A Community-Based Approach to Address SDOH in Care Coordination of Patients

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Forum on Aging in Rural Oregon

Tuesday, May 16, 2023

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Comagine Health

Comagine Health is a national, nonprofit health care consulting firm.

We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system.

Comagine Health as the QIN-QIO

- Contracted by the Centers for Medicare and Medicaid Services (CMS) as the **Q**uality **I**nnovation **N**etwork - **Q**uality **I**mprovement **O**rganization
  - **(QIN-QIO) for:** Idaho, Nevada, New Mexico, Oregon, Utah and Washington

- Comagine Health provides technical assistance to health care organizations and community partners through:
  - 1:1 meetings
  - Webinars
  - Learning Series/ECHO sessions
  - Sharing best practices
  - Developing provider-facing and patient-facing materials

Comagine Health Projects

- Care Coordination
- Emergency Preparedness
- Chronic Disease
  - Diabetes
  - Hypertension
  - Chronic Kidney Disease
- Cardiac Rehabilitation
- Immunizations
- Tobacco Cessation

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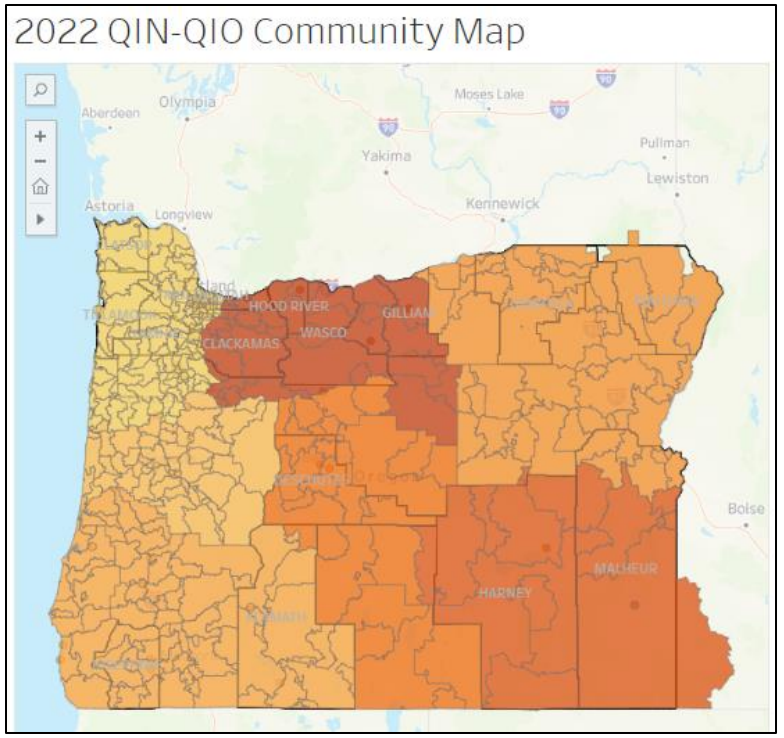
Community Hospital Utilization Goals

- Decrease emergency department (ED) visits for Medicare beneficiaries
- Decrease hospital utilization for super-utilizers (beneficiaries who visit the hospital three or more times per year)
- Decrease 30-day hospital readmissions for Medicare beneficiaries
- Have a Public Health Emergency Preparedness Plan

Hospital Utilization Data - Oregon

- In Oregon, about **69.7% of Medicare beneficiaries are utilizing the hospital** (through emergency department visits, observation stays, and inpatient discharges)*
- In Rural Oregon, about **81.1% of Medicare beneficiaries are utilizing the hospital****



*Data from Comagine Health – representative of CMS claims during the 12-month period between December 1, 2021 and November 30, 2022.

