Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network
Serving Kansas, Nebraska, North Dakota & South Dakota

Care Coordination:
It Takes A Community

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Direction Home

April 16, 2015

GLOBAL/LOCAL: COMMUNITY-BASED CARE COORDINATION

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VICE PRESIDENT, PLANNING & QUALITY IMPROVEMENT

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WHO IS ON THE CALL WITH US TODAY?

Please answer the poll now to let us know which perspective you represent.

- ❑ **Hospital**
- ❑ **Nursing Home**
- ❑ **Home Health/Hospice**
- ❑ **Assisted Living Facility**
- ❑ **Retail Pharmacy**
- ❑ **Long term services and support provider**
- ❑ **Primary Care**
- ❑ **Other**

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NY TIMES SEPT 28, 2014

N.Y. / REGION

1019 COMMENTS

Fighting to Honor a Father's Last Wish: To Die at Home

By NINA BERNSTEIN SEPT. 25, 2014

http://www.nytimes.com/2014/09/26/nyregion/family-fights-health-care-system-for-simple-request-to-die-at-home.html?_r=0

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QUESTIONS TO RUN ON ….

How can I think more globally about my local community?

How do I learn more about how my community can contribute to our goals?

Where will I start tomorrow in my own community?

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COMMUNITY-BASED ORGANIZATIONS (CBO): WHO ARE WE AND HOW DID WE GET TO THIS TABLE?

- 2011 RWJF survey of 1,000 primary care physicians
  - 85%: Social needs directly contribute to poor health
  - 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care
  - 1 in 7 prescriptions would be for social needs
  - Psychosocial issues treated as physical concerns

HOW FAMILIAR ARE YOU WITH LONG-TERM SERVICES AND SUPPORTS AVAILABLE IN YOUR COMMUNITY?

Please answer the poll now to help us understand your familiarity with long-term services and supports in your community.

- ❑ **Very familiar**
- ❑ **Somewhat familiar**
- ❑ **Not familiar at all**
- ❑ **I am not familiar with the term "long-term services and supports"**

AREA AGENCIES ON AGING

National network built on a common framework:

- **Planning and Community Organizing**

Grass roots foundation that grows with community needs:

- **Long-term services and supports (LTSS) for many populations**

FRONT DOOR TO LTSS CARE COORDINATION

Information

Resources

Care Coordination

Nutrition

Transportation

Assessment

Transitions

Caregiver Support

Housing

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DRIVING FORCES FOR IMPROVING CARE COORDINATION

1. Overcoming jargon and adopting a global perspective

2. Sharing data for shared outcomes

3. Paying for performance

MOVING PAST JARGON

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WHY DOES LANGUAGE MATTER?

Care vs. support

Patient vs. consumer vs. client vs. community member

Provider vs. provider

Skilled vs. unskilled

You have to understand how your partners are hearing you or else you will miss out on half of the conversation……

DEFINING CARE COORDINATION

“the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”

McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

LANGUAGE ASIDE: CONSIDER GLOBAL PERSPECTIVE

1. Numerous participants are typically involved in care coordination; INTERDISCIPLINARY

2. Coordination is necessary when participants are dependent upon each other to carry out disparate activities in a patient's care; BIO-PSYCHO-SOCIAL

3. In order to carry out these activities in a coordinated way, each participant needs adequate knowledge about their own and others' roles, and available resources; PERSON-CENTERED PLANNING

4. In order to manage all required patient care activities, participants rely on exchange of information; IT SOLUTIONS

5. Integration of care activities has the goal of facilitating appropriate delivery of health care services. HEALTH & INDEPENDENCE

