Dual Eligible Initiatives, Coordinated Care Transitions Programs (CCTPs) and Affordable Care Organizations (AFOs) Create Care Models and Opportunities for Social Work

W. June Simmons, CEO
Partners in Care Foundation
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W. June Simmons, President & CEO
Partners in Care Foundation - San Fernando, CA

June Simmons, MSW, is the founding President and CEO of Partners in Care Foundation. Ms. Simmons takes an active role in developing initiatives and proactive programs which meet the mutual needs of patient populations, providers and healthcare delivery networks to encourage cost-effective, patient-friendly integration of care from hospital to home and community. Ms. Simmons has just completed a term on the National Advisory Council of the National Institute on Aging (NIA). She is currently a member of the Institute of Medicine Workgroup on Transforming End of Life Care. Partners in Care currently leads innovative initiatives to bring local home and community based organizations into full integrated service delivery systems across our broad regions and addressing the great diversity of our region. A strong leader in bringing forth population health management strategies that integrate medicine and home and community services.

Objectives

Participants will be able to:
• Describe key Affordable Care Act issues impacting social work/long term supports and services practice
• Recognize key target populations for social work intervention
• Describe central social work strategies and interventions in this changing environment
Bringing medicine, patients and community-based services together.

Spending on health care

US outcomes are worse – need to spend more wisely
The Expanded Chronic Care Model: Integrating Population Health Promotion

Health Care Delivery System Transformation

- **Acute Health Care System 1.0**
  - High quality acute care
  - Accountable care systems
  - Shared financial risk
  - Case management and preventive care systems
  - Population-based quality and cost performance
  - Population-based health outcomes
  - Care system integration with community health resources

- **Coordinated Seamless Health Care System 2.0**
  - High quality acute care
  - Accountable care systems
  - Shared financial risk
  - Case management and preventive care systems
  - Population-based quality and cost performance
  - Population-based health outcomes

- **Community Integrated Health Care System 3.0**
  - High quality acute care
  - Accountable care systems
  - Shared financial risk
  - Case management and preventive care systems
  - Population-based quality and cost performance
  - Population-based health outcomes
  - Care system integration with community health resources
Targeted Patient Population Management with Increasing Disease/Disability

- Hot Spotters!
- Evidence Based Self-Management, Home Assessment and HomeMeds
- Chronic Condition(s) with Mild Functional &/or Cognitive Impairment
- Complex Chronic Illnesses w/ major impairment
- End of Life
- Home Palliative Care
- Post Acute and Long Term Supports and Services
- Well – No Chronic Conditions or Diagnosis without Symptoms
- Chronic Condition with Mild Symptoms
- in OECD, for every $1 spent on health care, about $2 is spent on social services
- In the US, for $1 spent on health care, about 55 cents is spent on social services
Targeting Home & Community-Based Services in Active Population Health Management

Examples: Hospice & home palliative care

Examples: SNF diversion, Respite Care, Home Modifications, home monitoring, daily meals, assisted transportation

Examples: Coaching & Patient Activation, Home-delivered Meals; Referral to Self-Management Classes

Examples: Stanford Healthier Living; Diabetes Self-Management; Matter of Balance

Examples: Activity programs & education @ senior center

Dual Eligibles – The Ultimate Case Study:
Age + Poverty = Worse Health, Higher Cost

Sources: Centers for Medicare and Medicaid Services; Kaiser Family Foundation, Medicare Payment Advisory Commission
Avoidable Hospitalizations for Duals

Over $4 billion potentially avoidable...not to mention the patient suffering this represents

The Upstream Approach: What would happen if we were to spend more addressing social & environmental causes of poor health?
Concentration of Risk

• Functional Limitation
• Dementia
• Frailty
• Serious illness(es)

Scope of the Problem

• 1.7 million Americans die of a chronic disease each year
• Chronic diseases affect the quality of life for 90 million Americans
• 87% of persons aged 65 and over have at least 1 chronic condition; 67% have 2 or more
• 99% of Medicare spending is on behalf of beneficiaries with at least one chronic condition
Projected “Boomers” Health in 2030