**Rural areas defined as zip codes with RUCA code = 10

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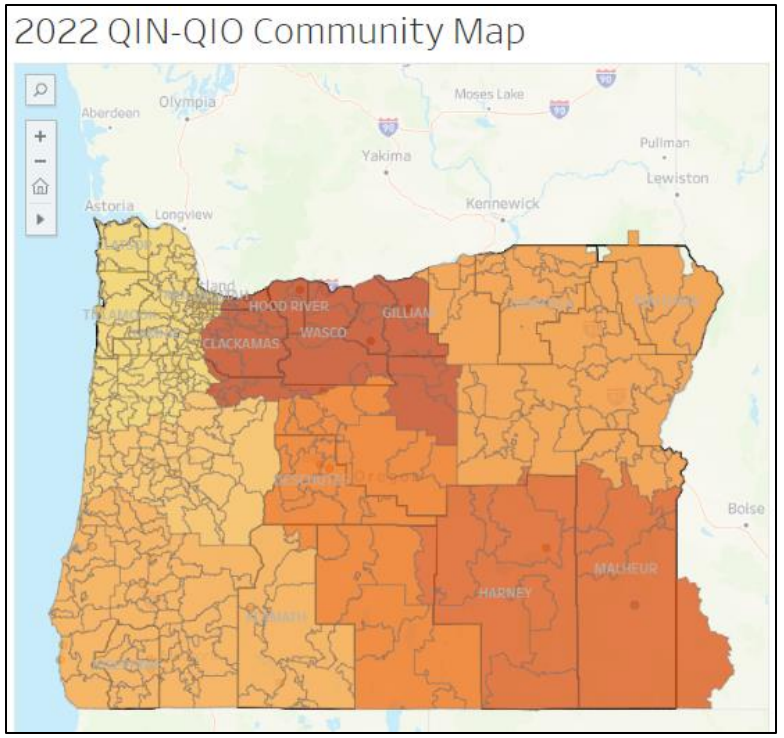
Hospital Readmission Data - Oregon

- In Oregon, about **15.0% of Medicare beneficiaries are readmitted** within 30 days of discharge*
- In Rural Oregon, about **13.4% of Medicare beneficiaries are readmitted** within 30 days of discharge**



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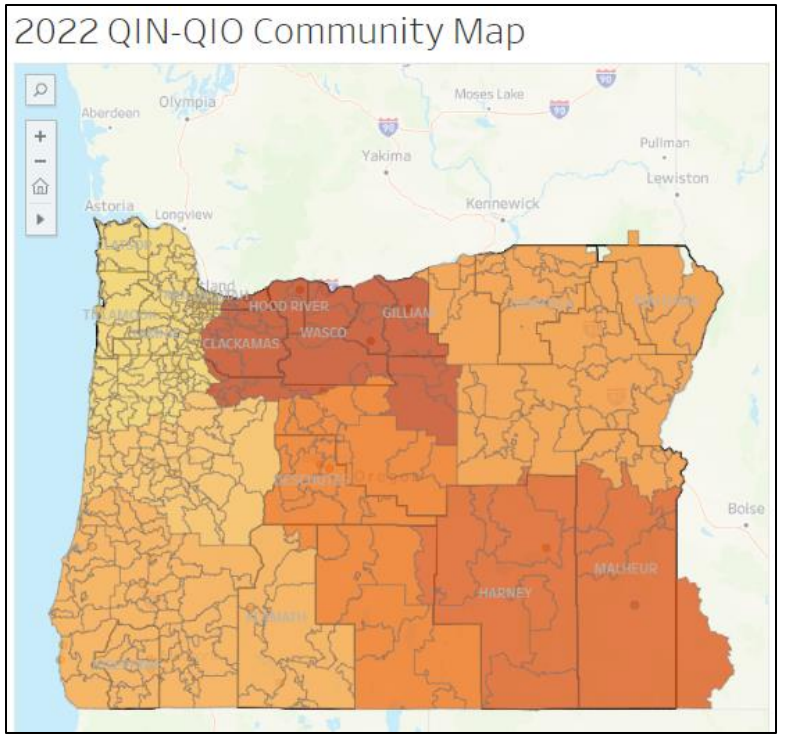
Super-utilizer Data - Oregon

- In Oregon, super-utilizers visit the emergency department about **4.1 times per year***
- In Rural Oregon, super-utilizers visit the emergency department about **4.1 times per year****



