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
December 19, 2013

This webinar series is made possible through the generous support of the Retirement Research Foundation

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.

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

Total health care investment in US is less

Targeted Patient Population Management with Increasing Disease/Disability

Targeting Home & Community-Based Services in Active Population Health Management

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

Many hospitalizations of dual eligibles are potentially avoidable, one study showed:
Total hospitalizations for dual eligibles, 2005: 958,837
Potentially avoidable hospitalizations: 382,846, 40%

For potentially avoidable hospitalizations, average length of stay:
- Medicare: 6.7 days
- Medicaid: $7,846
- Medicare: $321

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

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

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>
</tr>
</thead>
<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>
</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease</td>
<td>HomeMeds</td>
<td>Evidence-Based Leadership Council</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Adult Day/CRAS Assessment</td>
<td>Care Coordination Network</td>
</tr>
<tr>
<td>Diabetes (Billable)</td>
<td>Home Safety Evaluation</td>
<td>Care Transitions Provider Network</td>
</tr>
<tr>
<td>A Matter of Balance</td>
<td>Home Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Savvy Caregiver</td>
<td>Short &amp; Long-Term Care &amp; Service Coordination</td>
<td></td>
</tr>
<tr>
<td>Powerful Tools for Caregivers</td>
<td>Care Transitions Interventions</td>
<td></td>
</tr>
<tr>
<td>Arthritis Foundation</td>
<td>Exercise &amp; Walk with Ease</td>
<td></td>
</tr>
<tr>
<td>UCLA Early Memory Loss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Program

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 not of room for tests & treatments, or asleep/too 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 flow sheet & dx summary
  - Patient ID & info has to be exactly right or billing won’t go through
  - Do codes not known until dx is determined
  - We don’t know whose pt dx is (home, SNF, etc)
- 30-40% readmitted elsewhere – how do we know?

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-IC 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)

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℠
The Right Meds... The Right Way!
HomeMeds℠ 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.

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

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

Current MSSP Services Model:
(can be adapted for Duals as CMS rules change)

Overlapping Networks & Service Lines
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.

<table>
<thead>
<tr>
<th>All-Cause 30-day readmission rate</th>
<th>July 2010 – June 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to SNF</td>
<td>Home with Home Health</td>
</tr>
<tr>
<td>Cedars-Sinai</td>
<td>20.2%</td>
</tr>
<tr>
<td>All UHC Hospitals (Average)</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

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

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)

Project Charge

<table>
<thead>
<tr>
<th>Focus</th>
<th>SNF Patients and Home Health Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric</td>
<td>30-day all-cause readmissions to CSMC</td>
</tr>
<tr>
<td>Target</td>
<td>50% reduction</td>
</tr>
</tbody>
</table>

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

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.

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

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
- Friday “Tuck-in” Phone call
- Weekend Visit
- 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 = 13% 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
- June Simmons, MSW
- WWW.PICF.ORG
- jsimmons@picf.org