- More than 6 of every 10 will be managing more than one chronic condition
- 14 million (1 out of 4) will be living with diabetes
- >21 million (1 out of 3) will be considered obese
  - Their health care will cost Medicare 34% more than others
- 26 million (1 out of 2) will have arthritis
  - Knee replacement surgeries will increase 800% by 2030


Most of Costliest 5% have Functional Limitations

![Graph showing distribution of enrollees by chronic conditions and functional limitations](http://www.cahpf.org/docuserfiles/georgetown_trnsfrming_care.pdf)
Dementia and Total Spend

- 2010: $215 billion/yr
- By comparison: heart disease $102 billion; cancer $77 billion
- 2040 estimates: $375 billion/yr

Source: Hurd MD et al. NEJM 2013;368:1326-34.

Dementia Drives Utilization

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>No Dementia</th>
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<tbody>
<tr>
<td>Medicare SNF use</td>
<td>44.7%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Medicaid NH use</td>
<td>21%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Hospital use</td>
<td>76.2%</td>
<td>51.2%</td>
</tr>
<tr>
<td>Home health use</td>
<td>55.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Transitions</td>
<td>11.2</td>
<td>3.8</td>
</tr>
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</table>

Prospective Cohort of community dwelling older adults

Source: Callahan et al. JAGS 2012;60:813-20.
In case you are not already worried...

The Future of Dementia Hospitalizations and Long Term Services+Supports

10 fold growth in dementia related hospitalizations projected between 2000 and 2050 to >7 million.


3 fold increase in need for formal LTSS between now and 2050, from 9 to 27 million.


Because of the Concentration of Risk and Spending, Home and Community Care Principles and Practices are Central to Improving Quality and Reducing Cost
Surprise! Home and Community Based Services are High Value

• Improves quality: Staying home is concordant with people’s goals.

• Reduces spending: Based on 25 State reports, costs of Home and Community Based LTC Services less than 1/3rd the cost of Nursing Home care.

This is Our Expertise

• Highest risk, highest cost population is ours: functional limitation, frailty, cognitive impairment +/- serious illness

• We need a fully integrated service line that also addresses keeping people out of the top 5%
Building Our New Business Model: Focus Areas

<table>
<thead>
<tr>
<th>Evidence Based Self-Management</th>
<th>Assessments, Care Coordination &amp; Coaching</th>
<th>Efficient Delivery System Provider Networks</th>
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<tbody>
<tr>
<td>Chronic Disease</td>
<td>HomeMeds</td>
<td>Evidence-Based Leadership Council</td>
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<tr>
<td>Chronic Pain</td>
<td>Adult Day/CBAS Assessment</td>
<td>Care Coordination Network</td>
</tr>
<tr>
<td>Diabetes (billable)</td>
<td>Home Safety Evaluation</td>
<td>Care Transitions Provider Network</td>
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<td>A Matter of Balance</td>
<td>Home Palliative Care</td>
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<td>Savvy Caregiver</td>
<td>Short &amp; Long-Term Care &amp; Service Coordination</td>
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<tr>
<td>Powerful Tools for Caregivers</td>
<td>Care Transitions Interventions</td>
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<tr>
<td>Arthritis Foundation</td>
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<tr>
<td>Exercise &amp; Walk with Ease</td>
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<td>UCLA Early Memory Loss</td>
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Home and Community Based Services – a Specialty Practice Expertise

- Evidence-based approaches underlie all our work
- In-Home assessment and supports, long and short term – waivers/ Care Transitions
- Caregiver skills and support
What is Self-Management?

The actions that individuals living with chronic conditions must do in order to live a healthy life.

