Bringing the Focus to Complex Care

February 23, 2023

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The IPRO QIN-QIO

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- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

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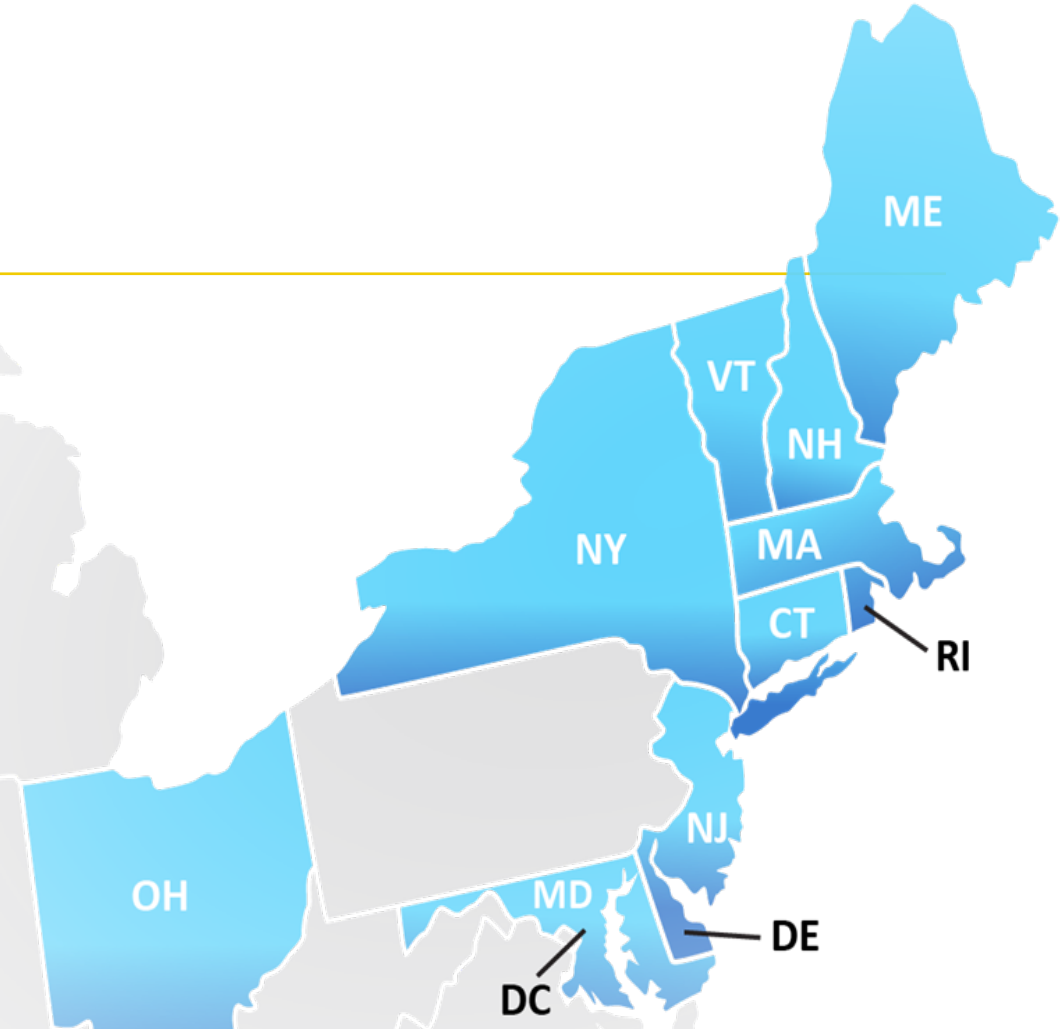
Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

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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?

Overview

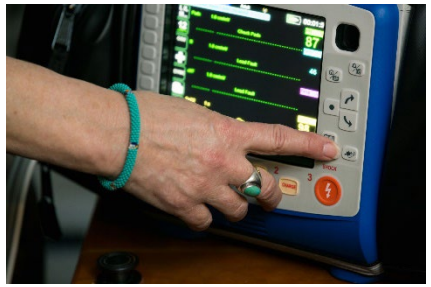
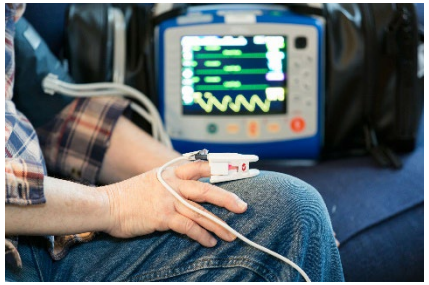
- Mobile Integrated Healthcare - SmartCare
- Series Wrap-up
  - Top ten takeaways from the series
  - Resources
- Roundtable Discussion

Today's Speaker

Brenden Hayden, Vice President of Mobile Health Services

Cataldo Ambulance Service




SmartCare

Delivering the Future of Healthcare



CATALDO AMBULANCE SERVICE, INC.

Timeline

2007 - Institute for Healthcare Improvement (IHI) introduces the "Triple Aims," designed to assist

- Health care systems in optimizing performance, reducing costs, and improving patient care
- Through a variety of interventions and metrics.

2010 - Affordable Care Act seeks to reduce health care costs by encouraging health care providers

- to form networks that coordinate patient care and reduce cost.

2014 - Cataldo began to develop a mobile integrated healthcare service delivery model.

2018 - Massachusetts funded a Mobile Integrated Healthcare (MIH) program

- Overseen by Department of Public Health, Office of Emergency Services (DPH/OEMS).

2019 - SmartCare was awarded the first MIH license in Massachusetts.

Present - SmartCare has 12 + units operating across MA with a multi-state expansion coming soon!

What is SmartCare Mobile Integrated Healthcare (MIH)?

Our Partners

commonwealth care alliance

CHA Cambridge Health Alliance

CareDimensions
HOSPICE | PALLIATIVE CARE | SUPPORT SERVICES

Atrius Health

MelroseWakefield Healthcare

MASSACHUSETTS GENERAL HOSPITAL

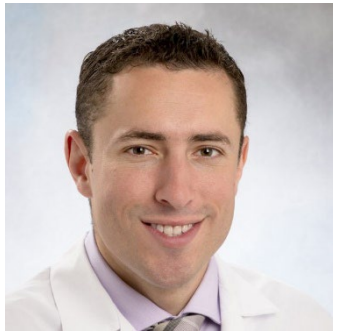
NEIGHBORHOOD PACE

Medically Home

Beth Israel Lahey Health

instED

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL



Scott Goldberg, MD, MPH

Dr. Goldberg is the SmartCare Medical Director. Board Certified in Emergency Medicine and EMS, he is passionate about the increasingly important role of MIH.

