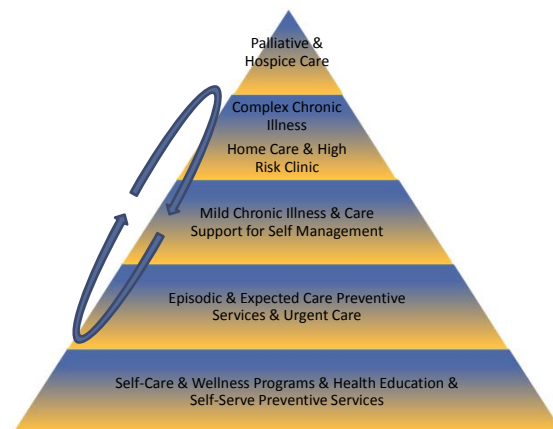


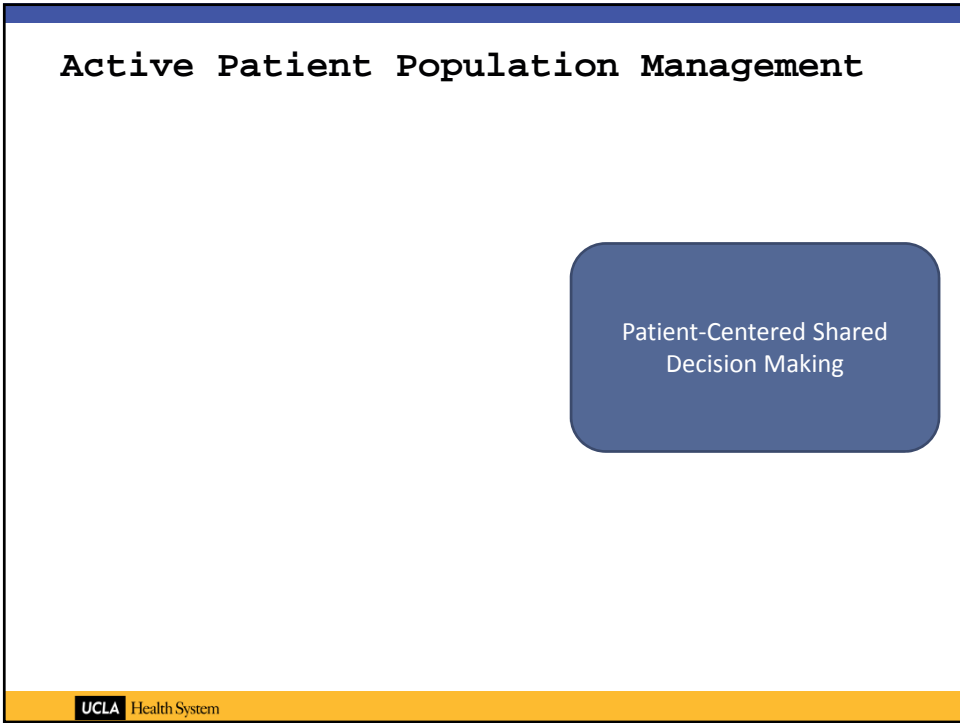
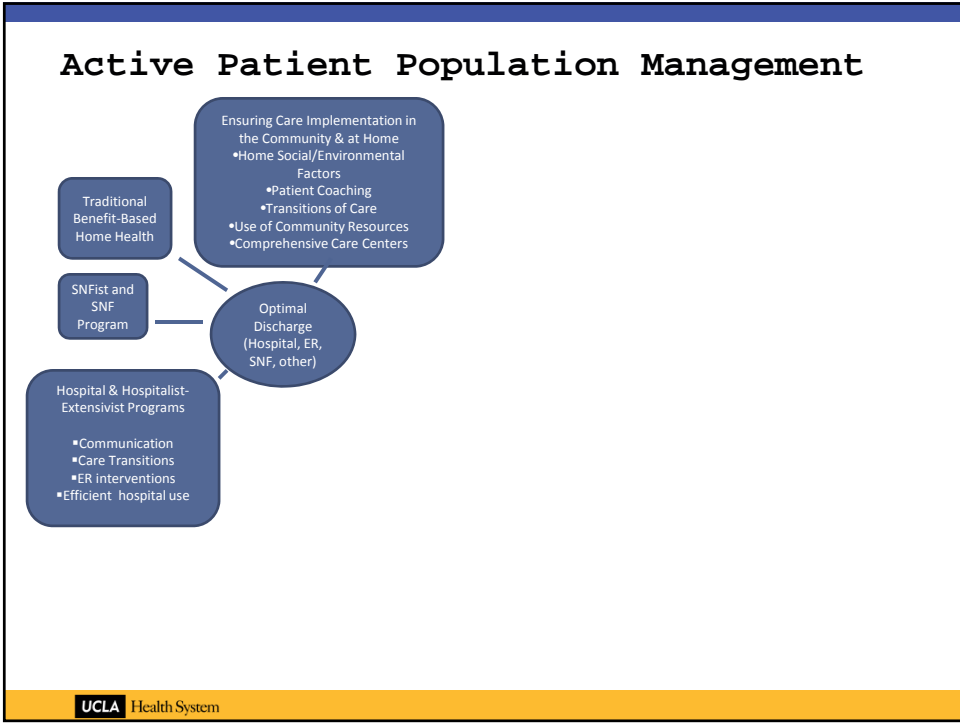
Integrating Community Services Into UCLA's Primary Care Innovation Model

