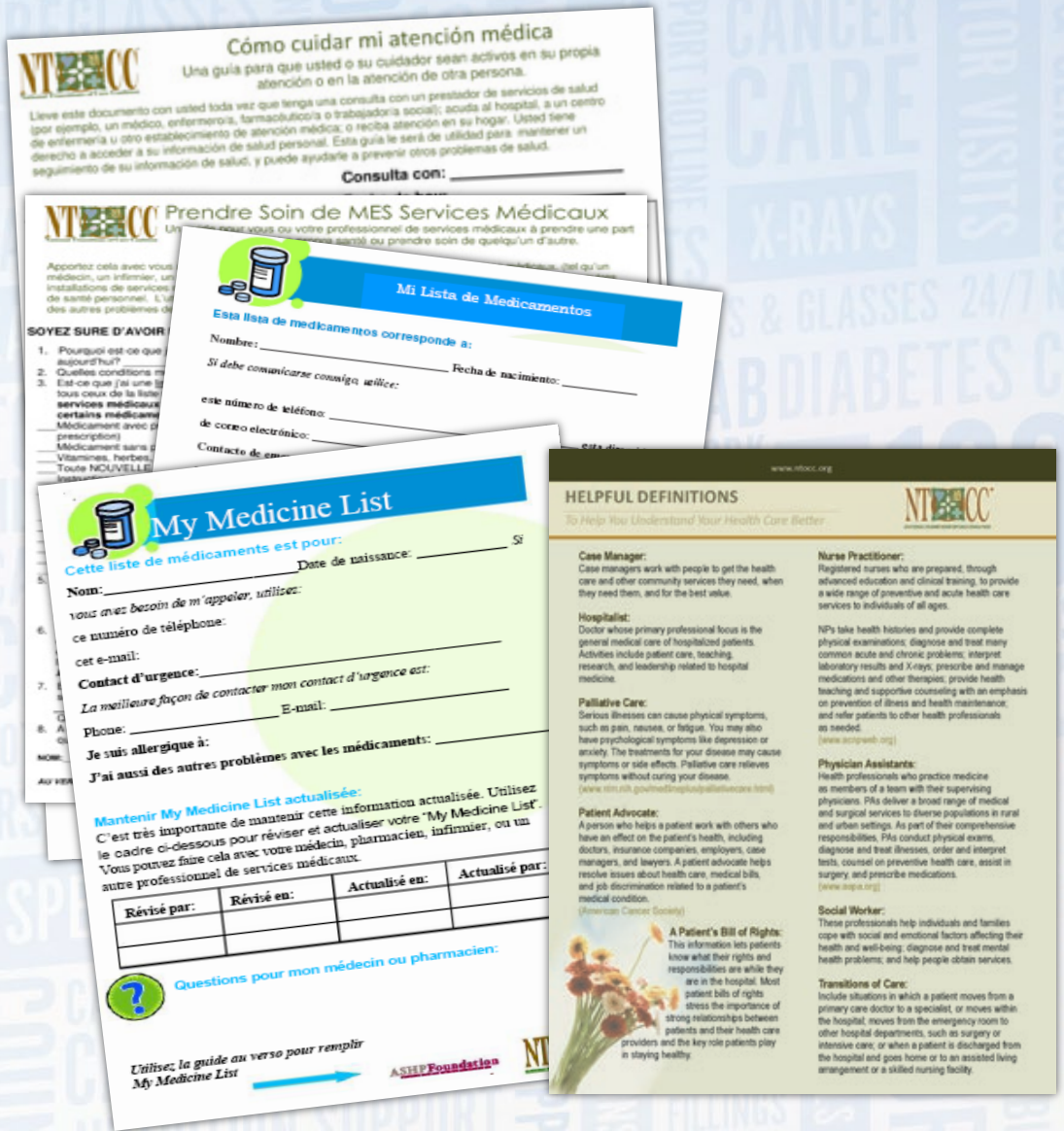
NTOCC Provides Tools & Resources for Patient and Family Caregivers



Tool Highlights

- Guidelines for a Hospital Stay with Helpful Definitions
  For Patient, Family, & Caregiver
- Taking Care of MY Health Care
  Français & Español
- My Medicine List
  Français & Español
- Patient TOC Bill of Rights

