Beyond the Walls: Partnering with Patients, Caregivers & Community Providers for Better Outcomes

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA
CONFERENCE ON AGING

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HUNTINGTON HOSPITAL SENIOR CARE NETWORK

Background

- Huntington Hospital (1892-)
  - Mission: To excel at the delivery of healthcare to our community
  - 626-bed acute care—highly medical: academic affiliation w/USC, level I trauma center, level III NICU

Background

- Senior Care Network (1984-)
  - Mission: To positively impact the health and well-being of adults throughout the care continuum
  - Focus: community-dwelling adults & older adults w/disabilities, family caregivers
    - Two worlds: health care and community-based services
    - Care coordination, care transitions, health navigation, health education, community resource center, caregiver support
    - Staff primarily public health nurses, social workers
    - Community partnerships

Making the Case To Move Beyond the Walls of the Hospital

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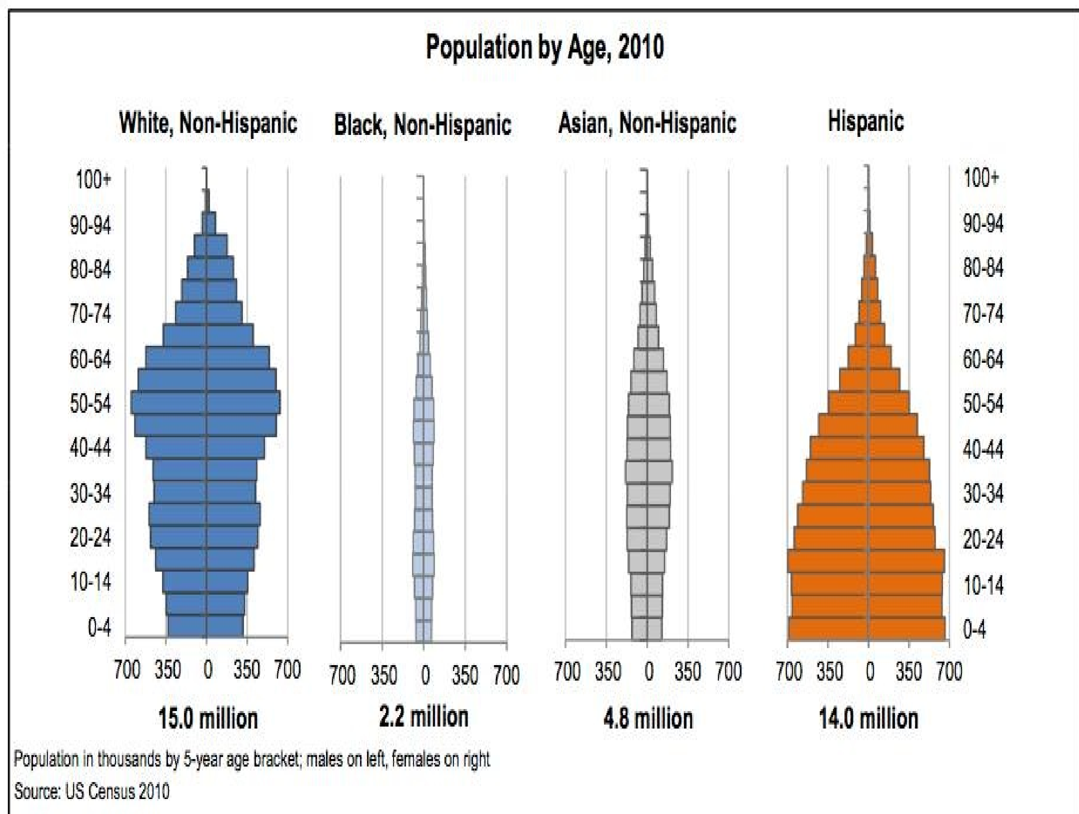
Significant Trends

- IHI Triple Aim
- Chronic disease management
- Readmissions & care transitions
- Realignment to managed care
  - Fee-for-service acute & primary care Medi-Cal, Medicare/Medi-Cal (dual eligibles)
  - Long term care / long term services and supports
- Uninsured / charitable care → Medi-Cal

"My teacher says little girls can grow up to be anything they choose! Why did you choose to be an old lady?"