Molly Joel Coye, MD, MPH
Chief Innovation Officer
UCLA Health System

SoCal Patient Safety Collaborative
December 14, 2011

Active Patient Population Management



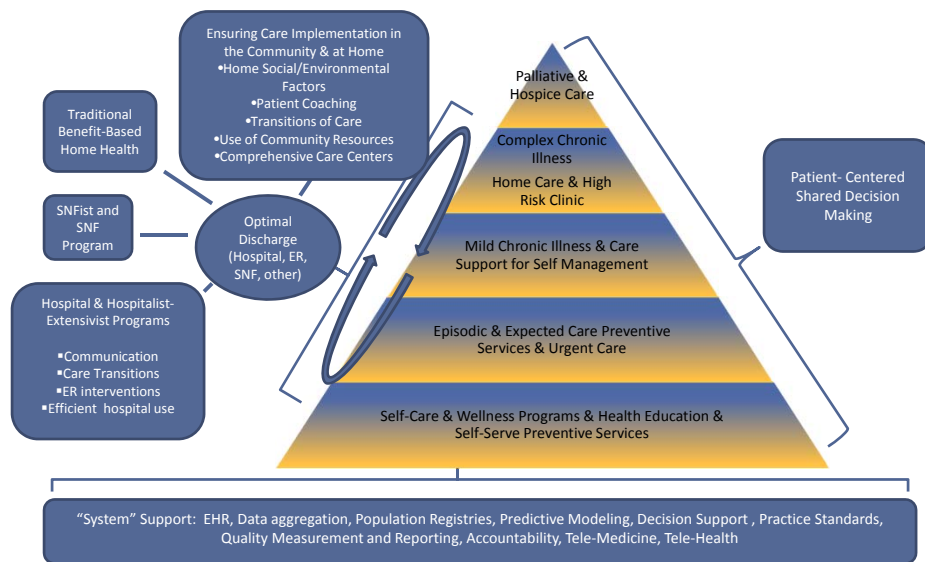


Active Patient Population Management

“System” Infrastructure Support:

EHR, Clinical Data Integration/Population Registries, Predictive Modeling, Decision Support , Practice Standards, Quality Measurement & Reporting, Accountability, Tele-Medicine, Tele-Health

Active Patient Population Management



Westside Care Transitions Collaborative

- Purpose: To improve post-hospitalization outcomes and decrease readmissions
- Formed between Partners in Care Foundation and the UCLA Health System and Faculty Practice Group, including Ronald Reagan UCLA and Santa Monica UCLA Medical Centers, and St. Johns Health Center

