Using community collaborative care planning to support interventions of for high-risk MAPs

MAP Program

December 15, 2022

EQIC

EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

This material was prepared by the Healthcare Association of New York State, Inc., a Hospital Quality Improvement Contractor under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/EQIC/HQIC-0100-12/05/22

Today's faculty

Brenda Chapman BS, RNC,
Program Manager,
Eastern US Quality
Improvement Collaborative,
Health Association of New
York State

Maria Sacco, RRT, CPHQ
Director, Quality
Advocacy, Research and
Innovation, Healthcare
Association of New York
State

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Today's speakers: Nuvance Health

Rowena Bergmans
Vice President
Strategic Payer and Community Partnerships for Nuvance Health

Ali Hussain, MBA
High Risk Navigator
Nuvance Health

Kevin McVeigh
Manager
Nuvance Health

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Agenda

- Nuvance Health presentation
- Next steps

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Multiple-admission Patient
Program Framework

STEP 1: Design your MAP program

- Create an internal multidisciplinary team
- Identify and invite community-based organizations to collaborate with your team
- Define program goals and measures
- Evaluate and adopt MAP program tools and resources
- Develop staff education for the MAP program

STEP 2: Identify patients that meet MAP program criteria

- Develop data sources for reports
- Review and determine eligible patients
- Develop EMR notifications
- Create a plan for healthcare team communication

STEP 3: Assess readmission risk

- Evaluate readmission risk using a standard assessment tool
- Gather information from patient and care partner
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

STEP 4: Customize interventions

- Create an individualized plan for each patient
- Coordinate a discharge plan with the MAP program team
- Engage emergency department staff in MAP program
- Ensure follow-up communication with post-discharge provider(s) occurs
- Provide post-discharge support and follow up

HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP

This material was prepared by the Healthcare Association of New York State, Inc., a Hospital Quality Improvement Contractor under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/EQIC/HQIC-0075-06/02/22