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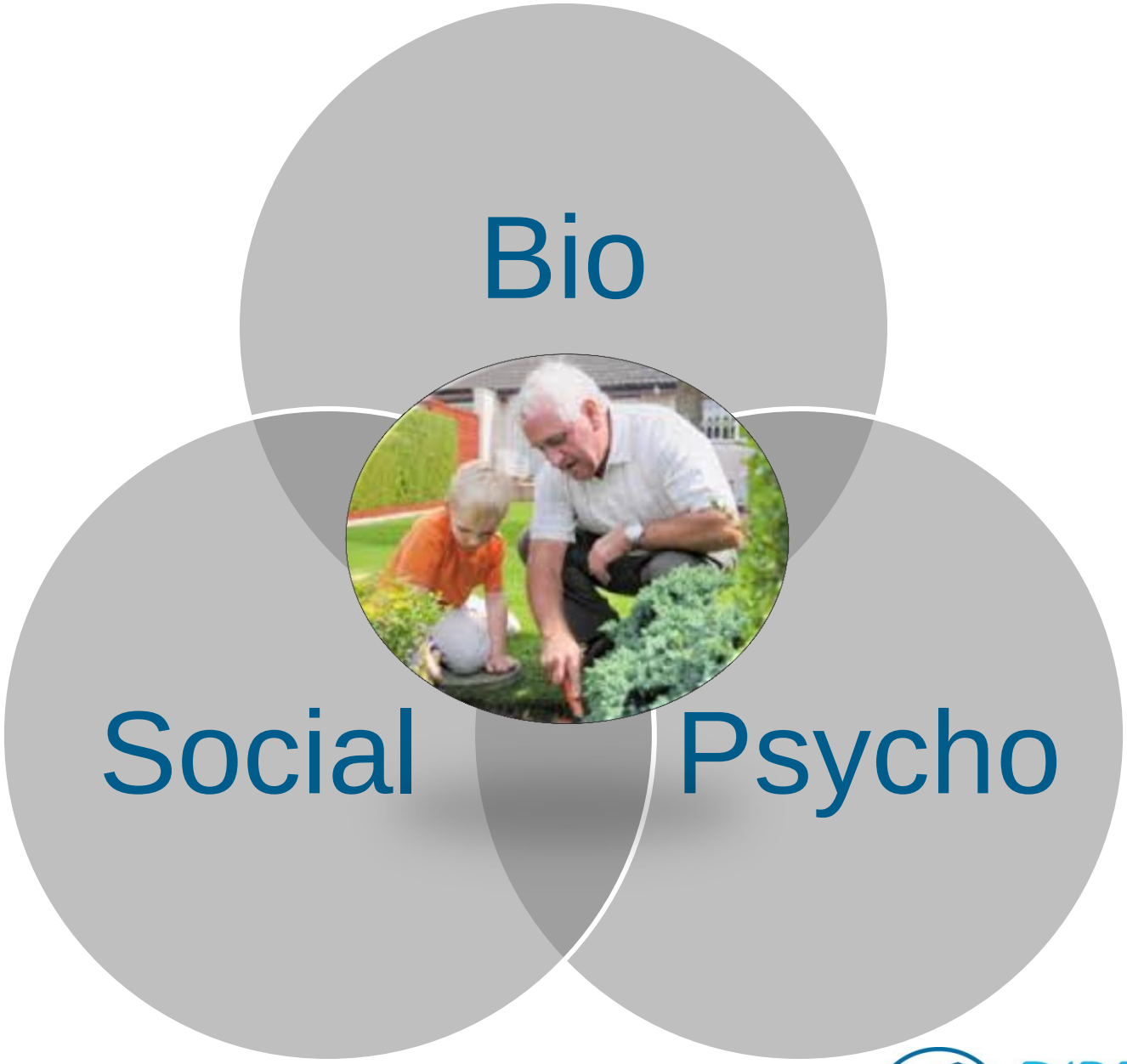
PERSON CENTEREDNESS, HEALTH AND INDEPENDENCE