- Physical Activity
- Medications
- Planning
- Manage Fatigue
- Better Breathing
- Working With Health Professionals
- Problem-Solving
- Family Support
- Managing Pain
- Communication
- Understanding Emotions
- Healthy Eating

CDSMP: The “Gold Standard”

- Improves health and quality of life
  - Benefits people at all SES and education levels
- Reduces health care costs
- Improvements and cost savings are sustained over time
- Findings documented over 20 years of research in a variety of settings
- Offered in many countries and in over 20 languages
Some Evidence-Based Programs

SELF-MANAGEMENT
- Chronic Disease Self-Management
- Tomando Control de su Salud
- Chronic Pain Self-Management
- Diabetes Self-Management

PHYSICAL ACTIVITY
- Enhanced Fitness & Enhanced Wellness
- Healthy Moves
- Fit & Strong
- Arthritis Foundation Exercise Program
- Arthritis Foundation Walk With Ease Program
- Active Start
- Active Living Every Day

MEDICATION MANAGEMENT
- HomeMeds

FALL RISK REDUCTION
- Stepping On
- Tai Chi Moving for Better Balance
- Matter of Balance

DEPRESSION MANAGEMENT
- Healthy Ideas
- PEARLS

CAREGIVER PROGRAMS
- Powerful Tools for Caregivers
- Savvy Caregiver

NUTRITION
- Healthy Eating

DRUG AND ALCOHOL
- Prevention & Management of Alcohol Problems

New Public and Private Models

- Readmission penalties inspiring rapid change
- CMS testing new CBO Medicare models
- Moving to all cause/all payers
- Integrated regional delivery system
Goals of Transition Programs

• Engage patients (&/or caregivers) with chronic illness and activate self-care & behavior change
• Follow post-discharge to ensure meds/services received
• Teach/coach regarding medications, self-care, symptom recognition and management
• Remind and encourage patients to keep follow-up physician appointments – ensure transportation

*How to achieve these goals differs across programs*

Best Practices (Coach focus group)

• Identify at-risk patients
  – Case managers who know patient & family provide fewer, but more appropriate patients
  – Hospital-based coach who gets to know staff, schedules, how to find patients – staff trusts more and therefore refers more
  – 24 hours pre-discharge is ideal time
• Room Visit
  – “I’m here on recommendation from”...someone patient knows – MD, case manager
• Efficiency
  – Field coach & hospital coach allows everyone to see more patients
  – Teamwork gives us more flexibility – cover more times of day and languages
**Issues/Challenges (Coach focus group)**

- **Identify at-risk patients**
  - Volume (automated at-risk patient ID) vs. quality (case manager – BUSY!)
    - Have case managers briefly review list for appropriate patients
  - Timing – often too late; patient already discharged
  - Weekends!
- **Room Visit**
  - Patients out of room for tests & treatments, or asleep/ill
- **Home Visit**
  - Hard to reach patients – not answering phone; no voicemail system
  - 48-hour home visit difficult – still too ill and exhausted
  - Family protects patient & blocks access
- **Efficiency**
  - We’re bugging case managers for information & they don’t have time – need direct access to face sheet & d/c summary
    - Patient ID & info has to be exactly right or billing won’t go through
    - Dx codes not known until d/c summary
    - We don’t know where pt d/c to (home, SNF, etc)
- **30-40% readmitted elsewhere – how do we know?**

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**Coleman Care Transition Intervention**

- Social Worker or Health Coach (one per 40 patients)
- Duration-30 days post hospital/SNF
  - One visit in hospital
  - One Home visit post-DC or post-SNF
  - Three follow-up calls within 30 days
- Based on four pillars
  - Medication Reconciliation & Management
  - Personal Health Record (PHR)
  - Primary care and specialist follow-up
  - Knowledge of red flags re: symptom exacerbation
- Results*
  - In RCT, CTI prevented 1 readmission per 17 patients
  - Savings $300,000 per 350 patients (cost<$170,000)

*California Healthcare Foundation “Improving Care Transitions” October 3, 2007
Coleman/Bridge Commonalities

- Identify at-risk patients
  - Unit Nurse
  - Care Managers or Discharge Planners
  - EMR system data/risk algorithm
- Room Visit
  - Introduce & Explain
  - Determine need, coachability or appropriateness
  - Consent
  - Begin assessment
  - Leave info
  - Schedule visit or calls
- Follow-Up at home or by phone
  - Verify discharge orders complete: meds, equipment, home health, etc.
  - Ensure MD visits scheduled w/ transportation if needed
  - Connect with resources, including meals
  - Verify understanding of self-care
  - Encourage healthy behaviors
  - HomeMeds for medication reconciliation & safety