Westside Care Transitions Collaborative

A Root-Cause Analysis (RCA) found the following areas in need of improvement:

- Coordination and communication among providers
- Medication management
- Timely support for patients discharged home
- Communication with patients and families about post-hospitalization care needs and alternatives
- Patient activation to improve self-care skills
- Late life care and decision support services including advance care planning for life-limiting illness

WCT Collaborative - Major Initiatives

- Identifying patients at high readmission risk
- Redesigning patient flow/discharge planning functions from hospitals
- Creating new gap-filling resources to smooth patient transfers (e.g. Care transitions, new UCLA urgent care center for post-discharge; in-home medical care program; home palliative care)
- Expanding offerings of evidence-based models for self-care (e.g., Stanford University's Chronic Disease Self-Management Program)
- Developing standardized transfer tools, processes and quality monitoring for SNFs
- Adopting home care best practices, including piloting and spreading a standard of one-hour response time 24/7 for home health and hospice admissions, whether discharged from hospital or ER

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UCLA Health System Blue Sky Visioning Session:

*How We Will Provide Integrated,
Accountable Care for Older Adults and
Patients with Complex Chronic Conditions*

December 7, 2011

4-8pm

LA Tennis Center Clubhouse



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Question for the day:

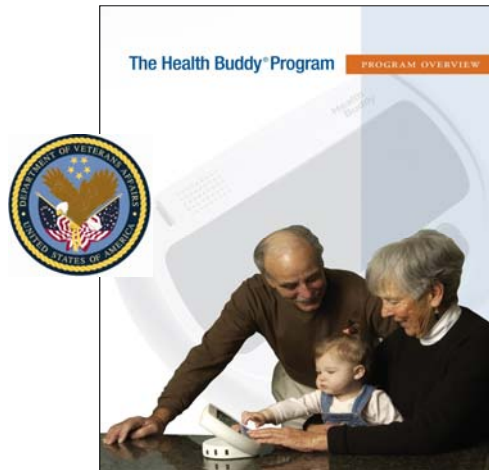
“What additional services do we want to include for older persons and individuals with complex chronic conditions over next 3 to 5 years, to keep them healthy and maximally independent?”

- Given a finite health care dollar, how would we choose to spend it to maximize value in keeping older adults healthy and maximally independent?
- Whom shall we focus our efforts on?
- What are the most promising interventions for improving health and maximizing function while maintaining or, preferably, reducing expenditures?
- What should we do ourselves and what can we provide for patients through community partnerships?

Guiding Principles for Our Work

- Target the factors that keep people from being healthy and independent in the community -- not just the disease
- Focus on the services we provide – link to other community-based services
- Seek excellence – find the best possible practices and make them our standard
- Practice at the top of our license – with room for innovation
- Resist reinventing the wheel – adopt proven methods whenever possible

Innovation All Around Us...



The Veterans Administration Home Telehealth Program

- More than 80,000 veterans now enrolled
- Saves \$11,000 / pt / yr
- Patient satisfaction > 90%

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Innovation All Around Us...



The Partners In Care Foundation:

- HomeMeds Program for medication management
- Home-Based Palliative Care Program
- Health Assessment for new Medi-Cal enrollees with state insurance expansion
- Direct contribution to UCLA Primary Care Innovation Model

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Improving the transition from hospital to home...

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June Simmons, CEO
Partners in Care Foundation

Molly Joel Coye, MD, MPH
Chief Innovation Officer, UCLA Health System



December 13, 2011

Rapidly Changing Environment

- Integrate clinical care and community-based services
- Eliminate the “silos” of care
- Know the population / target the intervention
- Reduce readmissions / lower costs / improve outcomes

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New Funding Streams

- CMS has made available **half a billion dollars** to help hospitals reduce preventable readmissions
- Grants are contingent upon completing an analysis of the underlying causes for readmissions (**root cause analysis**)
- Requires partnering with a qualified CBO (community based organization)
- Partners in Care Foundation is a qualified community-based organization -- joined with UCLA Health System to establish the Westside Care Transitions Collaborative

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The Solution: Care Transitions

What is Care Transitions?

