Bringing the Focus to Complex Care

December 15th, 2022

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Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Please chat in…

Who is on the webinar with us today?

- What organization you are with,
- Where are you located, and
- Your role within your organization.

Poll Question

What is your care setting?

Did you attend the first session?

- Yes/No

Overview

- Review of Screening Tools
- Referral Sources
- Tracking and Monitoring
- Open Forum

Learning Objectives for this Session

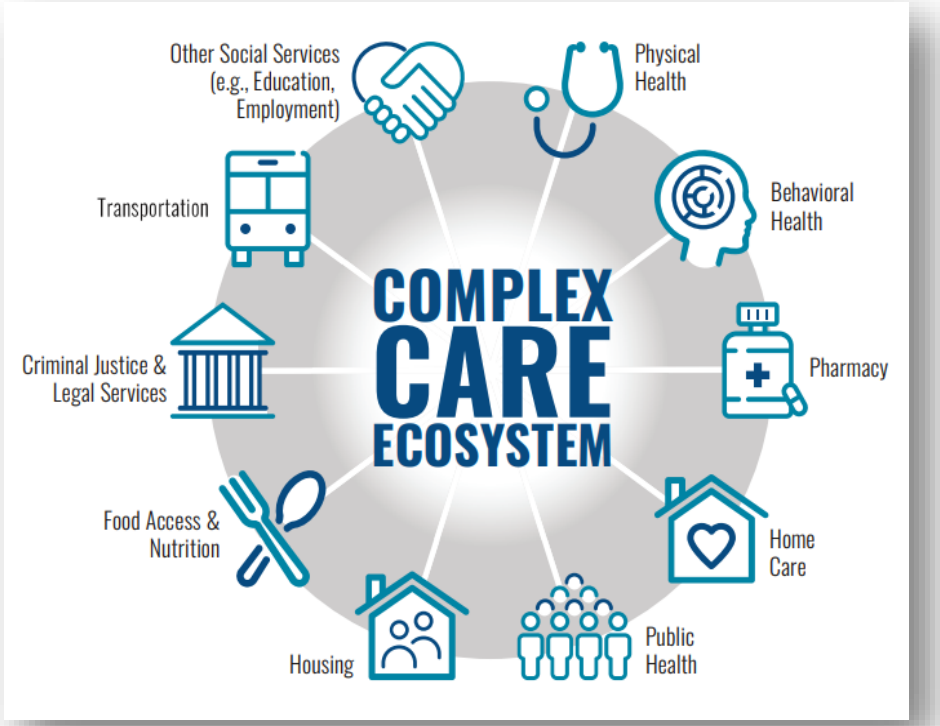
Upon completion of this event participants will be able to:

- Identify important validated screening tools,
- Consider available community resources to help support social, behavioral, and medical needs, and
- Investigate with your team a potential referral process to support multi-visit patients.

From our First Session

Complex Care is defined as a person-centered approach to address the needs of people who experience combinations of medical, behavioral health, and social challenges that result in extreme patterns of healthcare utilization and cost.

Multi-Visit Patient as defined by CMS a Medicare beneficiary with ≥ 4 or more hospital admissions OR ≥ 5 emergency department visits, observation stays, or admissions combined.