Medications & Care Transitions

- 72% of post-discharge adverse events are related to medications—and close to 20% of discharged patients suffer an adverse event. *
- 35% of Medicare patients taking 5 or more medications experience adverse drug events
- HomeMeds program – a social work solution

Value-Added Service: HomeMeds<sup>SM</sup>  
The Right Meds... The Right Way!  
HomeMeds<sup>SM</sup> proven solution in four important problem areas affecting seniors:
1. Unnecessary therapeutic duplication  
2. Falls and confusion related to possible inappropriate psychoactive medication use  
3. Cardiovascular problems such as continued high/low blood pressure or low pulse  
4. Inappropriate use of non-steroidal anti-inflammatory drugs (NSAIDs) in those with high risk of peptic ulcer/gastrointestinal bleeding

*Coach & software identify medication-related problems and pharmacist works with patient and prescribers to resolve them.*

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Care Transitions: Buy vs. Build Decision  
Patients discharged to geographically disparate parts of the County  

**Considerations:**
- Driving distances to patient home  
- Knowledge of local services  
- Training and experience  
- Language / Culture  
- Data collection / patient monitoring
Individual Hospital Approach: Each hospital must hire, train, manage and pay transitions directors and health coaches.

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

Overlapping Networks & Service Lines

Evidence-Based Self-Management Network
- National Network - EBLC
- Statewide TA Collaborative
- L.A. AAA/Senior Center Providers

LTSS Network
- Nonprofit Waiver Contract Holders for Care Coordination
- Vendor Network
  - Respite care
  - Meals
  - Assisted Transportation
  - Home Modifications
  - Home alert & monitoring
  - DME

Care Transitions/SNF Diversion Network
Current MSSP Services Model:
(can be adapted for Duals as CMS rules change)

- **Community Care Coordination**
  - RN
  - Social Worker
  - Client & Family

**Purchased Services** (Credentialed Vendors)
- Safety devices, e.g., grab bars, wc ramps, alarms
- Home handyman
- Emergency response systems
- In-home psychotherapy
- Emergency support (housing, meals, care)
- Assisted transportation
- Homemaker, personal care and respite services
- Replace furniture/appliances for safety/sanitary reasons
- Heavy cleaning & chores
- Home-delivered meals – short term
- Medication management (HomeMeds)

**Referred Services**
- IHSS
- Adult day health
- Regional Center
- Independent Living Centers
- Home Health
- Palliative/Hospice Care
- DME
- Caregiver Support
- Senior Center Programs
- Evidence-based Health Impacting Self-Care programs
- Long-term home-delivered meals
- Housing Options
- Communication Services
- Legal Services
- Benefits Enrollment
- Money management
- Utilities

**Partnering with Skilled Nursing Facilities & Home Health Agencies to Prevent Hospital Readmissions**

Kelley Hart, LVN, Katie Gurvitz, MHA,
Michelle Hofhine, RN

Turning on the High Beams
October 10, 2013
The Problem

The Cedars-Sinai 30-day all-cause readmissions rate for SNF & Home Health patients was higher than the average for all UHC hospitals.

All-Cause 30-day readmission rate
July 2010 – June 2011

<table>
<thead>
<tr>
<th></th>
<th>Discharged to SNF</th>
<th>Home with Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cedars-Sinai</td>
<td>20.2%</td>
<td>18.3%</td>
</tr>
<tr>
<td>All UHC Hospitals (Average)</td>
<td>17.8%</td>
<td>17.1%</td>
</tr>
</tbody>
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Project Charge

Focus: SNF Patients and Home Health Patients
Metric: 30-day all-cause readmissions to CSMC
Target: 50% reduction
Our Results

By engaging in robust performance improvement, Cedars-Sinai Health System identified interventions that reduced 30-day readmissions for SNF & Home Health patients by more than 50%.

