



Partners in Care Foundation Our Changing Health Care Landscape

Grand Rounds Motion Picture & Television Fund
By: June Simmons, CEO, Partners in Care Foundation

October 11, 2011



Agenda

- Partners in Care Foundation
 - Who we are
- Rapid Changes in Health Care Landscape
 - How we are responding
- Our Role in Community-Based Care
 - What we are providing



Partners in Care

Who We Are...

- Partners in Care is a transforming presence, an innovator and an advocate to shape the future of health care
- We address social and environmental determinants of health to broaden the impact of medicine
- We have a two-fold approach – evidence-based models for practice change and for enhanced self-management
- ***Changing the shape of health care through new community partnerships and innovations***



3

Partners in Care

Who We Are...

- Our mission is to serve as a catalyst for shaping a new vision of health care by partnering with organizations, families and community leaders in the work of changing health care systems, changing communities and changing lives



4

Rapid Changes in Health Care Landscape

How we are responding...

- Proactive population health management
 - The power of measurement and HIT
- Rapidly changing safety net
- Growing demand for alternative approaches and innovations in care
- Mandated changes (CMS / ACA)
- Home and community as the locus of care

5



Rapid Changes in Health Care Landscape

How we are responding...

Healthy Aging – the new longevity

Core areas of work and leadership:

- Health reform through population health management
- Prevention at every stage
- Evidence-based leadership for community health -- healthier living & self-management
- Coordination of care
- Patient safety – medications management
- Decision support – home palliative care

6



Rapid Changes in Health Care Landscape

How we are responding...

Rapidly changing safety net

Partners is meeting the demand with rapid deployment of care coordinators and software systems to address:

- Transitioning to managed care
- Providing health risk assessment and care coordination
- Closure of Adult Day Health Programs
- Redesign of community systems



7

Rapid Changes in Health Care Landscape

How we are responding...

- Redesign of community systems:
 - Meals Programs
 - Community congregate settings
 - Shared care



8

Rapid Changes in Health Care Landscape

How we are responding...

- **Growing demand for alternative approaches and innovations in care**
 - Hospital Transitions
 - HomeMeds
 - Complex Care Coordination
 - Home Palliative Care

9



Rapid Changes in Health Care Landscape

How we are responding...

- **Hospital Transitions**
 - 19.6% of Medicare, 16.5% of Medicaid patients are readmitted within 30 days, costing over \$15B annually
 - A large percentage of re-admissions are “potentially” avoidable
 - CMS guidelines have suggested that future reimbursements will be reduced for readmissions, especially those considered potentially avoidable
 - Most State Medicaid programs are following CMS lead

10



Rapid Changes in Health Care Landscape

How we are responding...

- **Transitions – a community shared transformational initiative**
 - Post-hospital changes must include multiple partners
 - A defined community with standardized information flow/standards of care
 - Redefine discharge plan/SNF/home health
 - Addition of the new “bridge to home” for post- hospital patient coaching and support