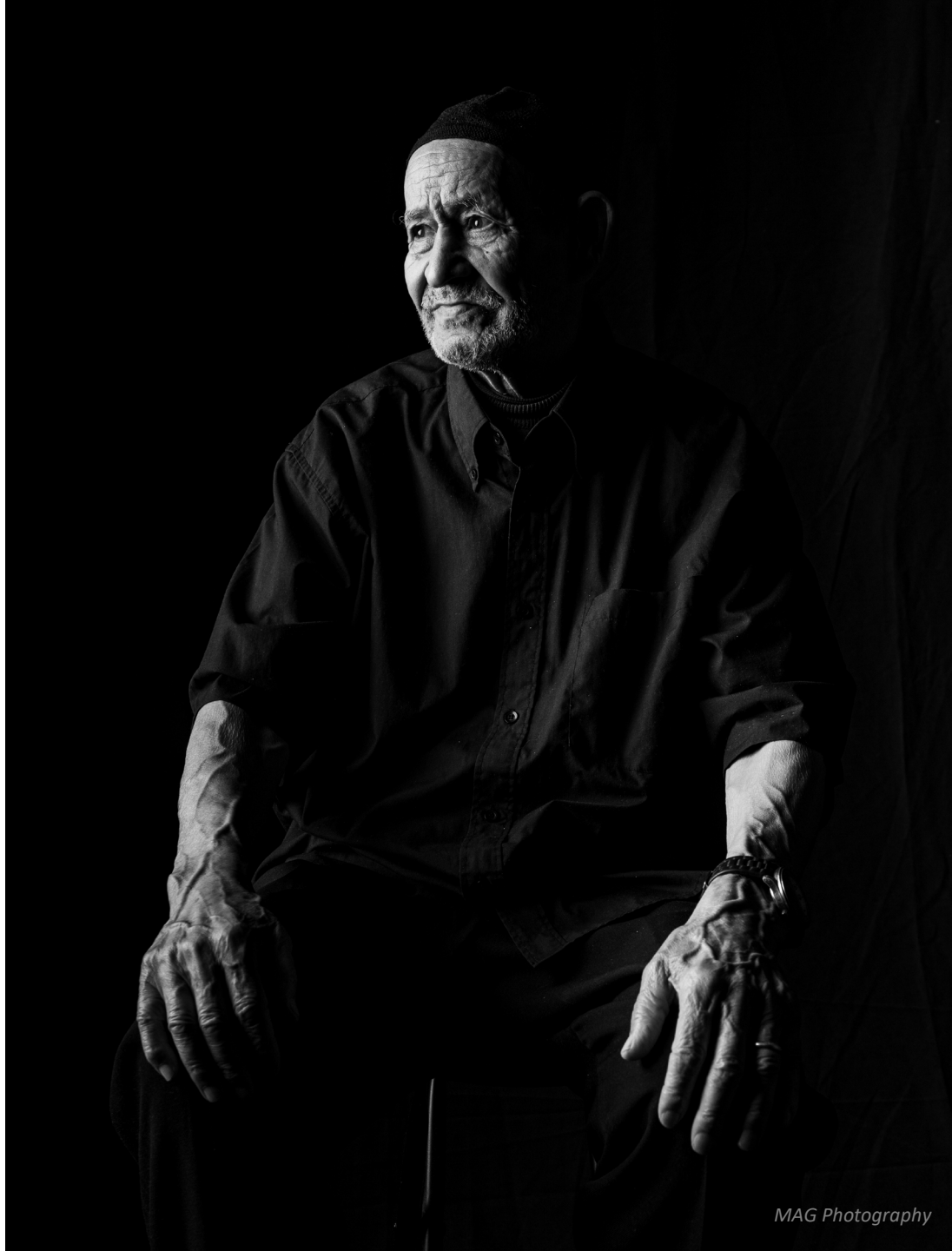


Introducing Speaker

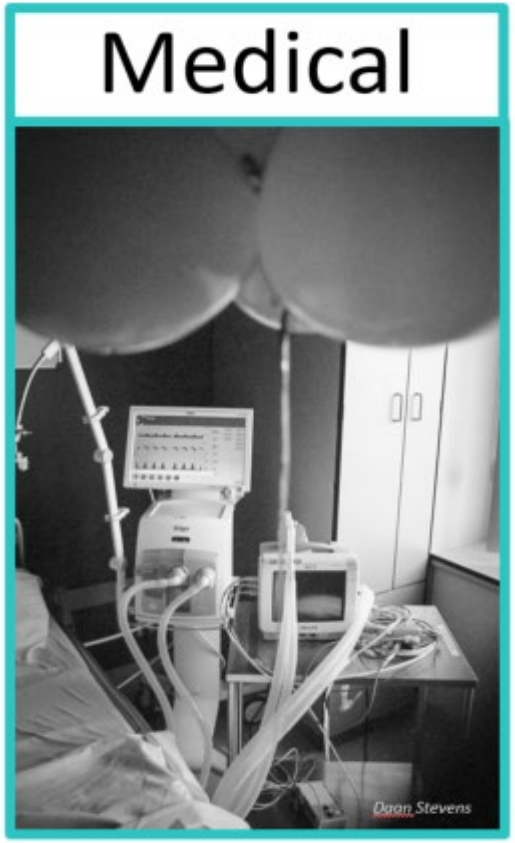
Karen D'Antonio BS, RN, CDOE

Quality Improvement Manager at Healthcentric Advisors

Our Patient



Medical



- Atrial fibrillation
- Heart failure

Social

- Marginally housed (couch at a friend's apartment)
- Food access

Behavioral

- Depression
- Alcohol use disorder
- Medication difficulties

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Chat Question

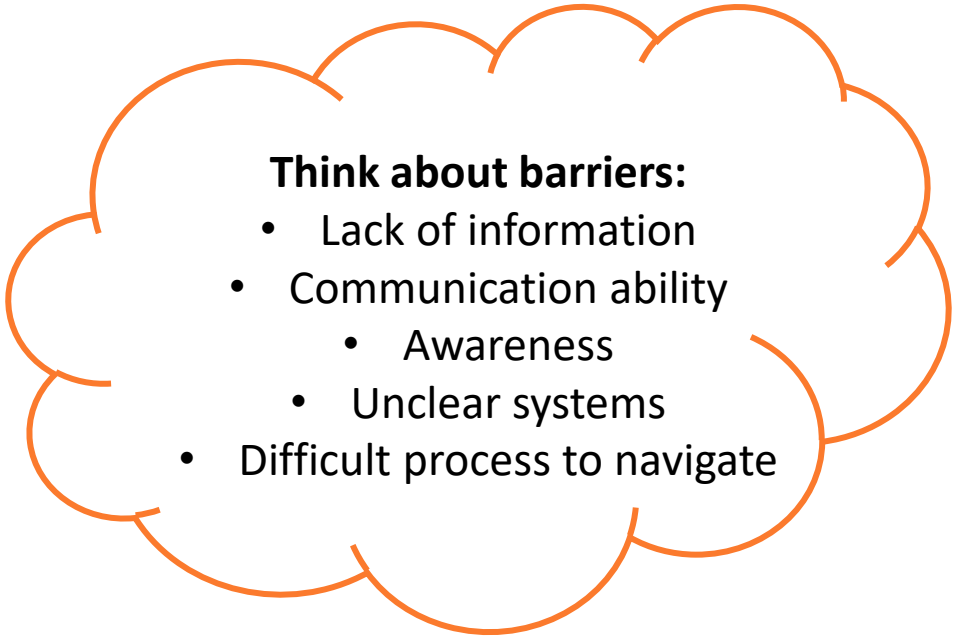
Once you've identified high utilizers/multi-visit patients, what screenings are you using? Are you using a single tool or multiple tools?

Is your tool home grown, embedded into your EHR?

Screening Tools

Choosing an effective screening tool:

- **Medical?**
  - Cost, understanding diagnosis, or access to healthcare/medications
- **Social/Economic?**
  - Food/Housing insecurity, transportation, insurance coverage/co-pays to high
- **Behavioral?**
  - Minimal insight, access, or adherence around treatment needs for anxiety, depression, substance use or other mental health concerns



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Chat Question

How do you determine what screening tools to use at your site?

Who is conducting the screenings?