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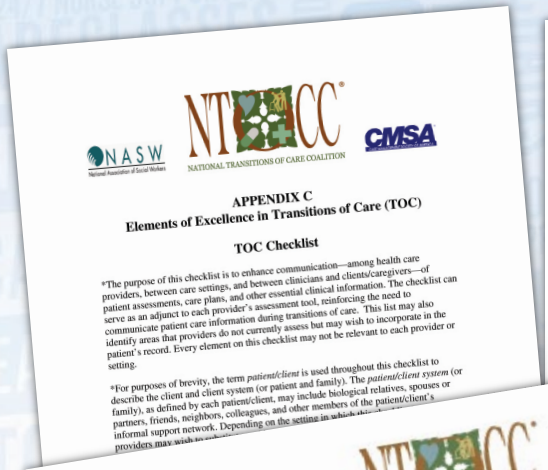
Additional NTOCC Tools, Resources, and Education for Providers



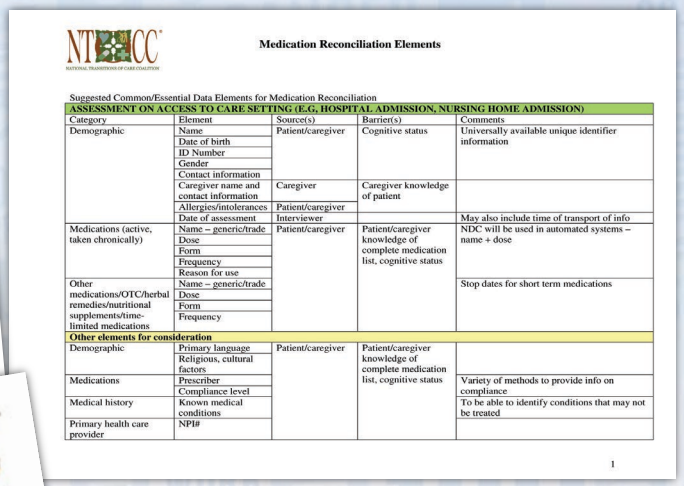
NASW · NTOCC National Transitions of Care Coalition · CMSA

APPENDIX C
Elements of Excellence in Transitions of Care (TOC)

TOC Checklist

*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. Every element on this checklist may not be relevant to each provider or setting.

*For purposes of brevity, the term *patient/client* is used throughout this checklist to describe the client and client system (or patient and family). The *patient/client system* (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client's informal support network. Depending on the setting in which this [illegible] providers may wish to [illegible]



NTOCC National Transitions of Care Coalition

Medication Reconciliation Elements

Suggested Common/Essential Data Elements for Medication Reconciliation

ASSESSMENT ON ACCESS TO CARE SETTING (E.G. HOSPITAL ADMISSION, NURSING HOME ADMISSION)				
Category	Element	Source(s)	Barrier(s)	Comments
Demographic	Name	Patient/caregiver	Cognitive status	Universally available unique identifier information
	Date of birth			
	ID Number			
	Gender			
	Contact information			
	Caregiver name and contact information	Caregiver	Caregiver knowledge of patient	
	Allergies/intolerances	Patient/caregiver		
	Date of assessment	Interviewer		May also include time of transport of info
Medications (active, taken chronically)	Name – generic/trade	Patient/caregiver	Patient/caregiver knowledge of complete medication list, cognitive status	NDC will be used in automated systems – name + dose
	Dose			
	Form			
	Frequency			
	Reason for use			
Other medications/OTC/herbal remedies/nutritional supplements/time-limited medications	Name – generic/trade			Stop dates for short term medications
	Dose			
	Form			
	Frequency			
Other elements for consideration				
Demographic	Primary language	Patient/caregiver	Patient/caregiver knowledge of complete medication list, cognitive status	
	Religious, cultural factors			
Medications	Prescriber			Variety of methods to provide info on compliance
	Compliance level			
Medical history	Known medical conditions			To be able to identify conditions that may not be treated
Primary health care provider	NPI#			