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Community Care Team

EQIC Presentation

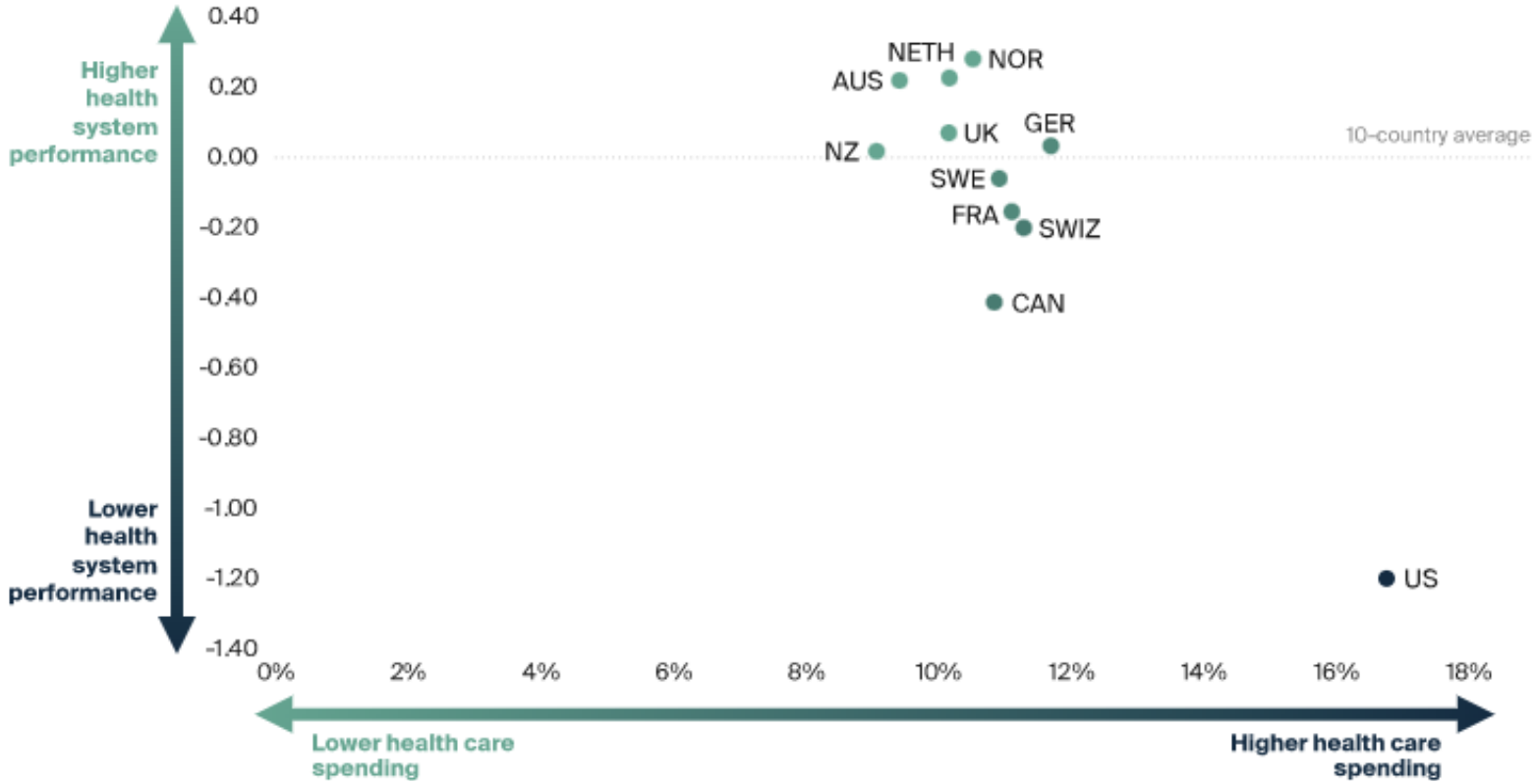
December 15, 2022

Nuvance Health™

Today's Agenda

1. Background, the problem we are solving for
1. What is a Community Care Team (CCT) and how does it function?
3. Outcomes

Health Care in the U.S. Compared to Other High-Income Countries

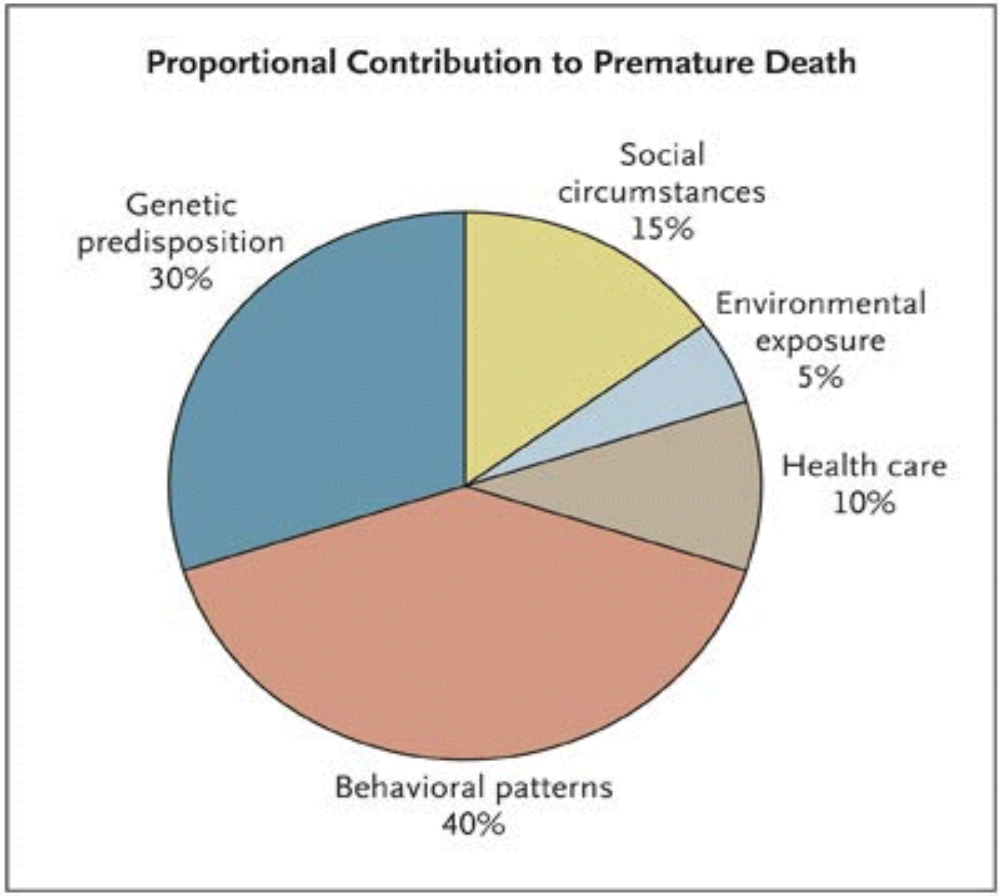


Note: To normalize performance scores across countries, each score is the calculated standard deviation from a 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Commonwealth Fund analysis.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

Drivers of Health Status



Schroeder, S.A., *"We can do better – Improving the Health of the American People*, NEJM. 2007.