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Geographic Coverage

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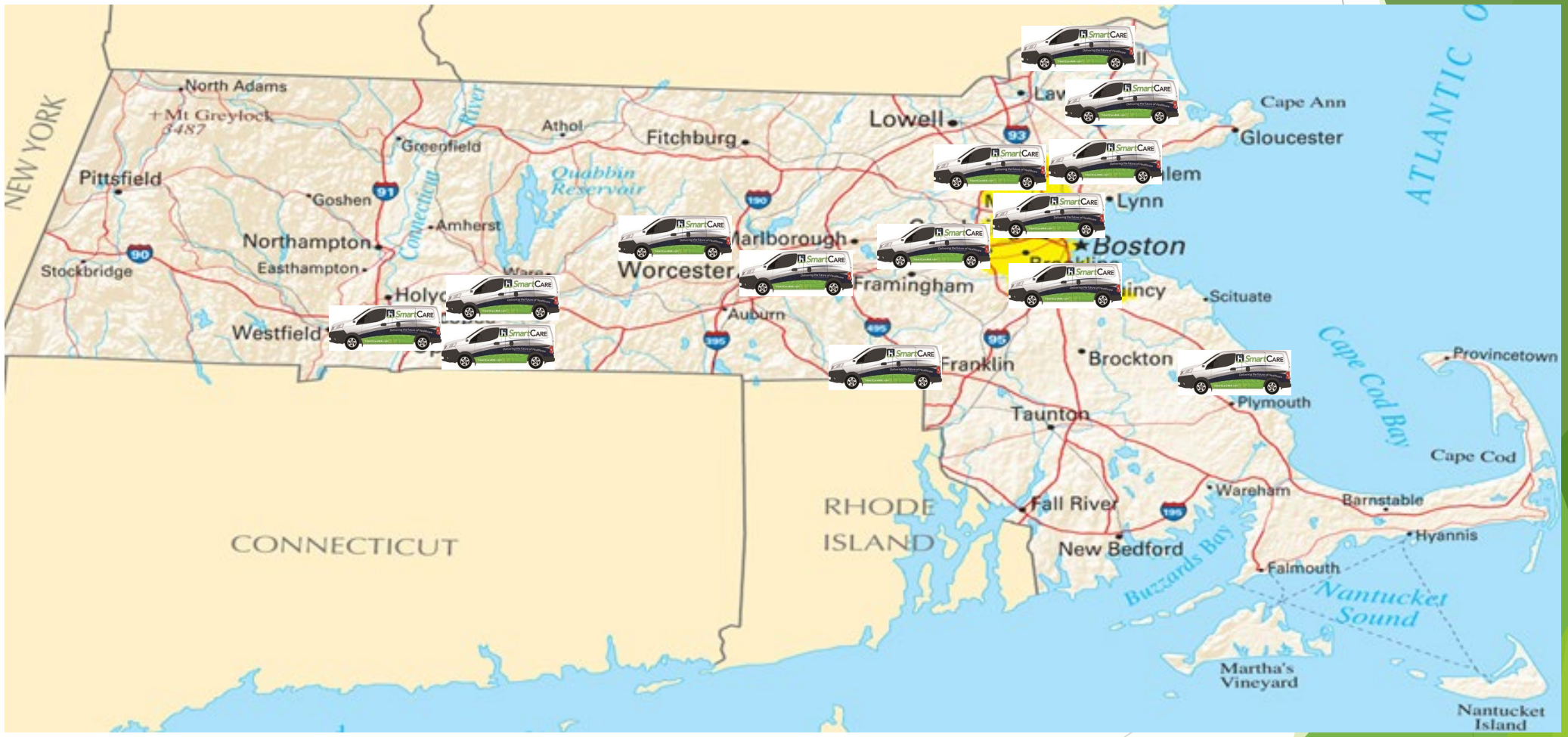
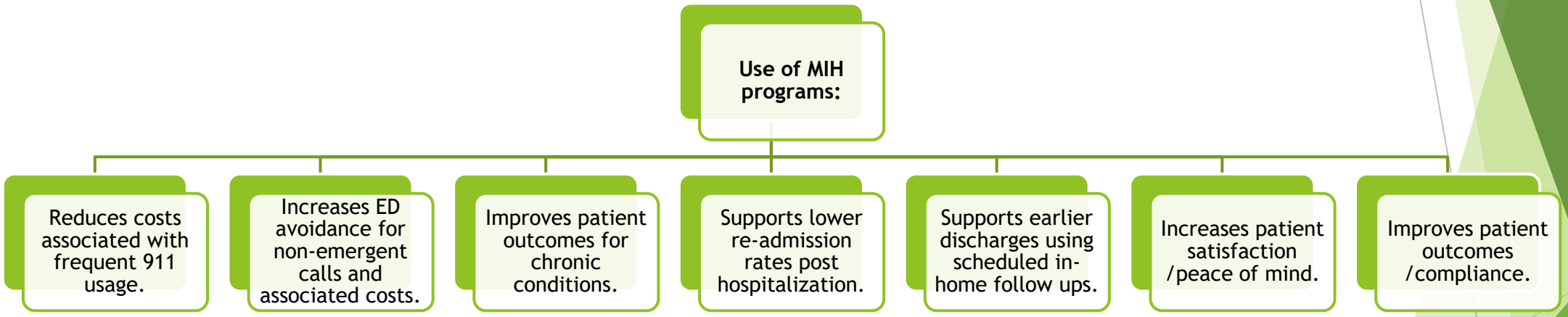


On Demand Urgent Care
…and So Much More!



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Who Benefits from Mobile Integrated Healthcare?

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MIH supports:

Care Providers:

Physician groups:	Urgent care alternative, after hours coverage, call center support, post op follow up
VNAs, Hospice:	Call center support, after hours urgent care, chronic care support
Home hospitals:	Monitoring and support
ESP/PACE:	Population management; support for chronically ill patients, options for homebound patients or patients with memory loss, post hospitalization follow up
Long Term Care:	Supplemental IV, psych and non-psych med management, urgent care alternative
Assisted livings:	Urgent care alternative, post hospitalization follow up, especially for memory impaired residents
Municipalities:	Population health support, testing, vaccination programs

Patients:

- On demand, after hours urgent care
- Chronic illness management
- ED alternative for high utilization 911 callers
- Post hospitalization follow ups
- In home care for homebound patients/frail elders/memory impaired patients
- Hospice on-call pain management
- Pre-scheduled follow-ups

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How Does it Work?

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The Partner Process

1. The healthcare partnership is established, including identification of medical control and a customized program is developed to meet the needs of a specific patient population
   Service requests are managed through the SmartCare Call Center.

2. Specially trained SmartCare paramedics and EMT's are dispatched to the patient's home for on demand, non-emergent/urgent calls, as well as pre-scheduled visits.
   On site, SmartCare paramedics and EMT's evaluate the patient and collaborates with the patient's existing Care Team.

3. Diagnostics, labs, and med management are available on site.
   SmartCare paramedics are able to escalate the care response if necessary.