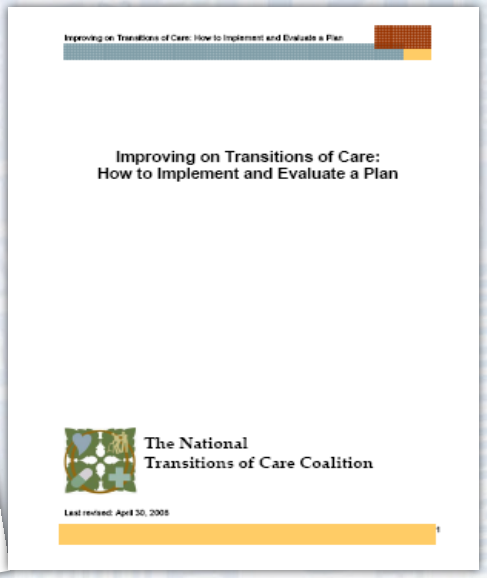
1

NTOCC National Transitions of Care Coalition

Transitions of Care Measures

Paper by the NTOCC Measures Work Group, 2008

www.ntocc.org



Improving on Transitions of Care: How to Implement and Evaluate a Plan

Improving on Transitions of Care:
How to Implement and Evaluate a Plan

The National Transitions of Care Coalition

Last revised: April 30, 2008

NTOCC National Transitions of Care Coalition

Improving Transitions of Care

THE VISION OF THE NATIONAL TRANSITIONS OF CARE COALITION

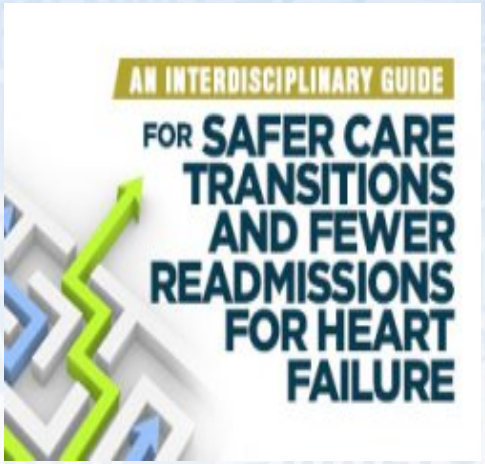
MAY 2008

NTOCC/PRIME Transitions of Care Pathways for Rare Respiratory Diseases

- 2 CE-accredited Pathways released in 2016, focusing on transitions of care for patients with
  - Pulmonary arterial hypertension (PAH)
  - Idiopathic pulmonary fibrosis (IPF)
- Provide disease-specific tools and resources for the interdisciplinary teams
- Available at primeinc.org/toc

CE = continuing education.

Heart Failure TOC Pathway



2.0 hours of ACCME, ACPE, ANCC, and CCMC credit

Developed in partnership with the NTOCC and led by a multidisciplinary advisory board, this Heart Failure Transitions of Care pathway provides essential interventions and tools to support system leaders and the interprofessional care team – including patients and their caregivers - in incorporating the latest evidence-based treatment and management approaches to ensure effective and safe transitions of care for patients with heart failure across healthcare settings.

Available At:

primeinc.org/toc

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Partnerships Addressing The Issues Related Opioid Use

- **Voices for Non-Opioid Choices** – addressing access for patients to non-opioid therapies and financial payment for non-opioid therapies
  - NTOCC has partnered with Pacira, Venn Strategies and multiple associations building educational information and resources
  - Several DC fly-ins meeting with legislatures and regulators discussing the issues at hand and alternative options
- **Allied Against Opioid Abuse** – AAoA - a partner-based initiative to provide education and awareness to prevent abuse and misuse of prescription opioids
  - Developing educational resources and promoting their availability to consumers, pharmacists, healthcare professionals and other stakeholders
  - Identifying opportunities to educate pharmacists and providers to help reduce misuse and abuse of prescription opioids among patients
  - Educating consumers via point-of-sale pharmacy materials

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Additional Resources

- IMPACT Newsletter
- Published Quarterly
- Address “Best Practices” in support of transitions of care (TOC)
- Discusses public policy issues that impact TOC
- Lists upcoming events
- Easy access by signing up as a subscriber

