Bringing healthcare, families and community-based services together.

Partners in Care FOUNDATION℠

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Opportunities and Challenges for Community-based Organizations

June Simmons, CEO
Partners in Care Foundation
September 11, 2017

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

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The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

aginganddisabilitybusinessinstitute.org

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ERE

Aging and Disability BUSINESS INSTITUTE

Health Happens at Home

Why patients need healthcare and community-based organizations to form partnerships to address social determinants of health

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What Happens When Patients Go Home

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Why healthcare needs eyes & ears in the home

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Why EHRs may not recognize adherence issues

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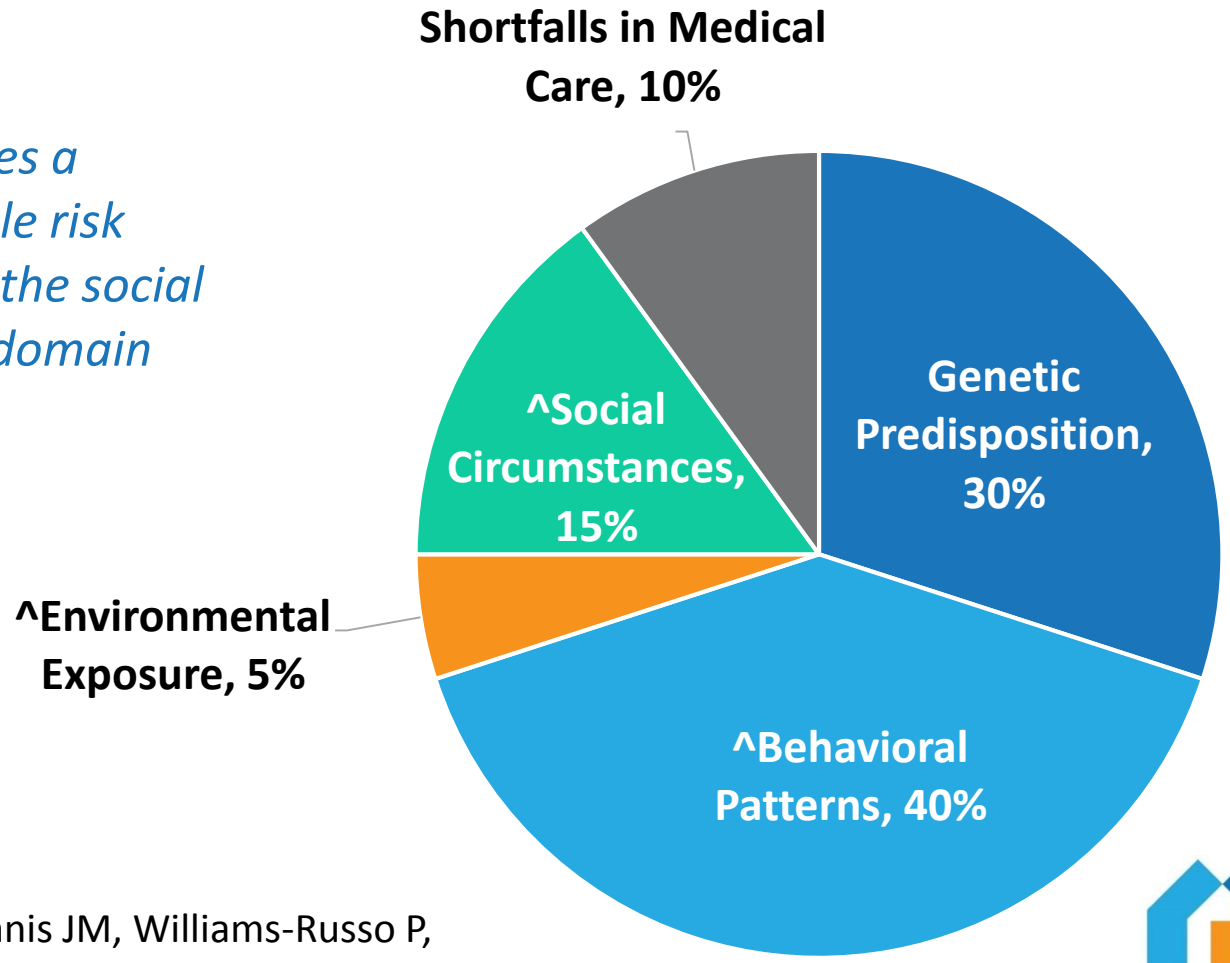
CBOs Can Affect 60% of US Premature Deaths

^ Indicates a modifiable risk factor in the social services domain



Adapted from McGinnis JM, Williams-Russo P, Knichman JR. The case for more active policy attention to health promotion. Health Affairs (Millwood) 2002;21(2):78-93.