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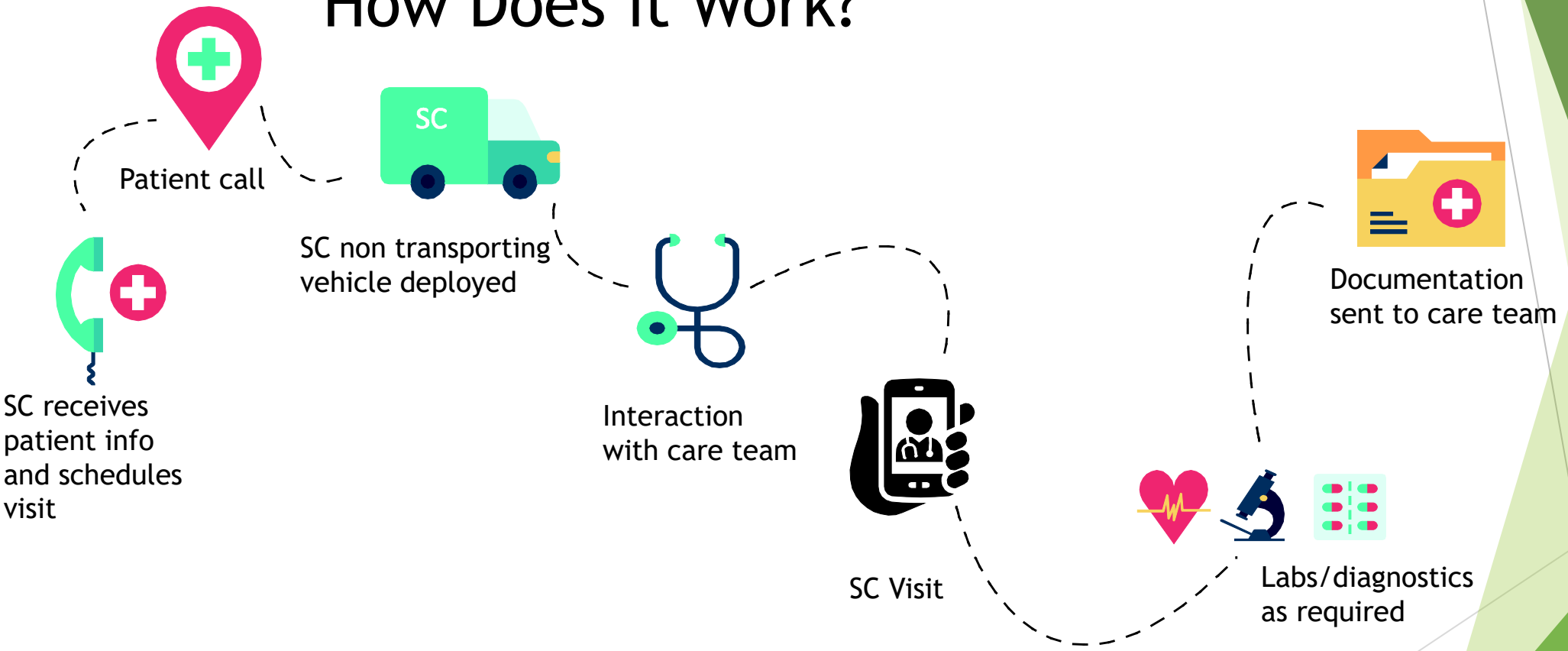
How Does it Work?



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Data

Response	Time	Results
• The average response time for an immediate response is 35 minutes.	• The average time spent with a patient is 75 minutes.	• Less than 10% of evaluations result in a transport to the E.D.

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The Big Picture

SmartCare paramedics are specially trained to a national MIH standard.

Smartcare utilizes a fleet of non-transporting vehicles equipped with a broad array of tools and medications.
No lights and sirens are used.

Should any patient require emergent care, the SmartCare paramedic will escalate the call and accompany the patient to the ED.

Once on site, patient assessment is performed, and information is communicated to the patient's care team for further instructions.

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Who Pays for the Visit?

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Partner Payers

Currently in Massachusetts, MIH is not recognized by third party payers. Healthcare partners are the direct payer.

What are Patients and Providers Saying?

"The SmartCare medic was a caring and compassionate caregiver!"
Daughter of SC patient

"Thank you for the care you've provided my mother. I felt she was in good hands."
Son of SC patient

"I have incredible peace of mind when the SmartCare medic arrives."
Wife of SC patient

"These visits have made all the difference to my father who was calling 911 every day."
Daughter of SC patient

"My high anxiety patients have commented on how pleased they are with SmartCare."
NP, SC Partner

"The SC medic saved my patient from visiting the ED for a Foley bag replacement. Thank you!"
Doctor of SC patient

"These medics go above and beyond to help their patients."
Doctor, SC Partner

"The opportunity save these patients a trip to the ED is just awesome! "
Executive Director, SC Partner

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Questions and Contacts

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Brenden Hayden
VP, Mobile Health Services
Bhayden@Cataldoambulance.com
781-873-4342

Bringing the Focus to Complex Care

Wrap-Up and Discussion

Top Ten Takeaways

- Defining Complex Care
- It Takes a Village
- Data, Data, Data
- Assess and Screen
- Health Equity
- Community Based Organizations
- Community Health Workers/Navigators
- Dedicated Team & Multidisciplinary
- Primary Care's Important Role
- Care Coordination at its Best

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Increasing the Focus on Complex Care

- Identify individuals at high-risk by using internal methods such as population health data and known drivers of utilization.
- Recognize individuals who have had multiple hospital visits.
- Map a plan to develop and integrate processes and interventions to assist in meeting the needs of identified patients.