Scope of the Problem

Fragmented system

- *Poor coordination of services*
- *Disconnect between the Hospital and Community*

+

Limited Definition of Health

- *Social Determinants impact the health and well being of patients and how frequently they come to the hospital*

+

Inadequate Resources for Social and Behavioral Determinants of Health

- *Overuse of acute services*
- *Underuse of preventive services*

= ***Poor Outcomes, Wasted Resources, Unsustainable Finances***

What is a Community Care Team?

Group of invested stakeholders who collaborate to provide patient-centered care navigation for vulnerable populations

Goal of improving outcomes by connecting to wrap-around services through multi-agency partnership

Share the belief that community collaboration is fundamental to improving health outcomes for vulnerable populations

Review of Baseline Data

Norwalk Hospital - 2013

One year, top 40 ED visitors

1376 visits

Average annual = 34 visits

Danbury Hospital - 2014

Six or more visits in 6 months

262 patients with total of 2945 visits

Average annual = 22 visits

Vassar Brothers Medical Center

15 or more ED visits in one year

FY19 – 74 individuals with 1988 visits

- Average annual = 27 visits

FY20 – 62 individuals with 1851 visits

- Average annual = 30 visits

CCT Populations

Legacy population characteristics

- 36% female; 64% Male
- 50% White; 30% Black; 20% Hispanic or Other
- 20% Homeless; (85% have history of unstable housing or homelessness)
- 60% have substance misuse; 37% alcohol misuse
- 55% have a mental health diagnosis
- 65% have at least one chronic disease
- >25% have no PCP; 73% have no behavioral health provider
- 95% are Medicaid, Medicare or self-pay

How does the CCT Operate?

1. Identify target population
   - Homeless or Emergency Department Frequent Utilization

2. Obtain consent for release of information

3. Research the individual's history and identify needs:
   - Mental health, medical, substance, housing, legal, insurance

4. Present to the team and develop individualized Care Plan:
   - Need for treatment, housing, insurance, social support, linkage to medical/mental health treatment

5. Implement plan: Community outreach or in ED

6. Revise and update plan depending on need

Individualized Care Plan

History:

- Reason for presentations
- Medical, psychiatric, substance use, social determinants

Needs assessment:

- Acute treatment, housing, insurance, linkage to primary care or specialty services, wrap-around social services

Specific recommendations:

- Medications to use or to avoid
- Contacts to notify
- Navigate to referral: primary care, addiction treatment, housing, psychiatric, social services

Community Partners: Norwalk/Danbury

Ability Beyond
Assn. for Religious Comm.
Catholic Charities
CHN, Connecticut
Continuum of Care Inc
Danbury Housing Authority
Danbury Shelter
Dorothy Day Hospitality Hs
Good Samaritan Mission
Homes with Hope
MCCA
Norwalk Board of Education
Norwalk Housing Authority
Open Door Shelter
Public Defenders Office
St Vincent's Health Services
State of CT, DMHAS
Triangle Community Center
Westport Human Services

AIDS Project
Behavioral Health Partnership
City Center of Danbury
Connecticut Counseling Ctr
Danbury HHS, Emergency Shltr
Danbury Housing Partnership
Day Street Clinic
Dubois Center
Greater Danbury CHC
Keystone House
Mental Health Connecticut
NCHC
Norwalk Police Department
Opening Doors, Fairfield Cty
Recovery Network of Program
SW Regional Mental Health Bd
State of CT, DSS
US Veteran's Affairs
Westport Police Department

Americares
Bridgeport Hospital
Community Health Center, Inc.
Connecticut Renaissance
Danbury Hospital
Danbury Police Department
Domestic Violence Crisis Ctr
Family & Children's Agency
Greenwoods Counseling
Liberation Programs Inc
New Reach, Inc
Norwalk Health Department
Norwalk Probation Department
Person to Person
Stamford Hospital
Supportive Housing Works
State of CT, Rehab Services
US Social Security Admin
Workplace Inc