Cognitive Needs Screening Tools

Mini-Cog©

- 3-minute screening
- Identify possible cognitive impairment
- Next step, more in-depth evaluation

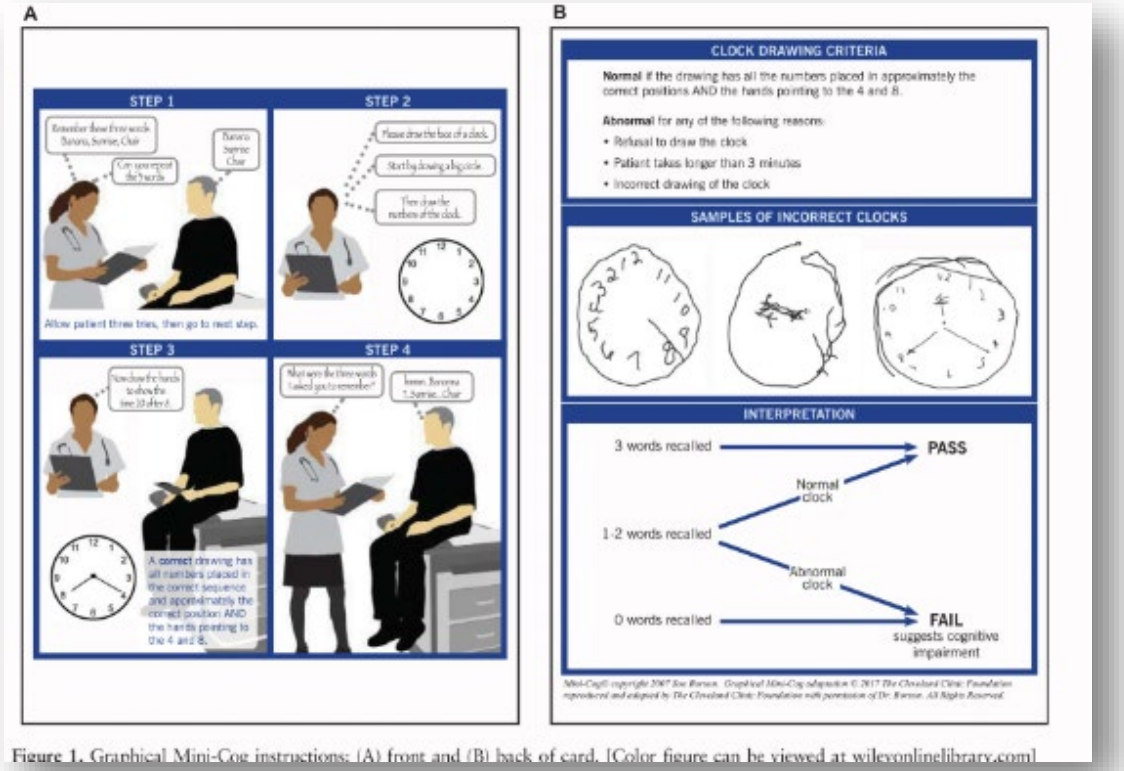


Figure 1. Graphical Mini-Cog instructions: (A) front and (B) back of card. [Color figure can be viewed at wileyonlinelibrary.com]

https://mini-cog.com/step-by-step-mini-cog-instructions/

Advance Care Planning (Questions to Consider)

The provider

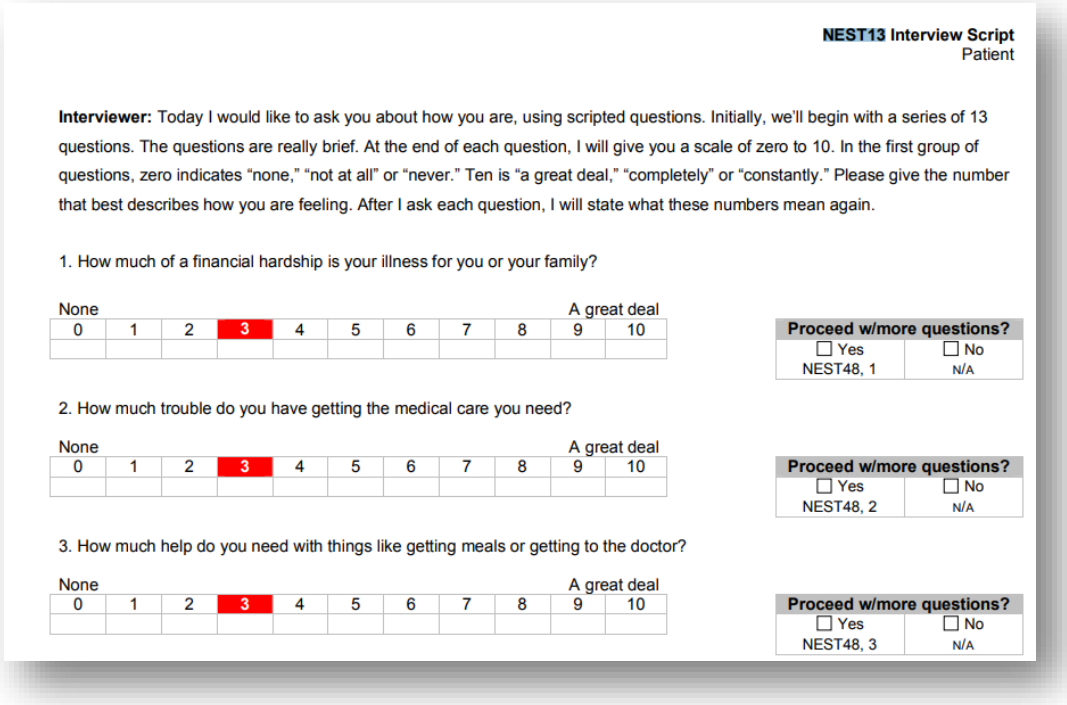
- Would you be surprised if this patient died in the next year?

The patient

- "If you were in a serious accident or a situation like that, where you couldn't speak for yourself, who would you want to work with the doctors to make decisions about your treatment?“

Potential screening tool

- Needs the end-of-life care screening tool (NEST-13)



NEST13 Interview Script
Patient

Interviewer: Today I would like to ask you about how you are, using scripted questions. Initially, we'll begin with a series of 13 questions. The questions are really brief. At the end of each question, I will give you a scale of zero to 10. In the first group of questions, zero indicates "none," "not at all" or "never." Ten is "a great deal," "completely" or "constantly." Please give the number that best describes how you are feeling. After I ask each question, I will state what these numbers mean again.