- The movement of patients through the continuum of care from one setting to the next
- Partners in Care's Post-Hospital Support System
 - Acute Hospital → Home & Community
 - Acute Hospital → Sub-Acute → Home & Community
 - Nursing Home → Home & Community

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Transition Goals

- Coordinate care transition from institutional setting (acute, sub-acute, long-term) to home
- Improve outcomes – reduce readmissions, reduce unnecessary SNF utilization, reduce errors and unnecessary services, reduce costs
- Patient advocacy, patient empowerment and patient education
- Identify and collaborate with appropriate community-based, social services

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The Problem(s)

- 19.6% of Medicare patients nationally are readmitted within 30 days – two-thirds of readmissions are avoidable
- Effective October, 2012, CMS will reduce hospital Medicare and Medicaid reimbursement based on the hospital's rate of readmission, beginning with 2011-2012 data
- Discharge planning, home health, and outpatient services are each still a silo – what's missing is the bridge connecting these services
- Patients leave the hospital without adequate understanding of their conditions and unprepared to comply with treatment
- At least 60% of readmissions are due to medication errors

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Costs to Medicare

- CBO reported that the average hospital admission cost \$30,500 in 2008
- CBO estimates Medicare will save \$7 billion over 10 years through reductions in payments to hospitals for readmissions
- Most common diagnoses resulting in readmits include heart failure, heart attack, pneumonia, and chronic obstructive pulmonary disorder

Root Cause Analysis

- Helps hospitals understand and reduce rates of preventable readmissions, often reveals surprising issues, patterns or gaps in service
- Helps hospitals choose appropriate interventions based on the reasons for readmissions identified in the analysis.

Root Cause Analysis (RCA)

- Partners in Care Foundation can design and help conduct the RCA to identify opportunities for system change within hospitals and health systems
- Our experience enables us to understand all elements affecting patients as they are discharged to their homes, nursing facilities, rehabilitation facilities, or home health

Root Cause Analysis Elements

- **Population Demographic Analysis:** Discover if readmissions disproportionately affect certain populations in the hospital's service area
- **Claims Data Analysis:** Identify factors associated with readmissions
- **Interviews, Group Discussion and Focus Groups:** Gain insight from interviews, group discussions and focus groups with providers, staff, patients, families, and agencies on the receiving end of post-discharge handoffs
- **Medical Record Reviews:** Includes random and/or targeted reviews of discharges that resulted in readmissions

Root Cause Analysis Elements

- **Process Assessment:** Observe and document discharge and other relevant internal processes, interview key staff, and assist with mapping various workflows and processes
- **Local Resource Survey:** Assist with identifying and connecting with local agencies, services and initiatives relevant to programs for reducing readmissions
- **Retreat to discuss preliminary findings:** Convene leadership to discuss the findings and use them as a basis for choosing an intervention and program design

WCTC Root Cause Analysis: Areas for Improvement

- Coordination and communication among providers
- Medication management
- Timely support for patients discharged home
- Communication with patients and families about post-hospitalization care needs and alternatives
- Patient activation to improve self-care skills
- Late life care and decision support services including advance care planning for life-limiting illness

Westside Care Transitions Collaborative

Major Initiatives

- **Identify patients at high readmission risk**
- **Redesign patient flow/discharge planning functions** from hospitals
- **Create new gap-filling resources to smooth patient transfers** (e.g. Care transitions, new UCLA urgent care center for post-discharge; in-home medical care program; home palliative care)
- **Expand offerings of evidence-based models** for self-care (e.g., Stanford University's Chronic Disease Self-Management Program)
- **Develop standardized transfer tools**, processes and quality monitoring for SNFs
- **Adopt home care best practices**, including piloting and spreading a standard of one-hour response time 24/7 for home health and hospice admissions, whether discharged from hospital or ER