- Policy Alerts
- Newly Introduced Bills addressing TOC & Care Coordination (CC)
- New TOC or CC legislation
- Regulatory Changes or Implementation
- All subscribers receive the alerts

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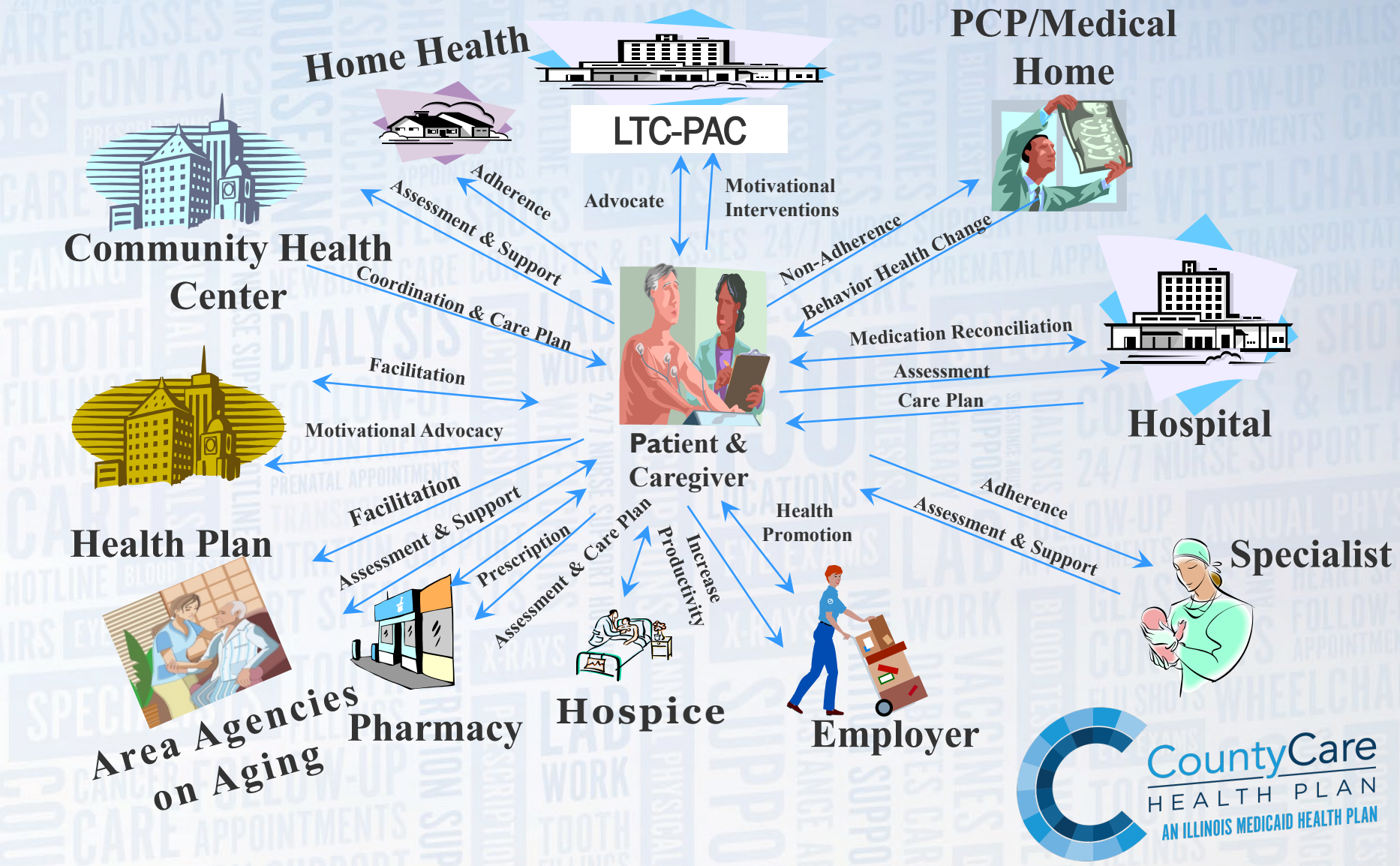
It is Complicated but Only Working Together as a Collaborative Team Addressing the Care Needs of the Patient & Family Caregiver Can Improve This Process



