CARING FOR PATIENTS AND THE VENTURA HOSPITAL TO HOME ALLIANCE

A Community Collaborative
In Person Centered Care

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Our Organization

History and Profile

- Community Memorial Hospital was established as a single hospital site in 1901
- Community Memorial Health System is the only community owned, independent, not-for-profit hospital organization in Ventura County, established in 2005 through the merger of Community Memorial Hospital and Ojai Valley Community Hospital
- The System also consists of a Skilled Nursing Facility, sixteen ambulatory clinics, four urgent care centers and three imaging centers
- Recent and Ongoing Construction
  - 338,000 square foot, 250- bed replacement facility Community Memorial Hospital, Parking Structures
  - Full renovation of 25-bed Critical Access Hospital Ojai Valley Community Hospital
  - 75-Bed Skilled Nursing Facility

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Community Memorial Health System
Where Excellence Begins with Caring
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Our Organization
- CMHS Hospitals
CMHS CFH Ambulatory Care Centers
CMHS Rural Health Clinics
CMHS Imaging/Diagnostic Centers
CMHS Skilled Nursing Facility
Urgent Care Centers
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Discussion Points

- Provide an overview of the Hospital to Home Alliance
- Explore care redesign that emphasizes referral partners rather than referral sources
- Highlight the role of person-centered care across the continuum and efforts thus far at integration within the Alliance

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CURRENT ALLIANCE MEMBERSHIP

- Three Health Systems (six hospitals)
- A Managed Care Organization
- Health Services Advisory Group
- Ten Home Health Agencies
- Seven Skilled Nursing Facilities
- A Large Multiservice CBO

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CHANGING DEMOGRAPHIC

- 1.85 million Californians age 60-64
  2.45 million by 2030 32% ⬆
- 607,000 Californians age 85+
  2.49 million by 2050 310% ⬆

Significantly higher rate of severe chronic health conditions + Greater functional limitations = More health and supportive services

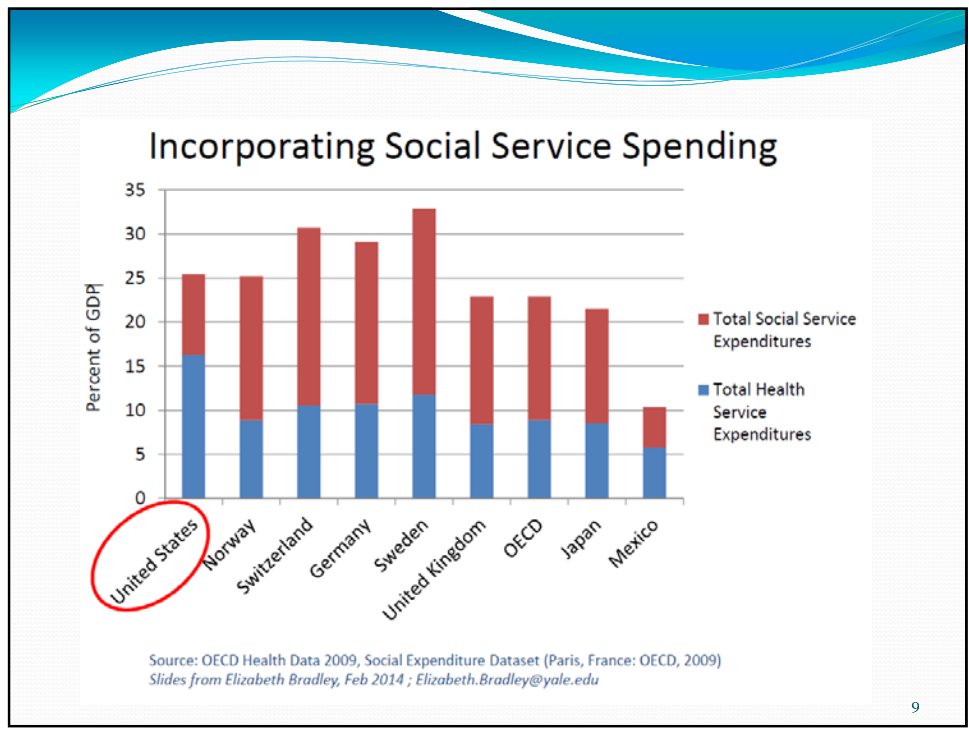
LACK OF INFASTRUCTURE

The impact of an aging population, described by some as an "age wave" and others as an "aging tsunami," will be felt in every aspect of society.