11



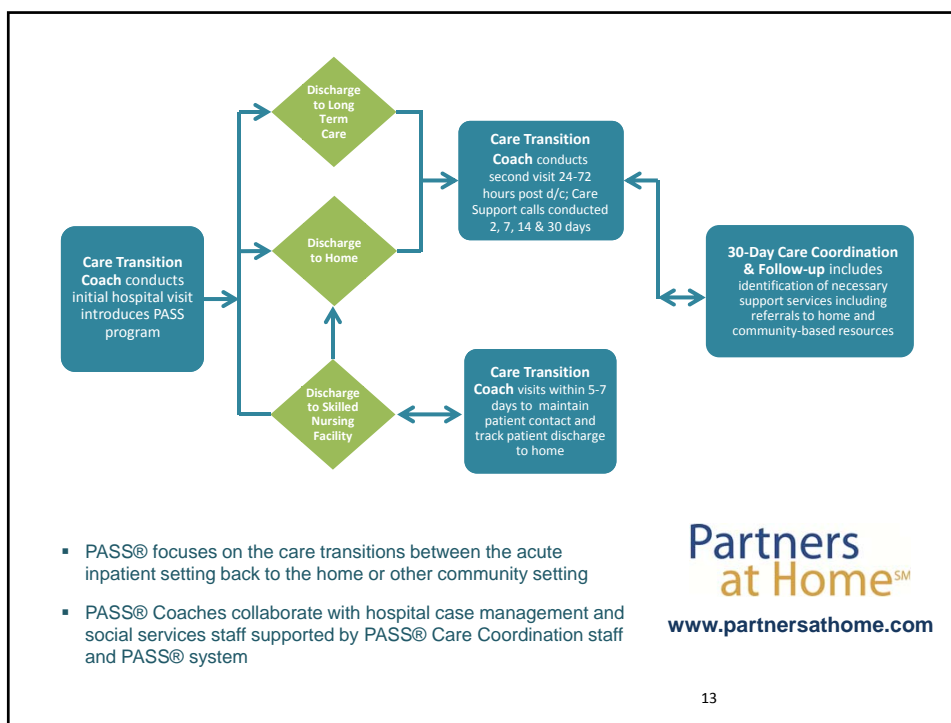
Rapid Changes in Health Care Landscape

How we are responding...

- **Hospital Transitions – the coaching model**
 - Transition care initiated by Health Coaches in the hospital followed by Care Coordinators and software technology
 - Daily interaction with hospital case management, social services and other appropriate staff
 - Interaction with patient:
 - Face-to-face during inpatient admission
 - Face-to-face at Home post discharge (48 – 72 hours)
 - Telephonic, day 2, 7, 14 & 30 post discharge

12





Rapid Changes in Health Care Landscape

How we are responding...

▪ HomeMedsSM

- Developed through funding from the John A. Hartford Foundation and the U.S. Administration on Aging
- HomeMedsSM is designed to enable community agencies to keep people at home and out of the hospital by addressing medication safety
- Embedded in PASS
- Practice change with workforces/settings that already go to the home – more cost effective use of existing effort



Rapid Changes in Health Care Landscape

How we are responding...

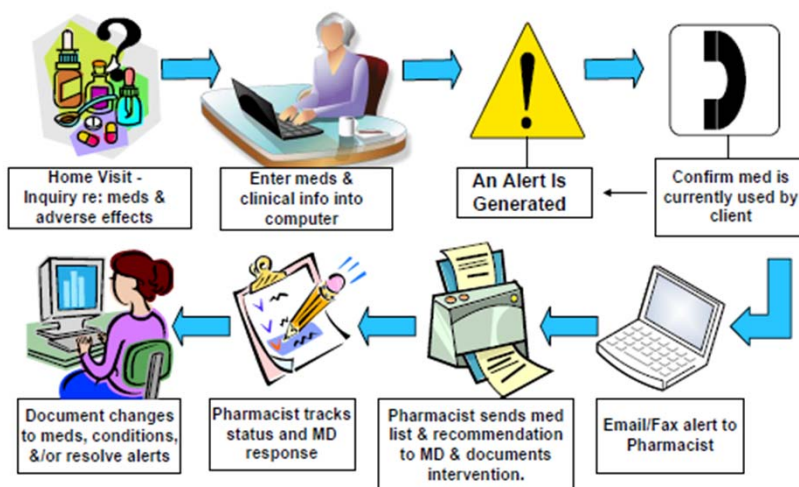
- **HomeMedsSM**

- **In-home collection** of a comprehensive medication list with notes on how each drug is being taken, plus vital signs, falls, symptoms, and other indicators of adverse effects
- **Use of evidence-based protocols** and processes to screen for risks and deploy consultant pharmacist services appropriately
- **Computerized medication risk assessment** and alert process with comprehensive report system
- **Consultant pharmacist** addresses problems with prescribers



Partners in Care
FOUNDATION
changing the shape of health care

HomeMedsSM Intervention Process



Rapid Changes in Health Care Landscape

How we are responding...