Important to and important for

Community planning

Livable communities, aging in place



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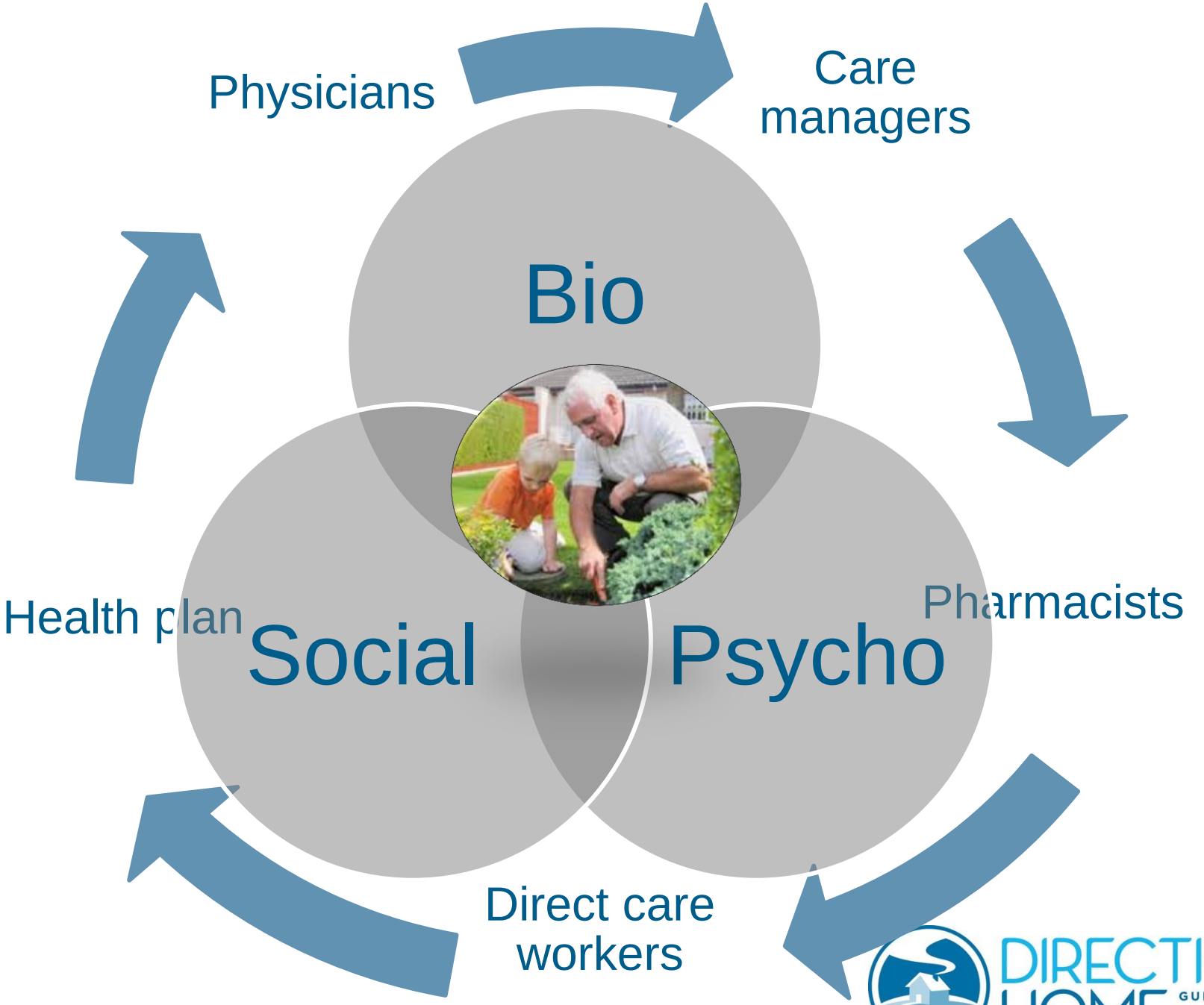
BIO-PSYCHO-SOCIAL