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CBOs & Social Determinants of Health (SDOH)

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Hospitals, Primary Care & CBOs

- *Hospital* – GET them well
- *Primary care* – KEEP them well
- *CBOs* – support wellness at HOME
  - Lifestyle/self-management
  - Medication management support
  - Appropriate nutrition through meals, teaching, benefits
  - Caregiver support
  - Assistance with activities of daily living
  - Transportation to healthcare
  - Reduce falls & environmental risks
  - Eyes & ears in the home for healthcare

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CBOs Close the Post-Discharge Gap

- Visit the patient within the critical period after discharge
- Medication inventory as actually taken at home, including OTCs/supplements
- Assure follow-up MD visits actually happen
- Assist the patient in knowing when/whom to call for help
- Assist with non-medical supports that improve patient well-being

Value Based Case Study

- CMS-funded Community-based Care Transitions Program (CCTP) reimbursed CBOs
- Hybrid approach of Coleman Care Transitions coaching & Bridge plus HomeMeds med rec

CCTP Site	n=	% readmit rate	% ↓ readmit rate	# Readmits Averted	$ saved @ $15,500/ readmit	Cost @ $500/pt.	**Net** Savings	**ROI (net)**
Westside	10,139	13.0%	38.4%	821	$12.3 M	$5.0 M	$7.3 M	**143%**
Glendale	5,933	14.1%	30.2%	361	$ 5.4 M	$3.0 M	$2.4 M	**83%**
Kern	7,176	13.4%	35.3%	523	$ 8.1 M	$3.6 M	$4.5 M	**126%**

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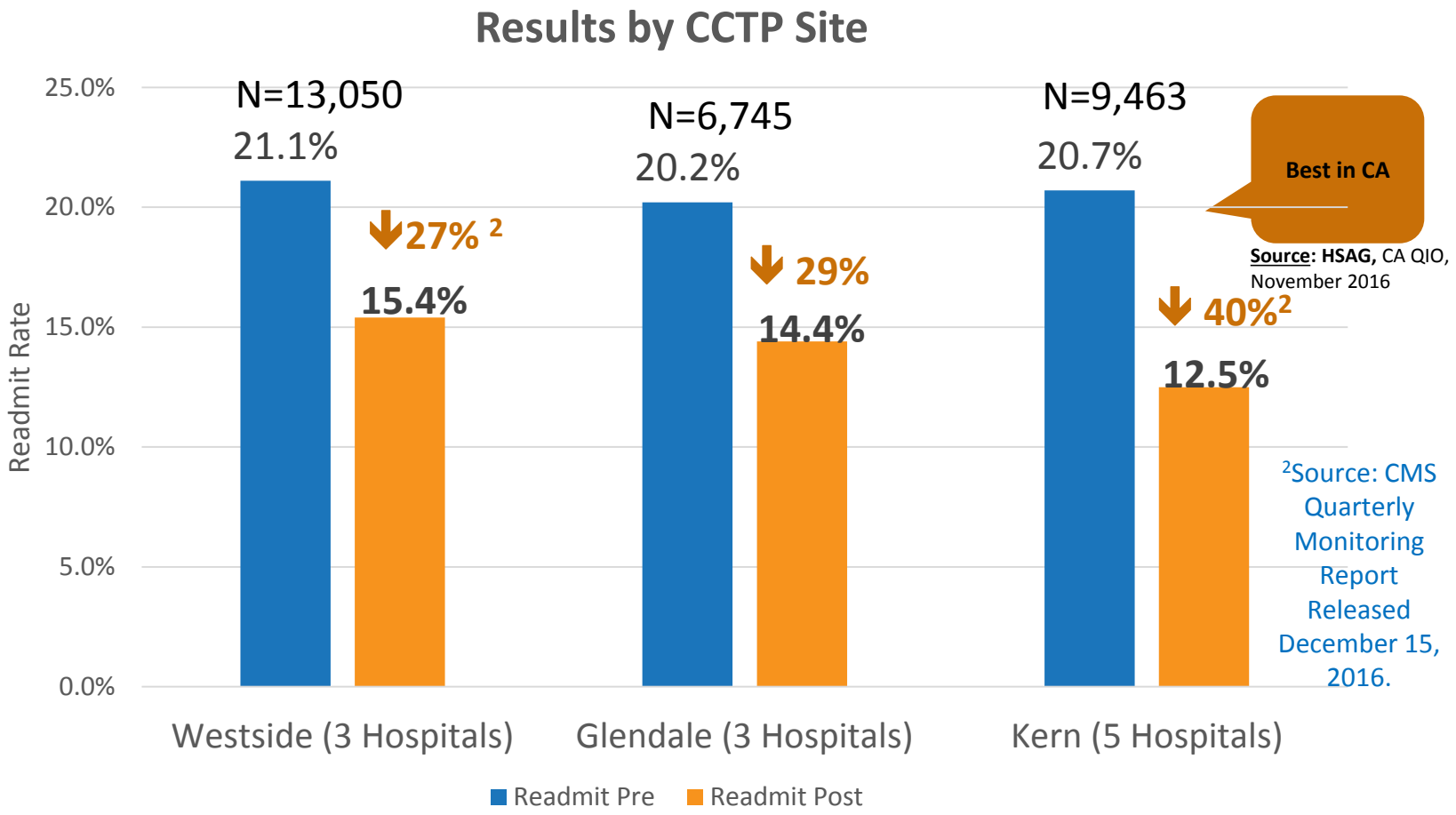
CCTP avoided 1,900 readmits