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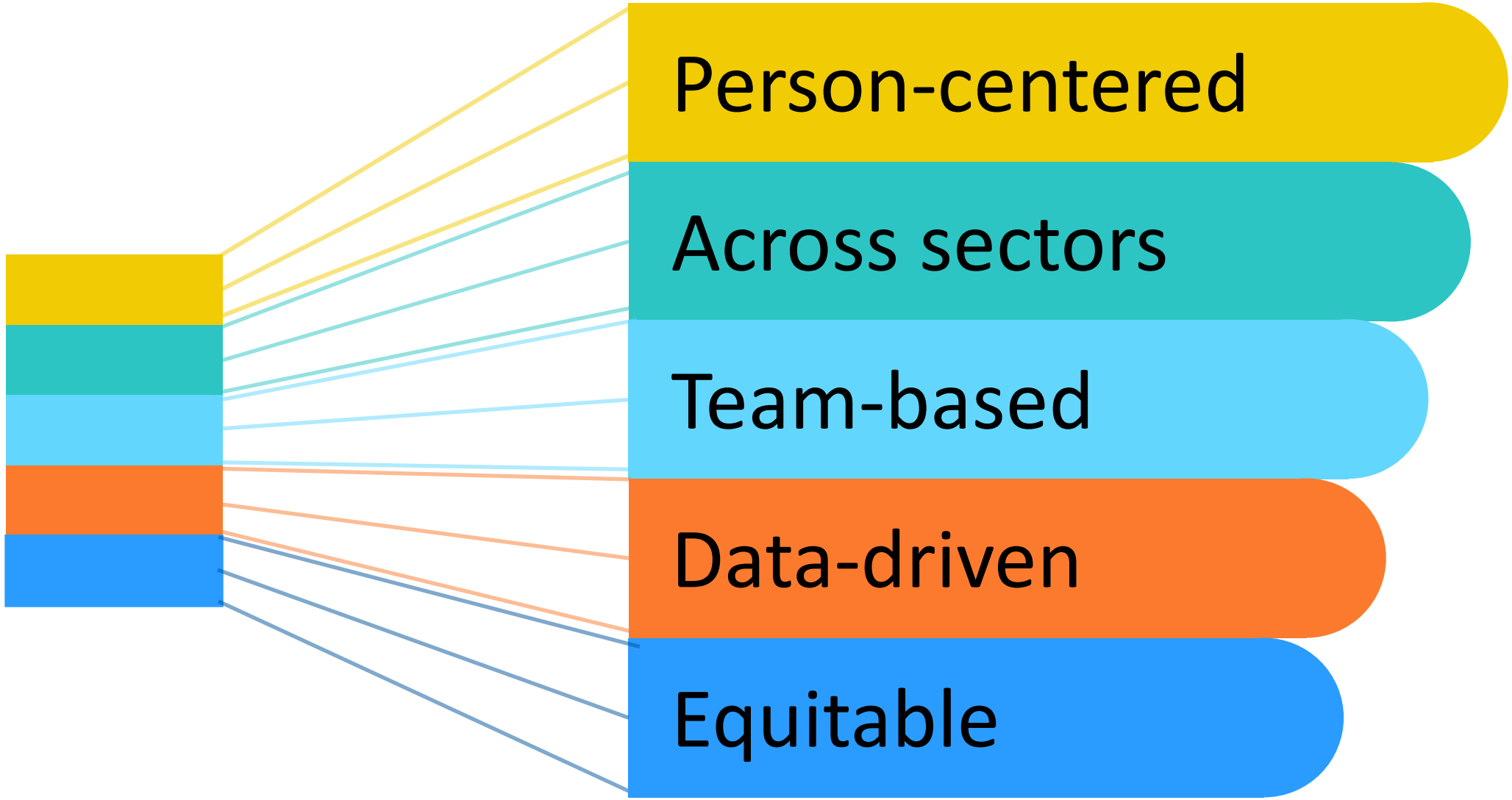
Defining Complex Care

> “Person-centered approach, brings together patients, families, community, and healthcare system to collaboratively improve health outcomes and wellbeing for people with complex health and social needs.”

Source: The National Center for Complex Health & Social Needs – An initiative of the Camden Coalition
https://www.nationalcomplex.care



Source: Humowiecki, et al. Blueprint for complex care, Dec 2018.
www.nationalcomplex.care/blueprint

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Top Ten Takeaways

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	Primary Care's Important Role	Care Coordination at its Best	

Complex care brings together entities across the health ecosystem to address barriers at the [individual, community, and system] levels. Through these efforts, there is a greater ability to … care for the population in need.

Director of Integrated Care Management for a clinically integrated network

Source: Humowiecki, et al. Blueprint for complex care, Dec 2018.
www.nationalcomplex.care/blueprint

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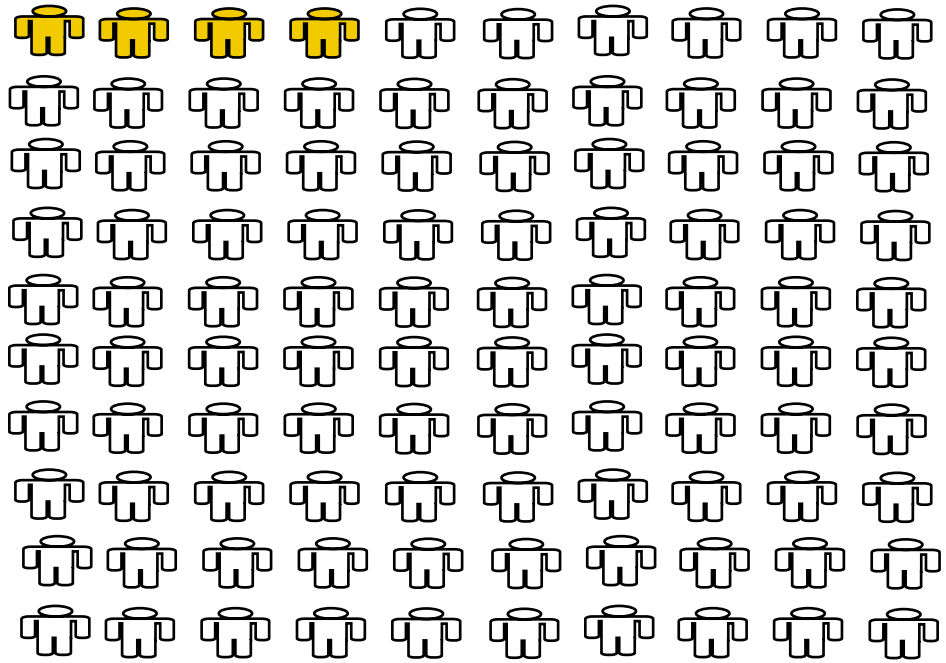
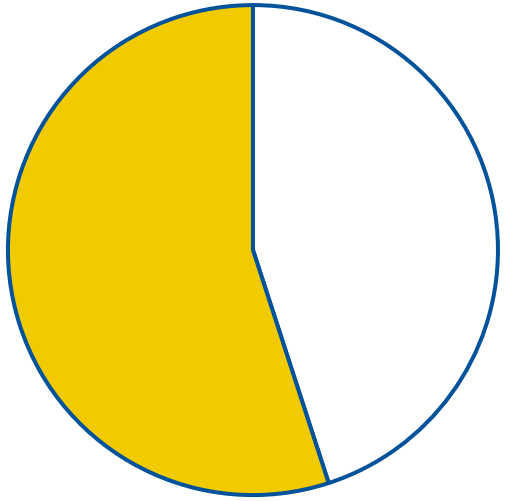
Multi-Visit Patients



4% drive

55% of readmissions



Explore Your Organization's Processes

Does your facility have a method to **identify** and **track** multi-visit patients with **complex care** needs?	**Options** Readmission reports, hospital ADT notifications, Medicare claims

1. Identify multi-disciplinary team
2. Review ≥5 multi-visit patients
3. Define the problem clearly
   - Coming from which care setting?
   - Why seeking care in ED?
4. Discuss different pilot options