1. How much of a financial hardship is your illness for you or your family?

None — A great deal

0	1	2	3	4	5	6	7	8	9	10

Proceed w/more questions?	
☐ Yes	☐ No
NEST48, 1	N/A

2. How much trouble do you have getting the medical care you need?

None — A great deal

0	1	2	3	4	5	6	7	8	9	10

Proceed w/more questions?	
☐ Yes	☐ No
NEST48, 2	N/A

3. How much help do you need with things like getting meals or getting to the doctor?

None — A great deal

0	1	2	3	4	5	6	7	8	9	10

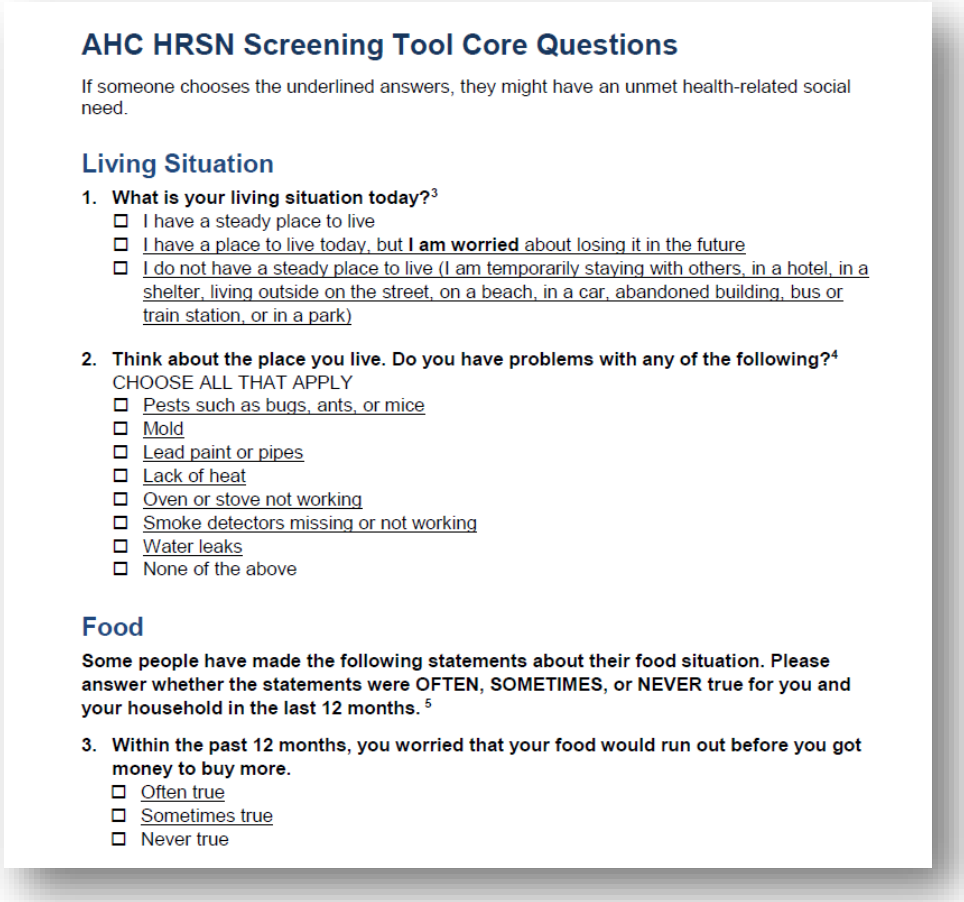
Proceed w/more questions?	
☐ Yes	☐ No
NEST48, 3	N/A

http://www.npcrc.org/files/news/needs_end_of_life_screening_NEST.pdf

SDOH Screening Tool

Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool

- Can be used across settings
- Assess the health-related social needs (HRSN)
- 5 core domains
- 26 questions



AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily 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)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

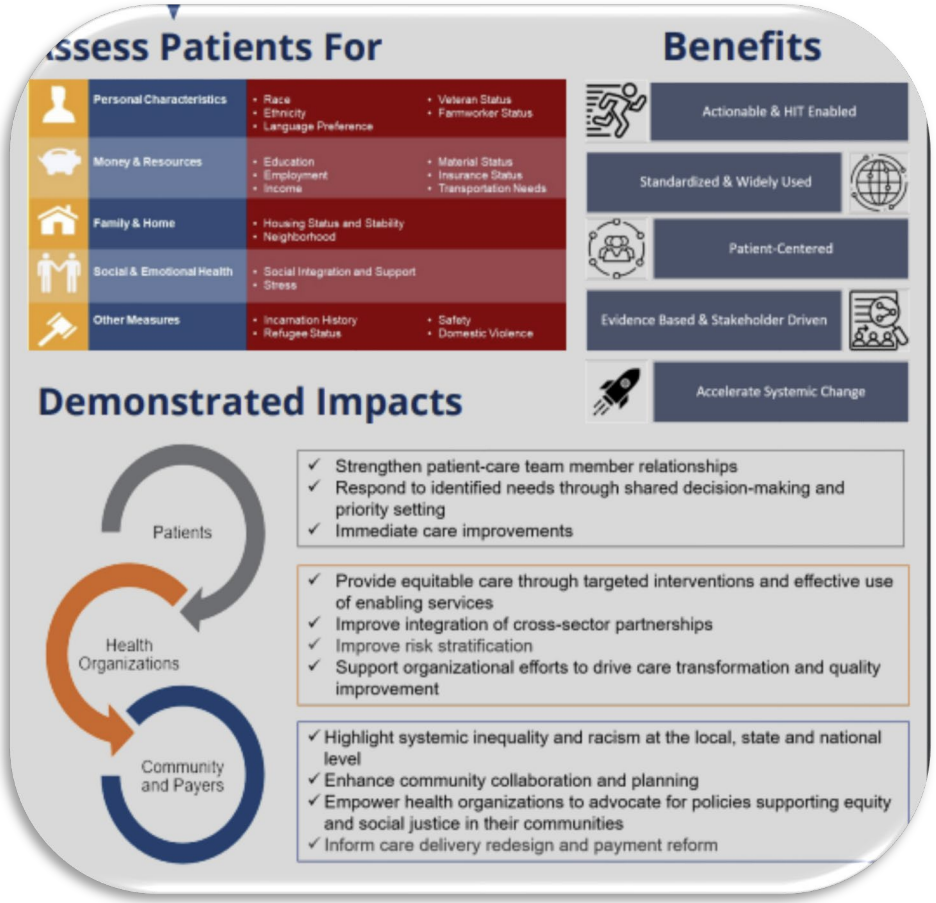
3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