Care Transitions: Dr. Eric Coleman's Coaching & Rush University Bridge Models



*Program to Date through Jul 2016

[1] Baseline (Pre): All-Cause, All-Condition, Medicare FFS: Westside & Glendale = Jan – Dec 2012; Kern = Apr 2012-Mar 2013

[2] CCTP (Post): Medicare High-Risk FFS Population, Readmission Rate to Date (Westside= May 2013 – Jul 2016; Glendale = May 2013-Mar 2016; Kern = Nov 2013 – Jul 2016

Key Factors in Changing Results

- Root cause analysis
- Customized **targeting** criteria
- Fast startup
- Partnerships with inter-professional team
- Volume
- Adaptable & responsive – changed approach to ethnic & hospital culture
- Trust of patients – motivational interviewing
- Evidence-based interventions
- Offering choices to patients

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Key to Value – Careful Targeting

Partners/UCLA CCTP Readmission Risk Criteria	BOOST	LACE
Readmission within last 30 days; 2+ admissions in prior 12 months; or 2+ ED visits in last 6 months	☑	☑
Length of stay greater than 10 days		☑
8+ outpatient medications &/or adjustment of 2+ meds at discharge	☑	
Discharged home with limited caregiver support	☑	
Two or more chronic conditions	☑	☑
Depression as secondary diagnosis	☑	
Mild cognitive impairment, especially with inadequate caregiver support	☑	

Patients to be excluded:

- Children (patients under age 18 or 21)
- Patients with planned readmissions (e.g., inpatient chemotherapy)
- Patients who are enrolled in hospice.

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What do CBOs provide to support health and avoid readmissions?

- **Care Transition Choices**
  - Coleman model – in-home coaching
  - Bridge model – telephonic social work
- **Home visit with med review** & psychosocial assessment and service coordination – ***HomeMedsPlus***
- **Stanford Chronic Disease Self-Management Program** – also pain & diabetes version
  - In-person or online workshops

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HomeMeds – the core of value

- **Home visit** by Coach
  - Collect **comprehensive medication list**
  - **Adherence Inquiry:**
    - Patient understanding and how each drug is <u>really</u> being taken
  - **Record** BP/pulse, falls, uncharacteristic confusion, symptoms, and indicators of adverse effects
- **Use evidence-based protocols** to screen for risks
- **Computerized risk assessment** and alert process
- **Consultant pharmacist** to address problems w/ prescribers, patients, families & staff.