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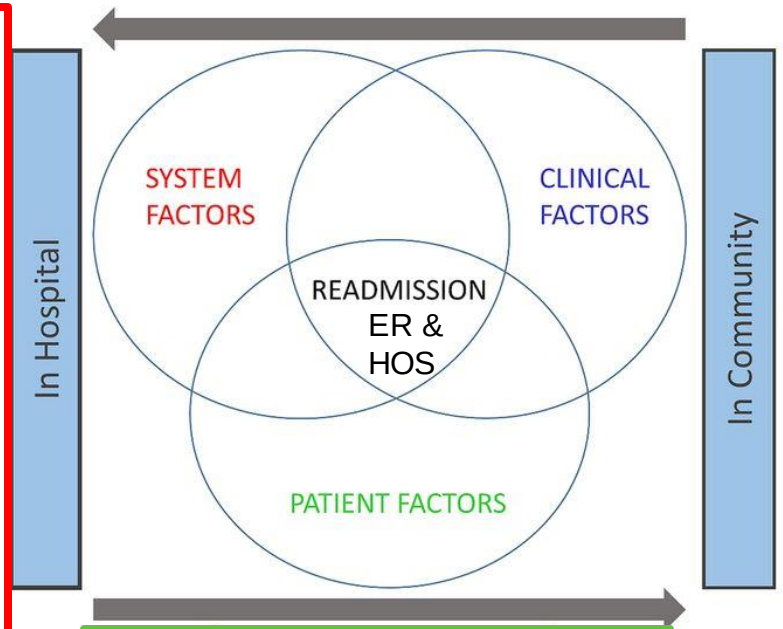
Factors Impacting Readmission, ER and Hospitalization

System Factors

- Discharge planning
- Transition of care
- Relationship with ambulatory clinics
- Social care services
- Interoperability
- Early or late discharge



Clinical Factors

- ICU experience
- Length of ICU or hospital stay
- Diagnosis
- Illness Severity
- Previous hospitalizations
- Adverse events

Patient Factors

- Age
- Social support
- Socio-economic status
- Health literacy
- Accessibility
- Substance misuse

BMJ Open

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Strategies for Addressing Avoidable Admissions

- Tools for preventing hospital admissions and readmissions exist both internally and externally
- Inside the hospital:
  - Use of data to make informed decisions
  - Use of quality improvement (QI) strategies to improve care transitions
  - Integration of services like hospice care, home health, palliative care, Meds-to-Beds, etc.
- Outside of the hospital:
  - Participation in community collaboratives or coalitions
  - Use of coordinated/wraparound services
  - Partnering with community-based organizations

Hospitals' Roles in Reducing Readmission

- Use of data
  - Administrative claims
  - EMR (codes, age, d/g, timeline)
  - Micro data from interviews, post-discharge calls
- Multidisciplinary team building
  - Medical staff, Social Workers, Case Managers, CHWs, etc.
  - Include family members and patients in the care plan
- Customize discharge planning
  - Timely post-discharge follow-up phone call
- Develop a follow-up plan with the patient
- Use of appropriate tools (i.e. screening and assessment tools)

Screening Tools for High Utilizers

The 8P Screening Tool
Identifying Your Patient's Risk for Adverse Events After Discharge

The 8Ps (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problems with medications (polypharmacy – i.e. ≥10 routine meds – or high risk medication including: insulin, anticoagulants, oral hypoglycemic agents, dual antiplatelet therapy, digoxin, or narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or history of depression diagnosis) ☐	☐ Assessment of need for psychiatric care if not in place ☐ Communication with primary care provider, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	

PRAPARE

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

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

Yes	No	I choose not to answer this question

are you? Check all that apply

	Native Hawaiian
	Black/African American
	American Indian/Alaskan Native

rite):

nswer this question

e past 2 years, has season or k been your or your family's ome?

	I choose not to answer this question

arged from the armed forces of

	I choose not to answer this question

most comfortable speaking?

rs, including yourself, do

is question

your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

8. Are you worried about losing your housing?

Yes	No	I choose not to answer this question

9. What address do you live at?

Street: _____

City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

Less than high school degree		High school diploma or GED
More than high school		I choose not to answer this question

11. What is your current work situation?

Unemployed	Part-time or temporary work	Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:		
I choose not to answer this question		

12. What is your main insurance?

None/uninsured	Medicaid
CHIP Medicaid	Medicare
Other public insurance (not CHIP)	Other Public Insurance (CHIP)
Private Insurance	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

