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Community-Driven, Multi-Payer Health Equity Solutions: An ECHO® Collaborative

Advanced Community-Clinical Teams

June 20, 2024 | 2:00-3:30 p.m. ET

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A Few Reminders

- ✓ Please introduce yourself and your organization in the chat
- ✓ Recording and slides will be shared following this session of the Health Equity Learning Collaborative
- ✓ Please keep yourself muted unless you have a question. We will have time for questions, but feel free to raise your hand at any time.
- ✓ A live transcript of the meeting is available. To turn on closed captioning, click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

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Agenda

1. Welcome and Introductions
2. TeamSTEPPS
3. An Example
4. Open Discussion
5. Next Steps

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Case Study – Setting the Stage

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- **Admission Dx**
- Dual Eligible admitted from a short-stay SNF admission for complications related to diabetes with a complicating condition of homelessness. Discharge to community with follow-up at the transitions clinic. Patient discharged to shelter.

- **Transitions Clinic**
  - Tx plan includes adding Ozempic to the medication regimen along with a long acting insulin.
  - Referral to CBO to address housing needs.
  - CBO explores housing voucher programs.
  - Patient readmitted for diabetes complications with blood glucose 600+.
  - Admission note reports noncompliance with diet and medication.

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Readmission Contributing Factors

- Unable to store medication.
- No Transportation to pharmacy to obtain prescriptions.
- Limited ability to administer medication according to the recommended schedule.
- Limited access to food that adheres to diet regimen.

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Readmission Root Cause Discussion

- Hospitalist reports that discharge meds were sent to the outpatient pharmacy but never picked up.
- CBO reports that the physician only made a referral for housing.
- Physician reports that the patient must take some responsibility for their care.
- Shelter manager reports that patients with complex needs should not be “dumped” on the shelter system.

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Evidence

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Accountable Health Communities (AHC) Second Evaluation Report: May 2023

- Accountable Health Communities (AHC) Model Evaluation

Accountable Health Communities (AHC) Model Evaluation

Second Evaluation Report

May 2023

Submitted To:
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, MD 21244-1850
Contract # HHSM-500-2014-000371
TO # 75FCMC18F0002

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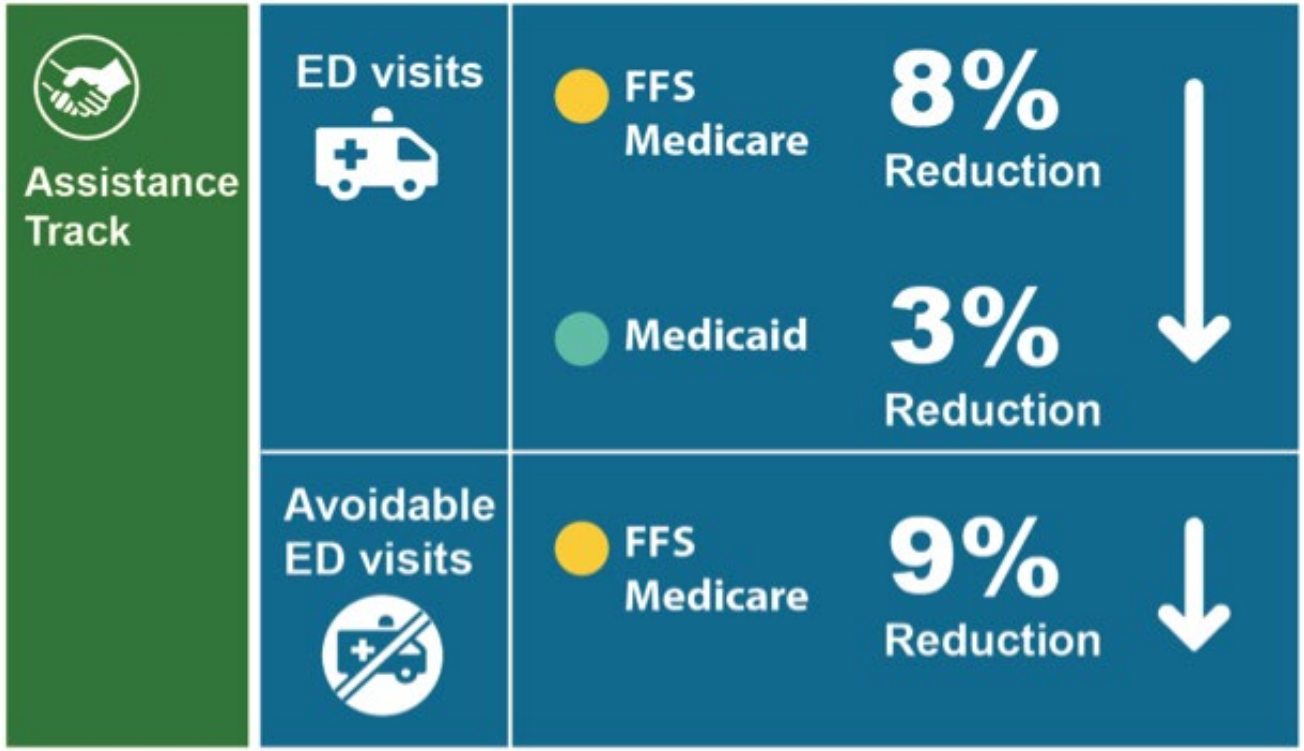
Statistically Significant Outcome (N = 1+ Million)