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Major Initiatives

- **Redesign patient flow/discharge planning functions** from hospitals
 - Project RED
 - BOOST
- **Identify patients at high readmission risk**

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Criteria for Identifying Inpatients at High Risk of Readmission

- Age 65+
- CHF
- Depression
- 2+ chronic conditions
- 2+ admissions within 12 months
- Length of stay >10 days
- Cognitive impairment

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Westside Care Transitions Collaborative Major Initiatives

- **Create new gap-filling resources to smooth patient transfers**
 - Care transitions / complex care coordination (coaching)
 - In-home medical care program
 - **HomeMeds**
 - In-Home Palliative Care

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Westside Care Transitions Collaborative Major Initiatives

- **Expand offerings of evidence-based models** for self-care
 - Stanford University's Chronic Disease Self-Management Program

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The Problem – Medications at Home

- Medication Errors at home are:
 - **Serious:** They cause approximately 7,000 deaths per year in the US
 - **Costly:** Annual cost of drug-related illness and death exceeds \$170 billion
 - **Common:** Up to 48% of community-dwelling elders have medication-related problems
 - **Preventable:** At least 25% of all harmful adverse drug events are preventable

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The Solution – HomeMeds

- **In-home collection** of comprehensive medication list, 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 – chosen for physician response
- **Computerized medication risk assessment** and alert process with comprehensive report system
- **Consultant pharmacist** addresses problems with prescribers

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HomeMedsSM Saves Money, Saves Lives

- 46.7% of the 7,000 older adults screened in 14 sites from 2007 to 2010 shown to have risk for medication-related injury – average of 2 to 3 potential problems per client.
- Falls and other adverse effects improved through collaboration between pharmacists and members of the care team
- **Estimated Savings from 7,000 Screenings:
\$1.5 million.**

(HRSA, 2010, www.hrsa.gov/patientsafety)

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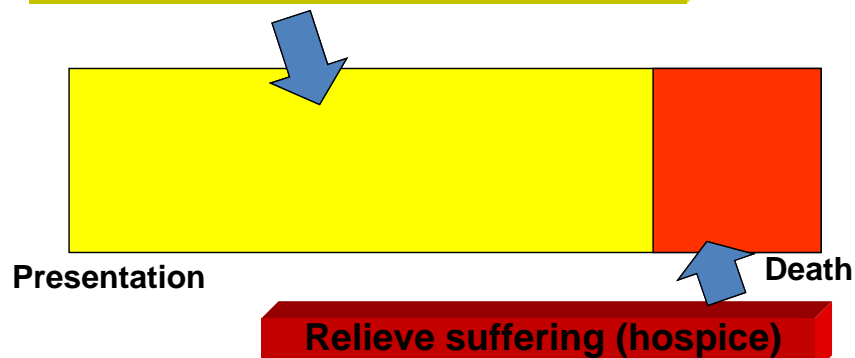