Population by Age, 2010
White, Non-Hispanic
Black, Non-Hispanic
Asian, Non-Hispanic
Hispanic
100+
90-94
80-84
70-74
60-64
50-54
40-44
30-34
20-24
10-14
0-4
700 350 0 350 700
15.0 million
2.2 million
4.8 million
14.0 million
Population in thousands by 5-year age bracket; males on left, females on right
Source: US Census 2010
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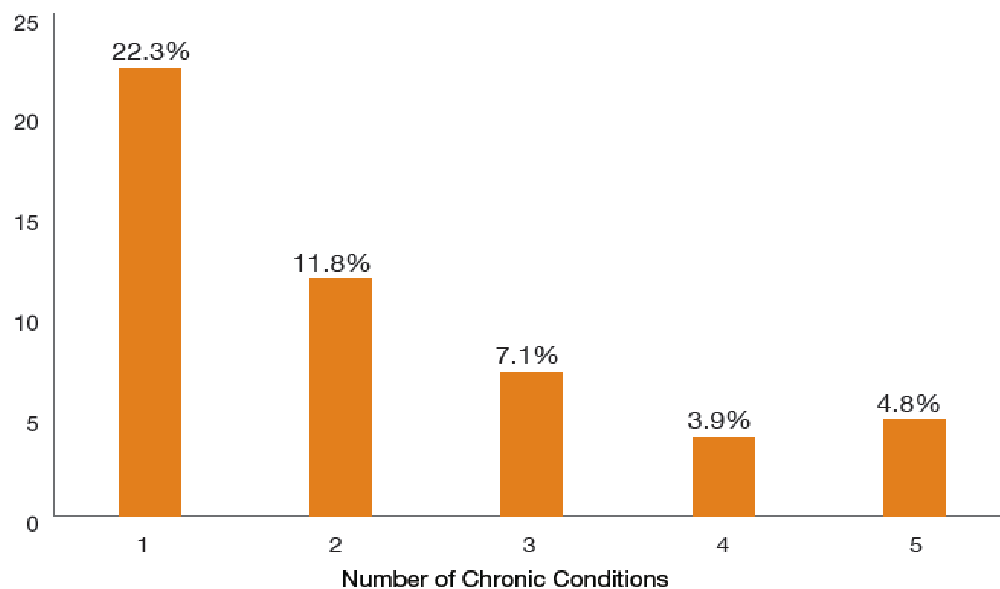
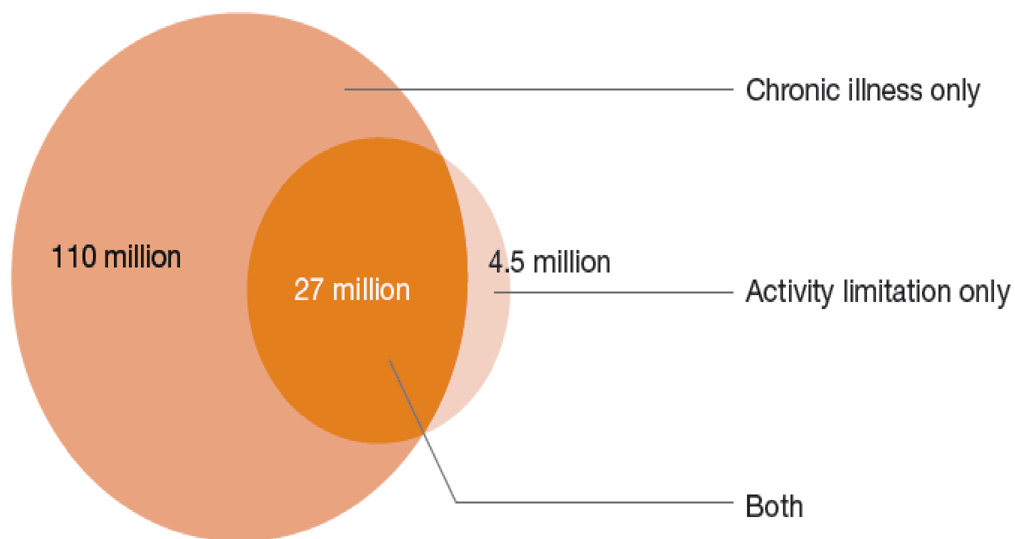
Over One in Four Americans Have Multiple Chronic Conditions



Source: Medical Expenditure Panel Survey, 2006

Extracted from: Chronic Care: Making the Case for Ongoing Care. Robert Wood Johnson Foundation, February, 2010.