The future for HomeMeds

Make HomeMeds a standard of care for home-based services, Medicare Advantage plans, etc.

- Connect aging services with healthcare delivery
- Resolve pharmacist reimbursement
- Enhance technology (and policy) for ease of use
 - Integrate into software for community services, EMRs, HIE, etc.
 - Standardize Rx barcodes for scanning

17



Our Role in Community-Based Care

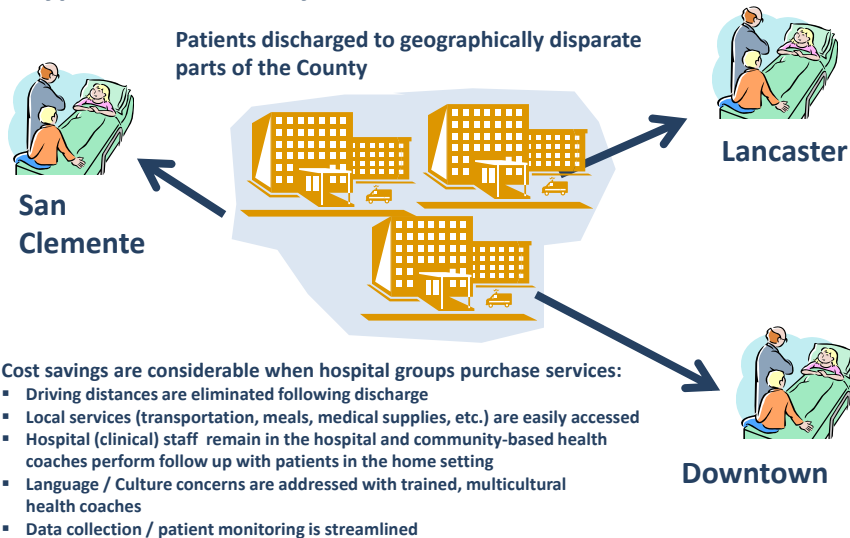
What we are providing

- Care transitions and HomeMeds are a natural fit
- Avoidable hospitalizations are resulting from unsuccessful transitions or medication complications
- Partners is a pioneer in community-based care
- The “future” has finally caught up with us

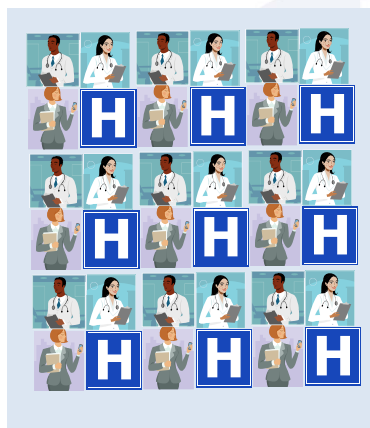
18



Care Transitions: Shared Regional Model Hypothetical County-wide Scenario



Individual Hospital Approach
Each hospitals must hire, train, manage and pay transitions directors and health coaches



Regional Model = centralized, cost-effective, efficient and experienced!



Our Role in Community-Based Care

What we are providing

- **In-Home Palliative Care**
 - Hospice – a big decision
 - Communication in need of major training
- **Key elements of our model**
 - Trust in home care team
 - Call Center 24/7
 - Decision support

21



Our Role in Community-Based Care

What we are providing

- Serve as community-based organization (CBO) for CMS grant to fund innovations in care transitions
- Lead root cause analysis and community strategic planning for transformational change – building collaborative communities

22



Closing Thoughts

- Times of great change are times of opportunity – danger and possibilities
- Partnering is essential – strength in numbers and shared vision
- Now is the time for a kinder more integrated system – we must all heed the call to lead together

23



For more information visit our websites:

www.picf.org

www.partnersathome.com

Handouts of today's presentation are available online after 2pm today:

www.picf.org>Events>Presentations

24