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

SDOH Screening Tool

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)

- Can be used across settings
- Translated in 25 languages
- 4 domains
  - Personal Characteristics, Money and Resources, Family and Home, Social and Emotional Health
- 21 questions

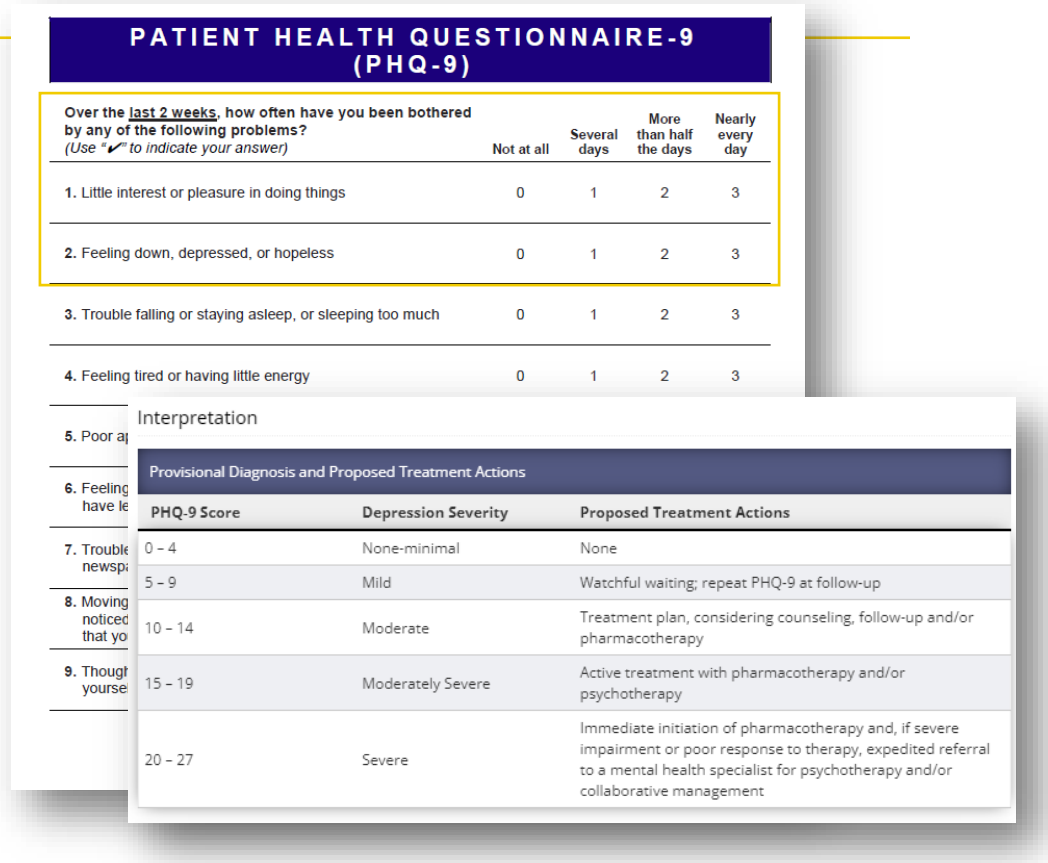


https://prapare.org/

Behavioral Screening Tools

Patient Health Questionnaire-2 (PHQ-2)

- Diagnostic tool- severity of depression
- 2 questions
- If patient identifies as being depressed, administer the PHQ-9



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3

Interpretation

Provisional Diagnosis and Proposed Treatment Actions

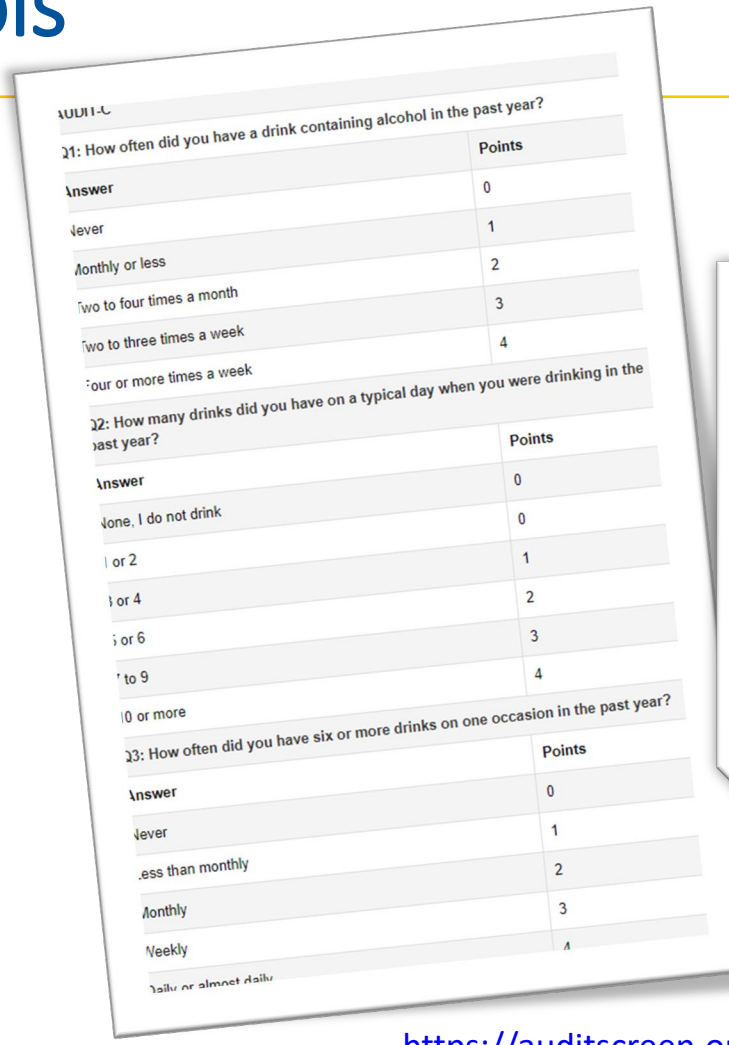
PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health