Comprehensive assessment

Eligibility and enrollment

Unique service structure



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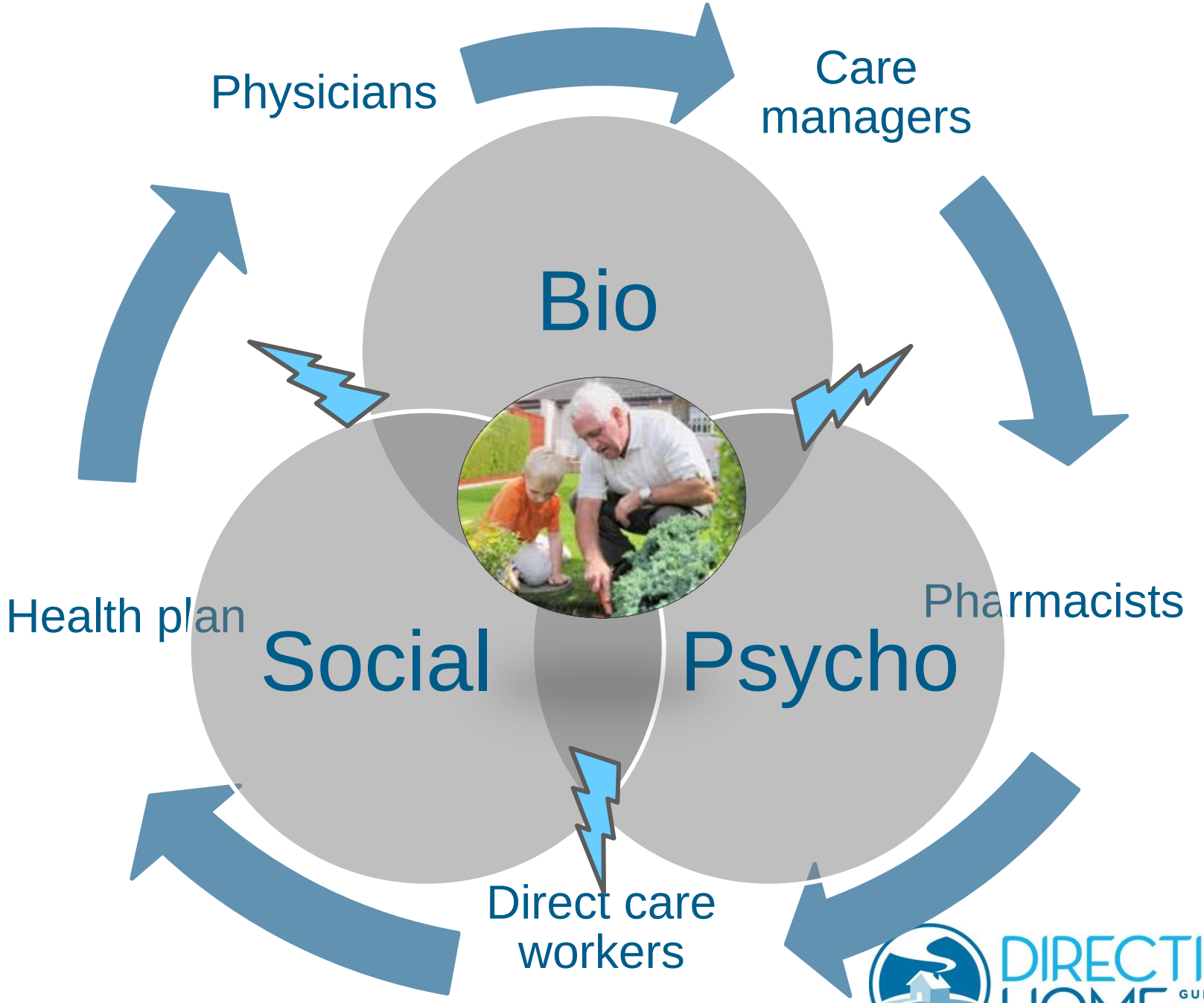
INTERDISCIPLINARY