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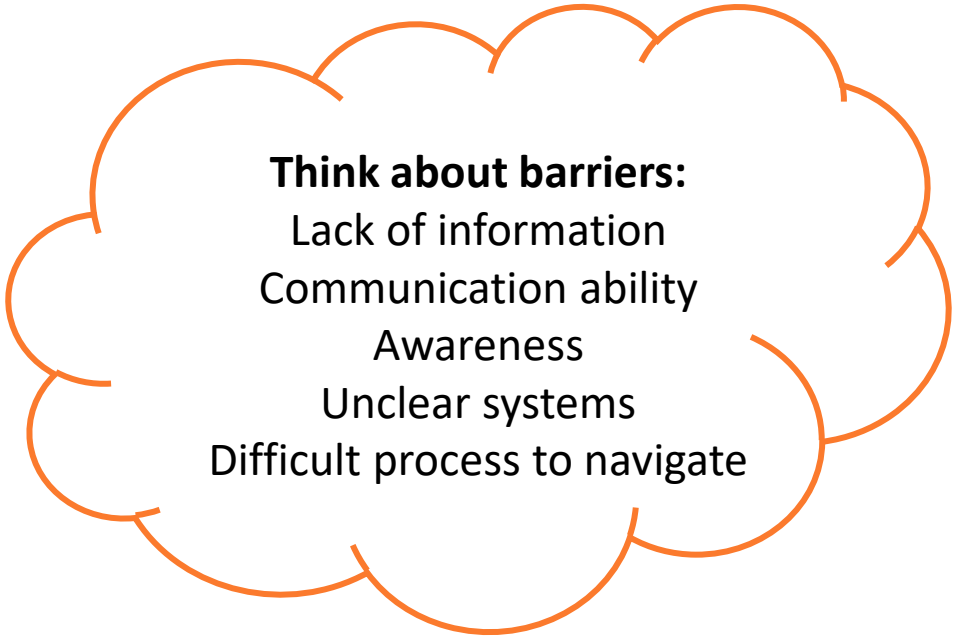
Assess

- Important to **gather information about the big picture** – from the chart, from rounds, from the patient, and from others in the community who share in care (family, caregivers, providers, etc.).
- Target those **who know the patient best.**
- **“Who’s not involved”** is a critical consideration. It triggers questions that result in identifying next step actions.
- MVP team maintains **continuity of issues & gains insight** to formulate more effective prevention strategies.
- The collaboration with stakeholders who reflect medical and social perspectives keeps the **focus on the whole person.**

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 too high
- **Behavioral?**
  - Minimal insight, access, or adherence around treatment needs for anxiety, depression, substance use or other mental health concerns



Screening Tools

Screening Tools	Medical	Substance Use	Mental Health	SDOH
Advanced Care Planning Guide	X		X	
Adverse Childhood Event (ACEs) Questionnaire			X	
AHC - Health-Related Social Needs		X	X	X
AUDIT (Alcohol Use Disorder Identification Test)		X		
BIMS Cognitive Impairment Screening	X			
CDC Addiction Medicine Toolkit		X		
Checklist Nonverbal Pain Indicators (CNPI)	X			
GAD-2 (Short version of GAD-7)			X	
INTERACT Stop & Watch Early Warning Tool	X			
Mini Cog for Older Adults	X			
Mini Mental Status Exam (MMSE)	X			
MoCA Cognitive Assessment	X			
PHQ-9 & GAD-7 (Depression & Anxiety)			X	
PHQ-2 (Short version of PHQ-9)			X	
Post-Traumatic Stress (PTSD) Checklist			X	
PRAPARE Tool				X
SAMHSA Screening Tools Chart		X		
Screening Patients for Food Insecurity				X
Screening Patients for Social Isolation and Loneliness				X
Screening Patients for Transportation Barriers				X

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How Disparities Contribute to Readmissions

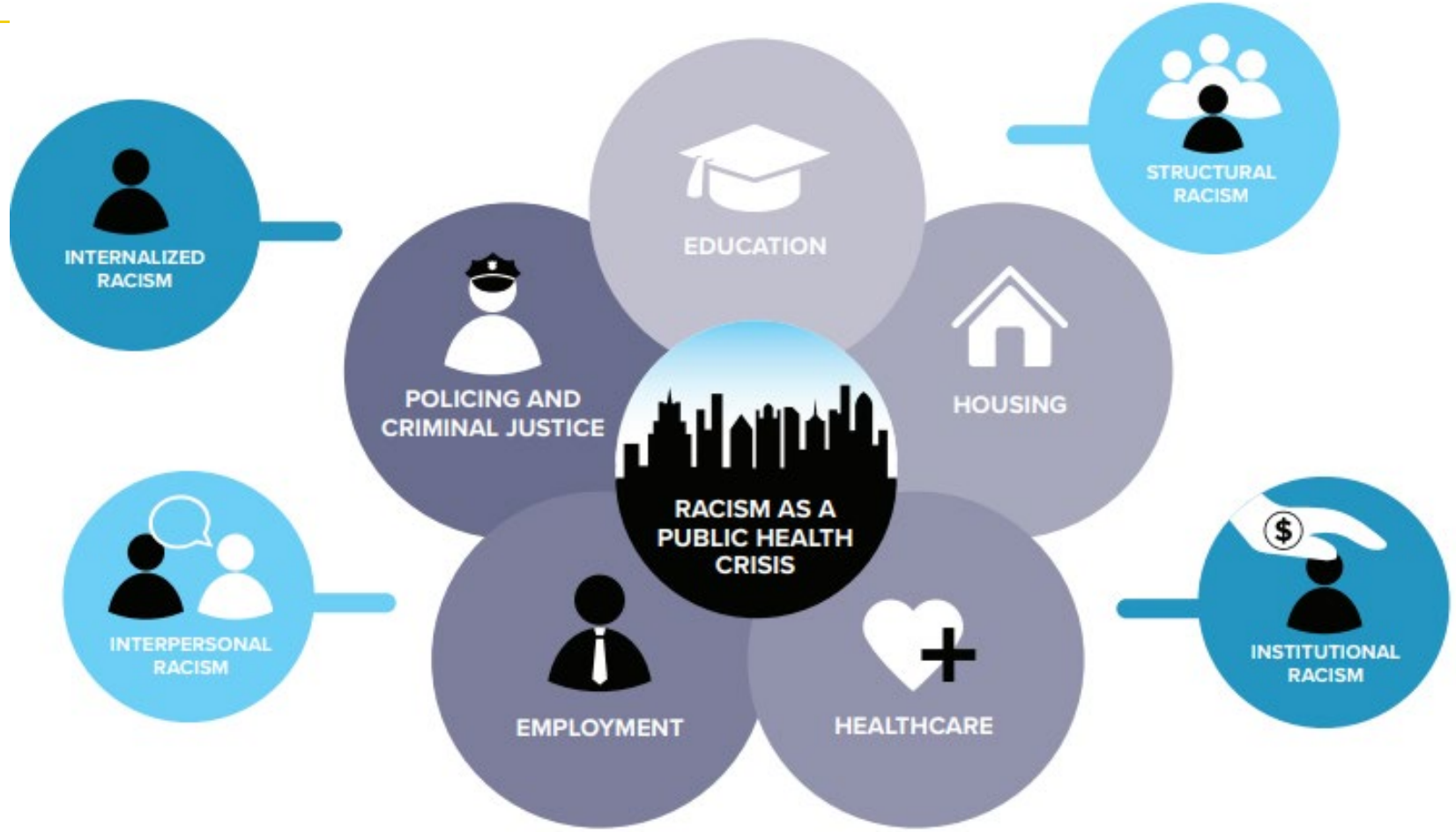
> While not all readmissions are entirely preventable, it is widely understood that a portion of unplanned readmissions could be prevented by addressing a series of barriers patients face prior to, during, and after admission and discharge.