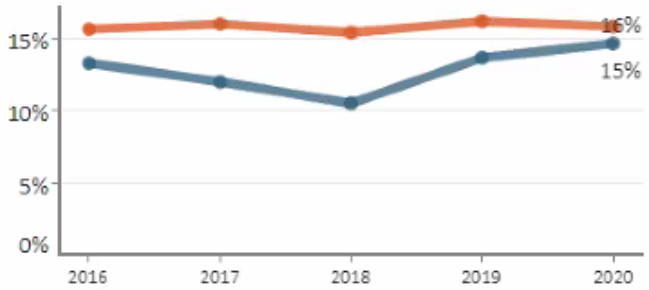
_____

I choose not to answer this question

Care Transitions Community Report: Southwestern New Mexico

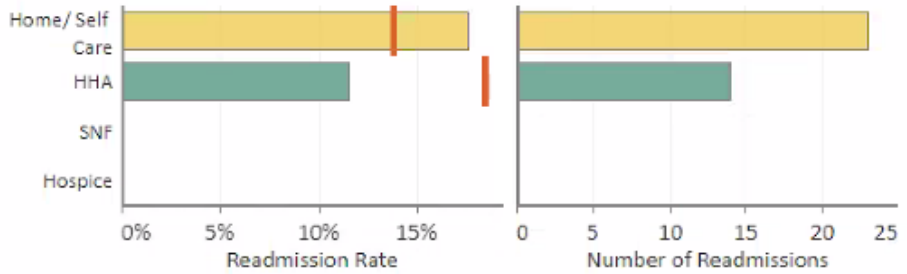
Hospital Readmissions, 2020

Trends in Readmission Rates



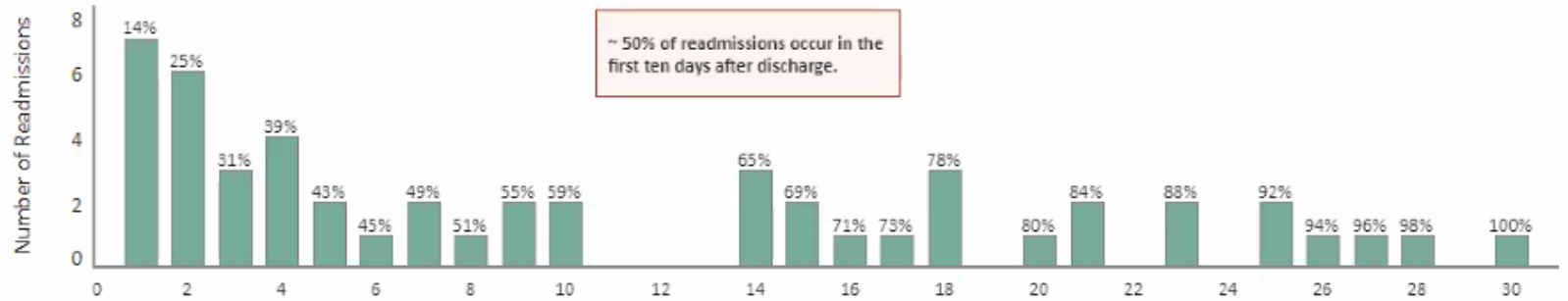
This graph shows the 30 day readmission rates over time for the **Southwestern New Mexico** community (**blue line**) compared to the rate for the other **New Mexico** communities combined (**orange line**). The readmission rate is defined as the number of readmissions within 30 days of discharge/number of live discharges.

Readmission Rates and Number of Readmissions by Discharge Destination



These graphs show readmission rates (left) and number of readmissions (right) for the **Southwestern New Mexico** community, by discharge destination (**colored bars**). Statewide readmission rates are also shown (**orange lines**). Note that patients discharged to home/self care account for the largest number of readmissions, even though they do not have the highest readmission rate. **NOTE: data is suppressed when the number of readmissions is less than 11.**

30 Day Readmissions By Days Since Discharge



This graph shows the number of readmissions (**blue-green bars**), by days since discharge, for the **Southwestern New Mexico** community, along with the cumulative percentage of 30 day readmissions. Note that approximately 50% of readmissions occur within ten days of discharge.

Develop Community Support

- Family/caregiver consulting
- IT readmission warnings
- Managed care services
- Pharmaceutical reevaluations
- Primary Care providers
- Community health worker, Home Health, Social Services
- Transportation, housing, etc.

CMS Framework for Health Equity 2022 – 23

CMS Framework for Health Equity 2022 – 23

- Screening for Social Drivers of Health
  - Race, ethnicity, language, age, income etc.
- Screen Positive Rate for Social Drivers of Health
  - Food insecurity, access to transportation