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Risk-Screening Protocols

HomeMeds is a TARGETED, EVIDENCE-BASED intervention addressing a **limited** group of medication-related problems chosen by national ***expert consensus panel*** [1]

- Targets problems that can be identified and resolved in the home.
- Chosen to produce positive response by prescribers
- Minimize "al*ert overload": based on signs/symptoms.*

1. Unnecessary therapeutic ***duplication***
2. Use of psychotropic drugs in patients with a reported recent ***fall*** and/or ***confusion***
3. Use of non-steroidal anti-inflammatory drugs (***NSAID***) in patients at risk of peptic ulcer/***gastrointestinal bleeding***
4. ***Cardiovascular*** medication problems -High BP, low pulse, orthostasis and low systolic BP

HOMEMEDS

[1]A model for improving medication use in home health care patients . Brown, N. J., Griffin, M. R., Ray, W. A., Meredith, S., Beers, M. H., Marren, J., Robles, M., Stergachis, A., Wood, A. J., & Avorn, J. (1998). Journal of the American Pharmaceutical Association, 38 (6), 696-702.

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Missing Data = Increased Risk

- **Typical in-home assessment includes:**
  - **Medications inventory –** Rx from all sources, OTC, borrowed, etc.
  - Patient **understanding** of meds & **adherence issues**
  - **Incidents/adverse effects – like falls, dizziness, confusion**
  - Physical & cognitive **functioning**
  - Screening for **depression**, **anxiety, sleep**
  - **Nutrition** – diet, shopping, affordability, ability to cook
  - **Financial** info: ability to afford care
  - **Transportation** for access to care
  - **Family & Caregiver** information
  - **Home safety** & housing conditions – **fall prevention**
  - **Advance directive –** inquire, introduce, encourage, document
  - **Behavioral health: Diet, physical activity, alcohol, tobacco**

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New Data – Med Group/Medicare Advantage

- *HomeMedsPlus* postacute home visit
- Looking for **population-level impact**
  - Baseline 30-day all-cause, all-hospital readmission rates:
    - High-risk (LACE 11+) = 31.3%; Others = 15.1%
  - Post-intervention readmission rates
    - Others = 13.7% (decrease 1.4%)
    - High-risk = 26.9% (decrease 4.4%) **= 3% absolute decrease, population-level**
  - Intervention group readmission rate: **10.6%**

HOMEMEDS PLUS

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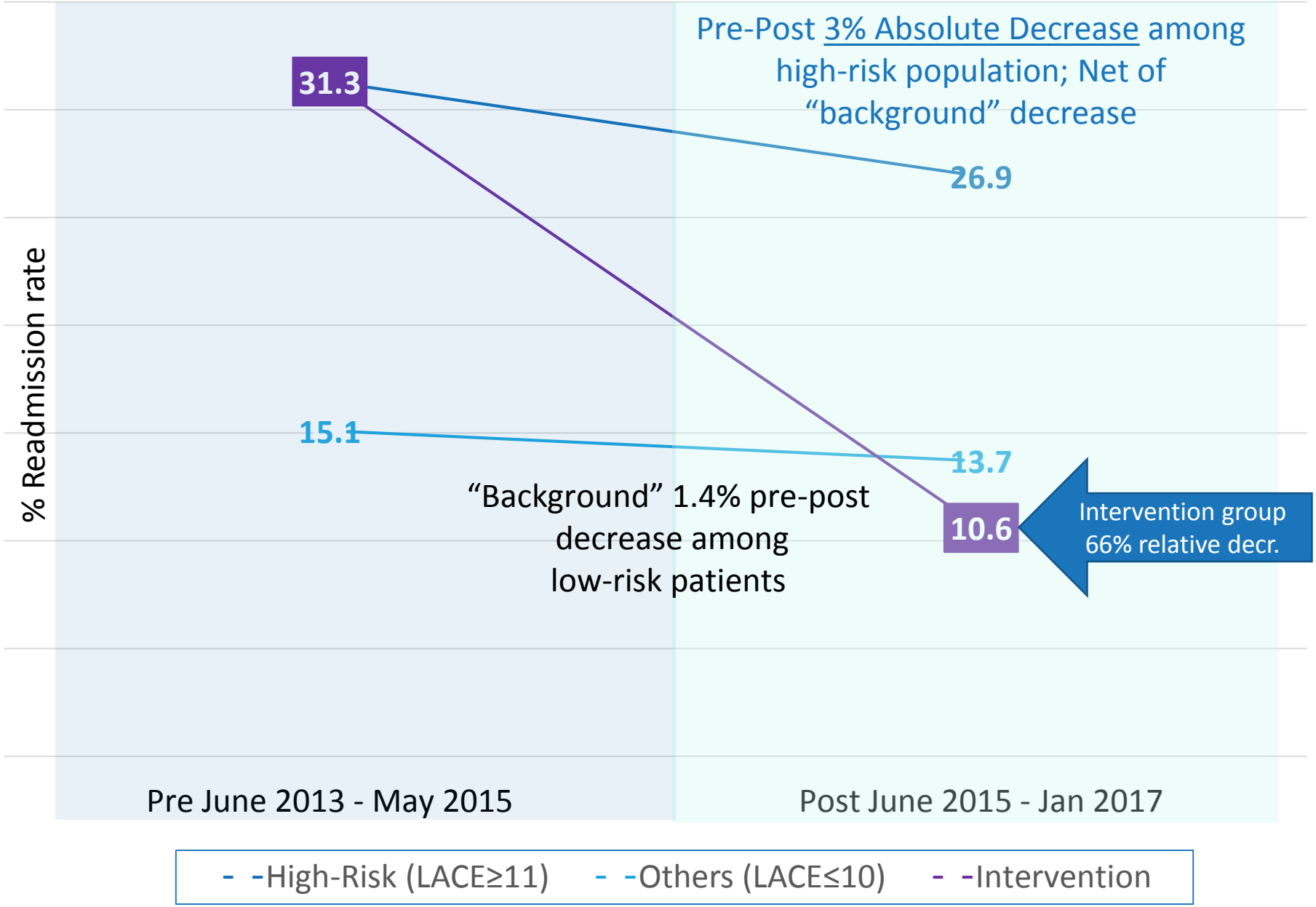
HomeMedsPlus: Population-level readmission outcomes in Medical Group/Medicare Advantage