- **CMS Office of Minority Health**

Guide to Reducing Disparities in Readmissions

Centers for Medicare & Medicaid Services. 2018. A Guide to Reducing Disparities in Readmissions. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Racism & Discrimination in our Health Care System



Yearby R, Lewis CN, Gilbert KL, Banks K. 2020. Racism is a Public Health Crisis: Here's How To Respond. Data for Progress. Accessed January 5, 2023 at https://www.filesforprogress.org/memos/racism-is-a-public-health-crisis.pdf.

Patient-Level Factors Predicting Hospital Readmission

- Socioeconomic Status
- Race and Ethnicity
- Disability Status
- Limited English Proficiency
- Low Health Literacy

Centers for Medicare & Medicaid Services. 2018. A Guide to Reducing Disparities in Readmissions. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

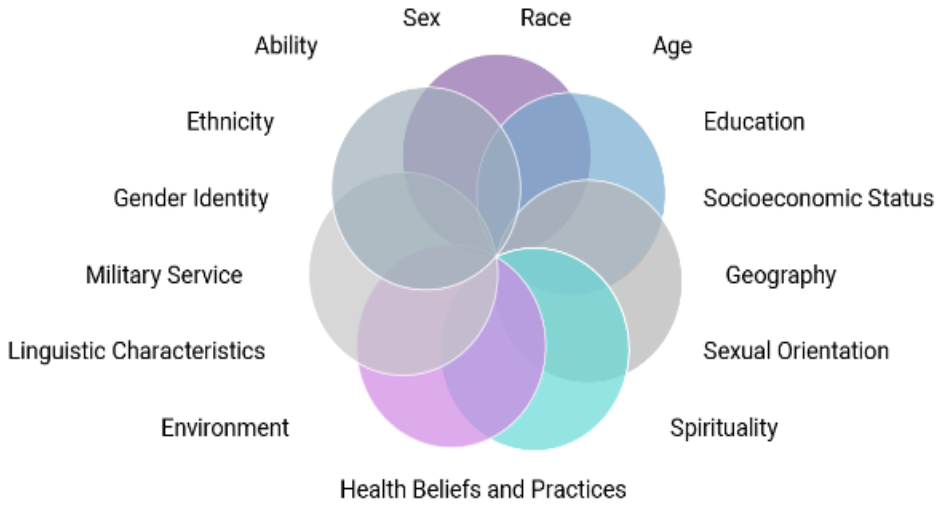
Condition-Specific Disparities in Hospital Readmission

Congestive Heart Failure (CHF)	• **Higher readmission rates for Black, Hispanic, and foreign-born patients with low English proficiency (LEP)**
Acute Myocardial Infarction (AMI)	• **Higher readmission rates for Black and Hispanic patients**
Pneumonia	• **Higher readmission rate for Black patients**
Chronic Obstructive Pulmonary Disease (COPD)	• **Higher readmission rate for Black patients**
Total Hip/Knee Arthroplasty (THA/TKA)	• **Higher readmission rate for Black patients**

Centers for Medicare & Medicaid Services. 2018. A Guide to Reducing Disparities in Readmissions. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Strategies to Close the Readmission Gap

1. Create a Strong Radar
2. Identify Root Causes
3. Start from the Start
4. Deploy a Team
5. Consider Systems and Health-Related Social Needs (HRSN)
6. Focus on Culturally Competent, Communication-Sensitive, High-Risk Scenarios
7. Foster Community Partnerships to Promote Continuity of Care



https://www.hrmssolutions.com/resources/blog/dashboards-to-visualize-your-organizations-hr-health/

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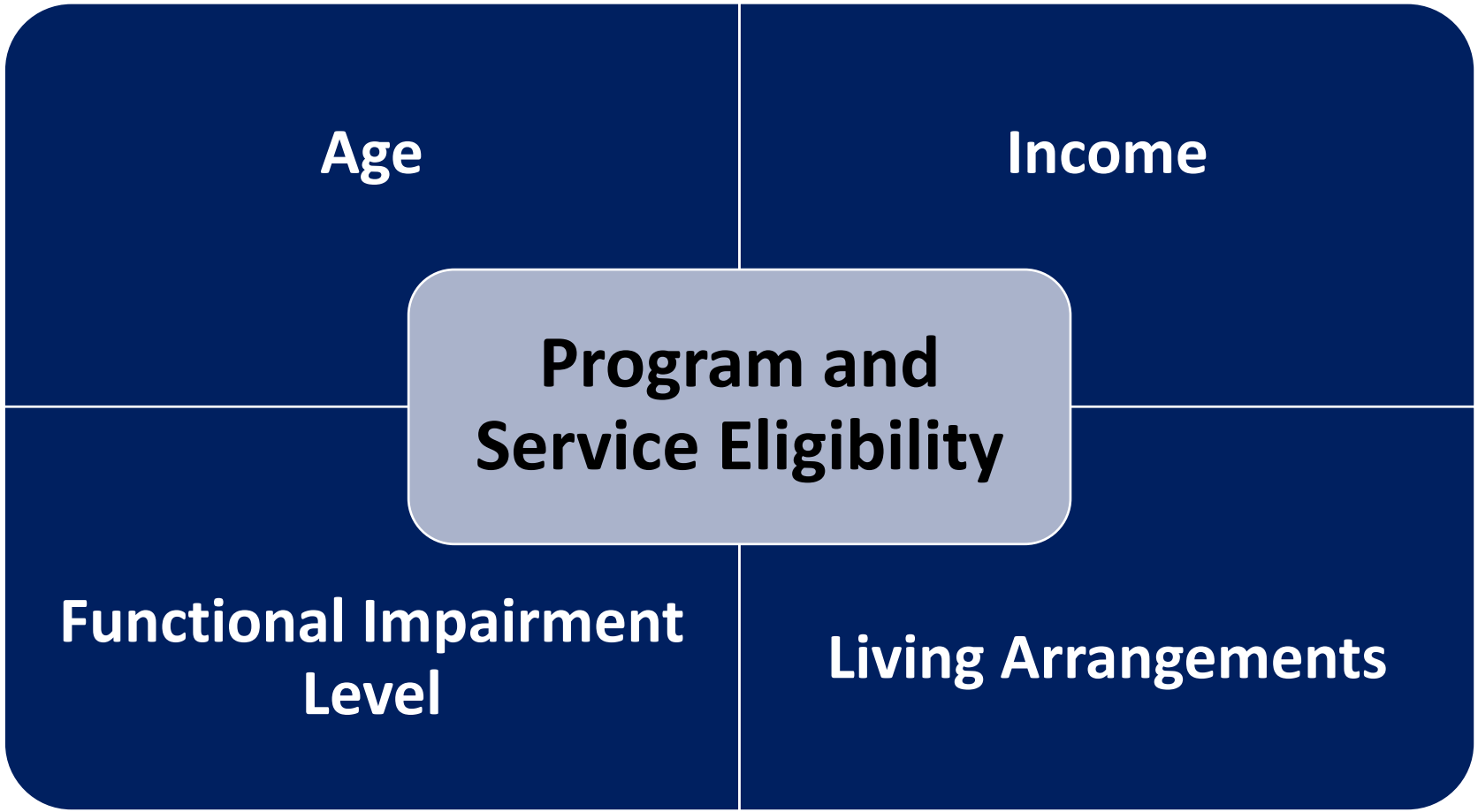
Key Points About Community Based Organizations



HESSCO
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Key Points About Community Based Organizations

HESSCO
Care. Support. Solutions.