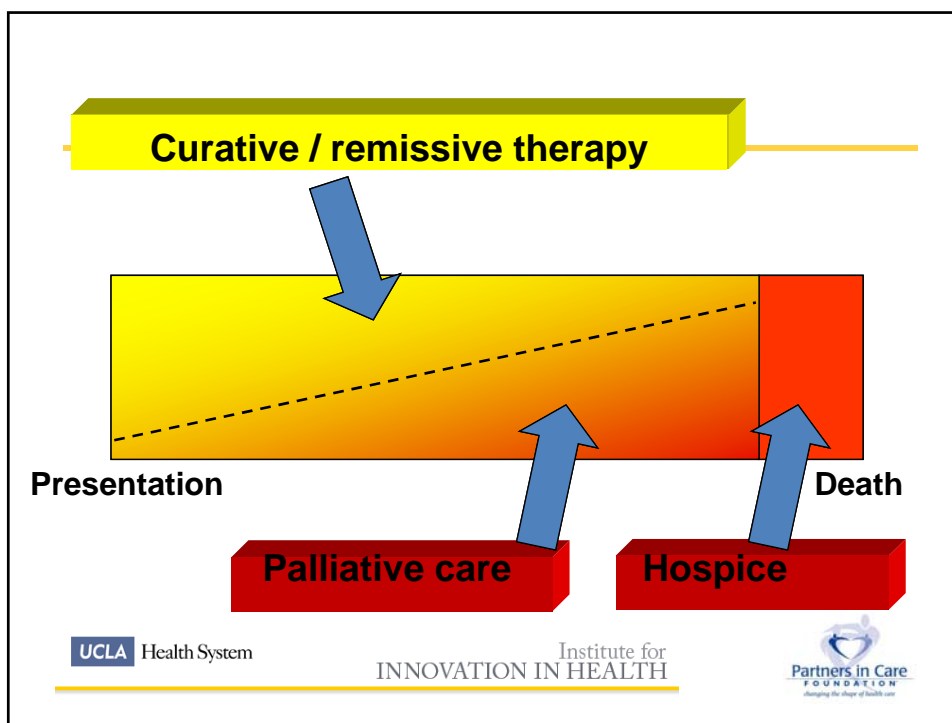
Challenges in Providing End-of-Life Care

- Fragmentation of care
- Aging population
- Costs of medical care
 - 25% of Medicare revenue is spent on 5% who die each year
 - Average cost of care in last year of life is \$26,000 (1996 costs)
 - Average cost of care in last 2 years \$ 58,000

A dichotomous intent

Curative / life-prolonging therapy





Home Based Palliative Care Model

- Bridge traditional medical care and Hospice care
- In home end-of-life care for patients with one year life expectancy
- Blended model of care
- Shift focus of care from hospital to home
- Honor patient choices for own care

Core Components of Palliative Care

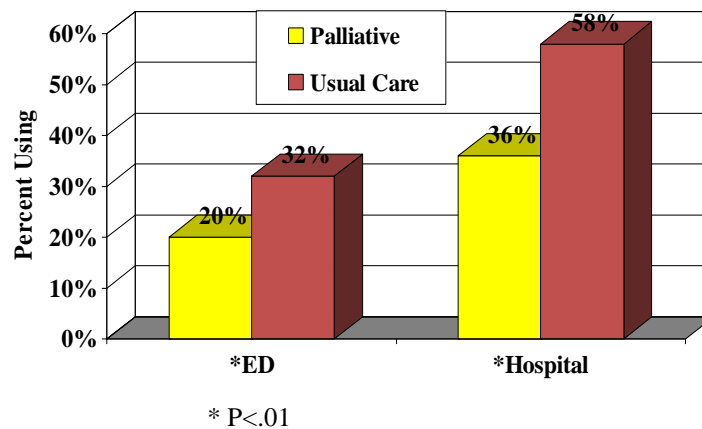
- Pain & other symptom management
 - comprehensive primary care to manage underlying conditions
 - aggressive treatment of acute exacerbation per patient and family request
- 24 hour phone support, visits if necessary
- Volunteer & bereavement services
- Transfer to hospice if appropriate

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Acute Care Service Use (n=297)

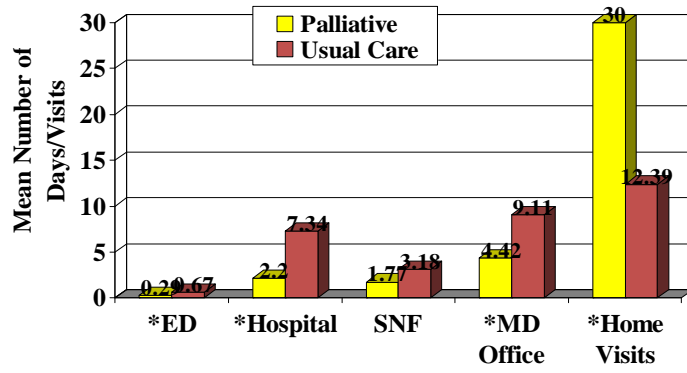


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Unadjusted Medical Service Use (n=297)