Identifying Outcomes of Interest

- Reach members who need to improve health behaviors, are non-adherent, or have complex social needs
- Meet members' community support needs
- Qualify members for benefits & programs
- Avoid adverse drug effects
- Improve medication adherence
- Improve self-care & self-management

- Improve Star ratings, HEDIS, meet NCQA CM standards
- Reduce inappropriate utilization
  - ED, Hospital, SNF/Rehab
- Optimize physician performance under MACRA
- Improve member satisfaction
- Improve member retention

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CBO Networks – An Innovative Approach

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One call does it all!

Partners at Home Growing Footprint

Expand Network footprint to cover added markets to meet our customer's needs

Network as of June 2016

Active Network Counties

Alameda
Butte
Contra Costa
El Dorado
Fresno
Humboldt
Imperial
Kings
Kern
Los Angeles
Madera
Marin
Mendocino
Merced
Monterey
Nevada
Orange
Placer
Riverside
Sacramento
San Bernardino
San Diego
San Francisco
San Mateo
San Joaquin
San Luis Obispo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Solano
Sonoma
Stanislaus
Tulare
Ventura
Yolo

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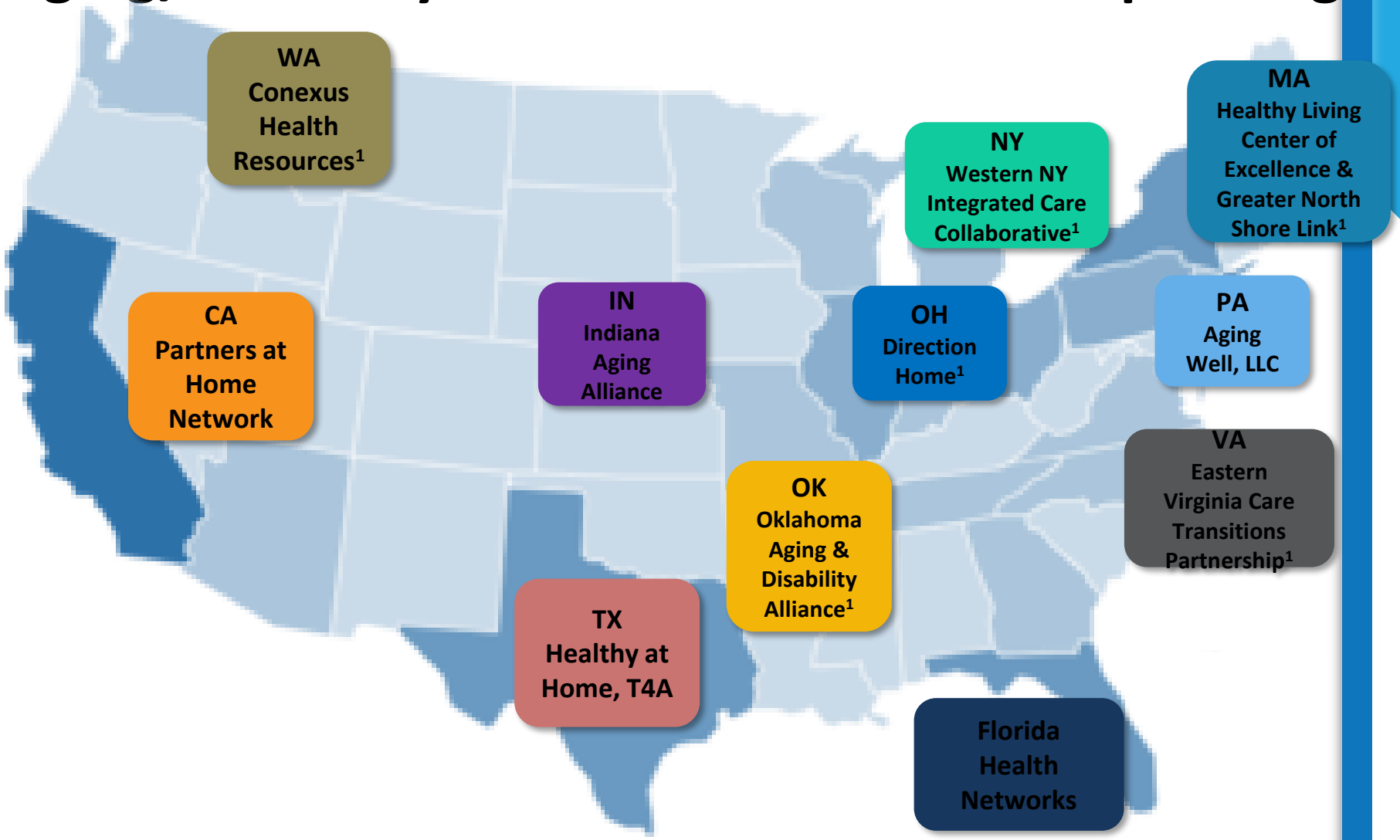
To Meet Increasing Needs, Statewide Aging/Disability Service Networks Are Expanding



[1]Not a full statewide network

Our Community-Based Network

Example of Multi-Payer Relationships

Hospitals Physician Groups

- UCLA Ronald Reagan
- UCLA Santa Monica
- Providence Saint John's
- Glendale Memorial
- Glendale Adventist
- USC Keck Verdugo
- Bakersfield Heart
- Bakersfield Memorial
- Kern Medical Center