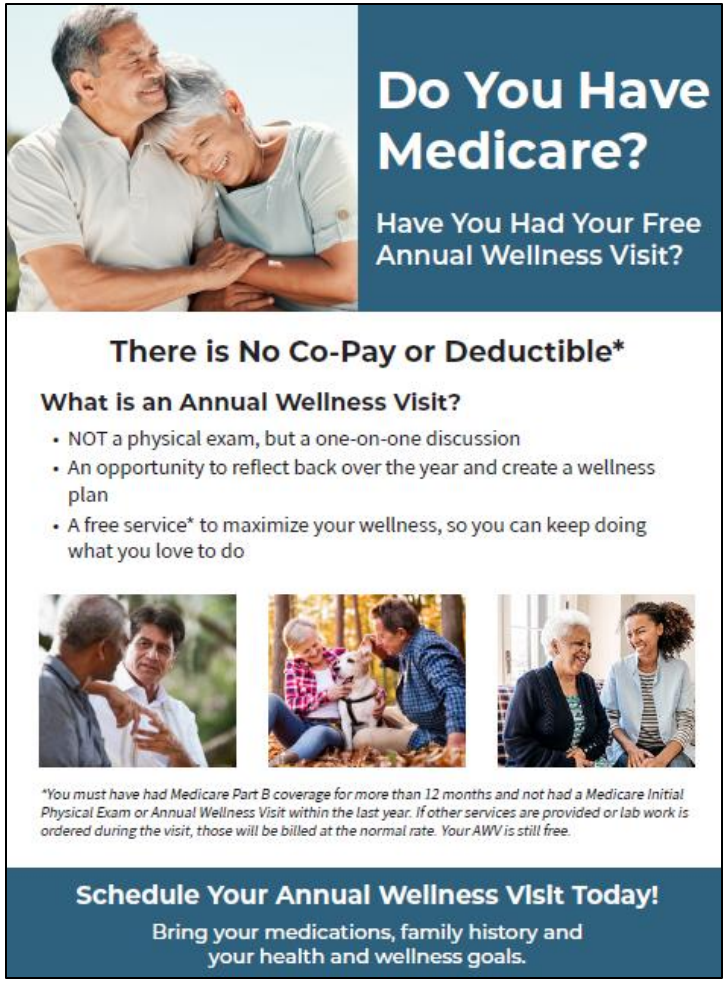
CMS Framework for Health Equity 2022 – 23

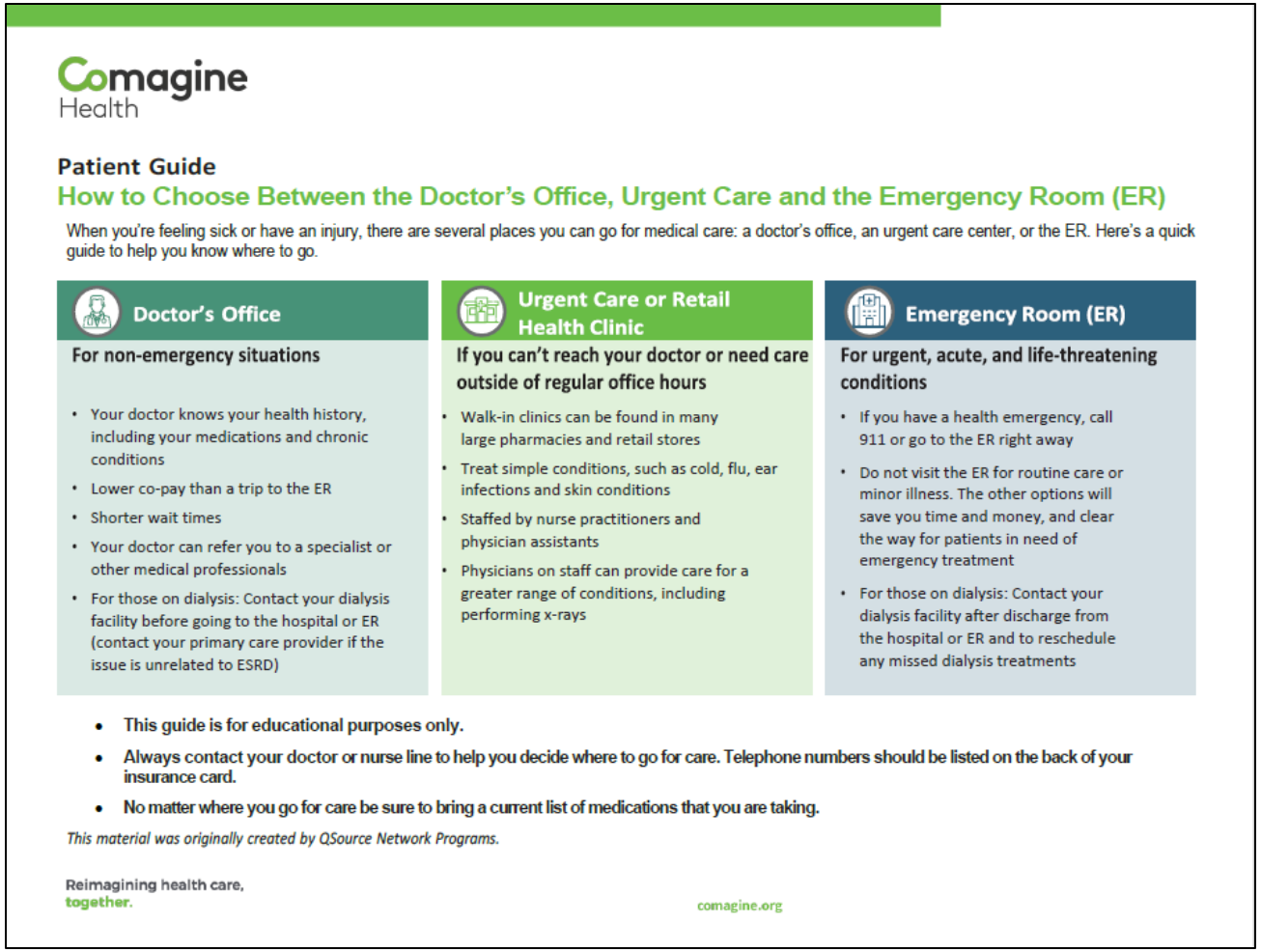
- Community may need to change
- Organization may need to evolve
- Language barriers and access to interpreter services
- What are some reasons that patients withhold information?
- What kind of education can be provided to overcome the barriers?