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

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Care. Support. Solutions.

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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Community Health Worker (CHW)

- Frontline public health worker with an understanding of the community served.
- Serves as a link between social and health services to facilitate access to services.
- Assist with goal setting, education to promote health behavior change, community resource navigation, care coordination.
- Telephone contact, home visits, community visits (including medical appointments).
- Works alongside care management team.

Why Add Community Health Workers?

- 3-year grant funded through Rhode Island Department of Health (RIDOH)
- Home Health is leveraging Community Health Workers to work directly with patients and families, as an extension of the HH team.
- BH Care Management resource through referral to LICSW for short term therapy in-home, community, and office engagement.
- CHWs work with patients to identify barriers to healthy living, provide links to community resources and develop plans to address long-term health needs.

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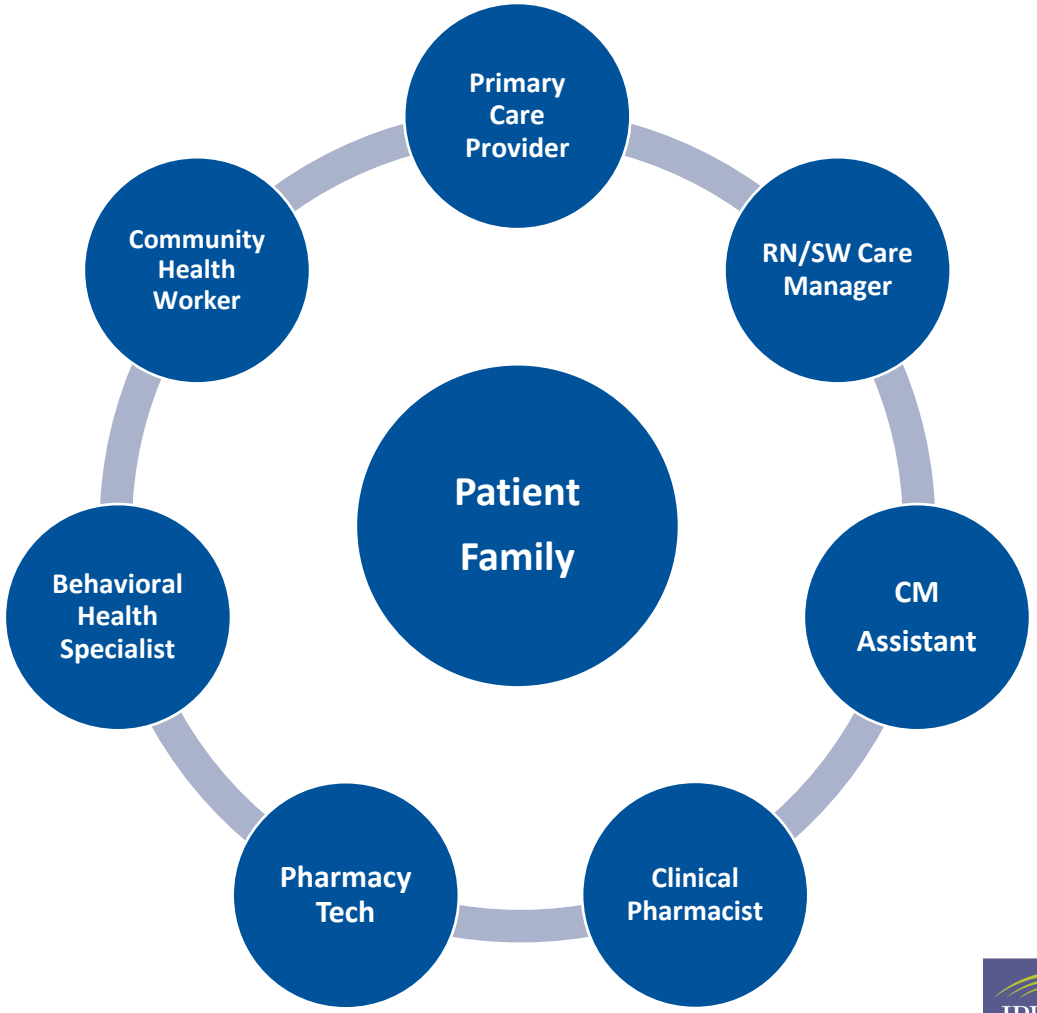
Integrated Care Management Team



Interdisciplinary and Cross-Continuum Partners

Internal & External Partners	How Did We Created This Partnership / Story of Success
IT/Data/EMR	They are embedded in our team and actively participate in our meetings. This enables them so they understand what we need and why. They prioritize requests. *Data Analyst was so connected to MAX program that he wrote his Master's Capstone on how data can support MVP's.
LEADs Team	Substance use DOU patients triggered their immediate intervention at bedside. They develop the plan for return. Contact information & recommended programs are pre-identified. And the team reaches out to MVPs in the community.
ACT Team/Community	MVP Team consistently identified and engaged while MVP was in house. We successfully re-engaged MVPs with their ACT team & community Quarterbacks.
Transportation	Access A Ride contacted & we learned how to expedite referrals. A top problem linked to a solution.
HD Centers	Identified the right person at the HD center to collaborate. New Quarterbacks identified.
Care Coordination Services	We investigated and linked MVP to care managers and community supports like MLTC Managed Long Term Care program - engaged them to become Quarterbacks.
ED Care Management	In place from 1st Pass of MAX MVP work. ED Care Alert Champions - flag, review MVP notes & engage ED team planning when MVPs present to the ED.
ED Providers	Commitment to develop a truly helpful ED alert; ease of identification and use.
Ambulatory Clinics	High priority appointments & continuum of care.
Pharmacy	Key partners to recommending medication strategies to support patients in community.
Skilled Nursing Facility	Prevent return by MVP Lead Social Work providing subject matter expert support at the nursing home during case conferences. Bring the MVP learning to the community.

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Choosing the Right Level of Care in a Medical Emergency

Frederick Health

Everyone knows that a primary care doctor is the best place to go when you are sick or in pain. By seeing your primary care physician on a regular basis, they will have your complete health history and an understanding of any underlying conditions you may have.

Sometimes you become sick or injured when the doctor's office is closed, and sometimes you need more urgent medical attention than your doctor can provide. This handout helps to explain **where to seek the best care in your time of need.**

Primary Care Call to make an appointment with your primary care provider if you have symptoms of a regular illness or need a regular check-up.

