Partners at Home...
Where Health Happens

June Simmons, President/CEO
Marcia Colone, Ph.D

11th Annual Kentucky-Tennessee Chapter Case Management Conference

American Case Management Association

October 30, 2017
Nashville, TN
There’s No Place Like Home
Getting to Know You

- RN
- LVN
- LCSW
- Case Manager
- SW
- Administrator
- Other
Session Objectives

• Highlight **seven** objective criteria for identifying patients better supported by community-based care *services*.

• **Provide tips** for discerning community-based organizations that will meet and exceed standards.

• **Differentiate roles** between hospital, primary care and community-based agencies in this innovative partnership.
The NEW Environment

- Constant change and uncertainty
- Obama repeal
- Influx of patients into HMO products
- Reimbursement systems in flux
- Consolidation as key driver
- New payment methods
- New quality criteria
- Increasing demands on you as nurses and medical professionals
- Patients with more complex, multiple chronic diseases
Discharge Planning Tied to IMPACT ACT

- Hospitals must consider availability and access to caregivers and community-based care, including supports even for people who are homeless
What Happens When Patients Go Home
Focus on Social Determinants of Health (SDOH)

- Safe Housing and Neighborhood Support
- Access to Care: Coaching & Navigation
- Community Connection/Caregiver Support
- Patient Engagement & Activation
- Benefits Counseling & Assistance
Audience Question

• How many of you feel that you’re being pulled to work outside of your scope because of the increasing needs of your complex patient population?
How CBOs Close the Gap

• Create a REAL continuum of care
• Address patient needs that are home based
• Visit the patient within the critical period after discharge
• Assist the patient in knowing when to call for help
• Assist with non-medical supports and improve patient health outcomes
Case Management in the Community

• Case management in health care setting
• Social services case management in community

Case management (CM): A health care service in which a single person, working alone or in conjunction with a team, coordinates services and augments clinical care for patients with chronic illness.

Other definition to come...
UCLA’s Collaboration with Partners

Lessons Learned!
It All Starts and Ends at Home

- New payer arrangements are driving care into the home
- Medicare FFS: TCM, CCM, Bundled: Ortho, Cardio
- Public & Commercial payers should adopt/scale
- LOS to be tracked vigorously
- Quality outcomes are now critical
- Consolidation of the post acute network needed
Establishing the Program

- Start-up slow and steady
- Staff understanding what this program is and how it improves patient care
- Physician understanding what this program is and why so important
- Identifying the right patients on time
- Meeting regularly to develop relationships with partners and set metrics
Lessons Learned

• Build the program and the patients will come
• Develop a communication plan to inform the organization-nursing, physicians
• Continue to communicate and share the quality metrics
• Identify the opportunities to improve
• Results exceeded expectations
Achieving Proven Results
Average Savings Feb 2015–Jan 2016

Care Transition using Dr. Eric Coleman’s Coaching & Rush University Bridge Patient-Activation Models

Partners’ participation in CMS’ Demonstration Project, Community Care Transition Program (CCTP) - Readmission Rates for Pre-Intervention Baseline, All Cause, All Condition Patients Compared to Post-Intervention CCTP Participants across 11 hospitals

<table>
<thead>
<tr>
<th>CCTP Site</th>
<th>Participants Served*</th>
<th>Average Readmit Rate**</th>
<th>Average # Readmits Averted per Year</th>
<th>Average $ Saved @ $15,500/ Readmit per Year³</th>
<th>Average Cost per Year @ $500/person</th>
<th>Average Net Savings per Year</th>
<th>Average ROI (net) per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westside</td>
<td>4,124</td>
<td>14.2%</td>
<td>284</td>
<td>$4.4 M</td>
<td>$2.1 M</td>
<td>$2.3 M</td>
<td>2.1:1</td>
</tr>
<tr>
<td>Glendale</td>
<td>3,048</td>
<td>13.3%</td>
<td>211</td>
<td>$3.3 M</td>
<td>$1.5 M</td>
<td>$1.8 M</td>
<td>2.2:1</td>
</tr>
<tr>
<td>Kern</td>
<td>4,047</td>
<td>12.4%</td>
<td>336</td>
<td>$5.2 M</td>
<td>$2 M</td>
<td>$3.2 M</td>
<td>2.6:1</td>
</tr>
</tbody>
</table>