Patient-Facing Educational Materials

- We have developed and distributed educational material on various topics based on the needs of our community partners
  - Medicare Annual Wellness Visit poster
  - Primary Care v. Urgent Care v. Emergency Department decision chart
- How effective are these materials?
  - Already promoting at barber shops and senior centers. Where else can we promote the material?
  - How can we make our outreach more effective?

Comagine Patient-facing Educational Materials





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Finding a Sustainable Program for Community Health Workers (CHWs) and Emergency Paramedic Services (EMS)

- Collaborated with CHW and EMS services to provide CHW training on helping patients navigate hospital discharge
- CHWs are well-trained to perform tasks that may reduce hospital utilization
  - Counseling to encourage adherence to clinical care plans
  - Psychosocial support
  - Making and confirming follow-up appointments
  - Helping patients understand medication regimens
  - Coordinating with patients' pharmacies
- Difficult to secure consistent funding
  - What can be done to keep programs running?

Promoting Access to Healthcare

- Barriers encountered by beneficiaries:
  - Cost – patient might not be able to cover copay
  - Health literacy – patient may not understand the healthcare system, discharge instructions
  - Transportation – patient may not have reliable transportation to/from medical visits
- Barriers encountered in Rural areas:
  - Lack of Specialty and Behavioral Health providers
  - Long distances to healthcare facilities and hospitals
    - LIBRARIES have been able to provide a safe space, computer equipment, and personnel to help seniors access telehealth services
    - Needs dedicated funding or ways to bill for services
- Does anyone here have any experience using telehealth at a library?
- Are you aware of the potential of using telehealth at a library?

Medicare Beneficiary Listening Sessions

Listening sessions:

- Partnered with Patient and Family Centered Care Partners (PFCCp) to host sessions to understand the successes and barriers of Medicare beneficiaries in accessing healthcare
  - 2 of 3 sessions hosted
  - Four to six beneficiaries attended per session
  - Findings to be compiled into a formal report for CMS

These listening sessions will:

- Allow beneficiaries to have their voices heard
- Provide insights for a formal report for CMS highlighting common themes and making recommendations
- Help guide our future work with CMS
- Bring about positive change in the healthcare system

Collaboration Outside of the Hospital

- Comagine Health has formed a collaborative to address high utilization
- Network with a team that shares the care of high-risk patients
- Improve the referral process – Unite Us, Emergency Department Information Exchange, Collaborate with nursing homes, home health, and faith-based organizations
- Work with primary care providers
- Webinars focusing on the use of telehealth in libraries, the role of paramedics in reducing readmissions, and more

Food for Thought

How can you use a collaborative to reduce readmissions, hospital utilization, and emergency department visits in your community?

Questions? Comments?

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Thank you!

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OREGON OFFICE of RURAL HEALTH

2023 Forum on Aging in Rural Oregon

OPPORTUNITY Just knock.

Thank you!

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