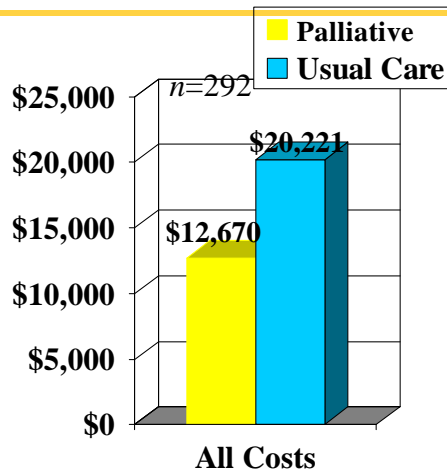
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Total Service Costs



- Adjusted costs of care for those in PC were 32.6% less than those receiving UC

• **Saves \$7,551**

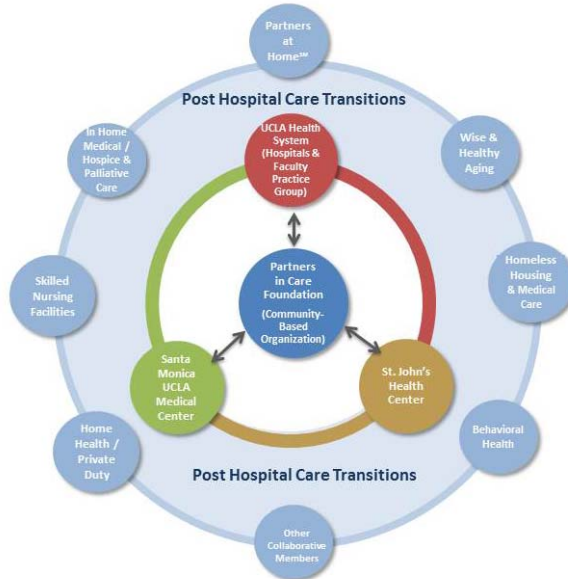
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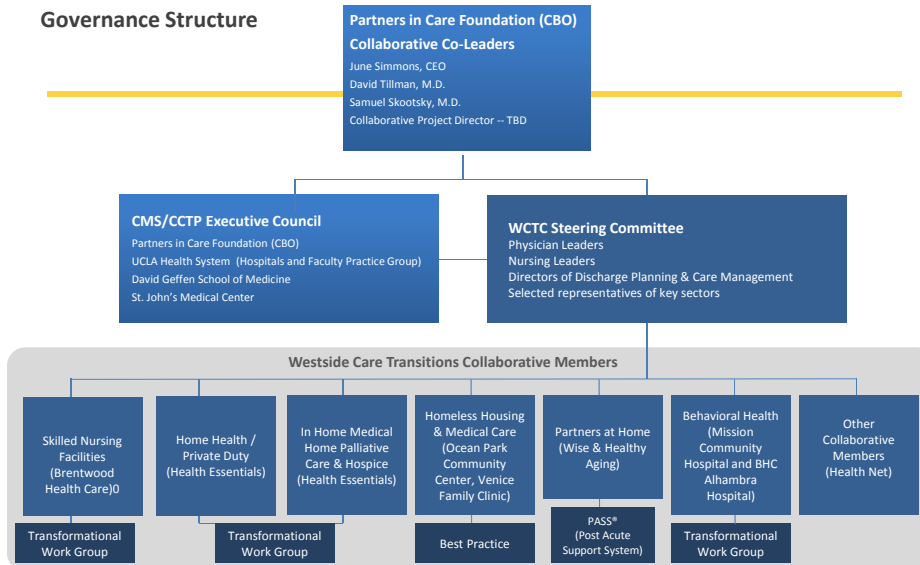


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Partners in Care
 FOUNDATION
 Changing the shape of health care

Westside Care Transitions Collaborative Governance Structure



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