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
- Cultural sensitivity, social determinates and population health focus
- Transitions of care and care coordination at imperative and every level of care
- Integrating behavioral health care with primary care
- ***Team*** leadership and communication

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Transitions Of Care & Care Coordination Resources

- CAN – Caregiver Action Network- Family Caregiving Resources – www.caregiveraction.org
- CAPS - Consumers Advancing Patient Safety – Toolkits www.patientsafety.org
- NTOCC - National Transitions of Care Coalition – Provider & Consumer Tools www.ntocc.org
- CMSA - Case Management Society of America – CM Medication Adherence Guidelines & Disease Specific Adherence Guidelines, CMSA Standards of Practice – CKP - www.cmsa.org
- ICM – Integrated Case Management - http://www.cmsa.org/Individual/NewsEvents/IntegratedHealthManagementTraining/tabid/380/Default.aspx
- AMDA's (Dedicated to Long Term Care Medicine™) Transitions of Care in the Long Term Care Continuum practice guideline - http://www.amda.com/tools/clinical/TOCCPG/index.html
- ACC and IHI – Hospital to Home – Reducing Readmissions, Improving Transitions - http://www.h2hquality.org/
- AHRQ – Agency for Healthcare Research and Quality - Questions Are The Answers – www.ahrq.org
- NASW – National Association for Social Workers - http://www.socialworkers.org/Resources
- VNAA Blue Print for Excellence – www.vnaablueprint.org

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Contact Information

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Email: cheri.lattimer@gmail.com

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HEDIS Measures

Breast Cancer Screening (BCS)

Laurel Chadde
Performance Improvement
Project Analyst, CountyCare

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BCS HEDIS Measure Definition

- The percentage of women 50–74 years of age who had a mammogram performed between October 1, 2017 and December 31, 2019 to screen for breast cancer
- Women 52-74 years of age as of December 31, 2019 with continuous enrollment October 1, 2017 through December 31, 2019
- Exclusions:
  - Members with bilateral mastectomy or two unilateral mastectomies
  - Members 66 years of age and older as of December 31, 2019 with frailty and advanced illness during the 2019

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BCS Performance by CME

	HY2019/CY2018 Rate	HY2020/CY2019 Rate*	Percentile			
			50th	60th	75th	Target 80th
CME A	60.6%	51.3%	58%	61%	64%	66%
CME B	61.6%	48.5%				
CME C	56%	46.2%				
CME D	64.4%	55%				
CountyCare Overall	64.3%	51.2%				

*YTD claims and eligibility data through 5/14/2019

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Member Barriers to BCS

- Last year CountyCare surveyed members on barriers to BCS. Top barriers identified:
  1. Do not have any symptoms, so do not believe I need a mammogram
  2. Transportation
  3. Other health priorities
  4. I have never been told I needed screening
  5. Fear of pain or danger caused by procedure
- Key takeaways:
  - Transportation
  - Education

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How can care coordinators help?

- Utilize care gap lists from Vision to identify patients in need of a mammogram
- Conduct member outreach and schedule the member for a PCP appointment, instruct the member to ask for a mammogram order
- Reference the mammography locations throughout Cook County list
  - http://www.countycare.com/Media/Default/pdf/CCR_0135_Mammography_Locations-030519.pdf
- Assist members with using the CountyCare transportation benefits
- Motivate members with the CountyCare Rewards Program incentive
  - Members 40-74 years will earn $25 when they get their mammogram
- Educate members about the importance of getting a mammogram and debunk misconceptions about the procedure

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Thank You
Spotlight
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Thank You!

Angela Violante, Nurse Care Coordinator, on her assistance with prompt facilitation of my member's HEAL application, who's Electricity was shut off.

If you have a care coordinator you want to give a special Thank you, Please email them to **Lanisha.Thadison@cookcountyhhs.org**

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Questions?
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We need your Feedback!

- Please take a short moment to complete the evaluation poll.
- Interested in a particular topic? Would you like to see it presented during this webinar?
- Please email your ideas to Lanisha.Thadison@cookcountyhhs.org

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Thank You!
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