Program Outcomes

Site	Total Individuals Served	Total Individuals Housed	Connected to Medical Home CY 21	Connected to Mental Health provider CY 21	Connected to Substance Use Provider CY 21	Decrease in inappropriate ED utilization FY 22
Norwalk	484	161	68	30	23	22%
Danbury	373	123	31	10	69	28%
Vassar Brothers Medical Center	69	11	54	46	28	Baseline being established year 1

Challenges & Successes

Challenges	Successes

• **Standardization vs. flexibility**
• **Documentation accessibility**
• **Fee for services vs. population health models**
• **Resources, particularly for addiction treatment**
• **Data management**
• **Philanthropic support**
• **Uninsured patients**
	• **Interagency communication**
	  • Infrastructure for further growth
	  • Creation of the hospital frequent visitor program
	• **Reduction in internal silos**
	  • Hospital interdisciplinary collaboration
	  • High risk care planning
	• **Collaboration with community partners**
	• **Increase in staffing, hiring**
	• **Community health workers**
	• **Reductions in Emergency Dept. Utilization**
	• **Internship/Residency Partnerships**
	• **Standardization of CCT Teams at Nuvance Health Network**

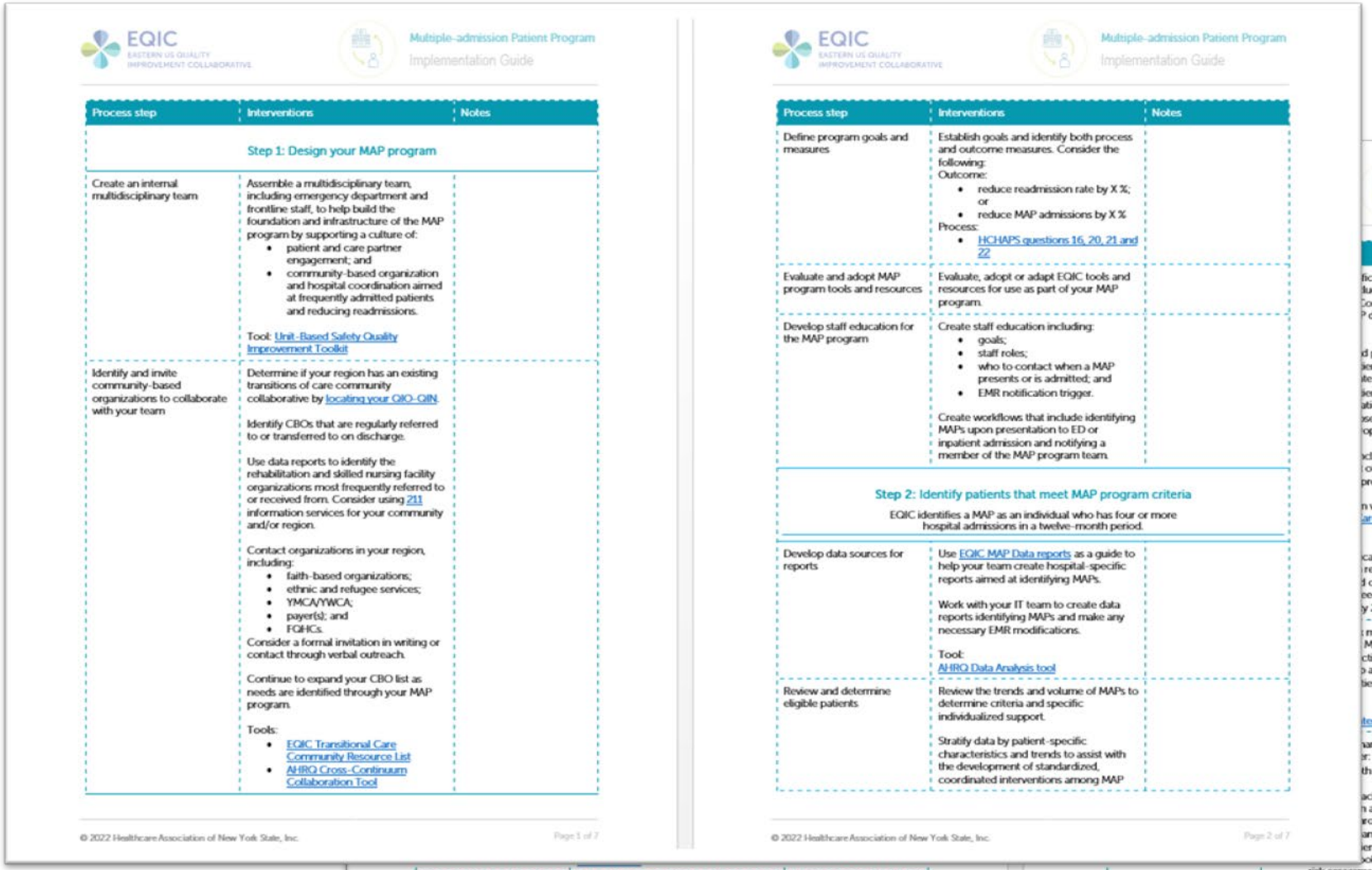
Questions

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Next steps

- Continue implementation and determine the sustainability of the MAP program.
- Identify and describe various ways of continuing collaboration with community-based organizations on the MAP program.

MAP Program Implementation Guide



EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Multiple-admission Patient Program
Implementation Guide

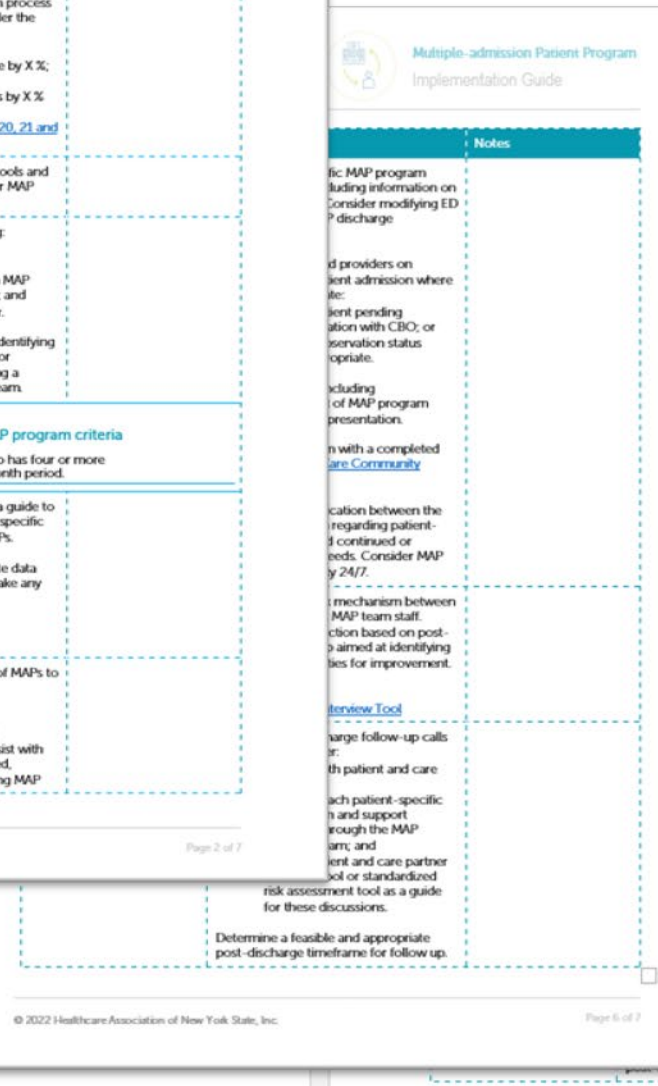
Process step	Interventions	Notes
Step 1: Design your MAP program		
Create an internal multidisciplinary team	Assemble a multidisciplinary team, including emergency department and frontline staff, to help build the foundation and infrastructure of the MAP program by supporting a culture of: • patient and care partner engagement; and • community-based organization and hospital coordination aimed at frequently admitted patients and reducing readmissions. Tool: Unit-Based Safety Quality Improvement Toolkit	
Identify and invite community-based organizations to collaborate with your team	Determine if your region has an existing transitions of care community collaborative by locating your QIO-QIN. Identify CBOs that are regularly referred to or transferred to on discharge. Use data reports to identify the rehabilitation and skilled nursing facility organizations most frequently referred to or received from. Consider using 211 information services for your community and/or region. Contact organizations in your region, including: • faith-based organizations; • ethnic and refugee services; • YMCA/YWCA; • payer(s); and • FQHCs. Consider a formal invitation in writing or contact through verbal outreach. Continue to expand your CBO list as needs are identified through your MAP program. Tools: • EQIC Transitional Care Community Resource List • AHRQ Cross-Continuum Collaboration Tool	