<table>
<thead>
<tr>
<th></th>
<th>Discharged to SNF</th>
<th>Home with Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td>25%</td>
<td>14%</td>
</tr>
<tr>
<td>30-day readmission rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pilot Period</strong></td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>30-day readmission rate</td>
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Root Causes for SNF Readmissions

A chart review of 150 SNF patients revealed recurring factors that likely contributed to preventable readmission within 30 days.

- Infrequent visits by a physician or advanced practice nurse
- Patient not seen by physician within first week of discharge
- SNF nursing staff unable to communicate with physician when needed
- Patient/Family not communicating Red Flags to SNF staff
- Lack of clinical oversight on weekends
- Medication Management/Reconciliation between hospital and SNF
- Patients at end of life without an Advance Directive/POLST completed
SNF Intervention: Enhanced Care Program

Pilot 1: October/November 2011
Pilot 2: January/February 2012

A Nurse Practitioner followed 115 CSMC patients in the SNF.
• They saw the patient in the hospital
• They saw the patient in the SNF 24 hours after discharge
• They saw the patient 1-2 times per week in the SNF
• When they saw something, they said something…
  (to the patient’s MD, the SNF staff & to the family)

Root Causes for Home Health Readmissions

A chart review of 45 Home Health patients revealed recurring factors that likely contributed to preventable readmission within 30 days.

• Patients & families often turn away Home Health agencies after hospital discharge
• Inconsistency in frequency of home visits post-discharge
• 45% of readmissions occurred on a Saturday or Sunday
• Patient/Family not communicating Red Flags to Home Health agency
• Medication Management/Reconciliation
• Physicians not responsive when Home Health Agencies have questions/concerns
Results

This intervention, tested twice, has demonstrated a statistically significant reduction in 30-day all-cause readmissions.

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<tr>
<th></th>
<th>n</th>
<th>30-day All-Cause Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Data:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Jan- Mar 2011)</td>
<td>150</td>
<td>25%</td>
</tr>
<tr>
<td>Test of Change I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Oct-Nov 2011)</td>
<td>48</td>
<td>10%</td>
</tr>
<tr>
<td>Test of Change II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Jan-Feb 2012)</td>
<td>67</td>
<td>12%</td>
</tr>
</tbody>
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Cycle I: Enhanced Home Health

**WHO**
All CSMC Discharges to a high volume Home Health agency

**WHAT**
In-hospital visit by nurse + 6 touch-points after discharge
- Home visit within 48 hours of discharge
- Friday “Tuck-in” Phone call
- Weekend Visits
- Medication Reconciliation
- 24-hour call number staffed by a nurse

**WHEN**
November 1 – 30, 2011

**WHY**
To determine if more rigorous home health services can prevent readmissions. (Baseline = 19% readmit rate)
Enhanced Home Health

Only 6.8% of the 59 TOC patients were readmitted within 30 days of discharge. This rate is less than 50% of the baseline rate observed during FY 2011.

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Time Frame</th>
<th>% Readmitted (All-Cause)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSMC discharges home with Home Health (any agency)</td>
<td>Jul 2010 - Jun 2011</td>
<td>19%</td>
</tr>
<tr>
<td>CSMC discharges home with TOC Home Health Agency*</td>
<td>Jul 2010 - Jun 2011</td>
<td>14%</td>
</tr>
<tr>
<td>Test of Change (n=59 patients)</td>
<td>November 2011</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

* The agency selected for the Test of Change had the highest proportion of Home Health referrals from Cedars-Sinai Medical Center.

Conclusions

• Readmissions can be prevented when hospitals take the lead to collaborate with partner agencies in the community.

• Intervening during the 14 days following hospital discharge is crucial for preventing avoidable readmissions.

• Clinical resources in the community (SNF, Home Health) need to be bolstered on weekends.

• Involvement & leadership from Primary MD are key in executing improvements related to readmissions.
Changing Times – New Opportunities

• Following patients across the continuum
• Connecting sites of care within sectors
• Connecting providers of care across sectors
• Articulating the value of social work
• Persistence is required

Come to our Website

• This presentation and others are posted
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• jsimmons@picf.org