Behavioral Screening Tools

AUDIT- C

- First 3 questions of the full AUDIT
- If screen positive do the full AUDIT which covers:
  - 3 key domains:
    - Alcohol intake, potential dependence on alcohol, and experience of alcohol-related harm
  - 10 questions

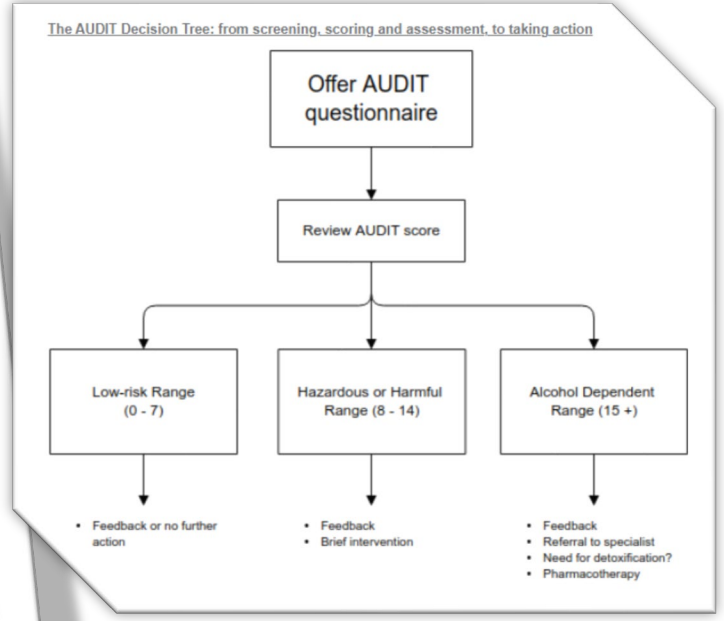


AUDIT-C

Q1: How often did you have a drink containing alcohol in the past year?	
Answer	Points
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4

Q2: How many drinks did you have on a typical day when you were drinking in the past year?	
Answer	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4

Q3: How often did you have six or more drinks on one occasion in the past year?	
Answer	Points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4



https://auditscreen.org/about/audit-decision-tree/

Introducing Speaker

Sheryl Leary, LSW, MBA

Director of Planning and Community Development for HESSCO, the Aging Services Access Point and Area Agency on Aging for South Norfolk County

Chat Question

Do you work with local community-based organizations?

Are you interested in building your community relationships?

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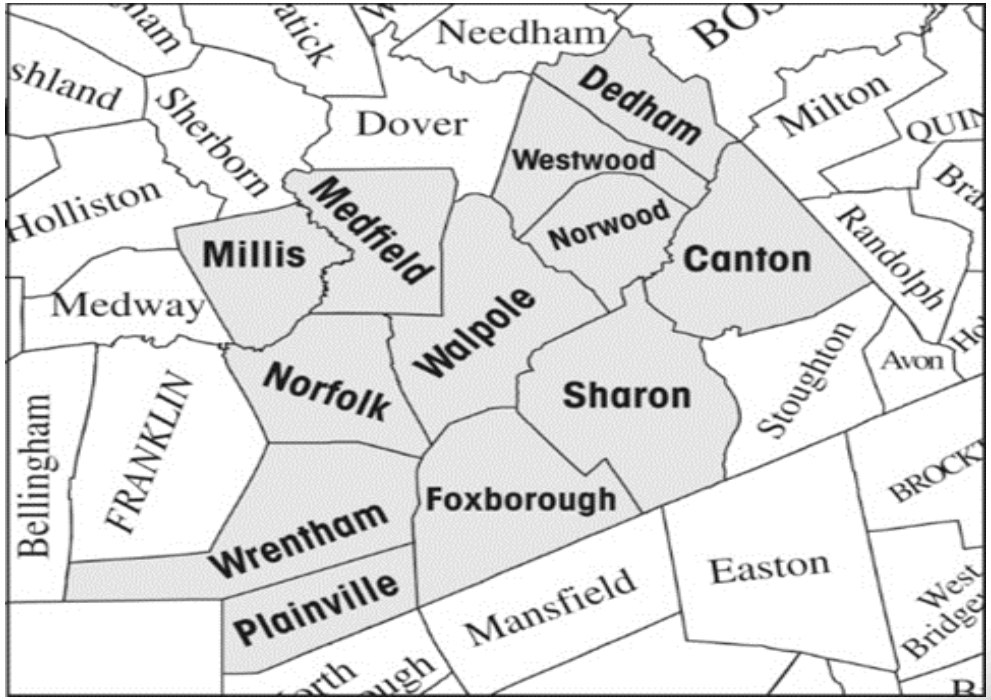
Bringing Focus to Complex Care

Area Agency on Aging and Aging Services Access Point Perspective

What is HESSCO?