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Multiple-admission Patient Program
Implementation Guide

Process step	Interventions	Notes
Define program goals and measures	Establish goals and identify both process and outcome measures. Consider the following: Outcome: • reduce readmission rate by X %; or • reduce MAP admissions by X % Process: • HCHAPS questions 16, 20, 21 and 22	
Evaluate and adopt MAP program tools and resources	Evaluate, adopt or adapt EQIC tools and resources for use as part of your MAP program.	
Develop staff education for the MAP program	Create staff education including: • goals; • staff roles; • who to contact when a MAP presents or is admitted; and • EMR notification trigger. Create workflows that include identifying MAPs upon presentation to ED or inpatient admission and notifying a member of the MAP program team.	
Step 2: Identify patients that meet MAP program criteria EQIC identifies a MAP as an individual who has four or more hospital admissions in a twelve-month period.		
Develop data sources for reports	Use EQIC MAP Data reports as a guide to help your team create hospital-specific reports aimed at identifying MAPs. Work with your IT team to create data reports identifying MAPs and make any necessary EMR modifications. Tool: AHRQ Data Analysis tool	
Review and determine eligible patients	Review the trends and volume of MAPs to determine criteria and specific individualized support. Stratify data by patient-specific characteristics and trends to assist with the development of standardized, coordinated interventions among MAP	

Engage emergency department staff in the MAP program	Use MAP program notifications/flags created by IT.	



Notes

ific MAP program
luding information on
Consider modifying ED
P discharge

d providers on
ient admission where
te:
ient pending
ation with CBO; or
bservation status
opriate.

cluding
of MAP program
presentation.

n with a completed
are Community

cation between the
regarding patient-
d continued or
eeds. Consider MAP
y 24/7.

mechanism between
MAP team staff.
ction based on post-
aimed at identifying
ies for improvement.

terview Tool

arge follow-up calls
er:
th patient and care

ach patient-specific
and support
rough the MAP
am; and
ient and care partner
ool or standardized
ment tool as a guide
for these discussions.

Determine a feasible and appropriate post-discharge timeframe for follow up.

Multiple-admission Patient Program
Implementation Guide

Notes

ific MAP program
luding information on
Consider modifying ED
P discharge

d providers on
ient admission where
te:
ient pending
ation with CBO; or
bservation status
opriate.

ncluding
t of MAP program
presentation.

n with a completed
Care Community

ication between the
regarding patient-
d continued or
eeds. Consider MAP
y 24/7.

k mechanism between
t MAP team staff.
ction based on post-
p aimed at identifying
ities for improvement.