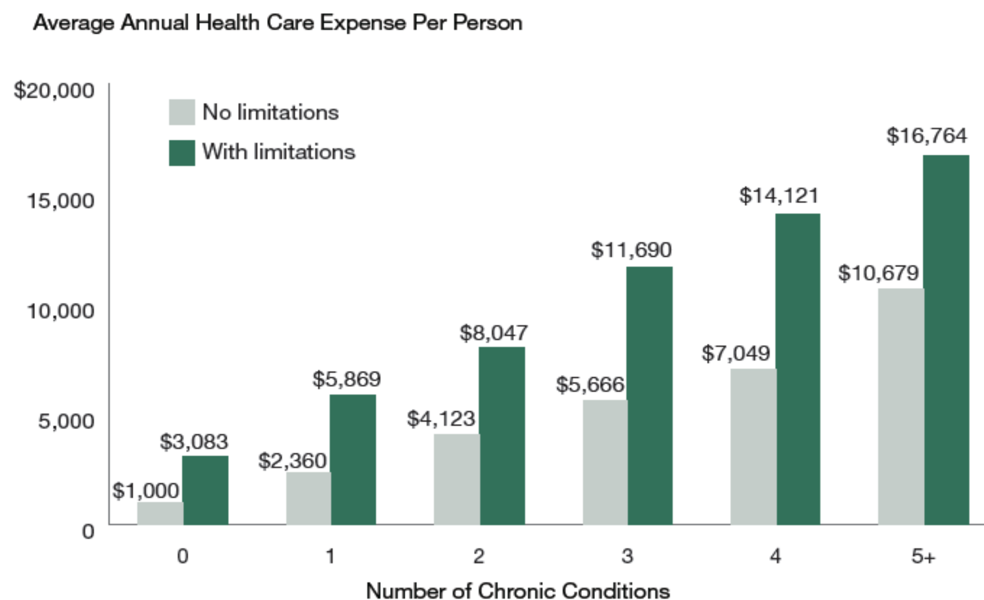
One-Fifth of Individuals With Chronic Illness Also Have Activity Limitations



Source: Medical Expenditure Panel Survey, 2006

Extracted from: Chronic Care: Making the Case for Ongoing Care. Robert Wood Johnson Foundation, February, 2010.

Health Care Spending Often Doubles for People With Chronic Illnesses and Activity Limitations



Source: Medical Expenditure Panel Survey, 2006

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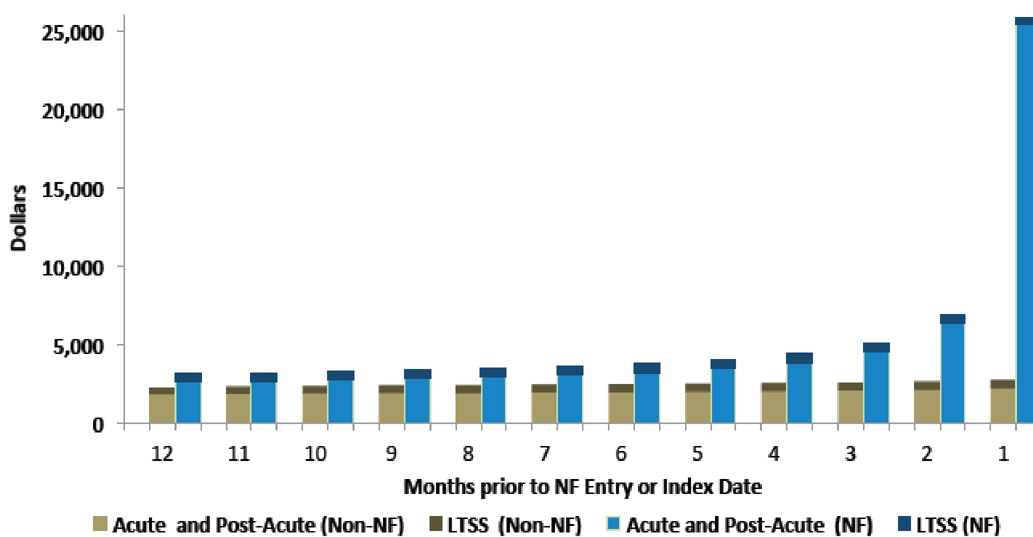
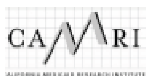
Average Medi-Cal and Medicare Expenditures for Dual Enrollees in 12 Months Prior to NF Admission