- Treatment of illness, including:
  - *Colds and coughs*
  - *Sore throat*
  - *Flu and flu-like symptoms*
  - *Ear infections*
  - *Urinary tract infections*
  - *Minor aches and pains*
  - *Allergies*
- Management of chronic conditions, such as:
  - *Diabetes*
  - *Heart Disease*
  - *COPD*
- General medical advice
- Annual Well Exams
- Immunizations
- Respiratory problems

If you believe a life is in jeopardy, always call 911!

Urgent Care is an option if you have a minor illness or injury, your primary care provider is not available, and your problem cannot wait.

- Treatment of illness, including:
  - *Colds, coughs, and upper respiratory infections;*
  - *Sore throat;*
  - *Flu and flu-like symptoms;*
  - *Ear infections/Earache;*
  - *Suspected urinary tract infection;*
  - *Sexually Transmitted Illness;*
  - *Fever* **If having seizures, go to the Emergency Department**
- Upset stomach
- Nausea or vomiting
- Adult IV hydration
- Skin rashes and infections
- Abscesses
- Sprains or suspected minor broken bones
- Musculoskeletal injuries
- Back pain or joint pain
- Toothache (if dentist is not available)
- Allergies
- Animal or insect bite
- Eye irritation and redness
- Minor cut/abrasion and sutures/stitching
- Minor burn
- Frequent, bloody, or painful urination
- Motor Vehicle Collision exams
- Workman's Comp exams
- Sports/DOT physicals
- Travel vaccines
- Laboratory and blood work
- X-Rays

(over)

Choosing the Right Level of Care in a Medical Emergency CONT.

The Emergency Department (ED) is open 24 hours a day, 7 days a week.
You should seek care at the Emergency Department without delay if you have a serious or a life-threatening illness or injury.

- Chest pain or other heart attacks symptoms, such as:
  - *Pressure, fullness, squeezing/pain in the center of your chest*
  - *Tightness/burning/aching under the breastbone*
  - *Chest pain with lightheadedness*
- Signs of a stroke, such as:
  - *Sudden weakness or numbness of the face/arm/leg on one side of the body*
  - *Sudden dimness or loss of vision*
  - *Loss of speech or trouble talking*
  - *Sudden severe headaches with no cause*
- Head injury or eye injury
- Sudden and severe headache or loss of vision
- Heavy bleeding that won't stop
- Dislocated joints
- Severe abdominal pain
- Deep cuts or severe burns
- High fever
- Severe asthma attack
- Loss of consciousness
- Severe or worsening reaction to an insect bite, sting, or medications
- Constant, severe/persistent vomiting
- Coughing up or vomiting blood
- Poisoning **Call Poison Control at 1-800-222-1222 and ask for immediate home treatment advice**
- Domestic violence or rape
- Feelings of suicide

If you believe a life is in jeopardy, always call 911!

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Top Ten Takeaways

Defining Complex Care	It Takes a Village	Data, Data, Data	Assess and Screen
Health Equity	Community Based Organizations	Community Health Workers/Navigators	Dedicated Team & Multidisciplinary
	Primary Care's Important Role	Care Coordination at its Best	

Our Current MVP Care Pathway At-A-Glance

Identify / Notify

- **Daily list** at 7am of our MVPs
- MVP list **sent to MAX Team** (ED, Inpatient Medicine, Inpatient RN, CM, SW, ED LEADs Team)

Assess

- MVP Social Services Subject Matter Expert (SME) identifies 2+ MVPs for **daily DOU Assessment**
- MVP SME writes the **MVP note** (we call it the Multi-visit Assessment & Follow-up Note)
- MVP SME serves as the **hospital-wide consultant** to care teams to integrate findings into the treatment plan and discharge plan

Engage / Link

- Reach out to **key stakeholders**, including family, community resources, case managers, Hemodialysis Centers, etc. to address DOU
- MVP SME serves as the interim **"Quarterback"** until community based "Quarterback" is in placed

Manage /Plan for Return

- **Huddle** to develop the next steps in **planning for the return** (MVP team & key stakeholders)
- **ED Care Alert** (called a "Hospital Intervention Note") is written
- **Continuous Improvement**: Weekly cross functional team conducts **case conferences** to improve care delivery

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Source: Humowiecki, et al. Blueprint for complex care, Dec 2018.
www.nationalcomplex.care/blueprint

Resources for Hospitals

- ✓ Reduces preventable readmissions
- ✓ Improves workflow
- ✓ Reduces med errors
- ✓ Prepares and empowers patients and families
- ✓ Requires understanding current barriers, adaptation, institutional commitment

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Resources for Hospitals & Nursing Homes

- Reduces readmissions
- Improves patient satisfaction
- Works in diverse populations
- Includes 12 discrete mutually reinforcing components
- Requires understanding current barriers, adaptation, institutional commitment

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Resources for Nursing Homes

- Reduces acute care transfers
- Helps identify and evaluate changes in resident condition
- Uses tools to improve communication among care teams
- Facilitates advance care planning
- Requires understanding current barriers, adaptation, institutional commitment

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Resources for Community Settings

- ✓ Uses healthcare “hotspotting”
- ✓ Provides community-based care management
- ✓ May reduce readmissions
- ✓ Facilitates patient link to primary care and social services
- ✓ Requires understanding current barriers, adaptation, institutional commitment

Camden Coalition

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Resources- Health Equity

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- ✓ Improving Care Transitions: A Guide to Tools & Resources for Providers and Patients
- ✓ Preadmissions Planning Checklist (English)
- ✓ Preadmissions Planning Checklist (Spanish)
- ✓ IHI STAAR Root Cause Analysis Tool
- ✓ Z Codes & Social Determinants of Health Resources
- ✓ A Guide to Screening Patients for Social Isolation

Coleman

- ✓ The Care Transitions Program®

AHRQ

- ✓ Project RED (Re-Engineered Discharge)
- ✓ Project RED Toolkit for Nursing Homes

CMS

- ✓ Guide to Reducing Disparities in Readmissions

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Open Forum

- What topics or information would be valuable for you to hear at future events?
- What insights have you been able to draw from attending the session(s)?
- What are your top 2 takeaways?

Upcoming Events

Date	Topic	Details
February 28 **10 - 11 AM**	Chronic Disease Prevention & Management	Partnering Beyond COVID-19 Prevention and Management of Patients with Chronic Disease: Heart Health
March 1 **12 - 12:30 PM**	Diversity, Equity & Inclusion	CLAS Theme 2, CLAS Standard 5 & CLAS Standard 6
March 2 **10 - 11 AM**	Addressing Opioid Misuse	A Pharmacy-Based Approach to Caring for Individuals with Opioid Use Disorder
March 2 **12 - 1 PM**	Diversity, Equity & Inclusion	Learn about the new CMS Health Equity Measures
March 2 **3 - 4 PM** **and** **March 8** **11 AM – 12 PM**	PCH Leaders & Stakeholders - Sharing Forum (2 sessions per quarter to enable broader participation)	2023 IPRO QIN-QIO Partnership for Community Health Leader Forum Q1: Supporting Staff Wellness
March 9 **12 - 1 PM**	Diversity, Equity & Inclusion	Health Equity Affinity Group Monthly Sharing Session

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