Exhibit ES-5. Assistance Track Impacts on Emergency Department Visits



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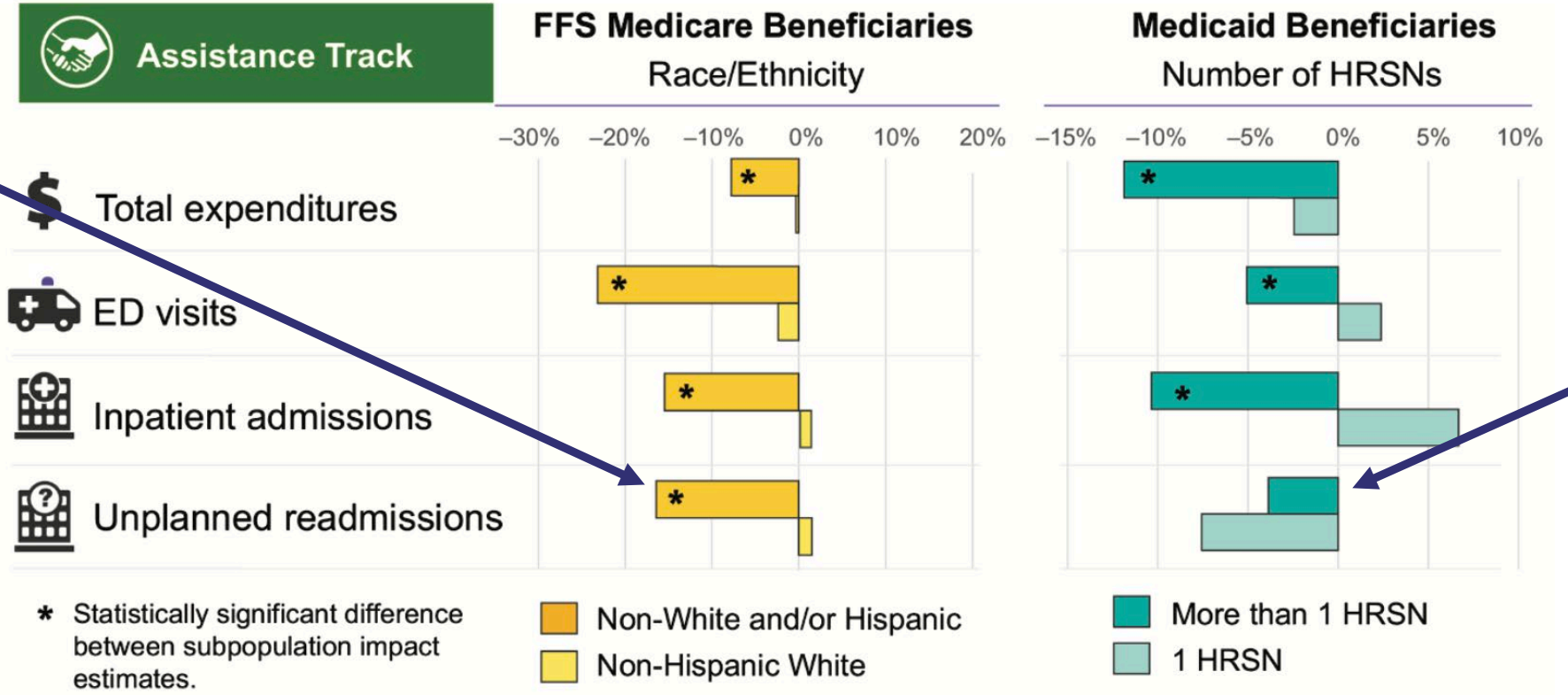
Impact of HRSN Screening and Social Care Navigation on Total Cost of Care

Exhibit ES-6. Assistance Track Impacts on Expenditures and Utilization for Selected Subpopulations



1. Impact on unplanned readmissions greatest amongst Medicare FFS Non-White and/or Hispanic participants.

2. Impact on unplanned readmissions greatest amongst Medicaid when there are more than one HRSN.

Post-Discharge Follow-Up Data

- JAMA: Medicare Transitional Care Management Program and Changes in Timely Postdischarge Follow-Up
- Cross Sectional Interrupted Time Series Study of **77 Million Medicare Discharges** from 2010 – 2019.
- Assessing timely primary care or specialty care follow-up after an inpatient discharge.
    - Transitional Care Management
    - Other medical follow-up post-discharge

JAMA Health Forum™

Original Investigation

Medicare Transitional Care Management Program and Changes in Timely Postdischarge Follow-Up

Timothy S. Anderson, MD, MAS; Shoshana J. Herzig, MD, MPH; Edward R. Marcantonio, MD, SM; Robert W. Yeh, MD, MSc, MBA; Jeffrey Souza, MA; Bruce E. Landon, MD, MBA

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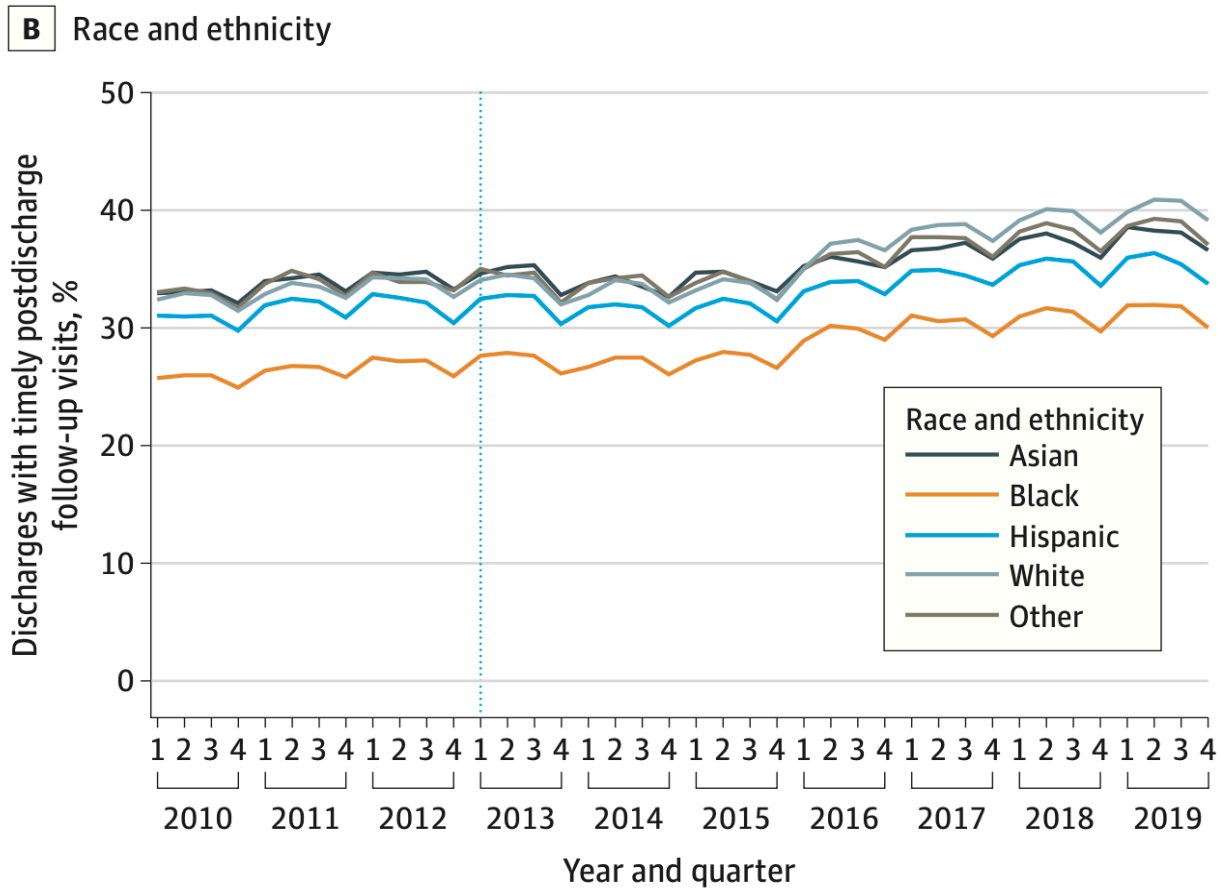
Impact of HRSN Screening and Social Care Navigation on Total Cost of Care



~ 30% of Black and Hispanic Medicare Beneficiaries received timely follow-up after discharge.

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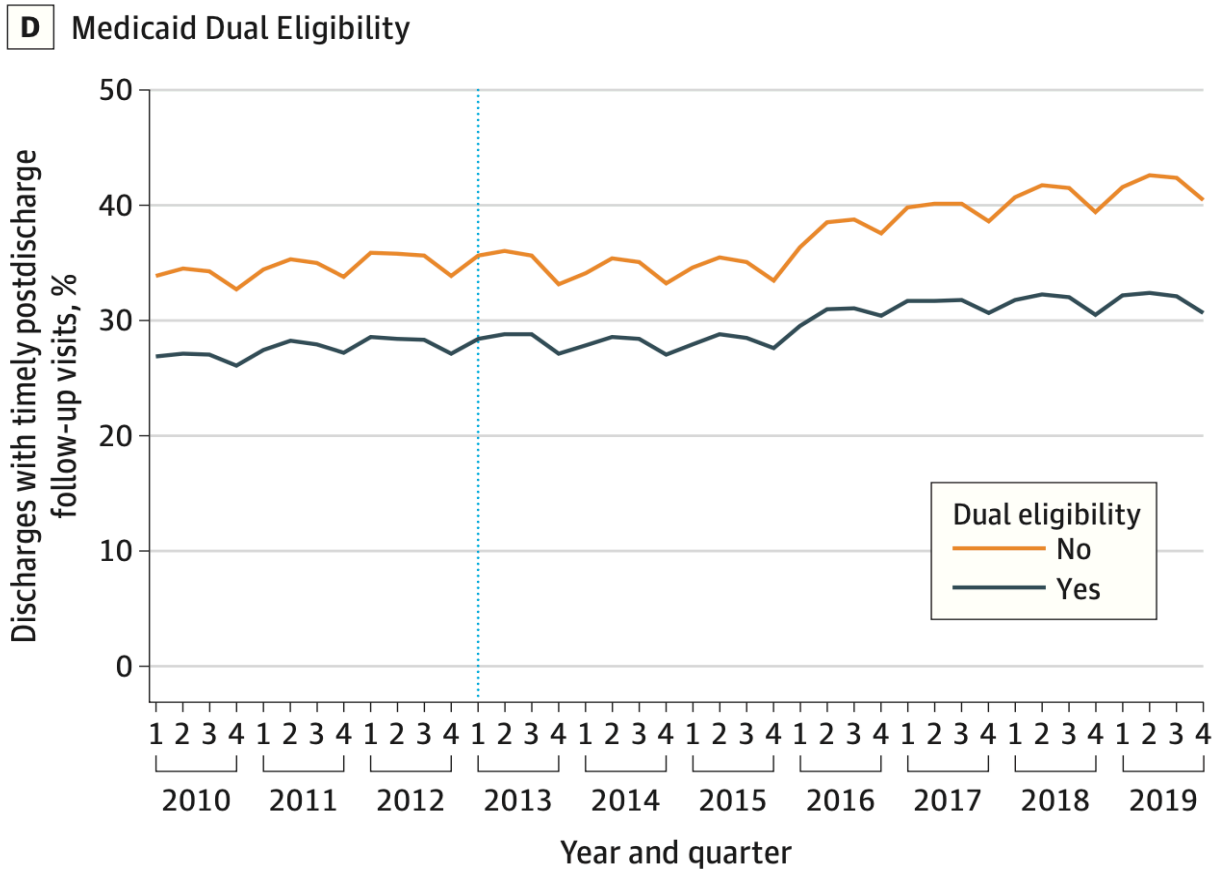
Impact of HRSN Screening and Social Care Navigation on Total Cost of Care



~ 30%. Dual Eligible Beneficiaries were the least likely to have timely follow-up post-discharge.

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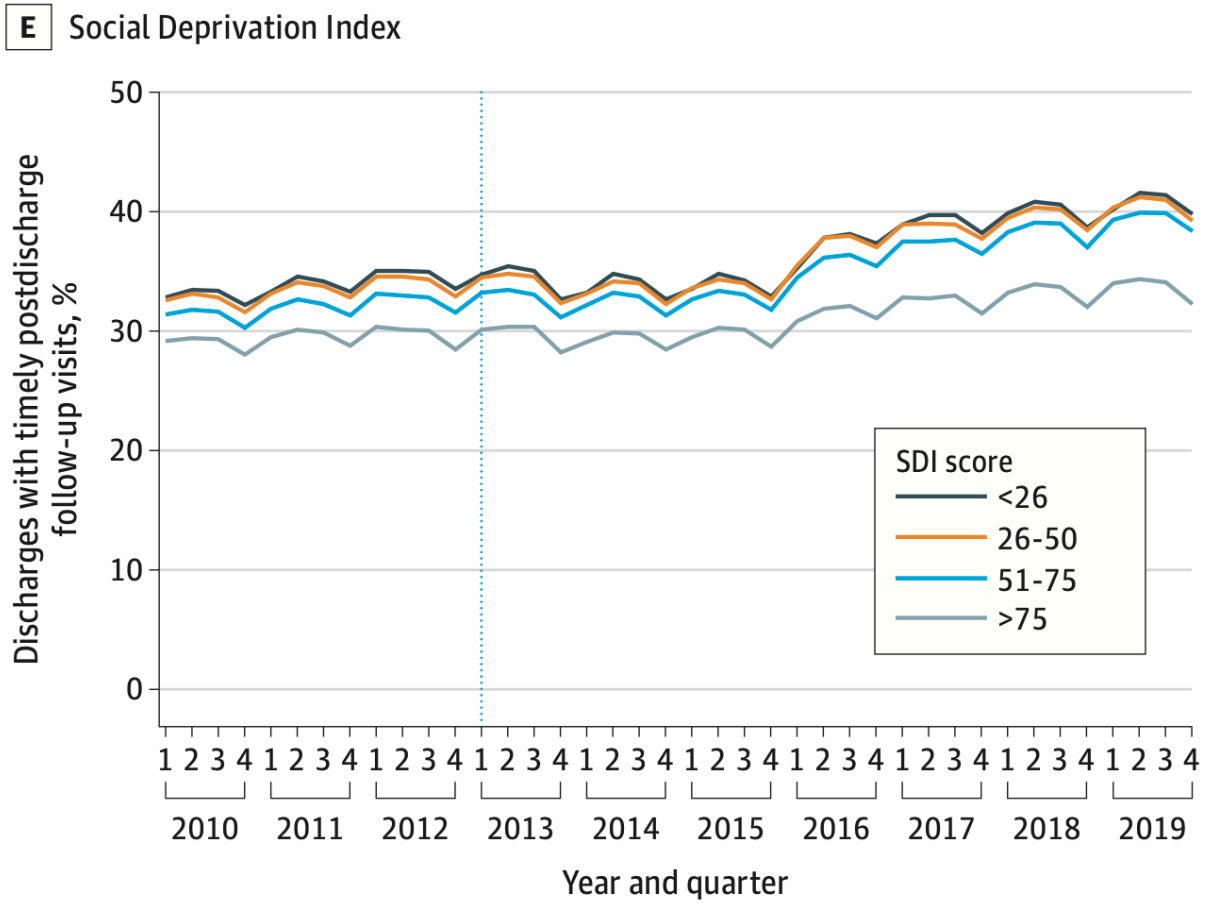
Impact of HRSN Screening and Social Care Navigation on Total Cost of Care



~ 30%. Populations with high social deprivation were the least likely to have timely follow-up post-discharge.

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Additional Evidence Resources

- Advancing health equity through organizational change: Perspectives from health care leaders
- Achieving health equity through eradicating structural racism in the United States: A call to action for nursing leadership
- Enhancing Support for Patients' Social Needs to Reduce Hospital Readmissions and Improve Health Outcomes

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TeamSTEPPS

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What is TeamSTEPPS?

- "TeamSTEPPS is an evidence-based set of teamwork tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare teams, including patients and family caregivers."

TeamSTEPPS®
Team Strategies & Tools to Enhance Performance & Patient Safety

Source: https://www.ahrq.gov/teamstepps-program/index.html

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Why TeamSTEPPS Matters

TeamSTEPPS can help your organization to:

- Cope with organizational stressors
- Support patients and peers
- Better understand risks and how to constructively cope with them
- Manage challenges arising from rapid changes in teams

Source: https://www.ahrq.gov/teamstepps-program/welcome-guides/frontline-providers.html

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Key Concepts

- Communication
- Team Leadership
- Situation Monitoring
- Mutual Support

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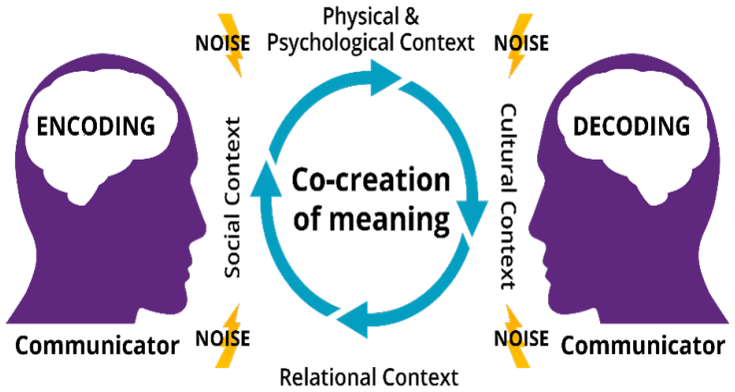
Transactional Model of Communication



Communication

- Verbal and nonverbal process by which information can be clearly and accurately exchanged among team members
- Common communication tools
  - SBAR (Situation, Background, Assessment, Recommendation or Request)
  - Closed-Loop Communication
  - Call-Out
  - Check-Back
  - Teach-Back
  - Handoff
  - I-Pass

Source: https://www.ahrq.gov/teamstepps-program/curriculum/communication/overview/index.html

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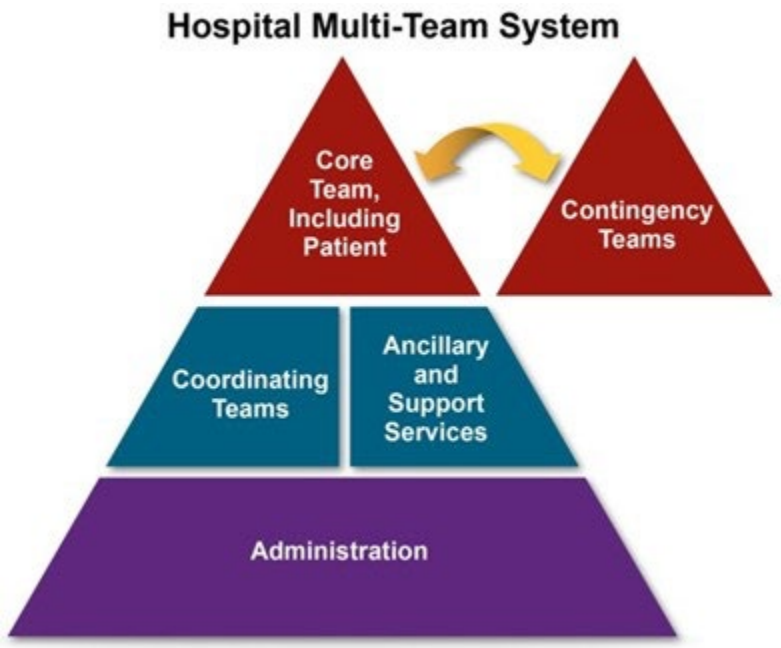

Team Leadership

- Includes:
  - Teams
  - Multi-Team System for Patient Core
  - Team Leadership
  - Ensuring Coordinated Team Activities

Source: https://www.ahrq.gov/teamstepps-program/curriculum/team/overview/index.html

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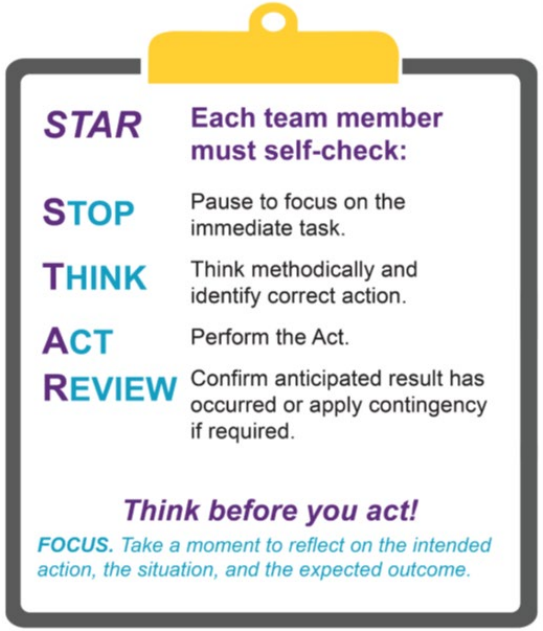
Situation Monitoring



Tools:

- STEP (Status of patient, Team Members, Environment, Progress towards goal)
- I'm Safe Checklist
- Cross-Monitoring
- STAR (Stop, Think, Act, Review)

Source: https://www.ahrq.gov/teamstepps-program/curriculum/situation/overview/index.html

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Mutual Support

- Tools:
  - Task Assistance
  - Formative Feedback
  - Advocacy and Assertion
  - Two-Challenge Rule
    - CUS
    - DESC (Describe, Express, Suggest, Consequences)

Source: https://www.ahrq.gov/teamstepps-program/curriculum/mutual/overview/index.html

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Information and Tools:

- TeamSTEPPS Tools:
  - https://www.ahrq.gov/teamstepps-program/resources/modules/index.html
- TeamSTEPPS Training Simulation Videos
  - https://www.ahrq.gov/teamstepps-program/resources/videos/index.html
- TeamSTEPPS Patient Videos
  - Patients describe their interactions with their providers who have used TeamSTEPPS
  - https://www.ahrq.gov/teamstepps-program/resources/patient/index.html

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Application of TeamSTEPPS

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- **Admission Dx**
- Dual Eligible admitted from a short-stay SNF admission for complications related to diabetes with a complicating condition of homelessness. Discharge to community with follow-up at the transitions clinic. Patient discharged to shelter.

- **Transitions Clinic**
  - Tx plan includes adding Ozempic to the medication regimen along with a long acting insulin.
  - Referral to CBO to address housing needs.

- **How Would the Outcome be Different if TeamSTEPPS is applied to this same case?**

Sample TCM + CCM + CHI Process Flow: Housing Insecurity

1. Inpatient Admission w/ Positive Housing HRSN Complicating Condition = **3.1%** **Increase in Hospital MS-DRG Payment.**

Billing: MS-DRG 638

Code	Detail
Z59.00	Homelessness, unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness

2. Discharge Planner schedules TCM Follow-up Visit with Transition Clinic.

Examples:
- Resident Clinic
- Transitions Clinic
- Heart Failure Clinic
- FQHC/RHC
- Home-Based Primary Care
- NP Clinic
- Chronic Disease Clinic

Billing: CPT 99496, 99490, 99439

3. Transitional Care Management (TCM) Post-Discharge Visit plus CCM:

Community Health Integration (CHI) Initiating Visit by Qualified Practitioner during Clinic Visit.

Physician, NP, or PA

New Patient

4. CHI to address Housing Insecurity.

5. CHI Auxiliary Staff to address Housing: CHW, Health Coach, BSW/MSW, other. Labor = 3 hours of CHI.

Billing: HCPCS G0023, G0024

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Financial Model: TCM + CCM + CHI

DRG / CPT / HCPCS	Descriptor	Rate	Subtotal
DRG 638	Diabetes with CC (Homelessness)	$5,180.94 (3.1% payment increase with CC HRSN)	$5,180.94
99496	TCM (7-Days)	$279.62	$279.62
99490	CCM (First 20 Min.)	$62.58	$62.58
99439	CCM each additional 20 Min (2 units)	$47.93/Unit	$95.86
G0023	CHI Service, 60 minutes per month	$80.56	$80.56
G0024	CHI Service, add 30 min (4 Units)	$50.26/Unit	$201.04
Grand Total			**$5,900.60**

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Outpatient Revenue Analysis

- Outpatient E/M Revenue: TCM ($279.62) compared to Standard E/M Visit New Patient Revenue (99203) = **$111.51**
- Concurrent CCM (1 Hour) + CHI (3 Hours)/Calendar Month
    - 1 hour of CCM provided concurrently = $158.44
    - 3 hours of CHI provided concurrently = $281.60
    - Total = **$440.05**

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Open Discussion

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Next Steps

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Reminder

- Emerging Community-Clinical Teams – 1st Thursday
- Advanced Community Clinical Teams - 3rd Thursday

Next Session for the ADVANCED Community-Clinical Teams is August 15th from 2 to 3:30 EST

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Next Session Topic

Example ECHO Session Topics

Emerging Community-Clinical Team Topics	Advanced Community-Clinical Teams Topics
~~✓ Landscape analysis~~	~~✓ TeamSTEPPS framework~~
✓ Partnership development	✓ Theory of Change: Alternative Payment Models (APMs)
✓ Determining return on investment	✓ Using APMs to advance health equity
✓ Value Proposition	✓ Sustainability through multi-payer alignment
✓ Contracting 101	✓ Payment incentives to reduce health disparities
✓ Billing and Coding 101	✓ Expanding target populations
✓ IT systems	✓ Blending and braiding services
✓ Quality	✓ IT Systems
	✓ Quality

If you have partnerships in place and already have one or more contracts with health systems or plans, join the **Advanced** Community-Clinical Team Call.

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Learning Collaborative Resources

- HELC ECHO Sessions Recordings & Resources: https://www.partnership2asc.org/healthequity/helc-resources/
- Partnership CHI/PIN Implementation Resources and Events: https://www.partnership2asc.org/implementation-resources/
- Freedmen's Health Consulting Implementation Resources: https://communityintegration.info

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Learning Collaborative Resources

- Overview: www.partnership2asc.org/heathequity/
- FAQ: www.partnership2asc.org/FAQ
- Example: https://www.partnership2asc.org/healthequity/example-participating-market/
- Health Plan Outcomes: https://www.partnership2asc.org/healthequity/healthplanoutcomes/
- CHI Implementation: https://www.partnership2asc.org/healthequity/chiimplementation/

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Thank you!

Tim McNeill, RN, MPH

tmcneill@freedmenshealth.com