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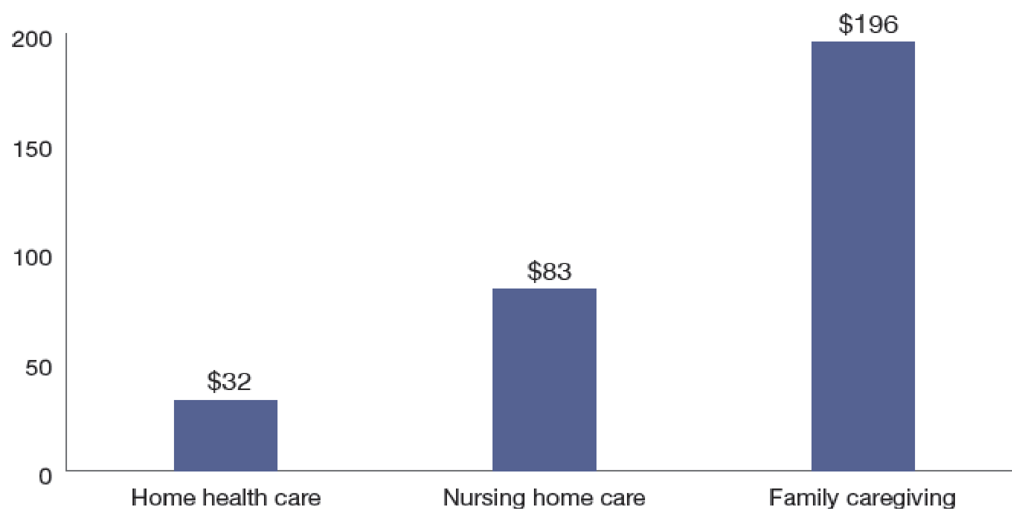
The Estimated Monetary Value of Family Caregiving Greatly Exceeds Spending on Formal Long-Term Care Services



Source: Arno, PS, Levine, C and Memmott, MM, "The Economic Value of Informal Caregiving," *Health Affairs,* 18: 2, March/April 1999.

Extracted from: Chronic Care: Making the Case for Ongoing Care. Robert Wood Johnson Foundation, February, 2010.

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Addressing Continuum of Care Needs

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Key Engagement Opportunities Across the Care Episode

Setting up a successful episode

1. Activate patient *(and caregiver)* early in episode of care

Reinforce self-management

2. Equip patient (*and caregiver*) with resources
3. Create feedback loops to address recovery complications

System control

Adapted from The Advisory Board Company. *Competing on Patient Engagement: Forging a New Competitive Identity for a Value-Driven Marketplace.* 2012.

Emerging & Best Practices

- Complex care management
- Care transitions initiatives
- Disease self-management programs
- Motivational interviewing
- Teach-back
- Patient activation
- In-home assessment—function, environment, psychosocial factors

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"What does work is the development of a personal, trusting, long-term, supportive coaching relationship—supported by sophisticated clinical support and information management capability"

~ Institute for Healthcare Improvement

Craig C, Eby D, Whittington J. Care Coordination Model—Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2011.

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Next Steps

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Considerations

- Analyze local factors
- Transcend acute care & medical settings
- Collaborate with high quality partners to address medical and social needs
- Target well
- Take a whole-person approach
- Remember the family caregiver
- Develop mechanisms for timely information sharing

Potential Measures of Success

- Increase in patient adherence to recommended care
- Decrease in avoidable emergency department and acute admissions, readmissions
- Increase in days spent in the community (non hospital, non nursing home)
- Increase in patient satisfaction

QUESTIONS /
DISCUSSION

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