The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the State's tremendous population growth, which continues to challenge the State's overall infrastructure planning.

Demographers project that California's population, now nearly 38 million, could reach 51 million by 2050

California State Plan on Aging – 2013-2017



HEALTHCARE REFORM AND CHANGING REIMBURSEMENT

Value Based Purchasing

- Readmission Reduction
- Medicare Spending Per Beneficiary

Alternative Payment Programs

- ACOs
- Bundled Payments

Shared Risk Contracting and the need for Population Health Management

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TRANSITION BREAKDOWN

- Multiple providers and programs
- Poor communication and collaboration
- Fragmented and siloed care
- Redundant efforts
- Frustrated patients and families
- Less than desired outcomes

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ALLIANCE EVOLUTION

- Began in 2014 as a hospital driven effort in partnership with Health Services Advisory Group (HSAG) Readmission Reduction Program
- Participation was based upon a required scope of service and insurance contracts including Medi-Cal and a charity care program

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EVOLUTION CONTINUED

- Initial focus started with home health around a best practice homecare model and required data submissions
- CMHS sponsored the development of a web based data collection tool
- We began with over 50 agencies. By the end of the first year that number was reduced to 17 and ultimately to 10

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EVOLUTION CONTINUED

- A similar process was started separately with Skilled Nursing Facilities
- Emphasis with SNFs on returns to the hospital with a focus upon: tracking returns using a version of the tool developed for the home health agencies, length of stay and clinical competencies
- This group began with 15 and narrowed to 7 by the end of the first year

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PROCESS IMPROVEMENT EFFORTS HOME HEALTH

- **Enhancing The Role Of The Liaison**
- **Care Coordination**
- **Data**
- **Criteria for Good Standing**
- **Communications**
- **Strategic Planning**
- **Scan Foundation Grant**

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PROCESS IMPROVEMENT EFFORTS IN SKILLED NURSING

- **Data**
- **Competency**
- **Criteria For Good Standing**
- **Quarterly Community Quality Assessment**

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ALLIANCE OUTCOMES

All Cause Readmissions	CMH – HSAG HASAG REPORT Q3 2015 - Q2 2016	Alliance Members
Home Health	18.2	10.5
Skilled Nursing	16.8%	11.2%

Skilled Nursing Average Length of Stay	Medicare	Medicare Advantage
2014	31	22
2015	26	23
2016	20	18

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LESSONS LEARNED

- Collaboration is key – moving from a hospital dictated process to a collaborative built on trust partnership and shared accountability has produced results
- Social determinants of health need equal if not more of our attention
- **REFERRAL SOURCES NEED TO BECOME REFERRAL PARTNERS**
- Data is essential and continues to be a challenge