- Mercy Hospital Bakersfield
- San Joaquin Community Hospital
- Health Care Partners
- MedPOINT Management
- Preferred IPA
- Regal Medical Group
- Citrus Valley Physician Group
- Alta/Prospect – Culver City Hospital

Health Plans

- Blue Shield of California
- Care1st
- Centene/California Health & Wellness
- Health Net
- L.A. Care
- Molina Healthcare
- Anthem/CareMore
- Kaiser Permanente
- For MSSP, Medi-Cal Home & Community-Based Services Waiver, we have contracts with all LA County Medi-Cal Plans

Government

- CMS
- Administration for Community Living (ACL)
- City of L.A.
- County of L.A.
- CA Department of Aging
- CA Dept. of Health Care Services
- CA Dept. of Public Health

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New Frontier Post-CCTP

- Partnering with medical groups & health systems for new Medicare Part B benefits/codes:
  - Transitional Care Management (TCM)
  - Chronic Care Management (CCM)
- TCM: CBO coach to assess for socioeconomic & behavior issues, create integrated plan
- Provider reviews integrated care plan, bills, pays CBO
- CCM: 12 months of care coordination for multiple chronic conditions
  - Connect to services

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Buy vs. Build: Why Partner?

- Community: A new specialty for SDOH
- System of Care vs. Social Work Staff
- Broad geographic coverage
- Diversity in language, culture and skills
- Efficiency – unpredictable spread of need
- Quality – NCQA accreditation for complex case management; HEDIS & Medicare Stars

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Happy to Help!

- Sandy Atkins, Vice President, Strategic Initiatives

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