1 Baseline (Pre): All-Cause, All-Condition: Westside & Glendale = Jan – Dec 2012, Kern = Apr 2012-Mar 2013
2 CCTP (Post): Medicare High-Risk FFS Population
** Average readmit rate calculated using 4 quarters of data (Feb 2015 – Jan 2016).
³ Source: Health Services Advisory Group, average L.A. County cost for FFS Medicare Readmission, $15,500 published 2012 (2010-11 data)

Source: HSAG, CA QIO, November 2016

Highest % of readmission reduction in California
How involved are you in contracting decisions?

- Extremely involved
- Slightly involved
- Never involved
Show Us the Money

Partners has created a multi-payer strategy by contracting with health plans, medical groups (MG), and hospitals. Payment for services generally follows which entity is carrying the risk by product line:

- **MG Hospital**
  - Triage
  - Referral

- **Waiver**
  - Contract with multiple Medi-Cal plans for nursing home diversion & care transitions from SNF to community

- **Health Plan**
  - Contract with multiple health plans for Medicare, Medi-Cal, CMC/Duals, IFP, Commercial

- **MG Hospital**
  - Population where MG or Hospital holds full risk
  - Pay per Contract
Bundled Payment

Add a low-cost, high-value targeted home visit

- Environmental assessment
- Medication safety review
- Exercise
- Transportation to appointments
- ADL assistance
- Fall prevention education

- Med safety review
- Med adherence
- Self-care education
- Diet-compliant meals
- Transportation to appointments
- Depression & anxiety screen

- Coleman model coaching
- Med review
- Med adherence support
- Follow-up appointments
- Coaching for self-management
- Social services, benefits, meals, transportation

www.PICF.org
The Seven Factors and The Way Home

- 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
## Targeting Tiers of Need for Home Visit or Self-Management Support

<table>
<thead>
<tr>
<th>Risk Criteria/Needs</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute/LTPAC Use</strong></td>
<td>Primary care only</td>
<td>Intense use of primary care and specialty care for chronic condition</td>
<td>1+ ED visit or unplanned IP in past year; Intense use of primary care and specialty care for chronic condition</td>
<td>2+ ED visit or unplanned hospitalizations or SNF stay in past year</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td>&lt;5 prescribed meds</td>
<td>5-8 prescribed meds</td>
<td>5-8 prescribed meds</td>
<td>9+ prescribed meds</td>
</tr>
<tr>
<td><strong>Functional Impairment</strong></td>
<td>None known</td>
<td>Ambulatory, independent, with assistive devices</td>
<td>Occasional assistance needed with ADL or IADL</td>
<td>Daily hands-on assistance needed</td>
</tr>
<tr>
<td><strong>Cognitive Impairment</strong></td>
<td>None known</td>
<td>None or mild – able to arrange services or has caregiver who can do so</td>
<td>Mild to Moderate – needs assistance arranging services</td>
<td>Moderate to severe</td>
</tr>
<tr>
<td><strong>Social factors</strong></td>
<td>Any or none</td>
<td>Any or none.</td>
<td>Prepare caregiver for decline.</td>
<td>Likely caregiver issues</td>
</tr>
<tr>
<td><strong>Literacy/health literacy</strong></td>
<td>Speaks English; understands healthcare instructions</td>
<td>May need translation services or explanation but able to act on healthcare instructions</td>
<td>Not able to understand or act on instructions</td>
<td>Not able to understand or act on instructions</td>
</tr>
<tr>
<td><strong>Self-management</strong></td>
<td>Clinical signs outside of goal</td>
<td>Clinical signs outside of goal; at risk for decline</td>
<td>Clinical signs significantly outside goal</td>
<td>Clinical signs significantly outside goal/deteriorating</td>
</tr>
</tbody>
</table>
Why CBO Partnership Makes Sense

• Culturally Sensitive
• Broad geographic reach
• NCQA quality accreditation
• Experience in providing community based care
• Standards that can be relied upon and replicated
How Do You Ensure the Best Quality

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 has created **Partners at Home (PAH)**, a **statewide specialty network of Community-Based Organizations (CBOs)** leading the nation in prototyping models to provide patient-centered social services in the home and community.