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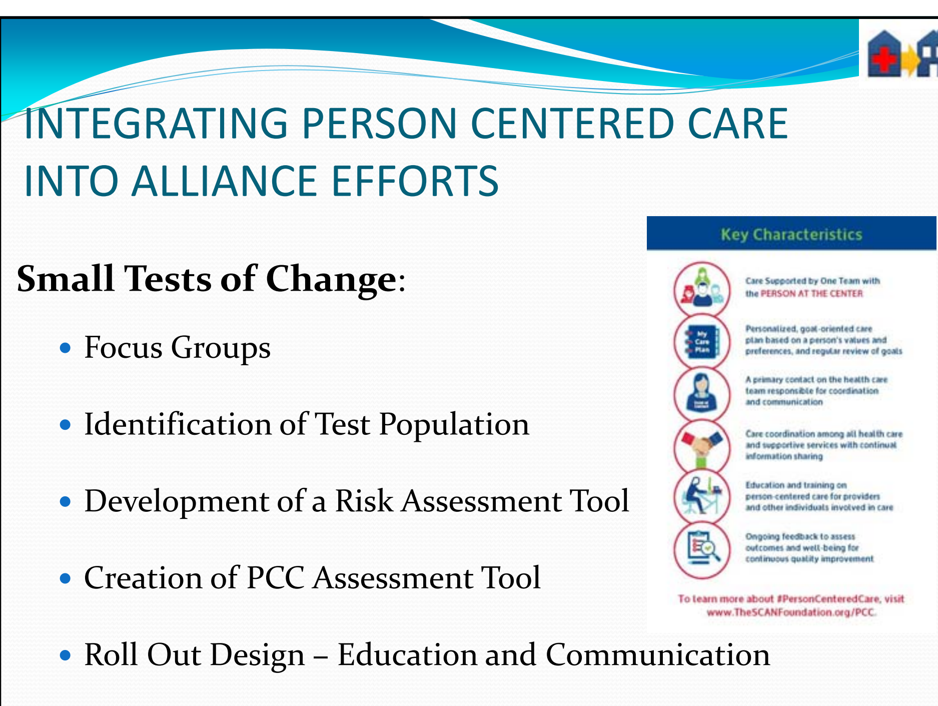
INTEGRATING PERSON CENTERED CARE INTO ALLIANCE EFFORTS
Small Tests of Change:
Focus Groups
Identification of Test Population
Development of a Risk Assessment Tool
Creation of PCC Assessment Tool
Roll Out Design – Education and Communication
Key Characteristics
Care Supported by One Team with the PERSON AT THE CENTER
Personalized, goal-oriented care plan based on a person's values and preferences, and regular review of goals
A primary contact on the health care team responsible for coordination and communication
Care coordination among all health care and supportive services with continual information sharing
Education and training on person-centered care for providers and other individuals involved in care
Ongoing feedback to assess outcomes and well-being for continuous quality improvement
To learn more about #PersonCenteredCare, visit www.TheSCANFoundation.org/PCC.
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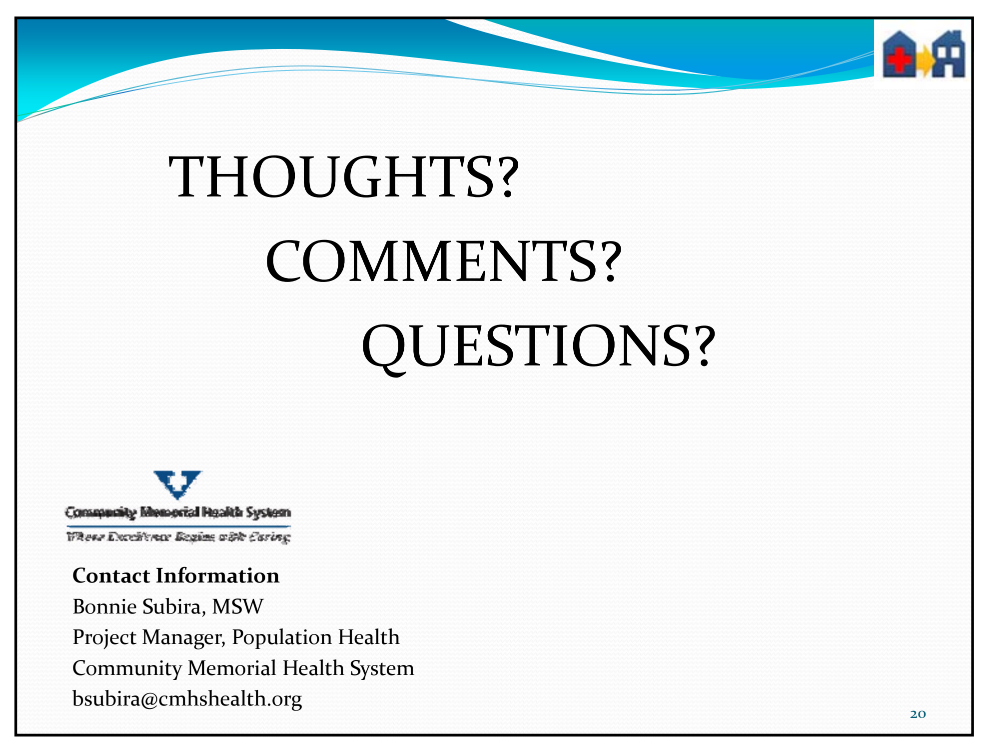
THOUGHTS?
COMMENTS?
QUESTIONS?
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