HESSCO is the **Aging Services Access Point** and **Area Agency on Aging** for 12 towns in South Norfolk County in Massachusetts. HESSCO is also a part of the **MetroWest Aging and Disability Resource Consortium.**

HEalth and Social Services COnsortium



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HESSCO Programs

Information and Referral	**Home Care Program**	**Nutrition Program**
Options Counseling	**Family Caregiver Program**	**SHINE (Serving Health Insurance Needs of Everyone)**

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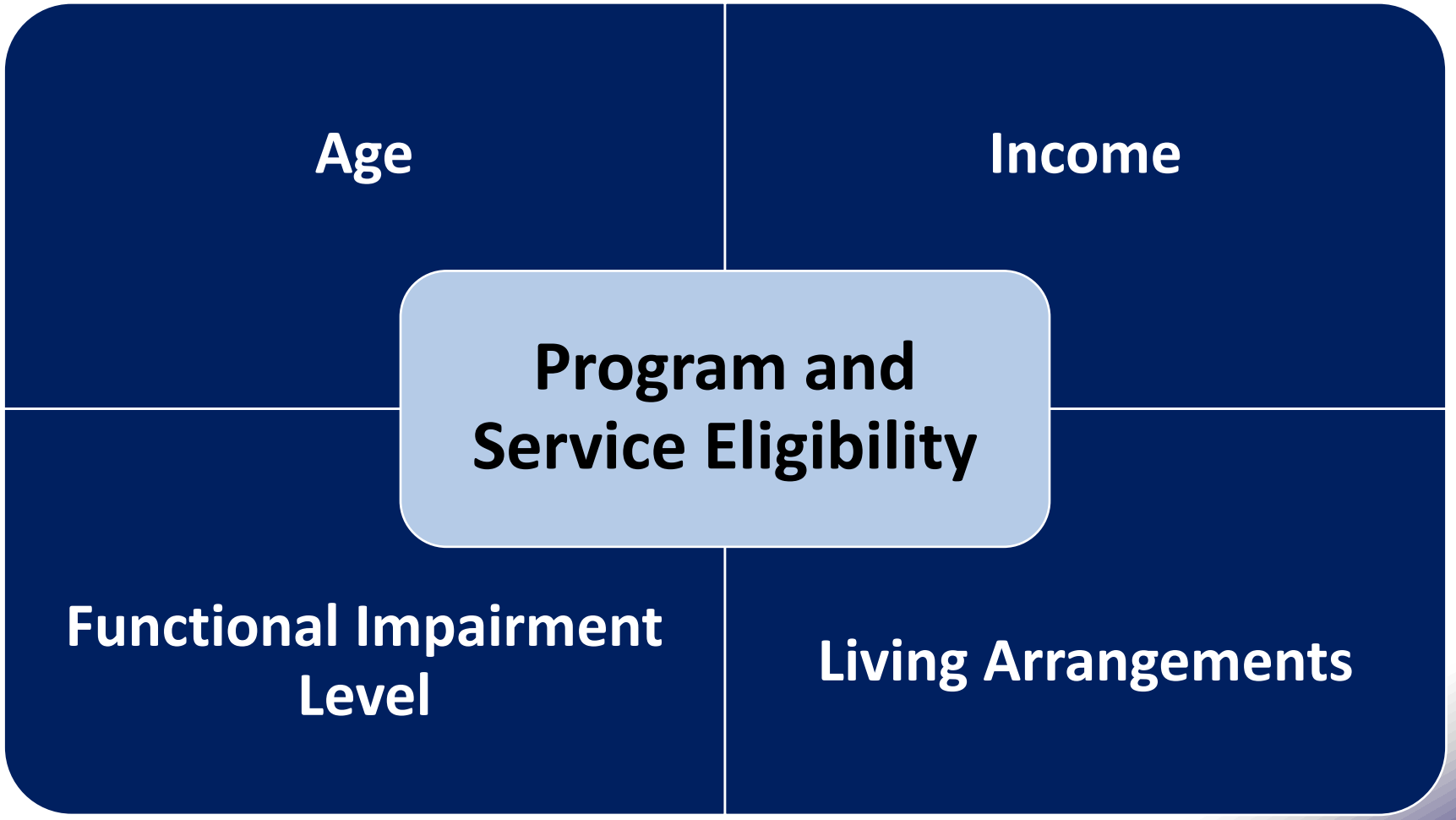
Key Points About Community Based Organizations



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Information and Referral

For agencies like HESSCO, most calls to refer a potential new consumer would go to Information and Referral.

The Information and Referral team will have a series of questions that they will ask to help determine the program path the consumer will start with at HESSCO.

As an Area Agency on Aging, HESSCO also provides Information and Referral support regarding any aging and disability program within the area, not just HESSCO services.

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Key Points About Community Based Organizations

When Making a Referral:

If you complete a standardized assessment and provide those results as part of a referral to a community-based organization, please provide the associated indication or recommendation in your referral.

For example, if you state in your referral that a PHQ-9 was completed with a score of 20 include “which indicates severe depression” in your referral language.

This will help our information and referral staff determine the referral pathway and the referral priority status.

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Key Points About Community Based Organizations

The Assessment

Focus may be more related to **functional impairments** rather than diagnosis.

