Bringing healthcare, families and community-based services together.
Opportunities and Challenges for Community-based Organizations

June Simmons, CEO
Partners in Care Foundation
September 11, 2017
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
Health Happens at Home

Why patients need healthcare and community-based organizations to form partnerships to address social determinants of health
What Happens When Patients Go Home
Why healthcare needs eyes & ears in the home
Why EHRs may not recognize adherence issues
CBOs Can Affect 60% of US Premature Deaths

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.
CBOs & Social Determinants of Health (SDOH)

- Housing, Meals, Transport
- Access to Care: Coaching & Navigation
- Community Connection / Caregiver Support
- Patient Engagement Activation
- Benefits Counseling & Assistance

changing the shape of health care
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
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

<table>
<thead>
<tr>
<th>CCTP Site</th>
<th>n=</th>
<th>% readmit rate</th>
<th>% ↓ readmit rate</th>
<th># Readmits Averted</th>
<th>$ saved @ $15,500/ readmit</th>
<th>Cost @ $500/pt.</th>
<th>Net Savings</th>
<th>ROI (net)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westside</td>
<td>10,139</td>
<td>13.0%</td>
<td>38.4%</td>
<td>821</td>
<td>$12.3 M</td>
<td>$5.0 M</td>
<td>$7.3 M</td>
<td>143%</td>
</tr>
<tr>
<td>Glendale</td>
<td>5,933</td>
<td>14.1%</td>
<td>30.2%</td>
<td>361</td>
<td>$ 5.4 M</td>
<td>$3.0 M</td>
<td>$2.4 M</td>
<td>83%</td>
</tr>
<tr>
<td>Kern</td>
<td>7,176</td>
<td>13.4%</td>
<td>35.3%</td>
<td>523</td>
<td>$ 8.1 M</td>
<td>$3.6 M</td>
<td>$4.5 M</td>
<td>126%</td>
</tr>
</tbody>
</table>
CCTP avoided 1,900 readmits

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

Results by CCTP Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Baseline (Pre)</th>
<th>CCTP (Post)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westside (3 Hospitals)</td>
<td>21.1% (15.4%)</td>
<td>27% (12.5%)</td>
</tr>
<tr>
<td>Glendale (3 Hospitals)</td>
<td>20.2% (14.4%)</td>
<td>29% (12.5%)</td>
</tr>
<tr>
<td>Kern (5 Hospitals)</td>
<td>20.7% (12.5%)</td>
<td>40% (12.5%)</td>
</tr>
</tbody>
</table>

*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


Best in CA

Source: HSAG, CA QIO, November 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
# Key to Value – Careful Targeting

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

**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.
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
HomeMeds – the core of value

❖ **Home visit** by Coach
  ❖ Collect **comprehensive medication list**
  ❖ **Adherence Inquiry:**
    ❖ Patient understanding and how each drug is **really** 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.
Risk-Screening Protocols

HomeMeds is a TARGETED, EVIDENCE-BASED intervention addressing a limited group of medication-related problems chosen by national expert consensus panel¹

- Targets problems that can be identified and resolved in the home.
- Chosen to produce positive response by prescribers
- Minimize “alert 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

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

Pre June 2013 - May 2015

- High-Risk (LACE≥11)
- Others (LACE≤10)

Post June 2015 - Jan 2017

- Intervention

Pre-Post 3% Absolute Decrease among high-risk population; Net of “background” decrease

“Background” 1.4% pre-post decrease among low-risk patients

Intervention group 66% relative decr.
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
CBO Networks – An Innovative Approach

One call does it all!

Service Coordination

Comprehensive Assessments

HomeMeds/Med Reconciliation

Evidence-based Self-Management

LTSS: Meals, home mods, transport., etc.

Behavioral Health Specialists
Partners at Home Growing Footprint

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

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

Network as of June 2016
To Meet Increasing Needs, Statewide Aging/Disability Service Networks Are Expanding

- CA Partners at Home Network
- IN Indiana Aging Alliance
- NY Western NY Integrated Care Collaborative
- OH Direction Home
- PA Aging Well, LLC
- MA Healthy Living Center of Excellence & Greater North Shore Link
- VA Eastern Virginia Care Transitions Partnership
- WA Conexus Health Resources
- TX Healthy at Home, T4A
- OK Oklahoma Aging & Disability Alliance
- Florida Health Networks

*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

---

**Partners At Home**
A Community Network of Partners in Care
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
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
Happy to Help!

- Sandy Atkins, Vice President, Strategic Initiatives
  satkins@picf.org
  www.picf.org
  818.643.3544