Shared training

Team consultation structures

Capacity for follow up



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DATA TO SHARE

Environmental factors

Health and wellness participation

Caregiver needs and services

DRIVING FORCES FOR IMPROVING CARE COORDINATION

1. Overcoming jargon and adopting a global perspective

2. Sharing data for shared outcomes

3. Paying for performance

SHIFTING PAYMENT POLICIES

Quality, Quality, Quality

- **Pay for performance**
- **Volume to value**
- **Population-based payments**

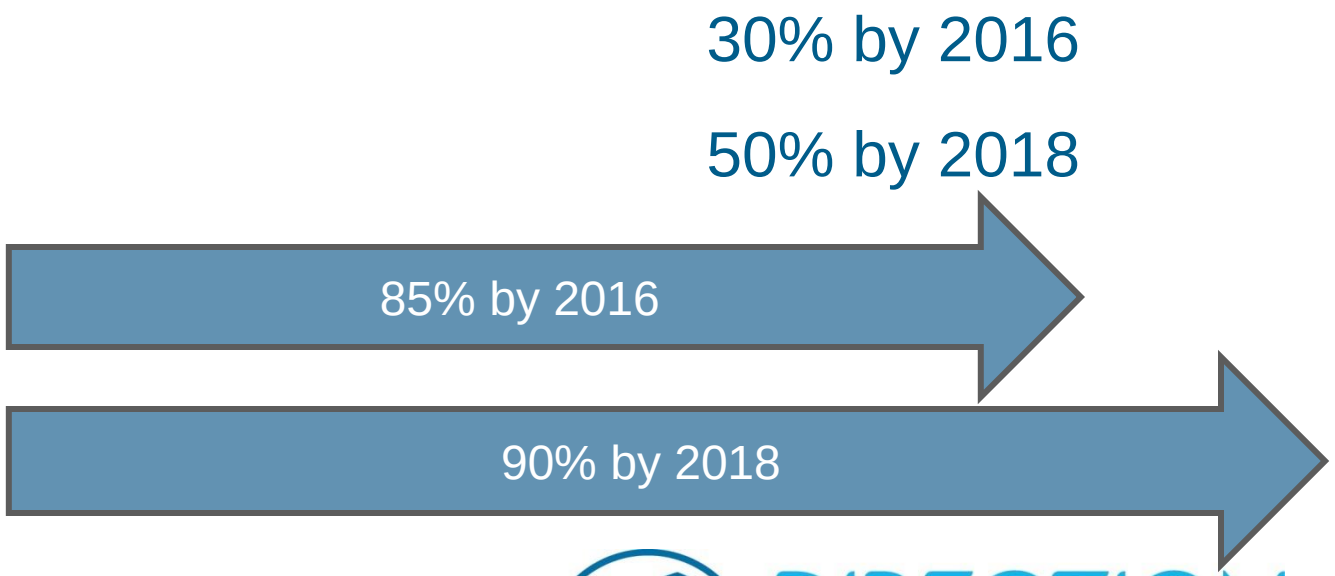
By 2018—90% of all Medicare spending is linked to quality

How?

- **Care delivery reform**
- **Incentives**
- **State-based reform**

TIMELINE FOR ACHIEVING HHS VISION FOR QUALITY-BASED PAYMENTS

Category 1—FFS, no link to quality	Category 2—FFS, w/ link to quality	Category 3—Alt. Payment Models	Category 4—Population-based
Limited Traditional Medicare FFS	Hospital Readmission Reduction Program, VBP	ACOs, bundled payments, medical homes	Duals Demonstrations, Pioneer ACOs



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HOW DOES COMMUNITY GET IN ON THE ACTION?

com·mu·ni·ty

kəˈmyo͞onədē/

Noun, **def. A group of vested people, as individuals or members of organizations, who have collectively identified and defined a purpose, established or adopted a goal, and developed or accepted a coordinated strategy for achieving said goal.**

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COMMUNITY PARTNER

Marcy Rose, Clinical Specialist (Paramedic)

Community Ambulance Service ▪ Minot, ND

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VALUE OF BEING A HIGH-QUALITY "PARTNER"

Changing perspective and proactively changing revenue and partnership model to ensure survival

- **Converse of WIIFM**

Also known as….the right thing to do

But when does it go too far?

SUCCESS = TAILORED COLLABORATION

Design thinking exercises for new payment models

- **Target audiences, payment method, value proposition**
- **Targeted, disease-based models**

Community stakeholders must be flexible

- **Employ quality improvement tools**
- **Focus on next creative solution dictated by need in the environment**

QUESTIONS TO RUN ON ….

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Where will I start tomorrow in my own community?

Connect in Your Community

- Kansas
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