To service plan, our assessment will ask questions regarding the consumer's ability to complete **activities of daily living, instrumental activities of daily living** along with an assessment of the consumer's entire **support network** and other **social determinants of health.**

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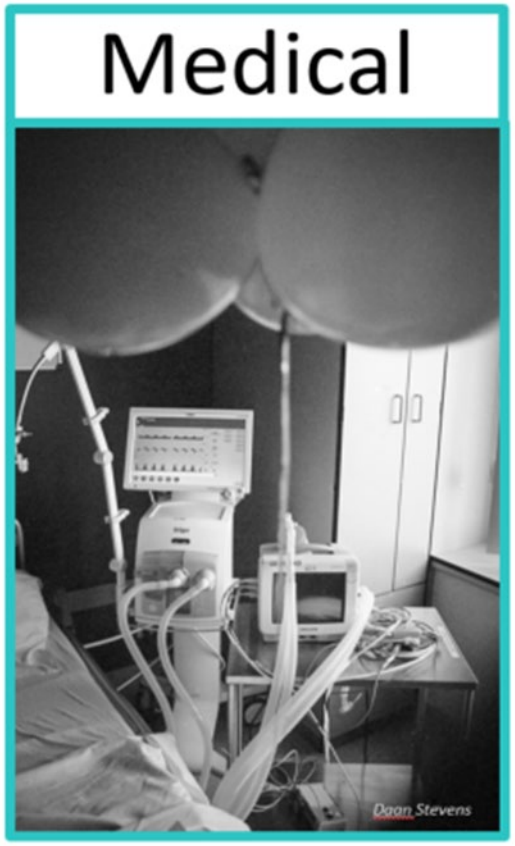
Our Patient



In the patient example provided, the medical diagnoses were Atrial Fibrillation and Heart Failure.

HESSCO's assessment would determine how these medical conditions affect his ability to ambulate, bathe and dress himself, and perform his general daily living tasks. Assistance with these activities and instrumental activities of daily living are the heart of our Home Care services.

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Our Patient

In the patient example provided, the social concerns around housing and food insecurity would be the first issues for our agency to tackle.

Due to lack of access to kitchen facilities, HESSCO would direct the consumer to prepared food options such as Meals on Wheels and local Soup Kitchens.

HESSCO staff would assess where consumer is at in search for stable housing and provide information, housing application support, and advocacy.

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Our Patient

In the patient example provided, the behavioral concerns of depression, substance use disorder and medication management are identified.

HESSCO would provide information to this consumer regarding outpatient counseling and substance use programs, but these issues may also require building a rapport with the consumer to gain trust.

Depression may also significantly impact an individual's ability to complete activities of daily living.

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Our Patient

HESSCO will also assess the following:

- Financial Stability and Access to Public Benefits
  - SNAP
  - MassHealth/Medicaid/Prescription Assistance
  - Phone/Internet
- Transportation Access
- Support Network
- Socialization Opportunities
- Brainstorm with consumer on restroom access and resulting medication management issues

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A Few Challenges for Many Community Based Organizations

- Workforce shortage of Direct Care Professionals
- Access to data and ability to use data specifically for concerns related to complex care
- Comprehensive transportation access (suburban communities)
- Lack of behavioral health support options (suburban communities)

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Referrals

- Get to know the communities where the multi-visit patient resides
- Build relationships to form a successful and impactful inventory of resources

Resources in the Community

- The Social Care Network (findhelp.org):
  - The mission is to connect all people seeking help with the programs that serve them — with dignity and ease. Free or reduced cost programs/services for all ages to provide assistance with food and housing, bill paying, and finding local social services.
- Eldercare Locator (eldercare.acl.gov):
  - A public service of the U.S Administration on Aging connecting the community to local services for older adults and their families.
    - Provide home delivered meals
    - Local transportation options
    - Case management services and more.

Closing the Loop

- Follow-up with patients to whom resources were given:
  - Did they utilize the resources?
  - Was the resource appropriate?
  - Was the resource easy to work with?
- Understanding that time is strained and hard to come by; start small!
  - Follow up with one patient a week
  - Follow up with one of your referral streams

Open Forum

- What are some of your challenges in conducting screenings and referrals?
- What success stories do you have in connecting with your community partners?
- Do you have any best practices around closing the loop with your referrals?

Want to learn more?

- Check out the Complex Care Compendium which highlights select models and practices related to complex care
  - https://drive.google.com/file/d/14qKTeQSpr1DR420n6xSH4e9XDSXSOXay/view

- Social Determinants of Health (SDoH) – A Guide for Getting Started
  - https://drive.google.com/file/d/1NUEHyVsQ95-noR55ULTEUgPiZzgwkXcM/view?usp=sharing

Complex Care: Understanding and Addressing Health Equity as a Driver for Readmissions

January 19th, 2023

Speaker: Laura Benzel, MS, BS, CSSGB (she/her/hers) Project Director, Health Equity Lead, Qlarant

- Explain how complex health and health care disparities contribute to excessive emergency room utilization, readmissions, and longer hospital stays;
- Recognize how accurate patient demographic data is foundational in identifying and addressing disparities, and ways to improve your organization's data collection capabilities;
- Identify best practices for screening for and addressing health related social needs (HRSN);
- Describe how culturally and linguistically appropriate services (CLAS) help advance health equity, improve quality, and eliminate disparities.

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Remaining Complex Care Schedule

Date	Time	Activity	Registration
01/05/2023	12-12:30pm	Learning Circle: Screening Review, Check-in	https://healthcentricadvisors.zoom.us/meeting/register/tZMkdeCrpz0oGdfIcDQoNSjbc7iC1TKYYSzK
01/19/2023	12-1pm	**Understanding and Addressing Drivers of Complex Care**	https://healthcentricadvisors.zoom.us/meeting/register/tZYrd-GqpzwvE9CwzYic2ylrsSlY0hbww9ds
02/02/2023	12-12:30	Learning Circle- Best Practice	https://healthcentricadvisors.zoom.us/meeting/register/tZ0kce6pqT8uEtJ7mZpmGP45ROQepu7I1EzT
02/09/2023	12-12:30pm	Learning Circle- Best Practice	https://healthcentricadvisors.zoom.us/meeting/register/tZAlc--sqDopGN2mUz8wQnasz4snAI4KoAdq
02/16/2023	12-12:30pm	Learning Circle- Best Practice	https://healthcentricadvisors.zoom.us/meeting/register/tZwrdOivrjkqG9Hax6Rzj9Jb-zFAlhdrCvMw
02/23/2023	12-1pm	**Wrap-up and Celebrate**	https://healthcentricadvisors.zoom.us/meeting/register/tZwvd-ipqjorH9AxmixvEh8psZwRozepC663