terview Tool

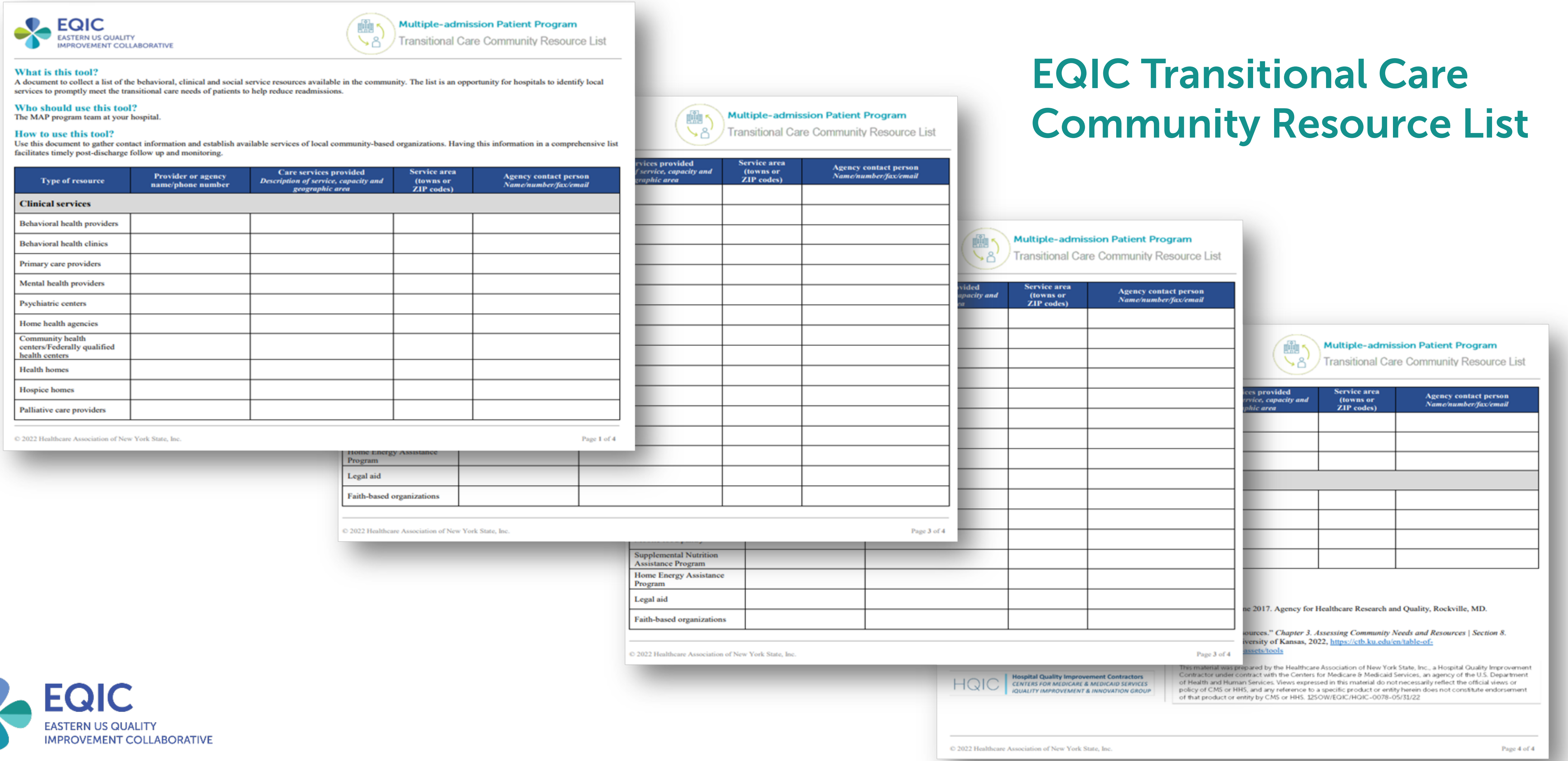
harge follow-up calls
er:
th patient and care

ach patient-specific
n and support
hrough the MAP
am; and
ient and care partner
ool or standardized
ment tool as a guide
iscussions.

le and appropriate
eframe for follow up.

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Tools and resources



EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Multiple-admission Patient Program
Transitional Care Community Resource List

What is this tool?
A document to collect a list of the behavioral, clinical and social service resources available in the community. The list is an opportunity for hospitals to identify local services to promptly meet the transitional care needs of patients to help reduce readmissions.

Who should use this tool?
The MAP program team at your hospital.

How to use this tool?
Use this document to gather contact information and establish available services of local community-based organizations. Having this information in a comprehensive list facilitates timely post-discharge follow up and monitoring.

Type of resource	Provider or agency name/phone number	Care services provided *Description of service, capacity and geographic area*	Service area (towns or ZIP codes)	Agency contact person *Name/number/fax/email*
Clinical services				
Behavioral health providers				
Behavioral health clinics				
Primary care providers				
Mental health providers				
Psychiatric centers				
Home health agencies				
Community health centers/Federally qualified health centers				
Health homes				
Hospice homes				
Palliative care providers				

© 2022 Healthcare Association of New York State, Inc. Page 1 of 4

EQIC Transitional Care Community Resource List

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Tools and resources

EQIC website

- MAP Program Syllabus
- MAP Program Framework
- Patient and Care Partner Interview Tool
- Circle Back Interview Tool
- High-risk Factors For Readmission
  Patient Tracking Tool
- AHRQ Data Analysis Tool

Complete the survey

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Thank you.

Brenda Chapman
bchapman@hanys.org

Maria Sacco
msacco@hanys.org

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE