Improving Care Coordination through Journey Mapping

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Session Goals

- Discuss how organizations can (and do) work together to form effective eco-systems
- Utilize a Journey Map activity to identify facilitators and barriers to health that individuals with complex care needs experience
- Explore opportunities for improvement and discuss ideas that can be transferable to other communities

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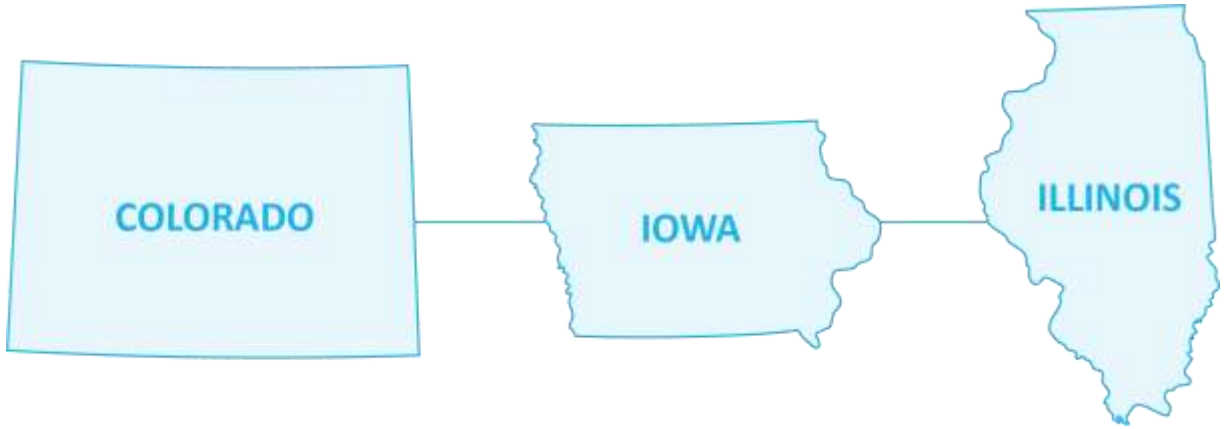
Quality Innovation Network - Quality Improvement Organization



Areas of focus:

Antibiotic Stewardship: Helping outpatient care settings prevent antibiotic overuse and misuse

Cardiac Health: Preventing heart attacks and strokes through evidence-based practice

Care Coordination and Medication Safety: Collaborating with communities to reduce avoidable hospitalizations

Diabetes Care: Providing diabetes self-management education classes and improve clinical outcomes

Immunizations: Promoting flu, pneumonia, and shingles vaccinations

Nursing Home Care: Using quality improvement strategies to improve care

Quality Payment Program: Helping Medicare providers transition from fee-for-service to value-based care

Transforming Clinical Practice Initiative: Conducting quality improvement assessments

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Telligen QIN QIO – Program Overview

Goals

- Make care safer
- Strengthen person and family engagement
- **Promote effective communication and coordination of care**
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care more affordable

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QIN-QIO Quality Improvement Projects

- The QIN-QIO task order will focus on the following high priority areas
  - Task Area 1: Long Term Care – Nursing Homes
  - Task Area 2: Community Coalitions
  - Task Area 3 : Quality Improvement Initiatives

QIN QIO 12th Statement of Work 2019-2024

- QIN-QIOs will utilize innovation, broad quality improvement initiatives and data driven methodologies suitable for spread across 5 Aims
  1. Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse
  2. Increase Patient Safety
  3. Increase Chronic Disease Self-Management (Cardiac, Vascular Health, Diabetes, slowing and preventing End Stage Renal Disease (ESRD))
  4. Increase Quality of Care Transitions
  5. Improve Nursing Home Quality

Task Settings and Areas

Priority Focus Area Network Type	Nursing Homes	Community Coalitions	Quality Improvement Initiatives
AIMS			
Improve Behavioral Health - focusing on Decreased Opioid Misuse	X	X	
Increase Patient Safety: Reduce all cause harm	X	X	
Increase Chronic Disease Self-Management (Cardiac and Vascular Health, Diabetes, slowing and preventing End Stage Renal Disease (ESRD)	X	X	
Increase Quality of Care Transitions	X	X	
Improve Nursing Home Quality	X		

The Impact of Fragmented Care

"The negative consequences of fragmented care may include the duplication of services, inappropriate or conflicting care recommendations, medication errors, patient and caregiver confusion and distress, and higher costs of care."

Carla Parry, PhD, MSW, Eric A. Coleman, MD, MPH, Jodi D. Smith, ND, GNP, Janet Frank, DrPH, and Andrew Kramer, MD. "The Care Transitions Intervention: A Patient-Approach to Ensuring Effective Transfers Between Sites of Geriatric Care." *Home Health Care Services Quarterly* 22.3 (2003): 1-17. Print.

What is Journey Mapping ?

- Journey Mapping (sometimes referred to as process mapping) is essentially mapping the journey of the patient through the process of care
- Is often used for the management of a specific condition or treatment
- Series of consecutive events or “steps”

Benefits of Journey Mapping

- Allows us to “see” and understand the patient’s experience
- Aims to maximize clinical efficacy and efficiency by eliminating ineffective and unnecessary care
- Forces us to focus on the coordination of multidisciplinary practice
- Allows us to alter the focus of care toward activities most valued by the patient

Care Coordination through Journey Mapping

- Screening patients to identify social needs
- Collecting social determinants of health data and using it to inform interventions
- Strengthening partnerships with other community agencies and organizations that serve the same populations
- Integrating home care
- Community accountability and building coalitions with community partners.

The Complex Needs of our Patients

Healthy People 2020 organizes the social determinants of health around five key domains:

Telligen Adds Value

- Improve Patient Safety & Reduce Harm
- Decrease Costs & Increase Efficiency
- Improve Patient Outcomes & Clinician Quality Scores
- Increase Patient & Provider Satisfaction
- Connecting Providers to Social Services
- Implementing Interventions with Acute & Post-Acute Providers to Improve Patient Transition Handoff
- Community Collaboration

Entities that address these such as behavioral health services, community based organizations and social services

Services they offer such as detox programs, medication adherence, public housing and food vouchers

Patient obtains needed necessities and proper treatment services

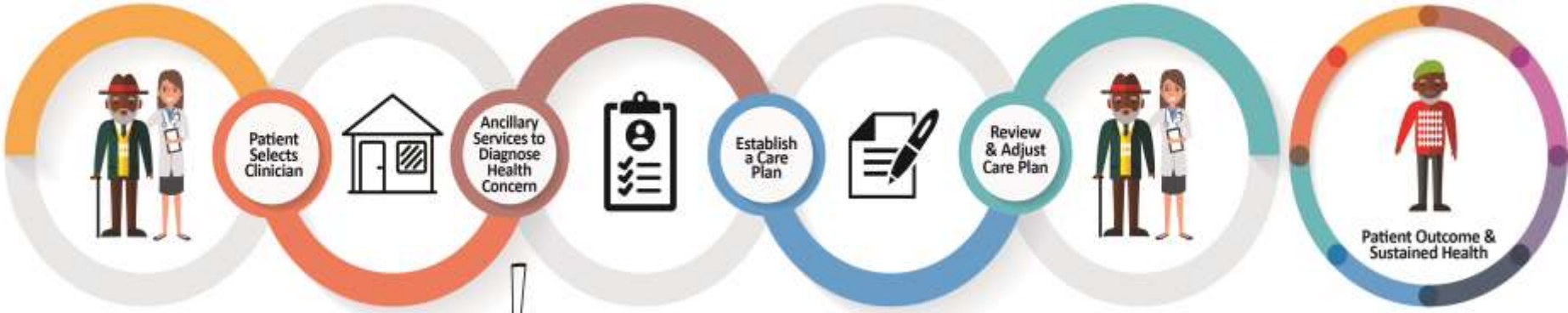
Patient's Journey

Health Concern & Social Determinants Impact

Learn Directions

Learn Self-Management

Patient Self-Managing



Clinician's Journey

Provide Information to Patients

Teach Back Written Directions

Teach Self-Management Clinical Follow-Up & Monitoring

Claim is Paid to Clinician

Case Manager/ Social Worker Referral

Analysis of Patient's Current Situation

Educates Patient on Available Options

Coordinates Needed Services

Follows Up to Make Sure Patient Services are Being Met

Patient Case is Closed

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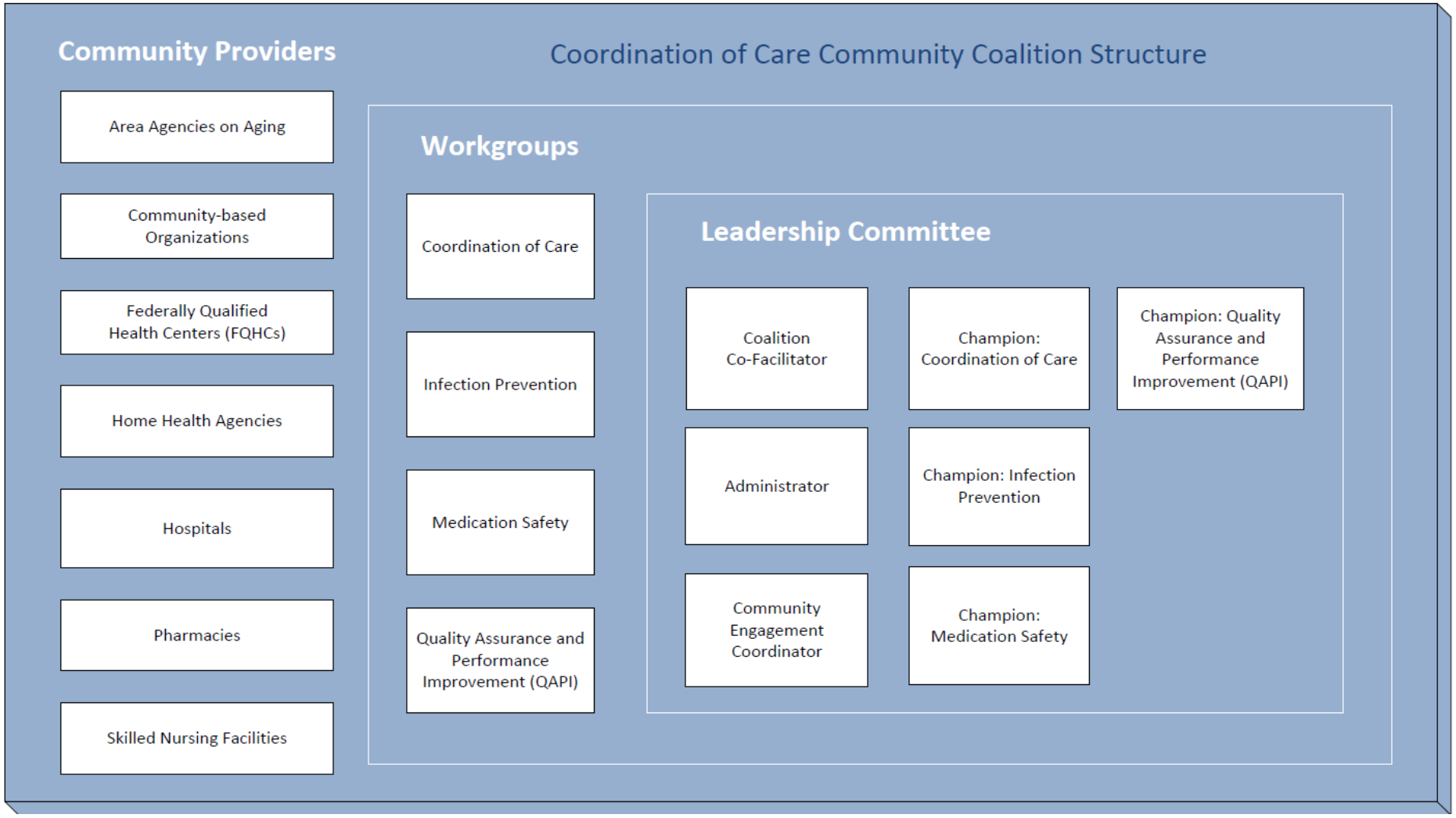
Evidence for Collaboration

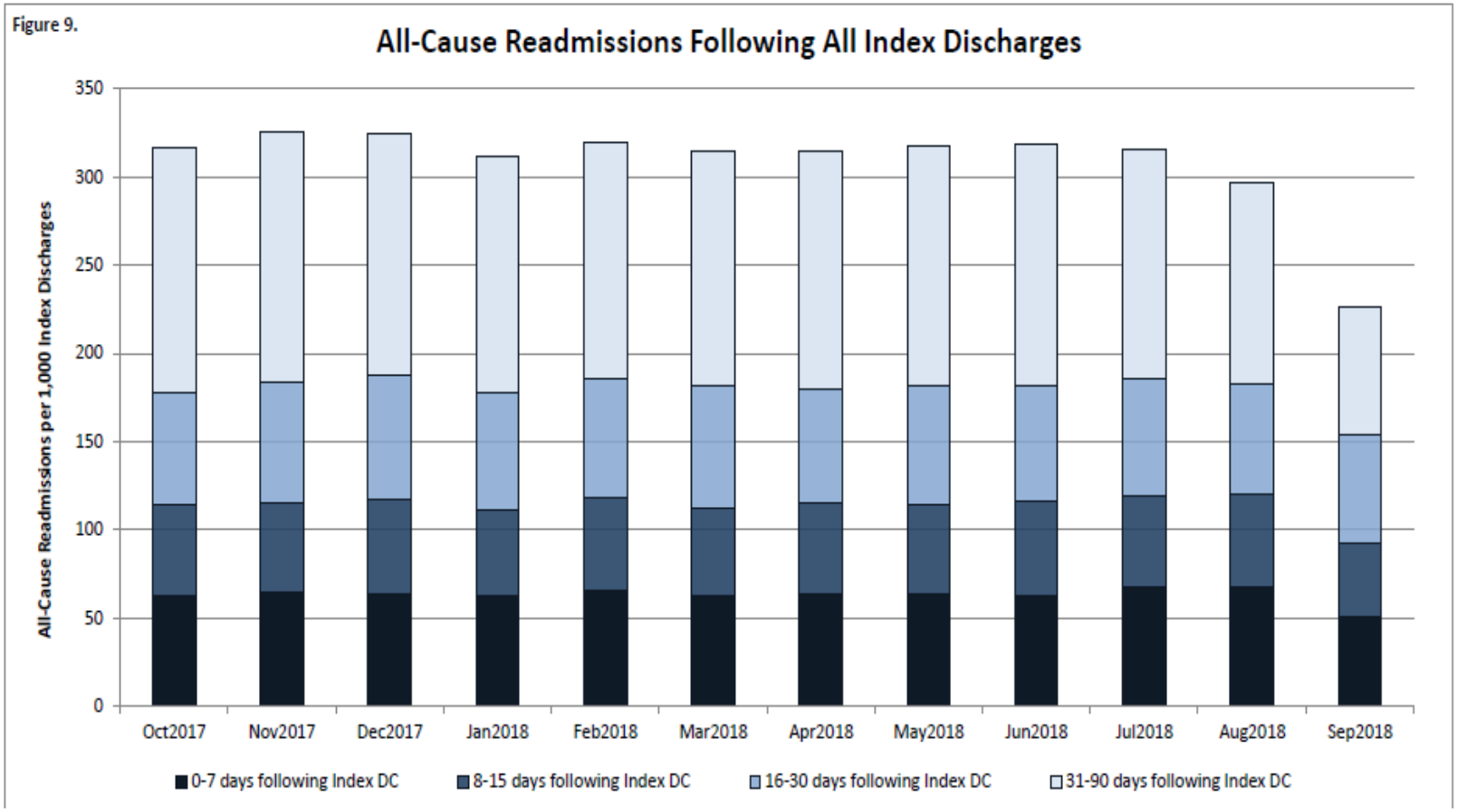
"After almost 50 years of inquiry, there is now sufficient evidence to indicate that interprofessional education enables effective collaborative practice which in turn optimizes health-services, strengthens health systems and improves health outcomes in both acute and primary care"

Community Coalitions

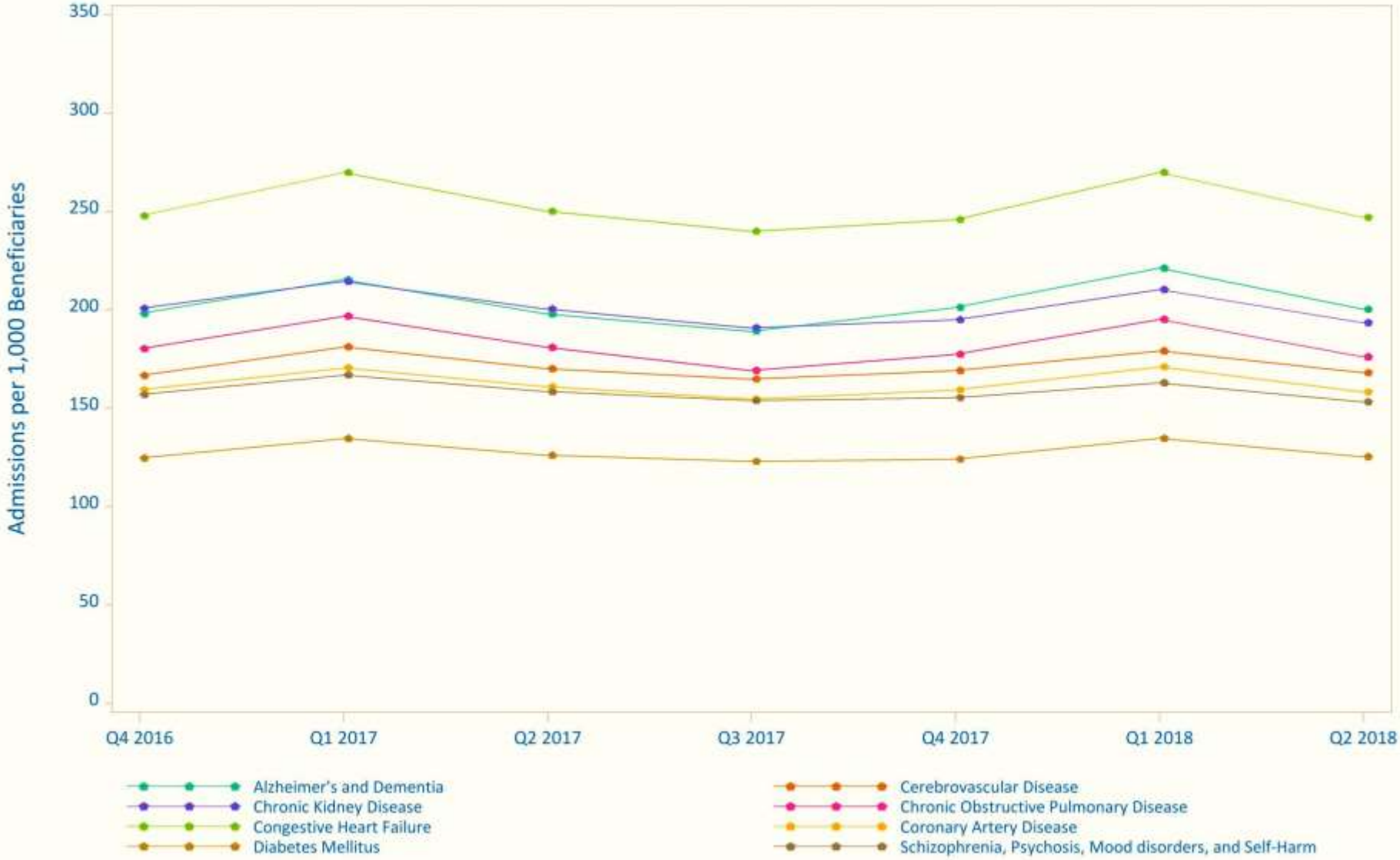


Illinois All Cause Readmissions

Illinois Statewide Data
All-Cause Readmissions Following All Index Discharges
Based on October 2017 - September 2018 Index Discharges and Subsequent Readmissions



Illinois
State
Quarterly Admissions per 1,000 Beneficiaries by Condition



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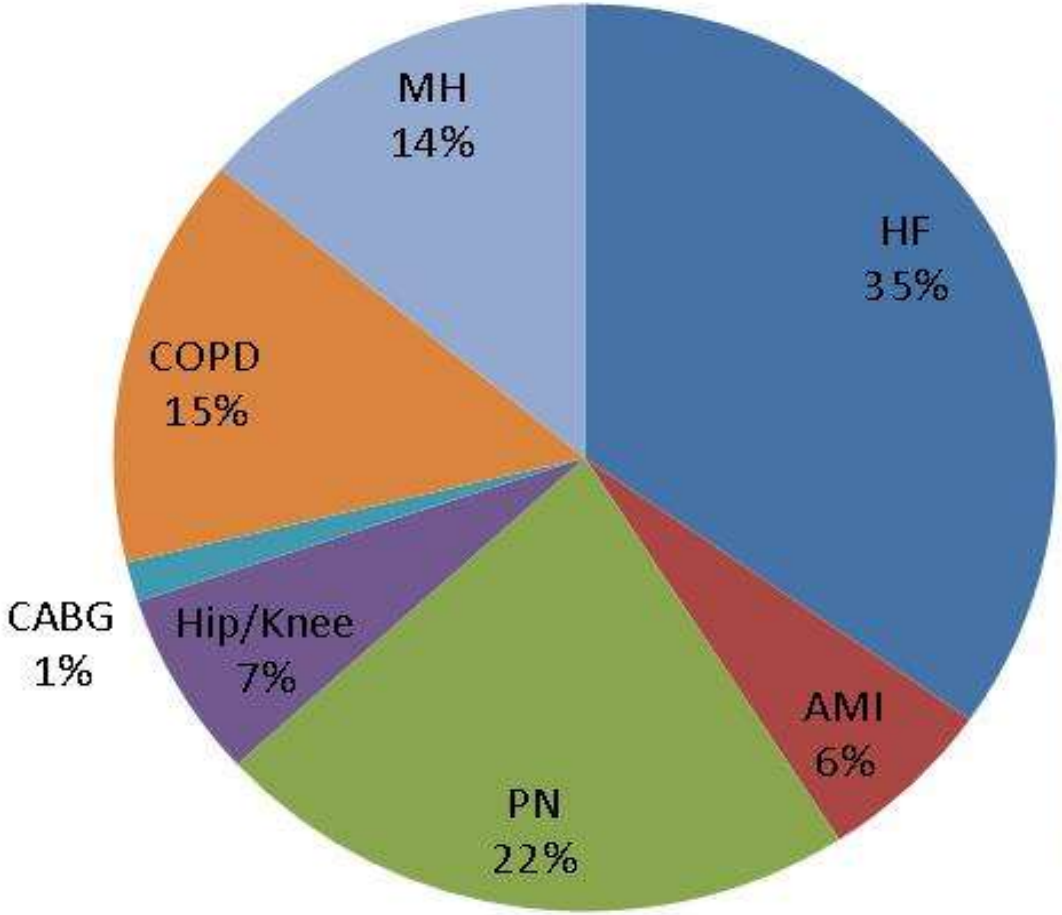
QIN NCC Quality Innovation Network National Coordinating Center

IL 30 Day All-Cause Readmissions per 1000 Index Discharges by Condition

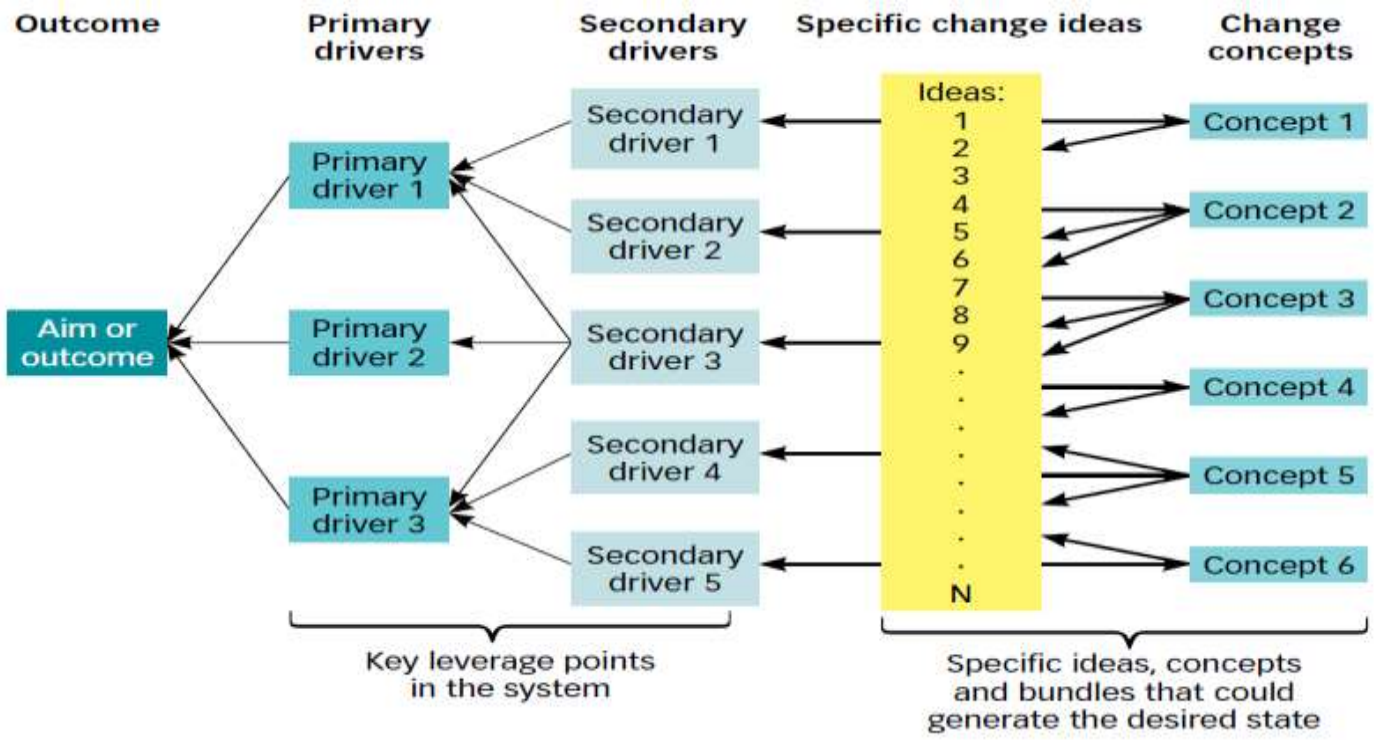
Shown as a % of all Penalty Conditions + Mental Health September, 2018



	Readmissions per 1000 Discharges
HF	201
AMI	137
PN	145
Hip/Knee	50
CABG	104
COPD	194
MH	203

What is a Driver Diagram?

Serves as a tool for determining and aligning actions that can be taken in the community to overcome barriers and met specific goals



Purpose of Driver Diagrams

- Identify primary and secondary drivers of community health improvement
- Serves as a framework for determining and aligning actions that can be taken across disciplines
- Relies on public health, healthcare and other sectors to work collaboratively
- Care coordination of health care and social needs are more effective when efforts are combined to address health issues

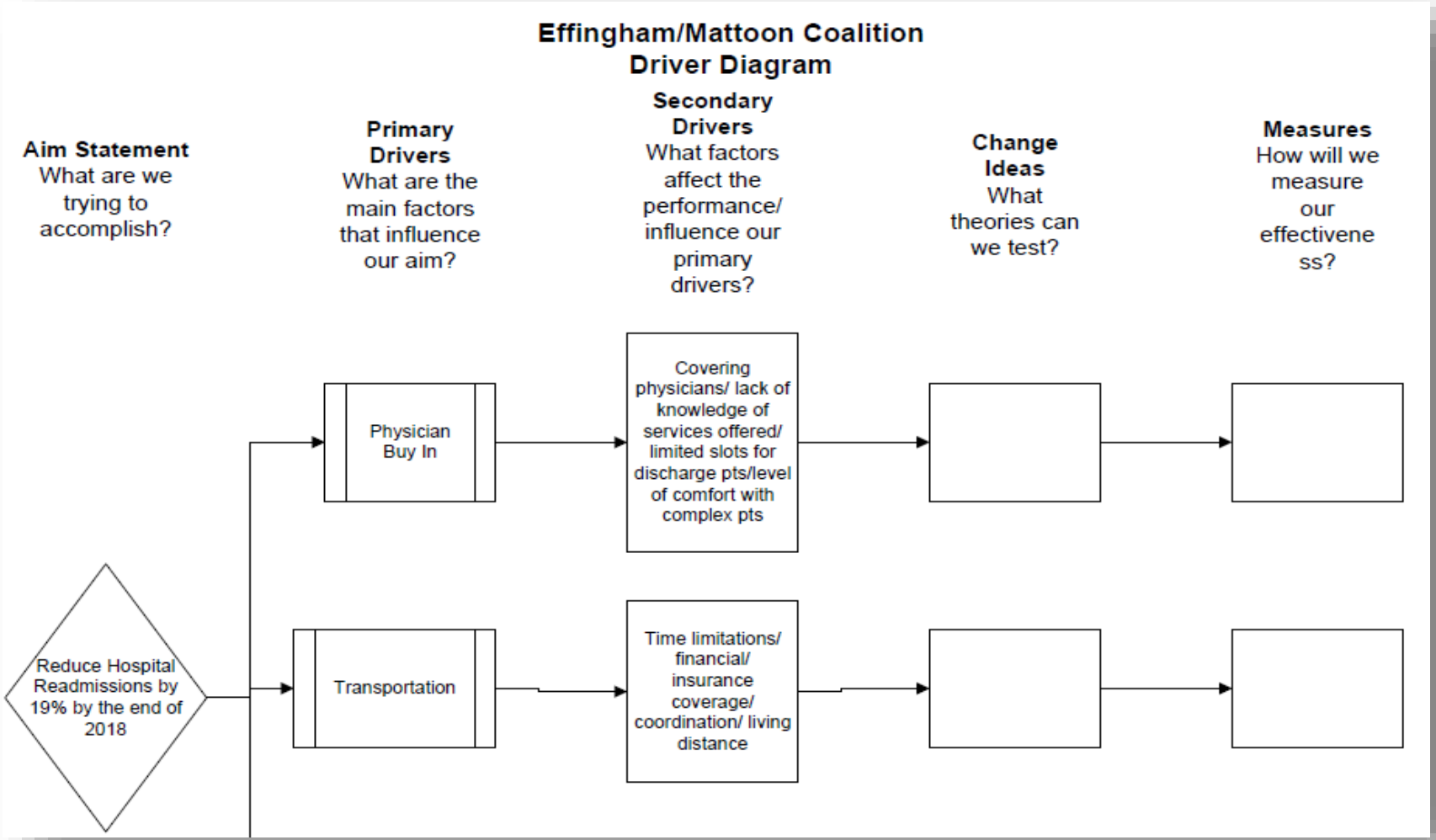
Key Elements

- Driver Diagrams can be used to plan improvement activities. They provide a way of systemically laying out aspects of improvement
- Organizes information on proposed activities to demonstrate the relationship between the AIM and the changes to be teste.
- Aim, Primary Drivers, Secondary drivers, Change concepts and Resources

Driver Diagram Discussion

- Behavioral Health
  - AIMS
    I. Increase access to BH services
    II. Decrease BH admissions/readmissions to the ER
  - Primary Drivers
  - Secondary Drivers
  - Changes Ideas/Concepts
  - Resources

Driver Diagram Example



Discussion

- Identify the primary drivers
  - *What are the some of the main factors contributing to lack of access to BH services?*
  - *What are some of the factors contributing to BH Admission/Readmissions in the ER?*
- What factors influence these primary drivers?
  - *What are the underlying factors influencing the primary drivers?*
- Recommend a change concept
  - *What are we trying to accomplish?*
  - *How will we know that the change is an improvement?*
  - *What changes can we make that will result in an improvement?*

Summary

- Telligen QIN QIO mission and role to build community coalitions designed create the environment where organizations can (and do) work together to form effective eco-systems
- Journey map and driver diagram discussion to identify facilitators and barriers to health that individuals with complex care needs experience
- Explored opportunities for improvement and discussed ideas that can be transferable within a unique community

Thank you for coming

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