PAH streamlines access to multiple community-based care “extenders,” including Health Coaches and Social Workers who are well-trained, culturally and linguistically competent, and experienced in helping patients whose health is fragile, and whose care is complex and costly.

Care/service plans are reviewed by Partners’ LCSW prior to submitting to Health Plan’s CM to ensure quality and coordination of care across the care continuum.

HomeMeds uses a coach to collect detailed medication information which is reviewed by a pharmacist whose recommendations are shared with the patient’s PCP and the Health Plan’s CM to ensure optimal evidence-based care.

The quality of Partners’ complex case management program has been recognized with accreditation by the National Committee for Quality Assurance (NCQA), one of the first two CBOs in the country to receive this designation.
Our Statewide Community-Based Network

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

WA
Conexus Health Resources¹

CA
Partners at Home Network

IN
Indiana Aging Alliance

NY
Western NY Integrated Care Collaborative¹

MA
Healthy Living Center of Excellence & Greater North Shore Link¹

PA
Aging Well, LLC

VA
Eastern Virginia Care Transitions Partnership¹

OH
Direction Home¹

OK
Oklahoma Aging & Disability Alliance¹

TX
Healthy at Home, T4A

Florida Health Networks

¹Not a full statewide network
Forming the Collaborative

- All partners open to change and flexible
- Create new workflows and systems
- Enhancement not encroachment
- Iterative learning, side by side
- Making adjustments along the way
- Two equally important components: nurses and social workers
- Work with case managers or care team to integrate non-medical services into care plans
Leading Into This Space

• Post-acute and post-SNF home services is now a priority
• Nurses as advocates
• Helping prepare patients for the next level of care – set clear workflow
• Helping hospital professionals to understand and address the needs of patients post discharge
• How will you lead into this space?
The Agency Script

- What to say when you get back to your agency
- The four steps you can take to ensure this collaborative will work
  - Monitor results and navigate adjustments
  - Integrate system needs as policy, process and continuum changes evolve
  - Determine what data should be communicated to help motivate more cooperation and inter-agency development
  - Lead, endorse, advocate and be strategic
Question

• Based on everything you have heard today, what do you think is the most valuable aspect of this collaborative care coordination model?
  – Improved patient health outcomes and greater stability for complex care patients
  – Better all around support for patients once they go home
  – Powerful way to address some of the patients social needs without adding more to your workload
  – Ensuring resources are directed appropriately—financial and human
Audience Question

• Based on the discussion today, where do you intend to start? What will you do first?
Thematic Topics

• This program [post acute in-home services] is where the future is; the home environment is where “this must go”.

• Nurses [and case managers] must understand their role as advocates so that they can help prepare patients for this next level of care.

• We are all obligated to post-acute services...the key question is...how do we want to lead into this space?
Open Discussion

• Questions?
• Comments?
In Summary

• We are building for the ‘long game’
• Collaboration equals measurable results
• It’s all about the patient in the center
• The future is now and we are the equal partners and leaders in this care continuum
• Financing will come and we need to be ready
Bold New Partnerships Between Physicians, Plans and CBOs

- New home and community-based specialty models of care, a critical component across the care continuum
- Depth of experience, with deep local knowledge and connections for essential life resources
- Full regional coverage with consistent tools, IT and results
- Evidence-based programs for chronic conditions, caregivers, medication safety and post-acute coaching and support
- Careful targeting

Together, we are achieving the Triple Aim!

Results and Value

- Improves discharge planning
- Reduces hospitalizations, readmissions, SNF & ER visits
- Improves quality scores
- Improve the patient experience
Marcia Colone
Vice President, Transition Management Office
Vanderbilt University Medical Center
615-936-0636
marcia.a.colone@vanderbilt.edu